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Authors

Abdul-Khabir, Wajidah
Hall, Timothy
Swanson, Aimee-Noelle
et al.

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Intimate Partner Violence and Reproductive Health Among Methamphetamine-Using Women in Los Angeles: A Qualitative Pilot Study†

Wajidah Abdul-Khabir, B.S.[1], **Timothy Hall, M.D. Ph.D.**[2], **Aimee-Noelle Swanson, Ph.D.**[2], and **Steven Shoptaw, Ph.D.**[2,3]

[1]MS-IV, UCLA - School of Medicine, 10880 Wilshire Blvd , Los Angeles, California 90024, United States

[2]Timothy Hall, Clinical Instructor; Aimee-Noelle Swanson, Senior Administrative Analyst, Steven Shoptaw, Professor, UCLA - Family Medicine, 10880 Wilshire Blvd , Los Angeles, California 90024-4142, United States

[3]Professor, UCLA - Psychiatry & Biobehavioral Sciences, 760 Westwood Plaza , Los Angeles, California 90095, United States

Abstract

Among women, methamphetamine (meth) use has been associated with intimate partner violence (IPV); however, few studies have looked at the context of IPV. This qualitative pilot study explored the experiences of meth-using women in Los Angeles County regarding (1) IPV in their most recent primary relationship, (2) use of contraception and reproductive health services, and (3) meth use during pregnancy. Participants (n=30) were recruited through community advertising and at 3 addiction treatment centers to participate in 15–20 minute, semi-structured interviews recorded with handwritten transcripts. The team analyzed transcripts for key themes. Participants reported IPV (n=19, 63%) as recipients (50%), perpetrators (40%), and/or both (27%), occurring mainly during active meth use or withdrawal. While most (n=25) continued meth use during at least one pregnancy, some (n=5, 17%) identified pregnancy as a motivation to quit or reduce use, suggesting an opportunity for intervention. Though most women knew about free and low-cost reproductive health services, few accessed them, with 33% citing aspects of meth use itself as a barrier. One third (45/133) of reported pregnancies were terminated by abortion. Most women (67%) began using before age 18, suggesting need for screening and intervention among adolescents.

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Corresponding Author: Dr. Timothy Hall, UCLA - Family Medicine, 10880 Wilshire Blvd Los Angeles California 90024-4142, United States, T: 1-310-794-8296 F: 1-424-652-2213, tmhall@mednet.ucla.edu.

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The authors have no conflicts of interest to report.

Keywords

domestic violence; reproductive health services; prenatal care; contraception; methamphetamine

Methamphetamine (meth) use, abuse, and dependence are associated with many health problems, including domestic violence or intimate partner violence (IPV), risk behaviors for HIV and other sexually transmitted infections (STIs), and poor outcomes in pregnancy (Brecht et al. 2004, Degenhardt and Hall 2012). Although meth use has been more intensively studied among men, equal rates of meth use are now found among women in the United States (Brecht et al. 2004, Community Epidemiology Work Group 2012). However, women and men differ in both patterns of meth use and common comorbidities. For example, female meth users have more symptoms of depression and are more likely to report using meth for self-medication and weight-loss purposes (Semple, Grant, and Patterson 2005). Female meth users are also more likely to be exposed to injury and violence than their male counterparts (Boeri, Tyndall, and Woodall 2011).

This project was conceived as a qualitative pilot study of meth-using women's experiences with IPV and reproductive health concerns, given that both are frequently reported by women attending our team's addiction treatment and research clinics. In this study, we examine responses of women with current or recent self-reported meth addiction, using focused interviews regarding (1) their experiences of IPV, (2) use of contraception and reproductive health services, and (3) meth use during pregnancy.

Meth and Violence

Multiple studies have documented IPV among meth-using women (Busch-Armendariz et al. 2010), but few have looked at the circumstances under which that violence occurs (Cartier, Farabee, and Prendergast 2006). Almost no studies have investigated women as perpetrators of IPV in relation to meth use. Because female meth users report greater overlap in their intimate partners and drug network, they are more likely to report initiation of meth use by an intimate partner and more likely to share meth or needles with such a partner (Cheng et al. 2009). In one large treatment trial, 80% of 562 female participants with meth dependence reported abuse or violence at the hands of their partners; 40% experienced both physical and sexual abuse (Cohen et al. 2003). Battered women in other studies have described experiencing sexually controlling acts such as refusal by their partners to use condoms or other forms of contraception, which may partly account for high rates of HIV, other STIs, and unintended pregnancies among women with IPV (Campbell 2002). IPV also has long-term health consequences for its victims even after the physical abuse has ended, including a three-fold increase in risk of gynecological problems among female victims of IPV (Campbell 2002).

Meth and Reproductive Health

In addition to the effects potentially mediated by IPV, meth use has been strongly associated with risks for HIV and other STIs both among women and among men who have sex with men, often thought to be mediated by sexual disinhibition and/or trading of sex for meth

(Colfax and Shoptaw 2005, Semple, Grant, and Patterson 2005). Use of meth and other stimulants by pregnant women has been associated with low birthweight and premature delivery, and possibly with developmental and cognitive effects in infants (Terplan et al. 2009). Women who use meth access reproductive and other health care at lower rates than women who do not use (Boeri, Tyndall, and Woodall 2011); nonetheless, healthcare services offer a potential site for intervention around meth addiction.

Meth Use vs. Dependence vs. Addiction

Recent changes in diagnostic categories have emphasized the continuum and overlap between "substance abuse," "harmful use" and "substance dependence." DSM-V prefers "substance use disorders (SUD)" as an inclusive category (American Psychiatric Association 2013) while the American Society for Addiction Medicine uses "addiction." Details of the forthcoming ICD-11 criteria are not yet available, but at least in regard to alcohol use disorders, a recent review has found substantial diagnostic agreement between the new SUD/addiction diagnoses and the combined ICD-10 "harmful use" and "dependence" diagnoses (Bond et al. 2012). In our clinical experience in Los Angeles with persons seeking treatment for methamphetamine use disorders, the diagnostic distinction between abuse and dependence is rarely helpful —though there may be distinctions between very heavy (i.e., daily or nearly daily) users and less heavy users in response to medications (Shoptaw et al. 2008, Brensilver, Heinzerling, and Shoptaw 2013). Consequently, we use meth *use* and meth *addiction* interchangeably, except when referring to prior studies that focused on one or the other. The women who participated in our study all self-identified as having problematic use of methamphetamine, whether actively using or in early recovery.

METHODS

Design

We used community advertising and direct approach at three addiction treatment centers to recruit participants for semi-structured brief interviews (Cook and Campbell 1979). This purposive, non-random sampling is commonly used to obtain data on difficult-to-reach populations such as persons with SUD (Salganik and Heckathorn 2004). While this design limits inferences to a larger population, it is often the only feasible design for such elusive populations (Sudman, Sirken, and Cowan 1988). To determine sample size for this qualitative research, we used a rough guide in which samples above 20 interviewees are likely to find ideas or experiences that are prevalent among 10% of a sampled population (Onwuegbuzie and Leech 2007).

Participants

We originally intended to recruit women from the community who were actively using meth; however, only two women had responded after two weeks of advertising in community newspapers and flyers posted in several free clinics. We therefore contacted directors of several addiction treatment facilities in Los Angeles County. Three treatment centers gave us permission to post or hand out informational flyers and to address women before or after a group meeting. Women who expressed interest in participating were

directed to a private room in the facility where the interviewer (WAK) explained the nature of the study and completed informed consent procedures. We ultimately recruited 28 women who were in early recovery at 3 treatment facilities, and 2 actively-using women who responded to community-based advertising. We combined responses from the actively-using and in-treatment groups for analysis.

Recruitment and interviewing protocols were approved by the Institutional Review Board (IRB) at UCLA, which granted waiver of signed informed consent to ensure anonymity. Participants received a $10 gift card as compensation; based on our experience with this population in Los Angeles, this amount was deemed non-coercive.

Inclusion criteria: (1) Age 18–45; (2) self-report of meth use most days of the week, either currently or immediately prior to current treatment for meth addiction; (3) self-report of being sexually active within the last 6 months. *Exclusion criteria:* (1) biologically male (self-report); (2) unable or unwilling to participate in a brief interview in English.

Semi-Structured Interviews

The interviewer conducted a semi-structured interview, lasting 15–20 minutes, with each participant. Interviews took place in private rooms in our research clinic or at the centers where women were receiving treatment. To reduce concerns of potentially replicating traumatic power relationships, the interviewer was a young woman. The interview comprised sociodemographic items, and several free-response questions regarding the women's reproductive health histories (e.g., history of STIs, number of children, access to reproductive health services) and history of using meth. The women were also asked, "Describe your current or most recent primary relationship." If respondents did not spontaneously mention IPV, they were prompted, "Were there any violent experiences in the relationship?"

Handwritten notes were taken during the interviews and reviewed immediately afterwards for clarification (Emerson, Fretz, and Shaw 1995). Though the full transcript was not reviewed with respondents, they were asked to repeat and clarify responses if needed. This method of note-taking is common in qualitative research and is generally deemed appropriate for this type of investigation into narrative themes or cultural categories (Emerson, Fretz, and Shaw 1995, Jackson 2010, Quinn 2005, Briggs 1986). Additionally, respondents often feel more comfortable with handwritten notes than with audio recordings (DeWalt, DeWalt, and Wayland 1998). Quotations below are reproduced from the handwritten transcripts.

Data Coding and Analysis

Responses to the open-ended questions were analyzed for recurrent themes, using iterative comparison of data (Glaser and Strauss 1967, Quinn 2005). Three members of the research team coded segments of the interview data in parallel, using predefined codes based on the stem questions (e.g., demographic statuses; mention of IPV as perpetrator, victim, or both; named barriers to accessing reproductive health care). Other codes were developed for themes that occurred in multiple respondents' answers (e.g., "I used meth during a

pregnancy because I didn't know I was pregnant", "I kept using meth because I planned to have an abortion"). Coding was done by hand, with results tabulated in Microsoft Excel. The coders adopted a conservative approach to coding to assure consistency of coding after each iteration, with complete agreement in coding at the third iteration.

RESULTS

Three-quarters of the women self-identified as Hispanic (see Table 1); however, all were fluent in English and had no apparent difficulty in understanding the questions or expressing their answers. The women's mean age was 29.7 years (range 21–44). Most (n=19, 63%) had only high school education or less. Respondents had used meth for a mean of 10 years (median, 10 years; range, 1–28 years), with two-thirds having started meth use before age 18.

Intimate Partner Violence

Nineteen women (63%) reported instances of violence to themselves or inflicting violence on partners. Violent incidents followed two patterns of occurrence. Some described violent interactions, either directly related to impulsivity, irritability, and/or paranoia associated with active meth use. Irritability and frustration related to physiologic withdrawal also served as a predisposing factor. In all, 18 of the women volunteered descriptions of IPV that occurred mainly or only in the context of active use or "coming down" from meth, rather than from other features of meth use such as living in specific neighborhoods, the experience of trading sex for drugs, or financial stressors.

> *Respondent 12:* "When I'm using, especially when we come down, we're 'at each other's throats'—verbally. It doesn't get physical no more, but it used to be physical. I used to pull knives and end up in jail. I was out of control, in that state of mind."

Most of the women admitted to experiencing IPV; 12 (40%) had partners who abused them physically or by forced sexual encounters. However, 15 (50%) identified themselves as perpetrators of IPV; of these, eight women were both perpetrator and recipient of violence.

> *Respondent 3*: "We had major domestic violence issues, especially since I started using. For the first 15 years, he was the abuser. I had black eyes. The cops were called constantly. He did some time. Then in 2008 I became the abuser. I caught him cheating on me and beat him with a baseball bat. I wasn't under the influence when I did that, I actually stopped for a month and was going through the phase of not having the drug and wanting it so I was really mad that I had stopped using for him but he had been lying to me. If the drugs weren't on my mind, I probably wouldn't have taken a baseball bat to him."

> *Respondent 16*: "We've been together for 11 years, but I've been sexually active with more than one partner. We use drugs together…I use meth. He uses meth, but we try to keep it from each other and never use together. But we do drink alcohol and smoke pot together. When we're high, I'll hit him and attack him with objects. I'm the aggressor. He's more verbally abusive than physical. He calls me an

alcoholic and tells me degrading things about myself. He uses my kids against me. He talks badly of me to them."

Disruptive, erratic, or drug-seeking behavior could provoke conflicts with non-using partners, while paranoia and affective instability predisposed users to violence:

Respondent 2: "[Now our relationship is] good. I've been with him for a year. He's not a user. He's a recovering addict for about six years. He is supportive of me. He is working. We live okay…When I was using, he was mad at me and the choices I made. He was mad when I took off at night and he had to wait for me to come back. He would kick me out of the house. I hid the meth use for a while until he found out. Then we got into a lot of arguments. I would hit him. (He wouldn't hit me.) Meth makes you more violent—it messes up your mind. I would think he was cheating on me."

Violence in Same-Sex Relationships

Though we did not systematically assess for sexual orientation or sexual identity, four women described same-sex primary partners in response to queries about their most recent relationship; of these, three also reported a history of male sexual partners. Their rates of IPV and STIs did not differ from those of the women reporting only male partners. As one woman described violence within her relationship:

Respondent 9: "Five and a half months ago I was in a relationship with a female. She was also a meth user and mainly an alcoholic. She was an abuser long before she met me, and she had done past time. I was in the relationship for four years but for the first year and a half it was good…then we both relapsed. My addiction took me places she didn't understand. I prostitute to support my habit. Our arguments made her flashback because her mom was a prostitute and [was] killed when she was 29. When using she would get physical with me. I was the receiver."

Contraception and STIs

Most women (70%) reported no prior diagnosis of an STI. More than half (n=17) also reported accessing reproductive health care once a year or less often. When contraception was used, the most common forms were condoms (20%, n=6) and Depo-Provera® injection (17%, n=5). However, 27% (n=8) reported never using contraception or STI prophylaxis of any kind. All but five women reported barriers to using or accessing contraception, including male partners' dislike of condoms:

Respondent 27: "[My partner] says 'why do I need a condom…have you been f---ing around with someone?' So I wouldn't use it to avoid the fight."

Respondent 30: "[My partner] told me he didn't like condoms...he wouldn't give me the dope if I didn't listen to him."

Most of the women were familiar with free services such as Planned Parenthood and community free clinics. Nonetheless, about a third of respondents (n=9) identified insurance or other financial issues as a barrier to accessing services. The same number identified aspects of the meth addiction itself as a barrier to accessing reproductive health, including

the chaotic nature of their lives while using, focus on getting their next fix, or apathy about self-care.

> *Respondent 10:* "I was afraid they would find out I was getting high. I didn't want to find out I had something because that meant he [my partner] was cheating on me. I didn't see any signs of anything wrong. So why should I go? It's just taking time out of me getting high."

> *Respondent 25:* "Before meth: I would only use it to get abortions. Now I go 3–4 times a year…Using the meth and denial—I wasn't in touch—I was too busy getting high."

Meth Use During Pregnancy

All but one participant reported past pregnancies. In total, these 29 women reported 133 pregnancies (mean, 4.6; range, 1–8 pregnancies). Of these, 45 (33%) had been terminated by therapeutic abortion and 6 pregnancies by spontaneous miscarriage. Of the 29 women who had been pregnant at least once, 25 (85%) reported continuing to use during at least one pregnancy. Four women reported abstaining during a pregnancy because they were in jail, rehab, or another structured setting where they could not use meth. Six women reported continuing to use meth during pregnancies that they say, retrospectively, that they had planned to abort:

> *Respondent 21:* "The first one: I didn't [use] because I was at my Mom's house. The second one: yes, because I wasn't going to keep the kid. If I were to keep the kid, I would stop."

> *Respondent 25:* "For my daughter I didn't use because I was for sure going to keep her. For the abortions, I didn't want to have them [the children] because I was using and thought something was going to go wrong. For my son, I was thinking about abortion but I decided to have him. He tested positive for meth."

Five women reported being able to stop using methamphetamine after finding out they were pregnant for at least one pregnancy. Four women reported harm-reduction strategies: one used cocaine but not meth; one reduced meth use substantially; and two stopped meth but used marijuana:

> *Respondent 10:* "Yes [I used] with my son because I didn't find out till he was five months. I stopped using meth after that, but still smoked weed. With my daughter I stopped meth when I found out but not weed."

DISCUSSION

In this sample of 30 women who reported extensive histories of meth use, we found high rates of IPV, with meth-using women as both perpetrators and recipients of violence, often associated with periods of meth use or coming down from a high, in both heterosexual and same-sex relationships. Some of these women reported that the IPV was severe—at times resulting in police involvement and jail time for themselves or their partners. This highlights the importance of recognizing links between meth use and IPV among women, particularly with respect to reproductive health and sexual behaviors.

Respondents reported histories of little or no access to reproductive health throughout multiple—mostly unintended—pregnancies, little use of contraception, and one third of pregnancies terminated by abortion. Some barriers to reproductive health services, such as experience of negative and judgmental interactions with clinic staff, may be remediable with relatively straightforward staff training and messaging in the clinic. Others, such as the general disruptiveness of meth use to one's life or fears of repercussions from partners, present greater challenge in developing interventions. Stories about reproductive health and IPV among our sample of women reflect high-risk sexual activity. These findings accord with previous studies showing obstacles to contraception among women experiencing physical or other abuse by their primary partner, particularly obstacles to use of condoms (Campbell 2002, Sobo 1993).

Several women reported attempting to stop or decrease meth use, or to substitute marijuana as a harm-reduction strategy during pregnancy, in cases where they reported wanting to keep the pregnancy. Considering both their infrequent use of reproductive health services when not pregnant, and reported motivation to decrease meth use while pregnant, this suggests a window of opportunity for screening and intervention. The high proportion of pregnancies terminated by abortion also suggests a possible moment for intervention. Assessment of substance use among women seeking abortions may be indicated, along the lines of Screening, Brief Intervention, and Referral to Treatment (SBIRT) (Babor et al. 2007, Humeniuk et al. 2012). As a harm-reduction method, implementing routine counseling about longer-term contraceptive methods such as injectable or implantable forms may also be helpful for women who indicate possible meth or other stimulant use on screening.

Of the four respondents who reported a current or recent same-sex primary relationship, at least three had also had some prior experience with male sexual partners, and only the youngest of the four had never been pregnant. Our findings are consistent with other studies on sexual behavior and identity among lesbian and bisexual women (Diamond 2008). This underscores the importance of a comprehensive approach to women's reproductive health care: it is important for clinicians to appreciate how patients describe their sexual identity or orientation, without assuming that this entails or precludes any particular kinds of sexual behavior or types of sexual partners.

Limitations

The women who responded to this study were 87% Hispanic, as compared to 47.7% for Los Angeles County overall. The small sample size, low ethnic diversity, and retrospective nature of the study may limit generalizability. Despite this, all were fluent in English and had spent most or all of their lives in the United States. No cultural factors were reported during the interviews that raised suspicion for specifically "Hispanic" factors—whether religious, linguistic, or otherwise—in their meth use.

Given that most respondents were in early recovery, their answers may have been influenced by the narratives common to such recovery programs (Mattingly and Garro 2000), or it may be that women who self-select into recovery programs differ in some way from those who continue using. While our sample size was relatively large for a qualitative study of such a difficult-to-reach population, the interviews were brief and focused. A broader ethnographic

study of the women's social context of use, family and sexual relationships, and health care access; a systematic survey in treatment centers of women in recovery from meth; or interviews and surveys with young women in their teens could all substantially expand on the findings reported here.

Further Research

While the association of meth use with IPV is not new, there has been little recognition or investigation of the role of women as perpetrators of IPV. Therapeutic interventions for women seeking treatment for meth addiction should address concomitant issues regarding IPV. In particular, programs and healthcare providers should be aware of the frequency of IPV and of the possible role of women as perpetrators as well as potential victims. Additionally, IPV occurs in both heterosexual and same-sex relationships in the context of meth use. Our pilot data suggests that IPV occurs largely in the context of active meth use or withdrawal, more so than being due to general contextual factors such as poverty or violent neighborhoods. If intervening around meth use could be an effective intervention for IPV, it would have implications for optimal treatment and monitoring of IPV offenders, family reunification and child custody, and the urgency of providing addiction treatment to persons involved in IPV.

Our data signal a need for pregnancy prevention and reproductive health options among young women at risk for methamphetamine use, including overcoming current barriers to reproductive care. A significant challenge in our findings is that the disruptiveness of meth use itself may be the most important barrier—the need to obtain more meth, the exhaustion of withdrawal, the difficulty in tolerating lines in public clinics, and concerns for being judged or lectured by providers on their drug use. Moreover, as most of our respondents started using meth before age 18, findings indicate the value of investigating preventive strategies among women and girls at younger ages, such as educational programs in school or social settings, or SBIRT interventions in clinical settings (Babor et al. 2007, Humeniuk et al. 2012).

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Table 1

Demographic characteristics of study participants

Participant characteristics	*N*=30 (% or SD)
Mean age	29.7 (SD=5.7, range 21–44)
Race/Ethnicity	
Hispanic	22 (73%)
Caucasian	7 (23%)
Asian	1 (3%)
Education	
Some High School	13 (43.3%)
High School Graduate/GED	6 (20%)
Some College/Vocational training	11 (36.7%)
Age started using meth	
Under 14 years old	6 (20%)
14–18 years old	14(47%)
Older than 18	10(33%)
Health insurance	
No insurance	17(57%)
Medicaid	7 (23%)
Private insurance	6 (20%)
Access to reproductive health services	
2 or more times per year	13 (43%)
Once a year	6 (20%)
Less than once a year	7 (23%)
Never	4 (13%)
Barriers to reproductive health	
Money	9 (30%)
Addiction/general chaos	9 (30%)
No Barriers	5 (17%)
Reported lifetime STI diagnosis	9 (30%)