COVER STORY: TOUGH QUESTIONS

PHOTO: DEJAN/GETTY IMAGES
“HE’S BEEN HIDING MY MEDICINE”

HOW CAN WE HELP SURVIVORS OF INTIMATE PARTNER ABUSE?  |  BY ELAINE VITONE

Yeats ago, a woman in her 50s came into her doctor’s office with diabetes and high blood pressure. Her eager young physician wrote out prescriptions for both, took steps to ensure that these injections and pills were affordable for the patient, and dutifully upped the doses over time as these problems persisted. Still, months and years passed, and the patient’s blood pressure and glucose continued to soar wildly out of control.

Then one day as the physician, Elizabeth Miller, was scratching her head at the chart again, she looked up at the patient and said, “I just can’t understand what I’m doing wrong. I can’t seem to help get this under control.”

Then, she paused.

The woman on the exam table hesitated. “I’m not sure how to tell you this. He’s been throwing my medicines away.” And out tumbled a devastating story of brutality and humiliation at the hands of her husband, for years.

In the clinic, abusive relationships, now known as intimate partner violence (IPV), can take on a number of unexpected guises, Miller says. Not following medical advice—nonadherence, as doctors call it—is just one. She’s come to see nonadherence as a possible red flag. Because many times, abuse survivors (usually women) are absolutely on board to follow their doctors’ orders. But their partners are trashing their pills. Or sabotaging the car on the day of their appointment. Or threatening violence if they go.

One in three women in the United States has experienced physical or sexual violence from a partner at some point in her lifetime. That number doesn’t even include nonphysical forms of IPV, like controlling behavior or emotional abuse.

All forms of IPV can have devastating effects on health, both in the short-term and the long haul. Survivors have much higher rates of depression, anxiety, post-traumatic stress, substance abuse and disordered eating. They have more unintended pregnancies and sexually transmitted infections, including HIV.
They're more likely to develop chronic pain and autoimmune disorders. And, as in the case of the woman from Miller's story, survivors often have little control over how well they manage whatever chronic health conditions they may face.

In 2011, Miller, a pediatrician who specializes in adolescent medicine, came to the University of Pittsburgh, joining one of her scholarly heroes—Judy Chang, an ob/gyn who studies doctor-patient communication in obstetric care. Miller is the director of Adolescent and Young Adult Medicine at UPMC Children's Hospital of Pittsburgh and a Pitt professor of pediatrics, of public health and of clinical and translational science. Chang is an associate professor of obstetrics, gynecology and reproductive sciences and of medicine. Between them, they have several decades of experience as women's health care providers and community advocates, as well as researchers investigating how social situations affect women's health.

Recently, we sat down with these two Pitt experts to discuss how we can better help survivors. They explained that physicians are extremely well positioned for this; the clinic can serve as a safe, accessible and confidential hub for information and support. And yet, Chang and Miller have found that the standard way doctors are trained to broach the subject of intimate partner violence (i.e., Do you feel safe in your relationship?) is missing the mark. The pair have devised a new strategy that they've shown to be effective at preventing women from falling through the cracks.

The following has been edited for brevity and clarity. For the full discussion, listen to our Pitt Medcast episode at pittmed.health.pitt.edu/pitt-medcast.

First, let's define some terms. What is intimate partner violence?

**Judy Chang:** Essentially it’s whenever there is [or is the threat of] either physical or sexual violence being perpetrated from one partner to another, or people being controlled and dominated and afraid to essentially make their own decisions and live their own free will.

**Elizabeth Miller:** There is still a common assumption it’s only about broken bones and bruises, when in fact so much of it is the emotional, the controlling behaviors—the sexual violence, things that happen in the bedroom; the coercion, the financial dependence, threats of taking the children away. All kinds of emotional and psychological abuse.

And, until relatively recently, health care providers had not even acknowledged the extent to which abusive partners can interfere with accessing care, can interfere with use of medication and adherence to medication, and even use substances—including opioids—as a way to control their partner.

**JC:** There is a new phenomenon sometimes called cyber abuse or cyberstalking. That can involve different technologies that track where people are, monitor their interactions. And in terms of social media, the threats of posting things that would be psychologically, professionally or socially detrimental.

**EM:** In one of our studies, we surveyed adolescents who were seeking care in confidential teen clinics. Over 40%, both boys and girls, reported experiences of cyber dating abuse in the last three months. Among the projects that we’ve been working on is: How do you help parents, adult allies, health care providers to actually talk to young people about healthy ways to use social media?

**Dr. Miller, you were the first to identify and quantify what’s now known in medical literature as reproductive coercion. Can you define it for me?**

**EM:** Reproductive coercion is a constellation of behaviors, often in the context of heterosexual, sexual relationships, where a male partner will explicitly attempt to impregnate his female partner against her wishes. In a study where I interviewed close to 60 young women with histories of being in abusive relationships, about a quarter described these kinds of phenomenon: flushing birth control pills, preventing her from getting to the clinic on time for her Depo-Provera injection, removing the birth control patch, pulling out her vaginal ring, breaking the condom, putting holes in the condom, removing the condom during sex and the like.

There were also stories along the lines of, Honey, we’re going to make beautiful babies together—pregnancy pressure—as well as threats to leave the relationship if she didn’t get pregnant.

We have shown that reproductive coercion is associated with other forms of intimate partner violence.

Often, women, and especially adolescents, do not necessarily recognize reproductive coercion as abusive behavior. Well, he’s never put his hands on me [violently]. And yet when I talk about it with my patients, inevitably they’ll lean in and say, That’s what’s going on for me, too. It is definitely a phenomenon that we need to be talking more about, making sure that young people are aware of and understand the strategies to prevent pregnancies that they don’t want. We can offer contraceptive options that a partner can’t interfere with, including the intrauterine device, and offering emergency contraception that she can take along with her, for example.

**About 30 to 35% of women who are murdered, what are some common misconceptions among clinicians about intimate partner violence?**

**JC:** The biggest one is the focus on leaving. The assumption that if they really wanted to address the violence, that leaving would be the answer. And I can’t completely blame people for thinking that way, because it seems logical. The challenge is that it’s not always the safest thing.

About 30 to 35% of women who are murdered, are murdered by either a current or former intimate partner. There’s a high correlation between breaking up, filing for divorce, kicking the person out—essentially anything that ends the relationship—with the possibility of a homicidal attack. We can’t take that lightly.

It’s also not always feasible. There may be issues that person is dealing with financially, socially. Obligations to children and other family members, connections with community and other things that one might rely on. As well as the
very real issue of being in love with that person who is likely not always behaving in this way.

Dr. Chang, you’ve studied what motivates women to disclose their partners’ abuse and seek help from their health care providers. What have you learned?

JC: What was eye-opening to me was that these women said that even if we asked in the best possible way, and we were the nicest person ever, they still might not be ready to disclose.

It’s just hard. It’s scary. They may not have said it out loud to even themselves before. So what they wanted us to recognize is to have patience, but to also give them the information and resources and support without requiring the disclosure. To not keep all of that information hostage to the “yes” answer, but, instead, make it freely available, so that when they’re actually ready—to make a change, do something, tell somebody—that they have those resources.

That was an Ahh! moment for me, because I was trained in the preventive medicine model of screening, testing, diagnosis and referral or treatment. And that didn’t fit in there.

So now, we have a new concept: Maybe I don’t need to know the “diagnosis.” Maybe the patient actually needs to know that she can make her own reductions in experiences of abuse.

JC: I think a lot of health care providers sigh and say, “Yet another thing.” Right? And the common reason why they will not add another guideline, requirement, screening topic, et cetera, that we hear is the time issue.

And it’s very interesting, because it doesn’t take that much time to say what Liz just said. Compare that to not knowing why the blood pressure is not getting under control. Trying to figure out why this birth control method is not being used over and over and over again. Compare it to that, and really, where is the most effective use of your time?

If the usual preventive medicine paradigm—screen, test, diagnose and treat—doesn’t fit, what does? How can physicians reframe their thinking?

EM: We can move away from that goal of I have to get a disclosure, and I need to then get them out of this relationship—that sort of rescue fantasy—and move toward increasing awareness, building a relationship, being part of our patient’s support network and then doing what we can to empower them. Or to partner with them and be part of their solution.

JC: I think oftentimes we feel the responsi-

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