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Motivating Reasons for Leaving a Violent Relationship, Drug Use, and Transactional Sex: A Qualitative Study among HIV High-Risk African American Women

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An abstract of
A thesis submitted to the Faculty of the
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Abstract

Motivating Reasons for Leaving a Violent Relationship, Drug Use, and Transactional Sex: A Qualitative Study among HIV High-Risk African American Women

By Naomi S. David

Background: Human immunodeficiency virus (HIV) is a growing epidemic in the southern U.S., and African American women are disproportionally affected. Intimate partner violence (IPV), drug use, and transactional sex are each significant risk factors for HIV acquisition. Women experiencing IPV, drug use, and transactional sex simultaneously may have a compounded risk for contracting HIV. Furthermore, IPV, drug use, and transactional sex are interrelated and may increase the occurrence of one another. More research on the syndemic relationships of IPV, drug use, and transactional sex is needed to help with HIV prevention efforts in this high-risk, difficult-to-access population.

Objectives: To understand more about how and why women decide to leave IPV, and terminate drug use and transactional sex, this study explored the commonalities of motivating reasons women leave/terminate each, and the barriers encountered in doing so.

Methods: In-depth interviews were conducted with 14 women who had experienced IPV in the previous 12 months, and used drugs and/or engaged in transactional sex in the previous five years.

Results: Women reported a range of motivating reasons for leaving IPV, drug use, and transactional sex. There were some overlapping themes across each domain, which included *children*, *physical health and safety*, and *life dissatisfaction*. Financial insecurity and dependence were common barriers to leaving all three.

Discussion: Women may have varying motivating reasons for deciding to leave IPV, drug use, and transactional sex, but future research can further explore the themes of children, physical health and safety, and life dissatisfaction. Future HIV prevention interventions among women experiencing each domain may want to integrate an economic component that promotes financial security and independence for women.

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Finally, I would like to express my deepest gratitude to the women I interviewed. Thank you for sharing your personal experiences, and giving me insight into your impressive strength and amazing capacity for resilience.

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Chapter One: Introduction

Epidemic of HIV among African American Women

In the Southern United States, African-American women are disproportionately infected with Human Immunodeficiency Virus (HIV) [1, 2]. African American women represent 13% of the U.S. female population, yet account for 64% of new HIV infections [2]. Additionally, the rate of new HIV infections among African American women in the U.S. is estimated to be twenty times higher than new infections among White women [2]. Most HIV in U.S. women is acquired via heterosexual contact, and research has identified multiple risk factors that may contribute to racial disparities in heterosexual HIV transmission. Some of these factors include higher STI prevalence in the African American population, HIV stigma and discrimination, and socioeconomic inequalities [3].

Additionally, intimate partner violence (IPV), drug use, and transactional sex serve as significant risk factors for HIV among American women as a whole [4-6]. These three factors greatly increase a woman's risk of contracting HIV via heterosexual contact, and have compounded risks for women experiencing more than one of these [7].

HIV Risk among Women Experiencing IPV, Drugs, and Transactional Sex

IPV and HIV Risk

Women who experience IPV incur a higher risk of various mental and physical health disorders, including HIV [6]. The increased HIV risk has been associated with several behavioral risk factors, such as engagement in riskier sex and drug use. Riskier sex includes condomless sex, which may be more likely in a violent relationship in which the ability to negotiate condom use may be hindered for a woman. Women who report IPV

are also more likely to report a higher number of lifetime sexual partners, drug use, transactional sex, and sex with partners who are more likely to use drugs, or to have an STI [8]. Additionally, women who have experienced IPV incur increased HIV risk as a result of delaying or neglecting routine sexual health care. IPV survivors reporting more HIV high-risk behaviors may be paradoxically less likely to seek HIV testing [9]. Neglecting medical care can lead to increased HIV risk due to untreated STIs, which increase physiological susceptibility to HIV transmission and infection [10].

Drug Use and Sexual HIV Risk

A relationship between drug use and sexual HIV transmission has long been acknowledged in HIV research. Drug users, particularly crack/cocaine users, are more likely to engage in risky sexual behaviors, which in turn increase their risk for HIV transmission via heterosexual contact [4]. Some of these risky sexual behaviors include condomless sexual intercourse, and intercourse with multiple partners. This increase in sexual risk behaviors is likely motivated in part by crack/cocaine use because of the associated euphoric high and resultant impaired judgment. Some crack/cocaine users may not accurately assess a sexual behavior as risky while high, or may be more impulsive with their decisions [11].

Transactional Sex and Sexual HIV Risk

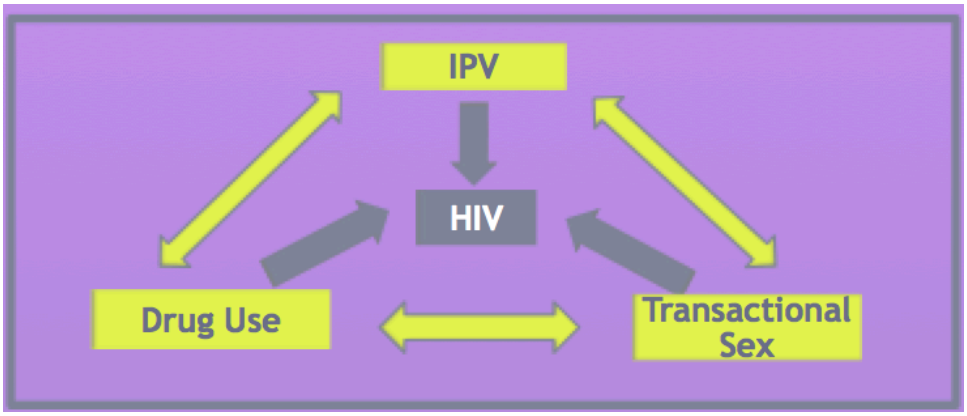
Transactional sex, which encompasses the trading or selling of sex in exchange for money, drugs, food, shelter, or any other commodity, is associated with a greatly increased HIV risk [5]. This increased risk occurs in women who identify as a commercial sex worker, as well as women who do not identify as such, but engage in transactional sex. Women engaging in transactional sex are at an increased risk for STIs

and HIV. Just as is true for women experiencing violence and using drugs, women engaging in transactional sex may not consistently use condoms during transactional sex. Women engaging in transactional sex may not always be able to utilize a condom during sex given their relative lack of power in this setting[5, 12]. Another factor increasing HIV risk among women engaging in transactional sex is their decreased likelihood of seeking care regarding their sexual health out of concern for being questioned about their sexual behaviors, or being stigmatized [13]. Additionally, a diagnosis or treatment for an STI may result in a temporary loss of income for a sex worker [13].

Syndemic Relationship of IPV, Drugs, and Transactional Sex

As previously outlined, IPV, drug use, and transactional sex are each associated with increased risk of HIV, but for those that engage in these behaviors simultaneously, the risk of acquiring HIV may be compounded. This combination of risk factors have syndemic relationships, meaning that together they produce an interaction that increases the risk for a negative health effect, such as HIV acquisition [14, 15]. Furthermore, these three factors are interrelated, and may promote the occurrence of each other (*see Figure 1 below).*

Figure 1:Associations between IPV, Drug Use, Transactional Sex, and HIV



In some cases, drug use leads directly to transactional sex because selling sex may be a means to financially support one's desire for drugs [16]. Drugs, such as crack cocaine, are highly addictive and may lead an addict to engage in riskier behavior than typical in order to secure the next high. Engaging in transactional sex for drugs, or money for drugs, is sometimes the only viable option for women who do not have the financial means to support a desire for drugs. Additionally, women abusing drugs may have unstable living situations, which can lead to decisions to engage in transactional sex for shelter, food, or other needs [17-19]

An association between transactional sex and IPV has been supported through various research studies. One study assessing the prevalence of partner violence among commercial sex workers found that 73% of participants had experienced physical or sexual abuse from intimate partners (non-commercial) in their lifetime. In the past year, 20% had experienced physical abuse, 8.9% had experienced sexual abuse, and 22.2% had experienced both physical and sexual abuse [20]. Additionally, violent relationships have been associated with financial instability, which may lead women to engage in transactional sex as a viable method to support themselves [19].

Lastly, research has demonstrated a reciprocal relationship between IPV and drug use. Female drug users in the U.S. have a much higher prevalence of IPV than non-drug users, and studies have highlighted several high-risk behaviors among drug users that increase risk of IPV [21]. Some of these behaviors include supplying drugs or sharing drugs with a partner, and involvement with buying, selling, or obtaining drugs [17, 22]. It is also suggested that crack/cocaine may increase a woman's verbal aggression towards an intimate partner, which could lead to a violent or negative response [23]. In turn, drug

use can be utilized as a coping mechanism for women experiencing abuse, or other stressors resulting from a violent relationship [24]. Research suggests that the more severe the abuse in a relationship, the more likely a woman is to engage in negative health behaviors, including drug use and drinking alcohol in excess [24].

Research Question

To better understand methods to mitigate HIV risk among women experiencing a violent relationship, using drugs, and engaging in transactional sex, this study explored the motivating reasons women that help women to leave or terminate each of these three high-risk situations. The study also examined barriers women had faced when attempting to leave each, and summarized traumatic life events for each participant.

The following research questions were explored:

- What are the motivating reasons for leaving a violent relationship and terminating drug use and/or engagement in transactional sex?
- What are the barriers to leaving a violent relationship and the barriers encountered when terminating drug use or engagement in transactional sex?

Study Purpose and Significance

These questions intended to investigate the parallels women may have in their decisions to leave a violent relationship, and terminate drug use and/or engagement in transactional sex. Additionally, information about barriers encountered and previous life events allows for a more comprehensive understanding of the syndemic relationship of IPV, drug use, and transactional sex, and how it compounds HIV risk. This study provided a unique opportunity to obtain elaborate, qualitative data with this hard-to-reach population, and may provide future researchers with a foundation to further HIV prevention efforts for

them. Identifying common barriers and motivations among these three factors could potentially lead to a more targeted intervention in this population.

To date, limited research has been conducted with HIV-negative women who have experienced IPV, drug use, and transactional sex, and to my knowledge, no other study has conducted in-depth interviews with women who have exposure to all three.

Chapter Two: Comprehensive Literature Review

Overview

The following literature review seeks to examine the HIV epidemic among African American women in the United States, as well as the syndemic relationship between human immunodeficiency virus (HIV), intimate partner violence, (IVP), drug use, and transactional sex. Literature examining HIV and the previously mentioned factors is summarized, and gaps in the literature are identified. This chapter concludes with an introduction of the current thesis study, and the significance of this project.

Literature Review Contents:

8. Multi-Faceted HIV Interventions for Women
9. Gap in Literature

1. Introduction

In the Southern United States, African-American women are disproportionately infected with Human Immunodeficiency Virus (HIV)[1, 2]. African American women represent 13% of the U.S. female population, yet account for 64% of new HIV infections [2]. The rate of new HIV infections among African American women in the U.S. is estimated to be twenty times higher than new infections among White women [2]. Additionally, as of 2007, 66% of women being treated for acquired immunodeficiency syndrome (AIDS) were African American [2]. The reasons for these disparities are incompletely elucidated, however, existing research suggests several factors to explain why African American women, particularly those living in the Southern U.S., are more vulnerable to HIV. Some of these factors include STI prevalence among the African American population, cultural issues such as stigma and discrimination, socioeconomic concerns, and a disproportionate prevalence of other HIV risk factors, including drug use, transactional sex, and intimate partner violence. The following literature review will focus on the HIV epidemic among African American women, and the syndemic roles that drug use, transactional sex, and intimate partner violence play. Additionally, previous research studies investigating the motivating reasons for deciding to terminate a violent relationship, drug use, and transactional sex will be explored.

2. African American Women and HIV Vulnerability

A lack of routine STI/HIV testing may result in a delayed knowledge of HIV status, for which early detection and treatment is advantageous [25]. In 2011, 73,600 HIV-positive

African American men and women were unaware of their HIV status [26]. Research indicates that African American women are less likely to know their HIV status compared to White women [26]. This late diagnosis can increase risk for sexual partners and contribute to continued unintentional sexual transmission of HIV in African American sexual networks. African Americans may be less likely to seek testing due to socioeconomic and cultural factors, such as poverty and sexual health stigma [3].Additionally, African American women have higher rates of Chlamydia and Gonorrhea compared to other racial groups, which leads to an increased physiological susceptibility to HIV transmission and infection when untreated [27].

Americans as a whole experience a pronounced stigma regarding sexual risk behaviors. This stigma surrounding sex and STIs may potentially deter women from seeking STI and HIV testing, or from honestly reporting high-risk sexual behaviors to their health care providers [3]. One study found that higher levels of perceived HIV stigma were associated with a decreased disclosure of a positive status among African American women [28]. Furthermore, one study found that African American were less likely to disclose a positive HIV status compared to White men, which perpetuates heterosexual transmission in this sexual network [29].

The increased HIV risk incurred by African American women may begin as early as childhood. It is estimated that 40% of African American women experience coercive sexual contact before age eighteen, yet only a small portion of African American women report a rape (6%) [30, 31]. Additionally, research recognizes links between childhood abuse, and an adult prevalence of drug use, riskier sexual behaviors, and intimate partner

violence, which have all been linked to increased HIV risk, as this literature review will later discuss.

It is important to note that the epidemic of HIV in African American women is concentrated in the southern U.S. This region experiences disproportionately higher rates of HIV diagnoses and AIDS related deaths compared to the rest of the country [32]. States in this region also exhibit higher rates of poverty, sexually transmitted diseases (STDs), more stigma surrounding HIV, and negative health outcomes for individuals living with HIV, which may all contribute to this regional disparity in HIV incidence [32].

Nine southern states in particular have been recognized by the Centers for Disease Control and Prevention (CDC) to target for reducing HIV transmission, and surveillance data has concluded that women and African Americans experience higher rates of HIV diagnoses in this southern region [32]. Additionally, these nine states have a higher percentage of HIV transmission from heterosexual contact, with higher rates of HIV-related deaths for women (compared to males) and African Americans (compared to other racial groups) [32].

3. Drug Use and Sexual HIV Risk

A relationship between drug use and heterosexual HIV transmission has long been acknowledged. Drug users, particularly crack/cocaine users, are more likely to engage in risky sexual behaviors, which increases their risk for HIV transmission [4]. Some of these risky sexual behaviors include condomless sexual intercourse, and intercourse with multiple partners. Research suggests that this increase in sexual risk behaviors may be motivated by crack/cocaine use because of the associated euphoric high from using.

Some users may not accurately assess a sexual behavior as risky while high, or may be more impulsive with their decisions [11].

4. Transactional Sex and HIV Risk

Transactional sex, which encompasses the trading or selling of sex in exchange for money, drugs, food, shelter, or any other commodity, is associated with a greatly increased HIV risk [5]. Women engaging in transactional sex may do so at varying degrees of involvement, and there are multiple classifications of transactional sex recognized in literature. Survival sex is a term designated for individuals who trade sex for survival necessities, such as food or shelter. Individuals engaging in survival sex may often be homeless or unemployed. In turn, commercial sex may be a more formal selling of sex for money and often involves a third party to negotiate terms of selling, and to operate finances [33]. Women engaging in transactional sex, at all levels are at an increased risk for STIs and HIV. There are several other factors involved with transactional sex that may mitigate or enhance an individual's risk.

Utilizing a male latex condom correctly when engaging in transactional sex greatly reduces the risk of HIV or STI transmission [34]. However, research studies indicate that condoms are often not consistently used during transactional sex, and that the decision to do so may not necessarily be in the power of the woman selling [5]. In some transactions, the buyer may hold all the power in the negotiation, and pressure the seller to forgo the use of a condom [5, 12]. Additionally, women regularly selling sex may be deterred from using condoms, despite the known sexual health risks associated with condomless sex. One research study concluded that some sex workers in the United States feared carrying condoms due to the concern that carrying condoms could result in

their arrest for prostitution. The women interviewed also reported that this fear of carrying condoms led to a decrease in their carrying condoms, which sometimes resulted in condomless sex with a client [35].

Another factor increasing HIV risk among women engaging in transactional sex is their decreased likelihood of seeking sexual healthcare. Women engaging in transactional sex may be deterred from seeking STI and HIV testing because of concern for being questioned about their sexual behaviors, or being stigmatized. Additionally, a diagnosis or treatment for an STI may result in a temporary loss of income for a sex worker [13].

Regarding the prevalence of transactional sex among African American women, one study administering randomized phone surveys to 1,371 African American and White women investigated financial motivations of transactional sex, and subsequent risky sexual behaviors. The study found that 13.1% of African American women interviewed reported engaging in transactional sex with someone who was not a regular partner (compared to 2.9% of White women). The survey responses also indicated that engaging in transactional sex is associated with a lack of education, financial instability, a need to care for dependents, and increased STI risk. Furthermore, remaining in a sexual relationship for the financial benefits was associated with reduced condom use, and concurrent sexual relationships [36]. This study demonstrates some of the complex interactions surrounding transactional sex, financial stability, familial responsibilities, and safer sex practices.

5. Intimate Partner Violence and HIV Risk

As of 2010, it is estimated that 35.6% of women have experienced sexual or physical violence in their lifetime, and 48% have experienced psychological aggression from a

partner [37]. Additionally, 22% of African American women have experienced a rape from an intimate partner in their lifetime [37]. Women who experience intimate partner violence (IPV) incur a higher risk of various physical and mental health disorders, including HIV [6]. The increased HIV risk has been attributed to various sexual and social behavioral risk factors, such as riskier sex and drug use.

Similar to women engaging in transactional sex, the ability to negotiate condom use may be hindered for a woman in a violent relationship. Compared to women without a history of IPV, women who have experienced sexual violence report being more fearful of negotiating condom use with a partner, and use condoms less frequently [6]. Another study found that women who had experienced a physically violent relationship as an adult were 80% less likely to report consistent condom use after receiving two safe sex counseling sessions, compared to women who had not experienced a physically abusive relationship [38]. Other riskier sexual behaviors associated with IPV include a higher number of lifetime sexual partners, drug use, transactional sex, and sex with partners who are more likely to use drugs, or have an STI [8].

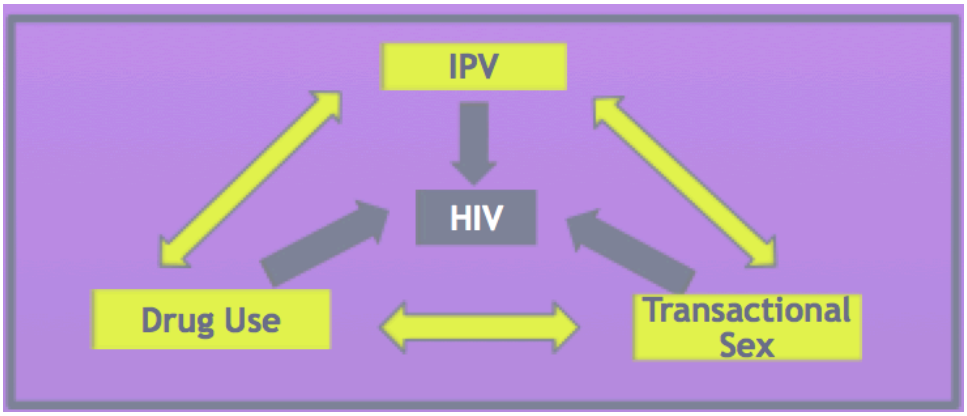
There is an additional sexual health risk for IPV survivors, in that they are more likely to delay or neglect routine health care. IPV survivors reporting more HIV high-risk behaviors were less likely to have been tested for HIV, despite a greater risk and higher estimated prevalence of HIV relative to women not experiencing IPV [9].

6. Syndemic Relationship of Drug Use, Transactional Sex, and IPV

In addition to drug use, transactional sex, and IPV all being independently associated with higher risk of HIV, these three behaviors are also associated with one another due to various risk factors, motivations, and coping mechanisms (see Figure 1). This

combination of risk factors have syndemic relationships, meaning that together they produce an interaction that increases the risk for a negative health effect, such as HIV acquisition [14, 15]. For those that engage in these behaviors simultaneously, the risk of acquiring HIV may be compounded. Additionally, these three have overlapping determinants that increase the likelihood of each, including poverty, childhood abuse, lack of social support, PTSD, and lack of higher education.

Figure 1: Associations between IPV, Drug Use, Transactional Sex, and HIV



6a. Link Between Drug Use and Transactional Sex

Individuals who engage in drug use are more likely to engage in transactional sex, because it provides financial support to purchase the drugs or direct exchange of sex for obtaining the drugs [16]. Drugs, such as crack cocaine, are highly addictive and may lead an addict to engage in riskier behavior than typical in order to secure the next high [18]. Engaging in transactional sex for drugs, or money for drugs, is a viable option for women that do not have the financial means to support a desire for drugs. Additionally, research indicates an association among women abusing drugs and having an unstable living situation, which may account for a decision to engage in transactional sex for shelter, food, or other needs [17-19].

6b. Link Between Transactional Sex and Intimate Partner Violence

An association between transactional sex and IPV has been supported through various research studies. One study in New York City assessing the prevalence of partner violence among commercial sex workers found that 73% of participants had experienced physical or sexual abuse from intimate partners (non-commercial) in their lifetime. In the past year, 20% had experienced physical abuse, 8.9% had experienced sexual abuse, and 22.2% had experienced both physical and sexual abuse. Lifetime prevalence yielded much higher results, with 57.8%, 42.2%, and 73.3% respectively [20]. Additionally, violent relationships have been associated with financial instability, which may lead women to engage in transactional sex as a viable method to support themselves [19].

6c. Link Between Intimate Partner Violence and Drug Use

Literature suggests that IPV and drug use have a reciprocal relationship, and that female drug users in the U.S. have a much higher prevalence of IPV than non-drug users [21]. Various studies have highlighted some of the daily high-risk behaviors for drug users that may elicit violence or aggression from a partner, including supplying drugs or sharing drugs with a partner, and involvement with buying, selling, or obtaining drugs [17, 22]. It is also suggested that crack/cocaine may increase a woman's verbal aggression towards an intimate partner, which could lead to a violent or negative response [23]. Literature also suggests that women who use drugs may be perceived by intimate partners as defying a gender norm, which could lead to an increased justification for abuse in the eyes of the perpetrator [18, 21].

In turn, drug use can be utilized as a coping mechanism for women experiencing abuse, or other stressors resulting from a violent relationship [24]. Research suggests that

the more severe the abuse in a relationship, the more likely a woman is to engage in negative health behaviors, including drug use and drinking alcohol in excess [24].

7. Common Motivations for Leaving a Violent Relationship, Drug Use, and Engagement in Transactional Sex

7a. Motivations for Terminating a Violent Relationship

Previous research has identified several factors women contemplate when assessing their safety and decision to terminate a violent relationship. Some factors women consider include economic status, for which a financial dependence can be a motivation to stay, emotional or psychological influence from a partner, and the nature and/or severity of abuse, for which an increase can result in leaving or staying due to an escalated fear. Additional factors include social and institutional support perceived for leaving, and presence of children/family investment, which can be both a motivation to stay or leave [39-41].

7b. Motivations for Terminating Drug Use

The decision to cease substance abuse has also been investigated. A previous study suggests that factors affecting one's decision to stop using drugs include various internal and external factors. Internal factors include attitudes toward the substance, a negative impact on one's self or others, influence from family or peers, and stigma. External factors include peer pressure, availability of substance, and situational barriers, such as cost, and accessibility [27, 42].

7c. Motivations for Terminating Engagement in Transactional Sex

Motivating factors to cease engagement in transactional sex have not been explicitly investigated in the research that we reviewed, however in a prior study, sex workers

identified harms of engaging in transactional sex. Risks and fears associated with selling sex included unprotected sex leading to an STI or pregnancy, physical violence, and psychological risks such as PTSD, depression, or an eating disorder [43]. One qualitative study also revealed that female sex workers using crack viewed themselves as unfit mothers [17]. It is reasonable to suggest that these fears and risks of transactional sex, as well as the belief that motherhood is not congruent with a drug-using life of prostitution, may be indicators of motivating factors women contemplate for ceasing transactional sex. Of note, engagement in transactional sex may not be considered a lifestyle or career choice by some sex workers, and instead viewed as a means to survive [17].

8. Multi-Faceted HIV Interventions for Women

This literature review has thus far demonstrated the complexity of the relationships between intimate partner violence, drug use, and transactional sex, as well as how they contribute to increased HIV risk among women. While this syndemic relationship and its effect on HIV is well known, currently available HIV prevention strategies generally do not address all three of these risk factors. This failure to address IPV, drug use, or transactional sex, may render such HIV prevention interventions ineffective in this hard-to-reach, high-risk population. This next section will explore existing HIV interventions for our target population that have combined elements of reducing intimate partner violence, drug use, or transactional sex.

Theall *et al*. conducted a study examining IPV experiences of African American female drug users who had previously completed an HIV intervention. Women either completed the National Institute of Drug Abuse intervention (control group), or one of two newly developed interventions dealing with motivation or negotiation skills to

decrease HIV risk behaviors. Six months following completion of the interventions, sexual and emotional abuse (not physical) had decreased for women in the two intervention groups [44].

An additional study investigating the effects of an HIV negotiation skills intervention on safer sex practices among 152 women who had experienced IPV in the previous year. Participants who completed 8 sessions on negotiation skills had improved or maintained their level of safe sex practices at one- year follow-up. The follow-up also examined levels of IPV, for which there was no increase or decrease. This study concluded that negotiation skills training benefitted women experiencing IPV, but did not have an effect on IPV frequency [45].

Lastly, a systematic review of IPV and HIV studies in the U.S. was conducted in 2007, and concluded that limited research examining the IPV-HIV link had been conducted (35 articles from 2000-2007), and that very few involved interventions (4 out of 35). Most of the research relating to HIV and IPV involved identifying rates of IPV among women living with or at risk for HIV. The writers recommended that subsequent research investigating HIV and IPV should include drug use, as it is an additional co-occurring problem in the HIV-IPV relationship [46].

Gap in Literature

Through this literature review, we can conclude that there is a significant gap in research investigating HIV prevention for women who experience IPV, use drugs, and engage in transactional sex. As demonstrated in earlier sections, IPV, drug use, and transactional sex are interrelated and all contribute to high-risk sexual behaviors; these factors are likely to be important in the heterosexual transmission of HIV among African American

women. Unfortunately, these three factors that put women at a high risk for HIV are also barriers that make this population difficult to access for HIV prevention efforts.

To our knowledge, there is no qualitative study that examines all at once the motivating reasons women have for terminating a violent relationship, drug use, and engagement in transactional sex, and there is no study investigating the barriers for all three either. In order to design effective interventions in this population and decrease HIV transmission, it is critical to gain more information about these three risk factors. Research investigating the motivating factors for leaving each, and the associated barriers in doing so, has the potential to identify commonalities across the risk factors, which may inform future targeted intervention strategies.

Chapter Three: Manuscript

Motivating Reasons for Leaving a Violent Relationship, Drug Use, and Transactional Sex: A Qualitative Study among HIV High-Risk African American Women

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Contribution of Student

I am the primary investigator of this study and the primary author of this paper. I conducted, transcribed, coded, and analyzed the 14 in-depth interviews herein described. I wrote this thesis with the guidance of my thesis advisor, Dr. Ameeta Kalokhe, and my thesis committee members, Dr. Sophia Hussen and Dr. Dawn Comeau.

Abstract

Background: Human immunodeficiency virus (HIV) is a growing epidemic in the southern U.S., and African American women are disproportionally affected. Intimate partner violence (IPV), drug use, and transactional sex are each significant risk factors for HIV acquisition. Women experiencing IPV, drug use, and transactional sex simultaneously may have a compounded risk for contracting HIV. Furthermore, IPV, drug use, and transactional sex are interrelated and may increase the occurrence of one another. More research on the syndemic relationships of IPV, drug use, and transactional sex is needed to help with HIV prevention efforts in this high-risk, difficult-to-access population.

Objectives: To understand more about how and why women decide to leave IPV, and terminate drug use and transactional sex, this study explored the commonalities of motivating reasons women leave/terminate each, and the barriers encountered in doing so.

Methods: In-depth interviews were conducted with 14 women who had experienced IPV in the previous 12 months, and used drugs and/or engaged in transactional sex in the previous five years.

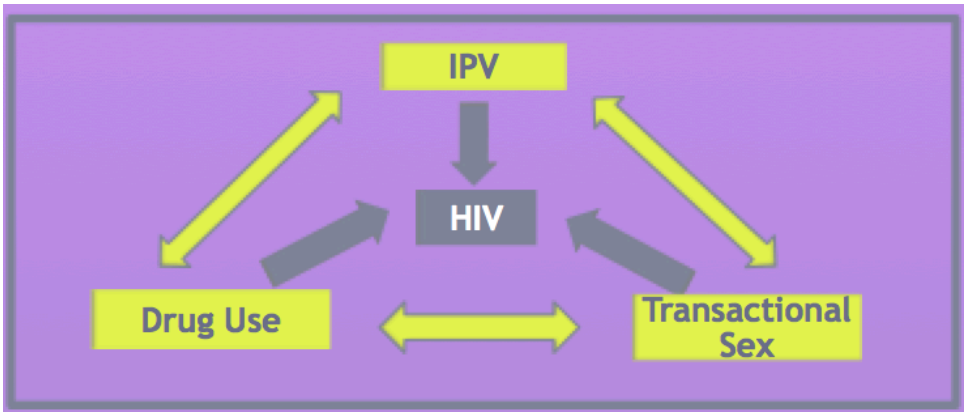
Results: Women reported a range of motivating reasons for leaving IPV, drug use, and transactional sex. There were some overlapping themes across each domain, which included *children*, *physical health and safety*, and *life dissatisfaction*. Financial insecurity and dependence were common barriers to leaving all three.

Discussion: Women may have varying motivating reasons for deciding to leave IPV, drug use, and transactional sex, but future research can further explore the themes of children, physical health and safety, and life dissatisfaction. Future HIV prevention interventions among women experiencing each domain may want to integrate an economic component that promotes financial security and independence for women.

Introduction

In the Southern United States, African-American women are disproportionately infected with Human Immunodeficiency Virus (HIV) [1, 2]. African American women represent 13% of the U.S. female population, yet account for 64% of new HIV infections [2]. Intimate partner violence (IPV), substance abuse, and transactional sex are significant socio-behavioral contributors to the ongoing HIV epidemic among women, but concurrently serve as obstacles to HIV prevention efforts reaching them [4-6]. They occur with frequency among HIV high-risk women, are interrelated, and can have a compounded effect on HIV susceptibility (Figure 1) [7]. This combination of risk factors have syndemic relationships, meaning that together they produce an interaction that increases the risk for a negative health effect, such as HIV acquisition [14, 15].

Figure 1:Associations between IPV, Drug Use, Transactional Sex, and HIV



Women experiencing IPV are more likely to engage in condomless sex, use illicit drugs, have less control over safer sex practices, have multiple and high-risk partners, and have higher rates of sexually transmitted infections (STIs), increasing their physiological susceptibility to HIV [8, 9, 24]. Women using crack or cocaine, common drugs of abuse in the South, are similarly more likely to engage in risky sexual behaviors, in part due to

impaired judgment and drug-induced impulsive sexual behavior[4]. Finally, women who engage in transactional sex incur heightened HIV risk because they are more likely to engage in unprotected sexual intercourse, have multiple high-risk partners, higher rates of STIs, and neglect to undergo medical testing and treatment for STIs [5, 12, 35]. Therefore, targeted HIV prevention interventions that help women who incur abuse and engage in drug use and/or transactional sex leave such situations or counter the resultant sexual HIV risk are highly needed.

Importantly, women are capable of terminating high-risk behaviors or leaving high-risk situations, and several attempt to or may be motivated to. Motivating reasons for leaving a violent relationship, terminating drug use, and disengagement from transactional sex have been investigated separately, but not among women who have experienced all three [17, 39-41, 43]. Improved understanding of women's motivations for risk reduction has the potential to inform future interventions aimed at decreasing HIV incidence among women who experience one or more of these socio-behavioral risk factors. This study provides a unique opportunity to qualitatively explore the triggers for and barriers to leaving each of these HIV high-risk behaviors and situations among a difficult-to-reach population, and thus may provide researchers with insight to further much-needed HIV prevention efforts.

In order to compare motivating factors for and barriers to leaving or terminating each, we conducted in-depth interviews with 14 women who had experienced IPV in the previous 12 months and engaged in drug use and/or transactional sex in the previous 5 years.

Methods

Study Design

This qualitative study was the second phase of a parent study focused on IPV and HIV susceptibility. Phase I utilized a cross-sectional, quantitative design to evaluate the association between experiences of IPV and immune changes linked to increased HIV susceptibility among HIV high-risk women. Women participated in a structured interview of validated measures spanning topics of IPV, post-traumatic stress disorder (PTSD), perceived discrimination, and other social behavioral topics. After completing several structured interviews, significant overlap in affirmative responses to questions about IPV experience, substance abuse, and transactional sex became apparent; thus, phase II, was designed to qualitatively explore the experiences of this unique, difficult-to-reach population and their attempts to lower their own HIV risk. The qualitative phase of the mixed-methods study served as a means to explore the perspectives of women exposed to IPV, drugs, and transactional sex, and to learn more about the motivating factors to leave or terminate each. Qualitative research methods were chosen because of their potential to elicit rich, organic responses and to understand the complex and unique experiences. Additionally, the exploratory nature of qualitative research renders it conducive for theory development and complimentary to quantitative data [47]. Furthermore, the National Institute on Drug Abuse Research has identified a need for qualitative research in the context of HIV prevention among drug users, more specifically hidden populations and racial minorities that are at a higher risk for HIV infection [48].

Study Setting

The study was conducted at a large, comprehensive HIV clinical care center in Atlanta, Georgia. The clinic provides HIV treatment and related services to over 5,000 men, women, and children. Additionally, the clinic building has a research unit (on a separate floor from the clinical care sites) where HIV treatment and prevention studies are routinely conducted. Interviews were conducted in either a private clinic room or office of this research unit.

Study Staff Training and Participant Safety

Ethical implications and the safety of participants were considered during this study; approval was awarded by the Emory University Institutional Review Board and Grady Health Systems Research Oversight Committee. Due to the sensitive nature of the study questions, the research staff underwent targeted trainings to ensure the safety of participants. Study staff members were all CITI-certified for Social and Behavioral Responsible Conduct of Research, and completed a sensitivity training with a nonprofit organization in Atlanta that operates a shelter and provides supportive services for domestic violence survivors and their children.

Precautions to protect the identity and physical safety of our participants were implemented. In line with the World Health Organization's Ethical and Safety Recommendations for Domestic Violence Research, study flyers and staff referred to the study as the 'Women's Health Study' to conceal the true nature of the study from potential IPV perpetrators [49]. Potential research subjects were notified of the true content of the study questions during the consent process of the initial study visit. Any identifying documents were kept in a locked cabinet at the study site, and the quantitative

surveys, audio files, and typed transcripts were stored on a password-protected computer drive. Transcripts were de-identified, and all names were changed.

To support participants experiencing intimate partner violence, drug use, or any mental or physical health issues, upon completion of the interviews, study staff offered and facilitated referrals to shelters, hotlines, and legal aid organizations. Additionally, each participant was given a list of IPV resources (i.e. domestic violence shelter and hotline, a mental illness organization, and a non-profit that fosters pets while women seek refuge in a shelter) disguised in a phone booklet of other community resources (i.e. hair salons and pharmacies).

Eligibility and Participant Recruitment

Eighty-five HIV-negative, high-risk women aged 18-60 were recruited into the quantitative phase of the study. HIV high-risk criteria included meeting at least one of the following risk factors for HIV in the previous 12 months: drug use, transactional sex, condomless sex with four or more men, sex with six or more men, sex with a known HIV-positive man, or sex with a partner that meets any of the previously listed risk factors. A subgroup of participants from the quantitative phase of the study were invited to participate in the qualitative phase. Participants were considered eligible for the qualitative phase if during the quantitative phase they reported experience of IPV in the previous 12 months, and engaged in transactional sex and/or drug use in the previous 5 years. It is important to note that the participants were in varying stages of involvement with IPV, drug use, and transactional sex. Eligibility was based on self-reported quantitative responses, and IPV exposure was determined with a score of 50 or higher on the Index of Psychological Abuse (a measure of psychological IPV) and a score of 57 or

higher on the Severity of Violence Against Women Scale (a measure of physical and sexual IPV) [50, 51]. These cutoffs were chosen to ensure that eligible participants had significant exposure to IPV in the previous 12 months.

Eligible participants were either contacted about Phase II via phone after their initial appointment, or approached in person during their initial visit once the study was completed. For some participants, Phase II interview took place either on the same day as their Phase I study visit; for others it was scheduled at a later date.

In-Depth Interviews

Fourteen (14) in-depth interviews were conducted and digitally audio recorded over a 3-month period by a single researcher (NSD). Before the start of each interview, a guided discussion on the study purpose, discussion topics, risks and benefits of participation, and confidentiality took place, and an informed consent was obtained from the participant. The semi-structured interview guide included questions prompting a summary of experiences with IPV, drug use, and transactional sex. Specifically, participants were asked about the following: (1) history and current exposure to each (2) motivating reasons for leaving IPV, drug use, and transactional sex, and (3) challenges and barriers experienced when attempting to leave the high-risk behaviors or situations. The interviewer (NSD) then worked with the participant to create a timeline diagram of significant events, which included experiences with IPV, drug use, and transactional sex, as well as other life events (i.e. such as imprisonment and death of a parent). Timeline diagrams were created by first adding details of the discussed events regarding IPV, drug use, and transactional sex, and then the participant had the opportunity to add any other

life events she perceived as significant. Subjects received $15 for participating in the qualitative study.

Analysis

Two researchers (NSD and HA) transcribed the recorded interviews verbatim, and imported the transcripts into MAXQDA for coding and analysis. NSD created a codebook after initially coding three of the interviews. The codebook and definitions were reviewed and edited by ASK and SAH after reading the initial transcripts. Codes were refined and NSD coded all 14 interviews with the edited codebook. Research and analysis were conducted utilizing a thematic analysis approach, which is an inductive methodology for identifying themes in the raw data and further interpreting those themes through comparison across interviews. In order to further compare and contrast the stories of the different participants, NSD wrote in-depth analytic memos consisting of case summaries of each participant with respect to the key constructs of IPV, transactional sex, and drug use. At this time, pseudonyms were assigned to each of the participants; these are the names listed with participant quotes below.

Results

Participant Characteristics

Between October and December 2014, 14 women participated in the qualitative study (Table 1). The average age of participants was 37.6, with a range of 30 to 49 years. All participants were African American. The majority of women had an annual household income of less than $10,000 (71% or 10/14). Education level varied among participants, with only 36% (5/14) pursuing education beyond high school. Sixty-four percent (64% or 9/14)), 57% (8/14), and 85% (12/14) of participants answered ‘yes’ to experiencing

physical, sexual, and emotional abuse, respectively, before the age of 18. Half of the women (7/14) identified their sexual orientation as 'heterosexual', while the other half identified as 'lesbian, gay, or bisexual.' Regarding current substance use, 43% (6/14) of women had used crack or cocaine at least once in the week prior to their initial study visit, 64% (9/14) had used marijuana in the week prior, and 64% (9/14) had eight or more alcoholic drinks in the week prior.

The qualitative interviews provided additional insight into the backgrounds of the participants. Several of the women had experienced a traumatic event in childhood, such as abuse or death of a parent, and attributed their initiation of drug use to this event. Women similarly spoke of using drugs as a form of coping, and for women that decreased their cocaine use over time, some of them acknowledged an increase in marijuana consumption or alcohol as a replacement. Other commonalities included periods of incarceration and homelessness, especially while simultaneously using drugs and selling sex.

Table 1: Demographics Information of Participants

Age Range	**n (%)**
30-35	7/14 (50%)
36-40	2/14 (14%)
41-45	3/14 (21%)
46-50	2/14 (14%)
Annual Household Income	
Less than $10,000	10/14 (71%)
$10,000-$20,000	4/14 (29%)
Education (highest level completed)	

Some high school	4/14 (29%)
High school/GED graduate	5/14 (36%)
Beyond high school	5/14 (36%)
Biological Child Count	
1-2	7/14 (50%)
3-4	3/14 (21%)
5-6	3/14 (21%)
7+	1/14 (7%)
Currently Employed	
Yes	4/14 (29%)
No	10/14 (71%)
Sexual Orientation	
Heterosexual	7/14 (50%)
Lesbian, gay, or bisexual	7/14 (50%)
Childhood Abuse (age 17 or younger)	
Physical abuse	9/14 (64%)
Sexual abuse	8/14 (57%)
Emotional abuse	12/14 (86%)
Current Activity (at time of interview)	
Cocaine/crack use (1+ in past week)	6/14 (43%)
Marijuana use (1+ in past week)	9/14 (64%)

Alcohol consumption (8+ in past week)	6/14 (43%)

Motivating Reasons for Leaving a Violent Relationship

Participants were asked to identify motivating reasons for leaving a violent relationship, or what it would take for them to leave their current abusive partner. Some responses included a general overview of why they wanted to end their relationship, while others commented on the 'tipping point,' or final motivator that made them want to leave. The three most common themes that emerged from the data were an escalation of violence, desiring a better life, and being tired of abuse. Other responses included children and family intervention. It is important to note that the interviewer spoke generally when asking about experiences with abuse, and several women spoke about a relationship that had taken place years before, rather than the one that supported their eligibility. Some of the women described more than one violent relationship, and the listed responses on Table 4 include all identified motivating reasons for leaving any violent relationship. Furthermore, it is important to note that not all women decided to end their relationship because of abuse. Some women had also decided to leave or attempted to leave, but were unsuccessful in doing so immediately due to various barriers. Unfortunately, some women's abuse increased after their decision or attempt to leave their partner.

Table 2: Motivating Reasons for Terminating a Violent Relationship

Motivating Reasons for Leaving a Violent Relationship	**n (%)**
Escalation of abuse	8/14 (57%)
Desired a better life	5/14 (36%)

Tired of abuse	3/14 (21%)
Children	2/14 (14%)
Family Intervention	1/14 (7%)

Escalation of Violence

Eight of the 14 women identified an incident of escalated abuse that motivated them to leave. These events ranged from a black eye to attempted murder with a firearm and stabbing with knives or other objects. Jen, a currently homeless mother of five, describes deciding to leave after a murder attempt in the following quote,

"Yeah one day he threw me in his car like 'I'm gonna throw you in a ditch, bitch, and kill you' and other shit and that was just a little bit too much. When I got away that last time I promised myself like…I didn't want to be beat." (Jen, age 35)

Women also described increases in controlling behaviors, such as being reprimanded for leaving the house, and partners that were increasingly jealous and accusing of cheating. Christine describes her controlling boyfriend,

"And it got worse, it didn't get no better. He started to the point where he wanted to lock me in the house, beat me up…I thought I was an old—I could've sworn I was about 50 years old, how he made me feel. Then it got to the point where I couldn't take the abuse no more, the hitting and the punching" (Christine, age 33).

Tired of Abuse and Desire for a Better Life

There was overlap in women discussing feeling tired of abuse and wanting a better life. Some women spoke generally about wanting more for themselves and their families, and others came to realize that they would be better off without their partner. Caroline, who recently left a three-year relationship where her partner restricted her from leaving their

home, spoke about the emotional abuse and realization that her condition wasn't going to change. She said in the following quote,

"I just got to the point where I wanted more for myself. I finally started to care about myself…I just finally said 'you know what, I need to do something for me' " (Caroline, age 41).

Similarly, Renee had decided that her abusive boyfriend wasn't going to stop, and that no one could help her but herself. Ashley wanted to be free of her abuse and drug using lifestyle, and Marissa grew tired of her alcoholic husband and desired an equal contributor, as well as a violence-free home. Additionally, several women described hopelessness and apathy at the height of their abuse, before they decided to leave.

Barriers to Terminating Violent Relationships

The women discussed several barriers to terminating a violent relationship. A major theme was a logistical challenge, such as needing shelter, lacking the financial means to sustain themselves, or wanting to move without interfering with their children's well-being. At the time of her interview, Anna was contemplating leaving her partner and commented,

"I do [want to leave the current abusive relationship], but its a matter of, um, finding a place for me and my 4 kids and I'm currently seeking employment right now, I think it was my mistake by allowing him to handicap me and me becoming codependent upon him because I wasn't working, so like I'm going to seek employment and try to save a little money and then move" (Anna, age 30).

Additionally, some women cited fear of retaliation from their partners as a major barrier to leaving. Women described having to physically escape and hide from partners, and

described sneaking belongings out of shared living spaces. Some women attempting to leave had to ultimately make a choice between their safety and their possessions, as Marissa describes,

"The only struggle [of leaving] was holding on to my belongings, but eventually I just said screw it, that's just material. And we left because all the tears, they run out. They were just a bunch of crap. And I know he say anything to get your way and once you get your way, well you right back to the same mode, so, it wasn't hard to leave at all. I didn't regret anything when I left" (Marissa, age 38)

Other women described partners that would restrain them from leaving, which ended in violent episodes, and sometimes legal action. Jessica, who left her abusive boyfriend in high school, had to change jobs since her ex-boyfriend would stalk her and harass other employees, and ultimately had to move to a different town to escape him.

Motivating Reasons for Terminating Drug Use

Twelve of the 14 participants reported use of an illicit hard substance (i.e. crack, cocaine, methamphetamines, heroin, or alcohol) in the previous five years. Women spoke about previous motivations for terminating drug use, or what would motivate them to stop in the future (if currently using). There were some recurring themes in responses, which included benefitting children, financial cost of drugs, adverse effects from drug use, and overall desire for self-betterment and a sober life. It is important to note that several of the women mentioned multiple motivating reasons for terminating drug use. A condensed list of mentioned reasons can be found in Table 3.

Table 3: Motivating Reasons for Terminating Drug Use

Motivating Reasons for Terminating Drug use	**n (%)**

Children	8/12 (67%)
Adverse physical effects	5/12 (42%)
Self-betterment/sober life	4/12 (33%)
Financial cost	3/12 (25%)
Rehabilitation	3/12 (25%)
Neglected responsibilities	2/12 (17%)
Intimate partner	2/12 (17%)
Work performance	1/12 (8%)
Family relationships	1/12 (8%)

Children

Eight of the 12 women cited a motivating reason for terminating drug use that involved their children. The theme of children is broad and spans from setting a better example for children, to include being a better parent, and wanting the best for their children. Renee mentioned wanting her four year-old daughter's approval, who was unhappy with her Mother smoking 'cigarettes' (actually marijuana)[1]. Jessica spoke about the negative effect drugs had on the relationship with her daughter, elaborating on how her irritability made her daughter not want to be around her. Another woman, Sylvie, cited her child's death from cancer and subsequent depression as motivation to quit.

"Well you know when my son died with cancer at 4 years old—it kinda turned my life around and it took a toll on me, you know. Where I didn't want to do any more crack, you

[1] Marijuana was not a qualifying drug for the study, but this particular participant answered the question about drugs in respect to her daily marijuana use, rather than her brief history of recreational cocaine use

know. Everything, you know it just took a big toll on me cause my kids are my everything and it just shut me down." (Sylvie, age 45)

Susanne, Christine, and Caroline all wanted to get clean so that their children could live with them again, Caroline commented,

"I couldn't function [on drugs], I couldn't be stable. You know, I couldn't. I tried, but I couldn't. I couldn't be a good mom. I tried, and I love my kids, I didn't' abuse them by neglecting, I didn't whip them or anything like that but um just by not being there. You know, it [drugs] affected. I couldn't keep a job, I didn't want to work because I knew you [employers] know that I had a thing about getting high so I couldn't work. And I just couldn't stay with nothing. School, whatever I tried, I just couldn't follow through." (Caroline, age 41)

Lastly, Ashley was pregnant and desiring to avoid a third child being born with cocaine in her system. She recalls,

"I went back to rehab when I found out I was pregnant again with my daughter. And um, so I took two of my kids through getting high, not going to my clinical support, none of that. I had two positive children come out with cocaine in their system and I promised myself I wasn't going to let her come out with that." (Ashley, age 42)

Financial Cost

Three of the participants mentioned wanting to terminate their drug use to avoid the financial cost of drugs. While referring to cocaine, Christine comments,

"Don't start doing this [using cocaine] if you don't have the money for it. And sometimes you gonna spend your last [dollar] to go get it, you know. And I had to start working on that because now I have bills, and I refuse to be homeless." Christine, age 33)

Several other participants also spoke of the financial cost of drugs, but did not describe it as a motivating reason to terminate. Additionally, participants mentioned that they were motivated to engage in transactional sex in order to pay for drugs.

Adverse Effects

Several of the participants mentioned adverse physical effects associated with drug use, and five women cited a physical consequence (or fear of one) as a reason for termination of drug use. These physical consequences included addiction, overdose, death, and pain. No woman cited an adverse effect as an isolated reason to stop drug use; these were described as secondary, supporting motivation for terminating drug use.

Sober Life and Self-Betterment

There was a final theme of women wanting to better themselves. Some women mentioned that they always figured they would stop drugs at some point, and that they would like to have a sober lifestyle. Christine said the following when reflecting on how she has decreased her drug and alcohol intake,

"But at the end of the day, I know my body [is] like you need to stop doing this. But eventually, yes, I'm gonna stop (laughs). Eventually I'm gonna stop. But it's sometimes—don't get me wrong, but you know it ain't like you can just cold turkey stop anything, it's a process. You have to work on it." (Christine, age 33)

Nicole describes her decision to stay clean after prison in the following,

"It was a decision. I was either going to continue to get high or not get high. And the decision was, I always knew what that grass was like on that side. I knew what it was like with the tricking off and the prostitution and the sucking penises, the stealing, the manipulation, I knew what all that was like. I never knew what it was like to be clean, be

sober, wake in the morning functioning, fix you something for breakfast, open the refrigerator up, take a bath every day, go to your doctor appointments, be by my kids, change their pampers, make their bottles, buy them wipes, buy them pampers, I never knew what that was like. So I wanted to try, and now I like it." (Nicole, *age* 33)

Overall, women mentioned wanting the stability of a sober lifestyle. Women stated that discontinued drug use could improve personal relationships, increase financial status, help them maintain family and work responsibilities, and increase general life satisfaction.

Barriers to Terminating Drug Use:

Women described multiple barriers to terminating drug use, which included social adjustments, physical pains, and mental challenges. Some participants identified their social groups or intimate partners that still use drugs as a barrier, since they had to either abstain from using while being tempted, or socialize with alternate groups that didn't use drugs. Christine cited her friends as a major barrier and the social repercussion in the following,

"Whew, the difficulty of trying to stop using drugs? Loss of friends, loss of..well, they were never your friends in the first place if they introduce you to it [drugs], but loss of friends" (Christine, age 33).

Additionally, some women spoke about the physical pain of withdrawal, and how that was difficult to overcome.

"It was really just the feeling, like the body feeling…your body don't feel the same, because it's in your blood. It's in your system. So it's like your system constantly doing this 360 and it's never going, like this is what your body's used to. And when you stop

trying to do stuff [drugs and/or alcohol], I get sick. So it's like, I hate the feeling of being nauseated and sick, that make you feel like oh I can't get outta bed" (Christine, age 33).

Some women mentioned that after eliminating crack or cocaine use that they compensated with other vices, such as alcohol and marijuana. Additionally, women who used drugs as a coping mechanism for other stresses saw their sobriety as a challenging barrier, as they felt the need to confront other social or psychological problems without the buffer of a substance. Caroline identified the following barrier in reference to her previous abuse in childhood,

"I mean just dealing with a lot of issues, it was hard to face a lot of my fears" (Caroline, age 41).

Lastly, some women discussed the combination of physical and mental challenges with ceasing drug use.

"Well physically there is the crack craving, you know that you don't want to be depressed—psychological and the mental. And then um whatever they put in the crack has a physical effect on you that you want it more. And then to take the shame and the depression off of you, which is the psychological part that makes you crave it and want it, to take away your problems" (Lynn, age 49).

Motivating Reasons for Terminating Engagement in Transactional Sex

Thirteen of the 14 participants had a history of providing sex in exchange for money, drugs, shelter, or any other necessities. When asked about motivating reasons for terminating engagement in transactional sex, the participants listed the reasons depicted in Table 3. Motivating reasons to stop selling sex included a desire for monogamy with

their partner, better physical safety, sexual health, and dissatisfaction with transactional sex.

Women viewed transactional sex as a necessity for survival. There are varying degrees of involvement in transactional sex among the women. There are disparities in the number of transactional sex partners that participants have had, the type of relationship (i.e. stranger, friend, intimate partner, etc.), and the sexual activities described in these relationships (oral sex, vaginal sex, anal penetration with object, etc.). There were also differences in the way participants viewed their engagement in transactional sex; some participants did not consider sex in exchange for money as 'selling sex,' particularly if they were in a romantic relationship.

Table 4: Motivating Reasons for Terminating Engagement in Transactional Sex

Motivating Reasons for Terminating Engagement in Transactional Sex	**n (%)**
Sexual health (STI fear)	5/12 (42%)
Desire for Monogamy	4/12 (33%)
Physical safety	4/12 (33%)
Dissatisfaction with selling	4/12 (33%)
Monetary motivation resolved	2/12 (17%)
Children	1/12 (8%)

Desire for Monogamy

Four of the women reported a desire to terminate transactional sex in order to maintain a monogamous relationship with their partner. Kim, who is currently in a committed relationship with a woman, stated that she would stop selling sex if she and her girlfriend

were to marry. Marissa described how she stopped selling sex while she was married to remain faithful to her husband, and Jessica, who started selling sex upon her release from prison for income, discussed her recent decision to stop selling sex since becoming more serious with her current boyfriend. Additionally, Anna, who has sold sex throughout her current relationship, desires to stop selling sex to avoid having excess partners, and because she desires a loving relationship with her sexual partner. She expresses her thoughts in the following quote,

"I don't want to feel as if I've had sex with every man in Atlanta just because I was down on my luck. I just want another option, another option out. I don't have other resources other than a mysterious guy—I want my worth to be more than just sex and money so, self-love I guess. I want a guy to love me for me, for myself." (Anna, age 30)

Physical Safety

Four of the participants identified concerns for safety as a motivation for terminating their engagement in transactional sex. These women reported fear of physical and sexual violence from a client, such as assault, rape, and death. Jessica describes her fear of safety in the following quote,

"It's too risky because like of course they can't come to my home, so I'd have to meet them somewhere. Their home, or a hotel. And you just never know what might happen. You know I've seen a lot, you know I watch the news—these girls are you know, getting set up, or rocked [assaulted] and shot, or getting raped. You know all these types of stuff and you don't really know who you're dealing with and so I took some chances you know, dealing with the ones [clients] I did deal with." (Jessica, age 36)

Sexual Health

Several participants expressed concerns about acquiring sexually transmitted infections (STIs), and five women noted it as a motivating factor to stop selling sex. A few of the women noted that they always use a condom, while others mentioned that condom use was inconsistent, particularly for clients they had been with more consistently.

Dissatisfaction with Selling

Four of the women reported being dissatisfied with selling and sought self-betterment or life satisfaction. Some of the women spoke of transactional sex as a 'lifestyle,' particularly when they were using drugs and selling sex during the same period. For some, this lifestyle was a negative situation that they wished to escape, while others viewed it as a period of bad decisions that was contingent on a drug addiction. Jen expressed that she had grown tired of selling sex, while Lynn mentioned that she didn't enjoy the lifestyle. Caroline describes her dissatisfaction with selling sex in the following quote,

"It's been years [since selling sex] because, I'm not at that state that I used to be. So I don't—I kind of like respect myself today. And I think like being out there like that [selling sex] and now I'm very particular, like I can't just be with anybody. Because I used to be with just anybody (laughs), so now I'm like no, I kind of just respect myself more." (Caroline, age 41)

Similarly, Anna describes that this is not the ideal situation; when asked if she foresees not wanting to sell sex in the future, she responds with the following,

"This is not an occupation. It's not a hobby, its not something I just do all the time, but I always know if push comes to shove it's something I could convert to or something…It's not a good one [option] but nevertheless, it's there." (Anna, age 30)

Barriers for Terminating Engagement in Transactional Sex:

There were a few barriers mentioned when terminating engagement in transactional sex, most of which dealt with financial stability. The women generally spoke of transactional sex as a choice they made to survive, not as something they enjoyed or were addicted to, such as the case with drugs. Therefore, when an opportunity to stop transactional sex happened, there were few barriers. A few women mentioned that clients would call and still be interested, but that this wasn't necessarily a barrier. However, women did cite that the missed income from transactional sex was a barrier, as they would rather benefit from the extra finances. Sylvie describes,

"Well yeah [there is a difficulty in stopping transactional sex], because see I don't have an income, ok? And you know, my bills and my children you know, and field trips and this that and the other, you know keep me going as far as selling my sex" (Sylvie, age 45).

Discussion

Across IPV, drug use, and transactional sex, a range of motivating reasons was identified for leaving or terminating each, however, there was some overlap in the responses. In regards to responses for individual women, it is important to note that women also had different motivating factors for their own responses across each domain. This suggests that, although IPV, drug use, and transactional sex may be interrelated, the motivating factors for terminating each are distinct.

Children

Children was the only response mentioned in IPV, drug use, and transactional sex. Eight women (67%) mentioned children as a factor in regard to terminating drug use, while only two (14%) cited it for IPV, and one (8%) for transactional sex. Previous research on

mothers contemplating leaving an abusive relationship have identified children as both a motivating reason to leave, and to stay [52]. Mothers often factor children into the decision to leave, but comfort of children or a desire to remain an intact family can persuade women to stay. Regarding transactional sex and drug use, one qualitative study also revealed that female sex workers using crack viewed themselves as unfit mothers [17]. Although our participants did not commonly mention children as a motivating reason to leave IPV or transactional sex, it is possible that children may have been considered when women cited other reasons dealing more with their general wellbeing. For example, women who spoke of desiring a better life as a motivation for leaving IPV may have been considering the collective life of themselves and their children.

Life Dissatisfaction

Three motivating reasons were identified in each category that relate to life satisfaction of the participant. *Desiring a better life* (IPV) was mentioned by five women (36%), *self-betterment/sober life* (drug use) was mentioned by four women (33%), and dissatisfaction with selling (transactional sex) was mentioned by four women (33%). These three each appeal to similar motivations of life satisfaction. This may suggest that women were motivated to terminate each because of their general disapproval of their situation, and/or desire to improve their circumstance. In regards to IPV, research has supported the concept of social exchange theory and satisfaction, suggesting that women may compare the rewards and costs of staying in a relationship [53]. No study was found that suggested drug users and women engaging in transactional sex are motivated by life satisfaction.

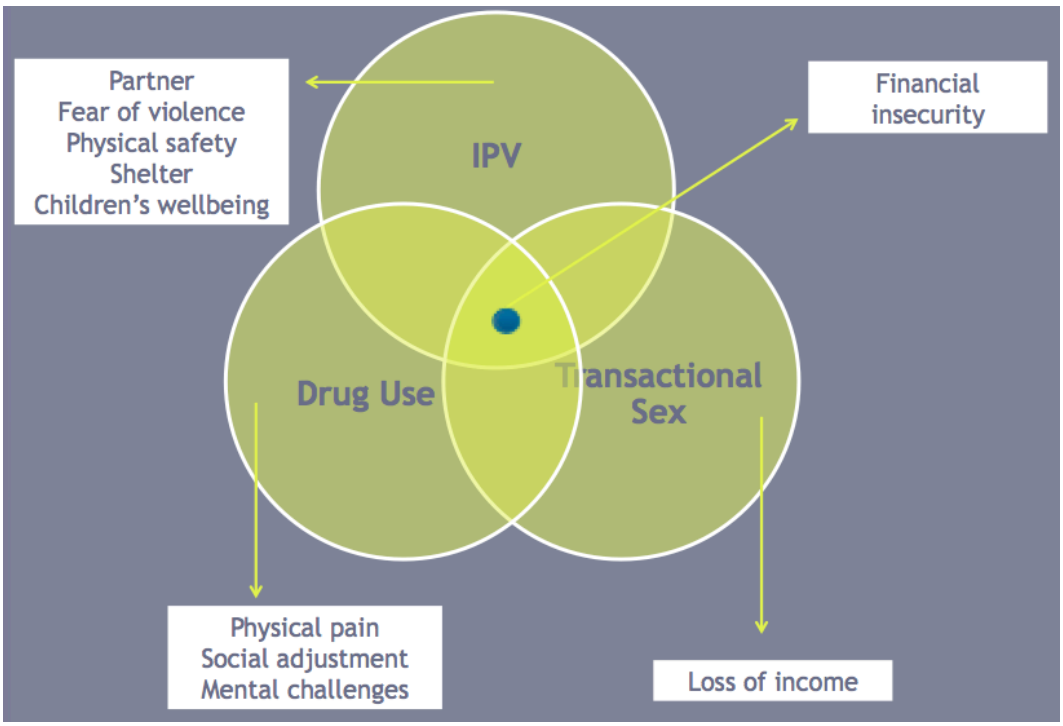
Physical Health and Safety

In each category, women identified a reason relating to physical health and safety. For IPV, eight (57%) women mentioned *escalation of abuse*, for drug use, five (42%) women mentioned an *adverse physical effect*, and for transactional sex, five (42%) women mentioned *sexual health* and four (33%) mentioned *physical safety*. It is important to note that, although physical health and safety was a concern and motivating reason to leave each domain, it wasn't necessarily enough to motivate the women to actually leave. For example, some women mentioned that drug use wasn't healthy for their body, or that selling sex without a condom was a sexual health risk, but they continued to engage in drug use and transactional sex. These motivating reasons for leaving are somewhat consistent with previous studies. Regarding leaving IPV, different studies have concluded that an escalation of violence, such as introduction of a weapon, can be both a motivator to leave, and motivator to stay due to an escalation of fear [40]. Regarding terminating drug use, one study found that a negative impact on oneself was a leading motivator to stop methamphetamine [42]. An additional study surveying motivating reasons for stopping cocaine, alcohol, heroine found that a drug-related hospitalization could be a motivator [54]. Regarding motivations for terminating transactional sex, no formal study has been executed. This concern for physical health and safety as a common motivator should be considered for future efforts in creating a multi-faceted HIV prevention intervention. Additionally, future prevention efforts may want to explore the disconnect among women who are aware of significant health consequences, but continue to engage in risky behavior.

Barriers for Leaving IPV, Drug Use, and Transactional Sex

There was little overlap when comparing barriers for leaving a violent relationship, and terminating drug use and transactional sex (Figure 2). However, one key finding is that financial insecurity was a commonly identified barrier to leaving IPV and transactional sex. Regarding IPV, financial insecurity created a barrier to women leaving who relied financially on their partners and therefore couldn't secure necessary monetary resources to find an alternative shelter or provide for their children on their own. Regarding transactional sex, financial insecurity was a barrier because terminating engagement in transactional sex meant a loss of income. Lastly, financial insecurity was not explicitly identified as a barrier to terminating drug use, but poverty and homelessness were both discussed as motivating reasons to initiating and continuing drug use. Additionally, of the participants who successfully completed rehabilitation programs, all attended the programs free-of-charge and acknowledged that they would not have overcome their addiction had it not been for the rehabilitation. It is possible that other women using drugs may desire to enroll in a rehabilitation program, but financial means to afford a program is a barrier in doing so. These barriers and conclusions are consistent with previous literature that that identifies poverty and financial insecurity as barriers to leaving IPV and transactional sex [13, 39].

Figure 2: Barriers for Leaving a Violent Relationship, and Terminating Drug Use and Transactional Sex



Limitations

A limitation for this study is the potential recall bias among participants. The women were recalling scenarios from years before, and reflecting back on their decision-making process. It is possible that the women misremembered events, or that the motivating reasons for stopping each were reflective of their current status, rather than the original decision. Another limitation during analysis is that the transcripts had one coder. This was mitigated by research team meetings that entailed discussing the codebook among NSD, ASK, and SAH, and continually discussing data and themes throughout analysis.

Conclusion

HIV prevention is a critical issue in the U.S., particularly among African American women in the southern states. Among those infected with and at risk for HIV, the difficult-to-access population of women experiencing IPV, using drugs, and engaging in

transactional sex is in need of further research to implement HIV prevention interventions, and interventions mitigating the exposure to each domain.

Research on the motivating reasons for women leaving IPV, drug use, and transactional sex is limited, as is research on the barriers encountered for women experiencing all three. This qualitative study demonstrates that women generally have distinct reasons for leaving each, although there is significant overlap pertaining to life dissatisfaction, effects on children, and personal physical health and safety. Additionally, financial insecurity was identified as a common barrier to leaving IPV, drug use, and transactional sex. Future research is needed to learn more about women experiencing one or more of these risk factors within the context of HIV prevention interventions. Our recommendations for future directions include (1) testing the findings from this paper on a larger, quantitative scale, (2) investigating life dissatisfaction, effect of children, and personal physical health and safety as a means to comprehensively address all three risk factors, and (3) integrate an economic component to HIV prevention interventions that promotes financial security/independence among women experiencing all three risk factors.

Chapter Four: Conclusion & Public Health Implications

Summary of Results

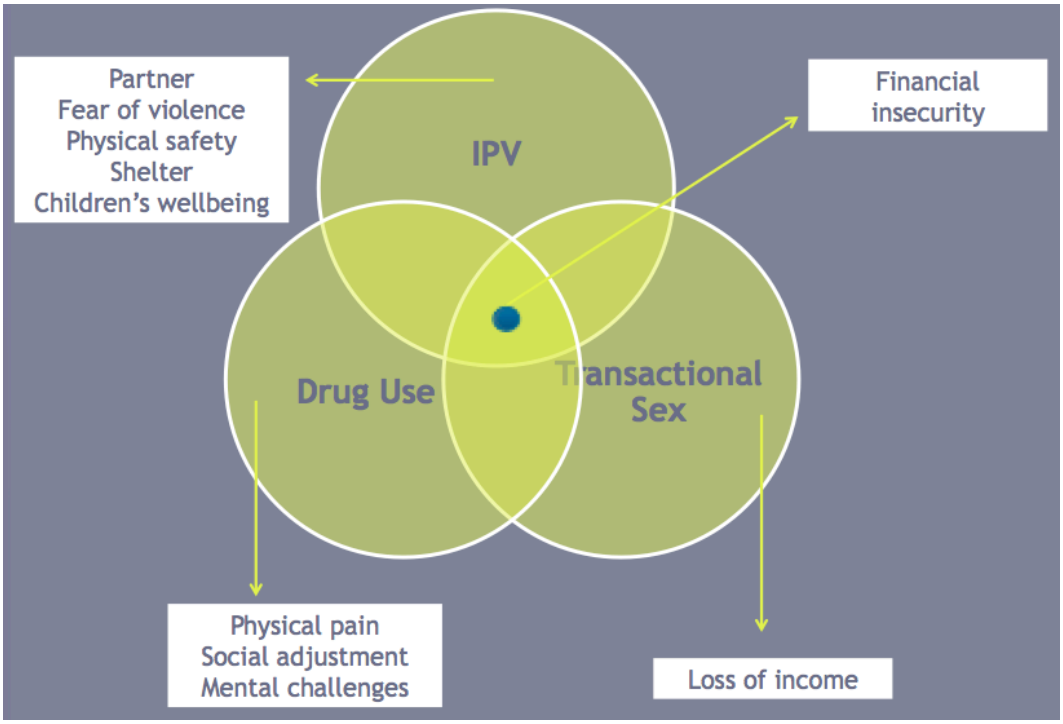
Across IPV, drug use, and transactional sex, a range of motivating reasons was identified for leaving or terminating each, however, there was some overlap in the responses. There were three common themes found in each category: children, life satisfaction, and physical health and safety; however, other motivations were unique to specific behaviors. This suggests that, although IPV, drug use, and transactional sex are closely interrelated, the motivating factors for terminating each are often distinct.

Children was the only response mentioned in IPV, drug use, and transactional sex. Eight women (67%) mentioned children as a factor in regard to terminating drug use, while only two (14%) cited it for IPV, and one (8%) for transactional sex. Three motivating reasons were identified in each category that relate to life satisfaction of the participant. *Desiring a better life* (IPV) was mentioned by five women (36%), *self-betterment/sober life* (drug use) was mentioned by four women (33%), and dissatisfaction with selling (transactional sex) was mentioned by four women (33%). These three each appeal to similar motivations of life satisfaction. Lastly, women identified a reason relating to physical health and safety in each category. For IPV, eight (57%) women mentioned *escalation of abuse*, for drug use, five (42%) women mentioned an *adverse physical effect*, and for transactional sex, five (42%) women mentioned *sexual health* and four (33%) mentioned *physical safety*.

Regarding barriers for leaving a violent relationship, and terminating drug use and transactional sex, there was little overlap (Figure 2). However, one key finding is that financial insecurity was a commonly identified barrier to leaving IPV and transactional

sex. While financial insecurity was not explicitly identified as a barrier to terminating drug use, poverty and homelessness were both discussed as motivating reasons to initiating and continuing drug use. Additionally, of the participants who successfully completed rehabilitation programs, all attended the programs free-of-charge and acknowledged that they would not have overcome their addiction had it not been for the rehabilitation.

Figure 2: Barriers for Leaving a Violent Relationship, and Terminating Drug Use and Transactional Sex



Strengths

A major strength of this study is the comprehensive data and detailed history on each participant with respect to the core domains of IPV, drugs, and transactional sex, and discussed motivations to use drugs and/or sell sex, interaction between domains or

promotion of further risk behavior, and other life events that contribute to exposure such as incarceration or childhood traumatic events.

Additionally, the sample of this population was diverse in their self-identified sexual orientation. Seven (50%) of the women identified as 'Lesbian, Gay, or Bisexual,' and the other half identified as 'Heterosexual or Straight'. Previous research has demonstrated the vulnerability of queer women to IPV. Research studies for queer women and IPV often investigate same-gender couples, while this study has queer women with opposite sex IPV. This study offers a unique perspective of an HIV high-risk population that prevention efforts inadequately reach: African American women who have experienced recent IPV and recently engaged in drug use and/or transactional sex.

Limitations

A limitation for this study is the potential recall bias among participants. The women were recalling scenarios from years before, and reflecting back on their decision-making process. It is possible that the women misremembered events, or that the motivating reasons for stopping each were reflective of their current status, rather than the original decision. Another limitation during analysis is that the transcripts had one coder. This was mitigated by research team meetings that entailed discussing the codebook among NSD, ASK, and SAH, and continually discussing data and themes throughout analysis.

Conclusion

IPV, drug use, and transactional sex occur as part of a syndemic and likely compound the risk of HIV infection in women who experience all three. Research on the motivating reasons for women leaving IPV, drug use, and transactional sex is limited, as is research on the barriers encountered for women experiencing all three. This qualitative study

demonstrates that women generally have distinct reasons for leaving each, although there is significant overlap pertaining to life dissatisfaction, effects on children, and personal physical health and safety. Additionally, financial insecurity was identified as a common barrier to leaving IPV, drug use, and transactional sex. Future research is needed to learn more about women experiencing one or more of these risk factors within the context of HIV prevention interventions. Our recommendations for future directions include (1) testing the findings from this paper on a larger, quantitative scale, (2) investigating life dissatisfaction, effect of children, and personal physical health and safety as a means to comprehensively address all three risk factors, and (3) integrate an economic component to HIV prevention interventions that promotes financial security/independence among women experiencing all three risk factors.

Public Health Implications

HIV prevention is a critical issue in the U.S., particularly among African American women in the southern states. Among those infected with and at risk for HIV, the difficult-to-access population of women experiencing IPV, using drugs, and engaging in transactional sex is in need of further research to implement HIV prevention interventions, and interventions mitigating the exposure to each domain.

As previously mentioned, the findings of this study are consistent with prior literature, and further highlight the potential for a comprehensive HIV intervention among women experiencing IPV, drug use, and transactional sex. An HIV prevention intervention focusing on children, life dissatisfaction, or physical health and safety should be explored. Also, interventions may consider integrating an economic component that enables women to be financial independent and secure.

The substantial threat of HIV among African American women exposed to IPV, drugs, and transactional sex speaks to the importance of HIV prevention funding being appropriated to reduce transmission among these women.

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Appendices

Appendix A: Informed Consent for Interview Participants

Emory University
Consent to be a Research Subject

Title: Intimate Partner Violence and Heightened HIV Susceptibility: Does Stress-associated Immune Dysfunction Play a Role?

Sub-study: A Qualitative Exploration of How Motivating Reasons for Terminating a Violent Relationship and Ceasing Drug Use or Transactional Sex Compare

Principal Investigators: Ameeta Kalokhe, MD MS (Emory University School of Medicine Department of Medicine and Rollins School of Public Health Department of Global Health), Naomi David, MPH Candidate (Rollins School of Public Health, Department of Global Health)

Funding Source: National Institute of Health

Introduction
You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study, or not to be in the study. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.**

Before making your decision: Please carefully read this form or have it read to you. Please ask questions about anything that is not clear.

You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form you will not give up any legal rights.

Study Overview
The purpose of this study is to learn more about any factors women think about when deciding to leave a violent relationship, stop drug use, and/or selling sex. The researchers are interested in exploring these factors, learning a person's history and experience with each, and discussing any difficulties in stopping or leaving a violent relationship, drug abuse, or selling sex.

Procedures
Participation in this study involves only an interview. The interview will be done by trained study staff. It will be in a private, one-on-one setting in a secure office. With your consent, the interview will be recorded and later transcribed. You will be asked about yourself. For example, we will ask about your experience with partner violence, drug use, selling sex, and any challenges you've experienced with these.

Eligibility
You are eligible for this study because of your answers to the previous study.

Risks and Discomforts
A risk of the study may be a loss of privacy and confidentiality. To reduce this risk, your name, contact information, and other identifying information will not be listed on the transcription. Also, all study documents will be locked in a filing cabinet. We will make sure study documents stored on the computer are password-protected. The audio file of your interview will be deleted once transcription is complete, and the transcription of your interview will be stored on the computer in a password-protected document.

You may experience emotional harm or discomfort by participating in this study. This is because we will be asking you to recall and reflect on experiences with a violent relationship, drug use, and selling sex. To reduce this risk, we will have counseling resources available to you. We will also provide you with the names and contact information of domestic violence support organizations.

Benefits
This study is not designed to benefit you directly. But, you may feel a sense of relief by discussing your prior experiences with partner violence, drug use, or selling sex. And, you will receive the contact information of domestic violence support services in the community. The study results may be used to help others in the future.

Compensation
You will be paid $15.00 for participating in this interview.

HIPAA Authorization and Confidentiality
The privacy of your health information is important to us. We call your health information that identifies you, your "protected health information" or "PHI." To protect your PHI, we will follow federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). We refer to all of these laws in this form as the Privacy Rules. This form explains how we will use your PHI for this study. This authorization describes how we may use or disclose your PHI. This authorization also describes how we may use or disclose your PHI for the optional studies in which you may choose to participate. If you sign this form, you give us your permission to use your PHI for the conduct and oversight of this research study.

The PHI that we may use or share for the research study includes your medical history and lab test results. This includes your responses to the questions about intimate partner violence, substance abuse, and selling and trading of sex.

Certain offices and people other than the researchers may look at or use your study records. These include:

- The Principal Investigator and the research staff.
- The Principal Investigator may use other people and groups to help conduct the study. These people and groups will use your PHI to do this work.
- The following groups may also use and disclose your PHI. They will do this to make sure the research is done correctly and safely. These groups are:
    - Government agencies like the National Institute of Health and Office for Human Research Protections
    - Emory and Grady offices who are part of the Human Research Participant Protection Program, the Grady Research Oversight Committee, and those that are involved in study-related administration and billing
    - Public health agencies

Emory and Grady Health System will keep any research records we create private to the extent we are required to do so by law. We will use a study number rather than your name on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results. We will use or disclose your PHI when we are required to do so by law. This includes laws that require us to report child abuse or elder abuse. We also will comply with legal requests or orders that require us to disclose your PHI. These include subpoenas or court orders.

Research Information Will Not Go Into the Medical Record:
We will not include any record of your participation in this study in your Grady Health System medical record.

Expiration of Your Authorization

As this is a research study, your authorization will not expire. You may, however, revoke your authorization later.

Revoking Your Authorization
You do not have to sign this form. Even if you do, at any time later on you may revoke (take back) your permission. If you want to do this, you must write to:

Dr. Ameeta Kalokhe
Woodruff Memorial Building Ste. 2101
Atlanta, GA 30322

After that point, the researchers would not collect any more of your PHI. But they may use or pass along the information you already gave them so they can follow the law, protect your safety, or make sure the research was done properly. If you have any questions about this, please ask.

In Case of Injury
If you get ill or injured from being in this study, Emory and Grady would give/arrange for you to have urgent health care. Emory and Grady have not set aside any funds to pay for urgent health care. Also, Emory and Grady have not set aside any funds to pay you if you become ill or injured from being in this study. The only exception to this policy is if it is proven that the negligence of an Emory or Grady employee directly caused your injury or illness. "Negligence" means the failure to follow a standard duty of care. If you believe you have been injured by this research, you should contact Dr. Ameeta Kalokhe (Phone: 404-712-1924).

Costs
There will be no costs to you for participating in this study, other than basic expenses like transportation. You will not be charged for any of the research activities.

Withdrawal from the Study
You have the right to leave the study at any time without penalty. You may refuse to do any procedures you do not feel comfortable with, or answer any questions that you do not wish to answer. If you decide to leave the study, you may request that your research information not be used.

Contact Information
Contact Dr. Ameeta Kalokhe at 404-712-1924 or akalokh@emory.edu:
Or contact Naomi David at naomi.s.david@emory.edu:
If you have any questions about this study or your part in it,
If you feel you have had a research-related injury, or
If you have questions, concerns or complaints about the research

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:
If you have questions about your rights as a research participant.
If you have questions, concerns or complaints about the research.
You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

If you are a Grady Health System participant, you may also contact Dr. Curtis Lewis, Senior Vice President for Grady Health System Medical Affairs at (404) 616-4261.

Consent

Please print your name and sign below if you agree to be in this study. By signing this consent form, you will not give up any of your legal rights. We will give you a copy of the signed consent to keep.

_____
Name of Subject

_____
_____
Signature of Subject
Date Time

_____
_____
Signature of Person Conducting Informed Consent Discussion
Date Time

_____
Name of Person Conducting Informed Consent Discussion

Appendix B: Interview Guide for Interviews with Study Participants on IPV, Drug Use, and Transactional Sex

Interview Guide

Aim 1: To explore parallels in the reasons for leaving, or considering to leave, a violent relationship and reasons for ceasing, or considering to cease, drug use and transactional sex.

Aim 2: To explore parallels in the barriers for leaving a violent relationship, and the barriers encountered when ceasing drug use or transactional sex

Aim 3: To better understand the temporal association between IPV, drug use, and transactional sex.

Introduction*:*

Thank you so much for coming back to do a follow-up interview with the Women's Health Study. As you may recall from your last visit, you were asked several questions about your personal history of exposure to violence or an abusive relationship, drug use, and sex in exchange for drugs, money, or shelter. The point of this interview today is to learn more about your experiences with these three behaviors/exposures, and to investigate any motivating factors for considering or deciding to leave a violent relationship, stop using drugs, or stop selling sex. The questions in this interview will ask in more detail about the behaviors and experiences you reported in the first part of the study. I appreciate you taking the time to discuss them fully again.

Similar to your last visit, I want you to know that your answers and participation in this interview will remain confidential. Also, you may refuse to answer a question at any point if you do not feel comfortable doing so. We would also like to record this conversation so it can later be transcribed for our analysis process. No one but the researchers involved in this study will hear your recording, and the recording will be deleted after it is transcribed. The data file will remain confidential and secured on a password-protected drive that only the researchers have access to. Any identifying information in your transcript will be removed to keep your participation anonymous.

Do you have any questions before we begin? May I turn on the recorder?

Background/Intro:

1. How would you describe an ideal relationship?
Probes: likes, dislikes, honesty, safety

2. Describe a current intimate relationship that you are involved in, or, if you are currently not involved in an intimate relationship, describe the most recent intimate relationship that you were involved in.

Probes: length of relationship, marital status, any children, previous relationship if currently single, cohabitation

Drug Use/Transactional Sex: Depending on how the participant responded in the initial survey, ask either/both of these sections as they apply

In your last interview, you mentioned you had previously used drugs/sold sex. I'd like to ask you more about your current and past behaviors while engaging in this.

Drug Use:
In your last interview, you mentioned some experiences that indicated that at some point in your lifetime you used drugs or illegal substances.

1. Please name all the drugs or illegal substances you have you used in the last 5 years.
Probes: drug type, frequency of use

2. If ever, describe a time you've considered quitting using drugs. What motivated you?
Probes: impact on physical or mental health, cost, family members or friends, negative impact of drugs on life

3. Thinking about the prior times you considered quitting or quit using drugs, what made it difficult to do so or to seek help?
Probes: difficulties encountered, detox pain, perceived social support, liked how the drugs felt, friends/family were also using

4. [If applicable] You mentioned currently using drugs at your last interview. What would it take for you to consider stopping now or to seek drug treatment or counseling?
Probes: perceived ability to quit, social support, effect on physical or mental health, cost, negative impact on life

Transactional Sex:

In your last interview, you mentioned some experiences that indicated that at some point in your lifetime you sold sex in exchange for money, drugs, or shelter.

1. If ever, describe a time when you stopped selling or trading sex or considered stopping to sell or trade sex. What motivated you?
Probes: attitudes towards selling sex, personal safety or health, safety of child or family member, self-esteem, viable means or just as a necessity)

2. What barriers or challenges did you experience in stopping to sell or trade sex?
Probes: lack of regular clients, no alternative to satisfy the 'need' for drugs, money, or shelter, got involved in a steady relationship, violence/abuse, stigma

3. Are you currently selling or trading sex in exchange for money, shelter, or drugs? [If applicable] What would it take for you to consider stopping or stopping to sell or exchange sex?

IPV History

In your last interview, you mentioned some experiences indicating that at some point in your lifetime, you experienced physical, emotional, or sexual abuse from an intimate partner. Now I'd like to take some time to ask you more about your experiences.

1. Thinking about a previous abusive relationship that you ended or left, what motivated you to end it or leave?
Probes: terms of split, personal safety, increased severity of abuse, children/pet safety, impact on your physical or mental health

2. Thinking about a prior abusive relationship that you were involved in, what made it difficult for you to end the relationship, leave, or seek help with leaving?
Probes: financial dependency, lack of support from family/friends, family investment, psychological/emotional wellbeing, lack of childcare, lack of awareness of support services, stigma

3. Describe any personal difficulties when this relationship ended
Probes: financial support, moving from cohabitation, children/pet custody

4. [If applicable] Thinking about your current relationship in which you have identified abuse, what would it take for you to consider leaving or for you to leave/end it or seek help from community support services?
Probes: terms of split, personal safety, increased, severity of abuse, children/pet safety, impact on your physical or mental health

Comparison of Motivating Factors

1. Reflecting back on the reasons you've considered stopping your use of drugs or selling sex, do you consider any reasons to be more or less important than others?

Timeline of Events

1. You've mentioned that you have used drugs/traded or sold sex and been in a violent relationship, and the motivations and barriers for leaving or considering to leave these experiences. Now I would like you to think back and tell me which began first—the drug use, your trading or selling sex, or the partner violence? Do you think one led to the other?
Probes: motivated to use drugs for coping, violence from partner due to selling sex/drugs

Review timeline of drug use, transactional sex, and IPV with participant. Perhaps write out timeline to visualize any potential trends, and discuss with them further

Closing

I want to thank you for sharing your experiences and thoughts with me. I know we covered some difficult topics, and I appreciate your openness. I want to express that your experiences are similar to those if many women, and that it's not your fault. Many women experiencing violence may be involved with drugs, or sell sex, and these are common patterns that this research study aims to explore.

1. Before we conclude, is there anything else you would like to add? Or are there any questions about the interview, or overall study?

*Thank you again for discussing your experiences. You may recall receiving this phonebook with resources during your initial study interview, and I'd like to offer you another copy, and go through some important contacts with you *review and distribute phonebook, ask if participant would like assistance contacting any resources*. I would like to again mention that this audio file will be deleted after transcription, and that the transcription will remain on a password-protected server. Any identifying information will be removed from your transcript.*