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A retrospective and prospective analysis of trading sex for drugs or money in women substance abuse treatment patients

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ABSTRACT

Background: Trading sex for drugs or money is common in substance abuse treatment patients, and this study evaluated prevalence and correlates of this behavior in women with cocaine use disorders initiating outpatient care. In addition, we examined the relation of sex trading status to treatment response in relation to usual care versus contingency management (CM), as well as predictors of continued involvement in sex trading over a 9-month period.
Methods: Women (N = 493) recruited from outpatient substance abuse treatment clinics were categorized according to histories of sex trading (n = 215, 43.6%) or not (n = 278).
Results: Women with a history of trading sex were more likely to be African American, older and less educated, and they had more severe employment problems and were more likely to be HIV positive than those without this history. Controlling for baseline differences, both groups responded equally to substance abuse treatment in terms of retention and abstinence outcomes. Fifty-four women (11.3%) reported trading sex within the next nine months. Predictors of continued involvement in trading sex included a prior history of such behaviors and achieving less abstinence during treatment. Each additional week of abstinence during treatment was associated with a 16% reduction in the likelihood of trading sex over the follow-up.
Conclusions: Because over 40% of women receiving community-based treatment for cocaine use disorders have traded sex for drugs or money and more than 10% persist in the behavior, more intensive and directed approaches toward addressing this HIV risk behavior are recommended.
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1. Introduction

Trading sex for money or drugs (i.e., sex trading) is common in individuals who abuse illicit substances, especially women. Among women seeking substance abuse treatment, between 30% and 41% endorse recent sex trading behaviors compared to about 6% to 11% of men (Burnette et al., 2008; Grella et al., 2000; Tross et al., 2009). Lifetime prevalence is even higher, with up to 51% of women and 19% of men seeking substance abuse treatment reporting these behaviors across their lifetime (Burnette et al., 2008). Participating in sex trading may vary by the primary substance of abuse, with up to 90% of crack cocaine users reporting involvement in sex trade (Jiwatram-Negrón and El-Bassel, 2015). These women also report higher frequency and intensity of cocaine use relative to those who are not currently or have never engaged in sex trade (Edwards et al., 2006; Jiwatram-Negrón and El-Bassel, 2015; Risser et al., 2006).

Heavy drug use plays an important, possibly cyclical, role in sex trade involvement. Sex trading may be initiated in order to support heavy substance use (Hoffman et al., 2000; Inciardi and Surratt, 2015), and substance use may escalate as a way to cope with involvement in sex trade (Mosedale et al., 2009). However, other factors appear to impact engagement in sex trade and may play a role in persisting in this behavior pattern as well. These include homelessness, unemployment, minority status, legal difficulties, and lower income (Burnette et al., 2008; Edwards et al., 2006; Gilchrist et al., 2005; Golder and Logan, 2007; Logan and Leukefeld, 2000; Jiwatram-Negrón and El-Bassel, 2015; Risser et al., 2006). Psychiatric issues may also be a significant contributing factor for or consequence of sex trade involvement. Women who traded sex in the past 30 days report greater psychological distress, including problems related to anxiety, depression, and PTSD, compared to those not recently engaged in sex trade (Edwards et al., 2006; El-Bassel et al., 1997). The presence of these factors may impact

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response to substance abuse treatment, which in turn may increase the likelihood of continued engagement in sex trade.

Successful substance abuse treatment may also be important from a public health perspective, as substance abusers who trade sex for drugs or money have higher rates of sexually transmitted diseases, HIV/AIDS, and viral hepatitis than substance abusers without sex trading histories (Burnette et al., 2008; Logan and Leukefield, 2000). The high rates of communicable diseases may reflect engagement in other high-risk practices by those who trade sex, such as injection drug use and other risky sexual behaviors (Logan and Leukefield, 2000; Jiwatram-Negrón and El-Bassel, 2015), highlighting the need to gain understanding of practices beyond sex trade involvement, such as reusing needles or not using condoms even with non-paying partners, that contribute to risk in this population.

Despite the high rates of sex trading in women who seek treatment for substance use disorders and the high prevalence of factors that may impact treatment success (e.g., homelessness, psychiatric comorbidity), few studies have focused specifically on this population. Some studies have demonstrated reductions in sex risk behaviors for up to 18 months following treatment entry in therapeutic communities (Cooperman et al., 2005; Woods et al., 1999) and up to six months in stimulant abusers who initiate Matrix model treatment (Shoptaw et al., 1998). All these studies (Cooperman et al., 2005; Shoptaw et al., 1998; Woods et al., 1999) found associations between treatment exposure (e.g., duration and intensity of treatment) and decreases in sexual risk behaviors. In addition, Gottheil et al. (1998) suggest that decreases in substance use itself also appear important for decreasing sex risk behaviors in their study of 447 cocaine dependent patients initiating intensive outpatient or individual counseling. These studies suggest that interventions that promote retention in treatment and reductions in drug use may be associated with risk reduction. However, none of them directly examined the impact of sex trade status on treatment response or whether women who trade sex for drugs or money benefit specifically from more intensive treatments designed to enhance treatment retention and abstinence.

Contingency management (CM) is an efficacious intervention that enhances engagement in treatment and reduces substance use. It provides monetary reinforcers upon objective evidence of drug abstinence. Across psychosocial treatments for substance use disorders, this intervention has the largest effect size (Dutra et al., 2008), and it is efficacious in a range of substance abuse patient populations and settings (Lussier et al., 2006; Prendergast et al., 2006). CM appears to be equally efficacious in reducing substance use in men and women (Rash and Petry, 2015), and it has benefits on improving multiple areas of functioning. For example, CM reduces psychiatric symptoms (Petry et al., 2013), improves quality of life (Petry et al., 2007), and decreases HIV risk behaviors (Ghitza et al., 2008; Hanson et al., 2008; Petry et al., 2010, 2011). CM protocols reinforcing stimulant negative urine samples reduce both stimulant use and sexual risk behaviors in men who have sex with men and have been recommended as a primary strategy for HIV prevention (Reback et al., 2010; Shoptaw et al., 2005).

No known studies have examined how women who trade sex for drugs or money respond to usual or enhanced substance abuse treatment relative to women who do not engage in these behaviors. Women with sex trade histories, with their higher rates of psychiatric and other life stressors, may benefit from enhanced treatments such as CM. Identification of treatments that promote treatment success among this group could have substantial impacts from a public health perspective due to their high rates of HIV risk behaviors and associated costs to the healthcare system.

One purpose of this study was to determine the proportion of women in substance abuse treatment at community clinics who have histories of trading sex for drugs or money, as relatively few studies have examined lifetime prevalence of these behaviors. We also examined whether women who engage in these activities differ in terms of baseline characteristics and participation in other risky sexual practices from those who do not trade sex for drugs or money. Another aim of this study was to evaluate how sex trade history impacts treatment outcomes, including retention, duration of abstinence achieved, and proportion of negative samples submitted, in response to usual care and CM. Lastly, we also sought to examine predictors of continued participation in sex trade after initiating substance abuse treatment.

2. Method

2.1. Participants

Participants were 493 women with cocaine use disorders who enrolled in randomized trials of CM at community-based outpatient psychosocial treatment clinics (Petry et al., 2004, 2005a, 2006a, 2011, 2012b). These clinical trials had common inclusion criteria: age 18 years or older, beginning intensive outpatient treatment at a substance abuse treatment clinic, ability to understand study procedures, and a DSM-IV substance use diagnosis. Exclusion criteria were significant uncontrolled psychiatric conditions (e.g., active suicidal ideation, bipolar disorder, schizophrenia) or being in recovery for gambling disorder (see Petry and Alessi, 2010; Petry et al., 2006b). University and other applicable Institutional Review Boards approved study procedures, and all patients provided written informed consent for participation.

2.2. Measures

At baseline, participants completed a checklist for the Structured Clinical Interview for the DSM-IV to assess substance use diagnoses (First et al., 1996), the Addiction Severity Index (ASI; McLellan et al., 1985), and the HIV Risk Behavior Scale (HRBS; Darke et al., 1991). The ASI evaluates medical, drug, alcohol, employment, legal, family/social, and psychiatric problems and derives composite scores ranging from 0.00 to 1.00 on each domain, with higher scores indicating greater severity of symptoms.

The HRBS contains five questions related to risky sexual behaviors and six related to injection drug use behaviors. Responses are coded using a 6-point scale from 0 to 5, with higher scores indicating higher risk behaviors. Summary scores are derived by adding the ordinal value of all responses on each scale, and the scales measure two distinct modes of HIV transmission (Darke et al., 1991; Petry, 2001). The HRBS has established psychometric properties for assessing HIV risk including internal reliability of 0.82 and 0.77 for lifetime and recent versions, respectively (Petry, 2001), and test-retest reliability of $r = 0.90$ for the lifetime version (Petry, 2001) and $r = 0.86$ for the past month version (Darke et al., 1991). High agreement is reported between substance abusers and their regular sexual partners regarding occurrence of sexual behaviors and drug injecting practices (Darke et al., 1991).

We used one item from the lifetime version HRBS sexual risk scale related to trading sex for drugs or money ("How often in your lifetime have you used condoms when you have been paid for sex with money or drugs, or when you have paid for sex with money or drugs?") to categorize participants. Response categories ranged from "never/no paid sex" to "every time" "often," "sometimes" "rarely," and "never." Anyone selecting a response other than "never/no paid sex" was coded as having a lifetime history of trading sex for drugs/money. Responses to this sex trade item were excluded from subscale and total HRBS scores, as by definition they differed between groups. The resulting sex subscale involved

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