Alcohol myopia and sexual abdication: Examining the moderating effect of child sexual abuse

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Abstract

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HIV and other sexually transmitted infections (STIs) are a major public health concern for women, and women who engage in risky sexual behaviors are at greater risk of contracting STIs. Risky sexual behaviors may include sexual abdication, that is, willingness to let a partner decide how far to go sexually, though this concept has not been well studied. Alcohol intoxication is a well-known risk factor for risky sexual decision making, and Alcohol Myopia Theory (AMT) is a cognitive physiological model that has been used to explain this relationship. One version of AMT is The Inhibitory Conflict Model which suggests that in order for intoxication to influence decision making, there must be high conflict between instigatory and inhibitory cues in the environment. The saliency of these cues is influenced by individual difference factors. One individual difference factor that has consistently been associated with both increased alcohol use and sexual risk taking is child sexual abuse (CSA) history. Few experimental studies examine in-the-moment sexual decision making involving alcohol when inhibition conflict is manipulated. Furthermore, it is unknown how alcohol intoxication, CSA severity, and inhibition conflict may interact to influence women's in-the-moment abdication likelihood. The current study examined these relationships with 132 women randomized into a 2 (alcohol, control) x 2 (high conflict, low conflict) experimental design. Following completion of a CSA questionnaire, participants read and projected themselves into an eroticized scenario in which there was either a condom present

(high conflict) or a condom absent (low conflict), and then indicated how likely they were to abdicate. Regression analyses yielded a significant 3-way interaction between CSA severity, alcohol and conflict condition on abdication likelihood. When there was high conflict in the scenario, abdication decreased as CSA severity increased for sober women, whereas abdication increased as CSA severity increased for intoxicated women. When there was low conflict, CSA severity and alcohol intoxication had no influence on abdication. These results may help explain the association between alcohol and risky sexual decision making among women with CSA.

Background

Women account for a quarter of all HIV/AIDS cases and sexually transmitted infections (STIs), such as Chlamydia and Gonorrhea, continue to be a major public health concern. Furthermore, negative health consequences of untreated STIs are often worse for women than for men, sometimes resulting in ectopic pregnancy or infertility (CDC, 2013). Women who engage in risky sexual behaviors are at greater risk of contracting STIs. Risky sexual behaviors may include unprotected intercourse, having sex with multiple partners, having sex with new partners of unknown STI risk, or abdicating sexual decision making to a new partner. Sexual abdication is defined as one's willingness to let a partner decide how far to go in a sexual encounter, and it is a construct that has not received much attention (Masters et al. in press; Stoner, et al. 2007). The current study used an erotic, second-person written scenario to explore women's in-the-moment intentions to abdicate sexual decision making to their partner.

One risk factor for risky sexual decision making is alcohol. Both correlational and survey data indicate an association between alcohol and risky sexual behavior. Furthermore, experimental evidence reports a causal relationship such that alcohol has been shown to decrease risk perception and increase intentions to engage in unprotected intercourse (for reviews, see George & Stoner, 2000; Hendershot & George, 2007; Rehm, Shield, Joharchi, & Shuper, 2012). A recent study found a positive relationship between alcohol use and sexual abdication specifically (Zawacki et al., 2009). While we do not know the mechanism for sexual abdication, one explanation for the influence of alcohol on unprotected sex is Alcohol Myopia Theory (AMT; Steele & Josephs, 1990). AMT is a cognitive-physiological model which argues that alcohol causes a decrease in cognitive processing ability resulting in a narrowed attention focus. Consequently, alcohol disrupts an individual's ability to process cues in the environment so that

impelling, instigatory cues have a more salient effect than inhibitory cues which require further cognitive processing. Instigatory cues may include high sexual arousal or the presence of a condom in a sexual situation signaling sexual safety. Inhibitory cues may include the presence of a new partner, of unknown STI risk or the absence of a condom signaling sexual caution. While the presence or absence of a condom is a situational cue likely to play a role in sexual decision making, few studies have actually manipulated condom presence (Conner & Flesch, 2001; Gilmore et al., in press).

One version of AMT is the Inhibitory Conflict Model. The Inhibitory Conflict Model suggests that in order for intoxication to influence decision making, there must be high conflict between the instigatory and inhibitory cues (Steele et al., 1985; Steel & Josephs, 1990). An example of a low conflict situation would be a highly arousing scenario with a new partner of unknown risk in which there is no condom available. In this case, the inhibitory cues of new partner, unknown risk, and no condom would be stronger than the instigatory cue of sexual arousal, making the individual unlikely to abdicate when either sober or intoxicated. However, if there had been a condom available in this scenario it would represent a high conflict situation in which the instigatory cues of condom presence and sexual arousal juxtapose the inhibitory cues of a new partner and unknown risk. According to the Inhibitory Conflict Model, in the latter situation alcohol myopia should lead the intoxicated individual to abdicate. In the current study we manipulated alcohol intoxication and condom presence in order to represent inhibition conflict.

Recent work has shown that individual difference factors are important when examining myopia processes because different cues will be salient for different people, depending on previous life experiences as well as personality and attitudinal factors (Davis et al., 2007). One

individual different factor that has consistently been associated with sexual risk taking is child sexual abuse (CSA) history. CSA is defined as any interaction for which the child is used for the sexual stimulation of the perpetrator, including contact and non-contact behaviors. In the United States, approximately 1 in 4 women report a CSA history (CDC, 2013) suggesting the sexual health implications affect a broad population of women. Extensive evidence suggests that women with a history of child sexual abuse (CSA), compared to non-abused women, are more likely to engage in high-risk sexual behaviors that may result in negative outcomes such as pregnancy, HIV, and other sexually transmitted infections (Cinq-Mars, Wright, Cyr, & McDuff, 2003; Hamburger et al., 2004; Koenig & Clark, 2003; Loeb et al., 2002; Senn, Carey, Vanable, Coury-Doniger, & Urban, 2006). These effects are more pronounced in women who experience more severe forms of abuse including penetration and multiple incidents (Loeb et al., 2002).

Sexual abdication is a risky behavior that may be especially relevant to women with a sexual abuse history who have been shown to be less assertive in sexual situations and to have greater difficulty refusing unwanted sexual advances (Johnsen & Harlow, 1996; Katz, May, Sorensen, & DelTosta, 2010; Livingston, Testa, & VanZile-Tamsen, 2007). Furthermore, CSA individuals often report feelings of powerlessness and submissiveness in sexual situations (Marx, Heidt, & Gold, 2005). To our knowledge, only one study has examined the relationship between sexual abuse history and sexual abdication. Masters and colleagues (in press) found that a history of adult sexual abuse increased a woman's anticipation of a negative response from a partner to insistence on condom use, which increased her likelihood of abdicating. Stoner and colleagues (2007) provide evidence that both intoxicated women and women with a sexual abuse history are more likely to respond passively in sexual situations. Examining the effects of CSA in the context of acute alcohol intoxication is especially pertinent because women with a history of

CSA, compared to non-abused women, report more past year heavy episodic drinking, alcohol dependence, and lifetime alcohol related consequences such as getting into fights (Lown, Nayak, Korcha, & Greenfield, 2011). Furthermore, CSA women are more likely than their non-abused counterparts to use alcohol before sex, increasing the likelihood of impaired sexual decision making (Wilsnack, Wilsnack, Kristjanson, Vogeltanz-Holm, & Harris, 2004). No study has looked at how CSA history and alcohol intoxication interact when inhibition conflict is manipulated.

Current Study

The current study used an erotic, second-person written scenario to investigate CSA as a potential moderator in the relationship between alcohol myopia and sexual abdication intentions. Given the previously cited research, we hypothesized:

H1: A main effect of CSA severity, such that as CSA severity increases we expect abdication likelihood to increase.

H2: A two-way interaction between alcohol and inhibition conflict condition such that:

A: When a condom is absent in the scenario (low conflict condition), there would be no effect of alcohol on sexual abdication intentions.

B: When a condom is present in the scenario (high conflict condition), there would be a myopia effect such that intoxicated individuals would be more likely to abdicate.

H3: Explore the potential moderating effects of CSA on these relationships.

Method

Participants

This study was part of a larger study designed to investigate the effects of alcohol intoxication on risky sexual decision-making. Female participants (*N*=132) were recruited from an urban community through flyers and newspaper advertisements for a study on "social drinking and decision-making". To be eligible, women had to be between the ages of 21 and 35 years, single, interested in dating opposite-sex partners (to increase the external validity of the erotic scenario), and social drinkers because the study included alcohol administration. Furthermore, the women had to have at least one heavy episodic drinking event in the past year (defined as 4 or more drinks on one occasion), because our target BAL was 0.10%. Participants were excluded from the study if they indicated problem drinking and if they were taking medications or had a health condition that contraindicated alcohol consumption. Demographic characteristics are contained in Table 1. Participants received $15 per hour.

Procedures

Participants were instructed not to drive to the laboratory and not to drink alcohol or take any drugs or medications for 24 hours prior to their appointments. Upon arrival at the laboratory, participants were greeted by a female experimenter who ensured they were above the age of 21 by checking a photo ID, and administered an initial breath test with an Intoxilyzer 5000 (CMI Inc., Owensboro, KY) to establish a 0 blood alcohol level. The experimenter then obtained informed consent, gave the participant a pregnancy test (Osom hCG-Urine Test, Genzyme General Diagnostics, San Diego, CA), and left the participant alone to complete background measures.

Alcohol Procedures and Administration

Participants were randomly assigned to either an alcohol (target BAL of 0.10%) or a control condition. Drinks consisted of one part 190 proof alcohol to 6 parts cran-apple juice,

body weight adjusted, and poured into 3 cups. Participants in the control condition were given the same amount of plain juice. All participants consumed their drinks in 9 minutes, with BAC tested every 3 minutes until participants reached the criterion. Participants in the control condition were yoked to participants in the alcohol condition so that the same amount of time passed following beverage consumption before starting the remaining procedures.

Erotic Scenario

Participants projected themselves into an erotic, second-person, written scenario in which the participant was the protagonist. The scenario depicted an interaction between the protagonist and a former male co-worker, "Joe", which progressed from spending time with him at a party to engaging in foreplay activities. Inhibition conflict was manipulated by randomizing participants into either a condition in which a condom was present in the scenario (high conflict condition) or in which a condom was absent in the scenario (low conflict condition). In the high conflict condition, the scenario ends when the man in the scenario says "I would love to be inside of you. Is that okay? *I have a condom*", and in the low conflict condition, the scenario ends when the man in the scenario says "I would love to be inside of you, *but I don't have a condom*. Is that okay?" All participants were described as taking birth control pills in the scenario. Following the scenario, participants recorded their sexual abdication intentions. The protagonist's beverage consumption in the scenario matched the participant's assigned alcohol condition in the experiment. For all participants, the male in the scenario was depicted as consuming at least 2 alcoholic beverages.

Detoxification and Debriefing

Sober participants were debriefed, paid and released following completion of the experiment. Participants in the alcohol condition remained in the laboratory until their BAC dropped to a .03 before being debriefed, paid, and released.

Measures

Childhood Sexual Abuse Severity

Finkelhor's (1979) questionnaire was used to determine participant's child sexual abuse severity. All questions regarding abuse history were behaviorally specific. Women reported how many times they experienced non-contact (e.g. showing their genitals), contact (e.g. sexual fondling), and penetrative (e.g. vaginal intercourse) sexual abuse before the age of 14 with someone 5 or more years older. There were 3 non-contact items, 5 contact items, and 5 penetration items. For each item, participants indicated whether it happened 0 times (coded as 0), 2-4 times (coded as 3), 5-7 times (coded as 6) or 8 or more times (coded as 8). Frequencies were summed and capped at 8 for each type of abuse. The total severity score was calculated by summing weighted non-contact, contact, and penetration frequency scores (non-contact + 2*contact + 3*penetration). The CSA severity score ranged from 0-48 with 50% (*n*=66) scoring 0, indicating no abuse experiences. The mean severity score was 9.56, SD 14.86.

Sexual Intentions

Following presentation of the scenario, participants were asked their sexual abdication intentions with a single item that read: "At this point, how likely are you to relax and let Joe decide how far to go?" Responses were indicated on a scale from 1 (*not at all likely*) to 5 (*very likely*).

Results

Table 2 contains means, standard deviations and t-test results for differences in CSA severity and abdication likelihood between each of the experimental groups (low conflict, high

conflict; alcohol, control). In the low conflict condition, CSA severity significantly differed between alcohol and control conditions, t (57) = -2.80, p <.01; however, CSA was included in the model which controlled for these differences. Abdication likelihood, t (129) = -2.75, p <.01 was significantly lower in the low conflict condition in which there was no condom available.

A Hierarchical Multiple Regression analysis was performed to examine conflict condition and CSA severity as potential moderators of the association between alcohol condition and abdication likelihood. Prior to conducting analyses, CSA severity was standardized to reduce multicollinearity and to better interpret the interaction (Aiken & West, 1991). CSA severity, alcohol condition, and conflict condition were entered in Step 1, two-way interaction terms were entered in Step 2, and the three-way interaction among CSA severity, alcohol condition and conflict condition was entered in Step 3 (Table 3). The first step in the regression analysis testing main effects was not significant, F (3,127) = 2.56, R^2 = .06, p >.05. Furthermore, the step including two-way interactions was not significant, F (3,124) = 2.23, R^2 = .11, p >.05. The third step, however, revealed a significant three-way interaction on abdication likelihood, F (1,123) = 8.68, R^2 = .16, p <.01.

To probe the interaction, we examined the effects of CSA severity and alcohol within the high and low conflict conditions (Figure 1). An analysis of simple slopes revealed that with high conflict, as CSA severity increased abdication likelihood increased for those who consumed alcohol, t (71) = 2.98, p <.01. Additionally, when there was high conflict in the scenario, as CSA severity increased abdication likelihood decreased for those who were in the control condition, t (71) = -2.20, p <.05. Neither slope for the alcohol or control conditions were significant when there was low conflict (both p's > .27).

Discussion

The results of this study support previous literature that alcohol myopia may only foster risky decision making when there is high inhibition conflict. In line with the inhibitory conflict model, we found no significant effects in the low conflict condition where inhibitory cues outweighed instigatory cues. However, we did find a significant effect in the high inhibition conflict situation in which there was a condom present: Abdication intentions increased as CSA severity increased when intoxicated, whereas, abdication intentions decreased as CSA severity increased when sober. The findings from this study suggest that CSA severity may be an important individual difference variable influencing alcohol's effect on sexual abdication.

While we hypothesized a main effect of CSA severity on sexual abdication, our results did not support this relationship. Previous literature indicates that women with a history of CSA report more inconsistent use of condoms, have more sexual partners, and are less able to make decisions about contraception (Loeb et al., 2002). Extensive evidence supports this relationship between CSA and sexual risk-taking. However, few studies have used experimental paradigms to examine in-the-moment sexual risk-taking, and no study has examined the relationship between CSA and sexual abdication intentions specifically. Despite rates of sexual risk being higher among women with a history of CSA than in the population at large, a large portion of women with a history of abuse are able to have safe and satisfactory sexual experiences, and some studies find no differences between abused and non-abused women (Loeb et al., 2002). We may not have seen a direct effect of CSA on sexual abdication because the experimental paradigm included other salient variables likely to influence this relationship. Acute alcohol intoxication and inhibition conflict may be important to examine in order to understand why some women with a history of CSA engage in risky sexual behaviors while other women do not.

Also inconsistent with previous literature, we did not find a significant two-way interaction between alcohol condition and conflict condition on sexual abdication intentions. Steele and Southwick (1985) reviewed 34 studies investigating alcohol's effect on social behavior in order to test their hypothesis that alcohol myopia's effect is influenced by inhibition conflict. They found that there was a powerful effect of conflict condition, such that alcohol's effect on a variety of social behaviors (e.g. assertiveness, risk taking, sexual interest) was influenced by the level of conflict between instigatory and inhibitory cues. However, Steele and Southwick (1985) did not take into consideration individual difference variables, such as sexual abuse history, that may influence the level of conflict experienced in a situation. In our study, the relationship between alcohol, inhibition conflict, and sexual abdication was moderated by CSA severity. This is consistent with findings from Davis and colleagues (2007), where individual difference variables (i.e. a priori perception of the risks/benefits associated with unprotected sex) influenced alcohol's effects on unsafe sex intentions in a sexual scenario. Findings from the present study suggest that alcohol's effect on sexual risk-taking appears to be influenced by a woman's child sexual abuse history.

Analyses revealed a significant three-way interaction between alcohol condition, conflict condition, and CSA severity on sexual abdication likelihood. When intoxicated, there was a positive relationship between CSA severity and sexual abdication likelihood. Women with a more severe history of CSA may be less able to focus on the inhibitory cues of a potentially risky new partner, and therefore be more likely to let him decide how far to go, increasing their risk. Previous research suggests that both intoxicated women (Purdie et al., 2011; Steele & Josephs, 1990) and women with a history of CSA (Messman-Moore & Long, 2003; Zurbriggen & Freyd, 2004) may have difficulty properly assessing risk in a sexual situation However, rather than

independent effects, in the present study intoxication and CSA history jointly determined risk in a high conflict sexual situation.

We also found an unexpected pattern of results in the control condition, in which CSA severity was negatively related to abdication likelihood. Perhaps, as a result of previous abuse experiences women have learned to associate sexual behavior with fear or anxiety and are more cautious in sexual situations when they are sober. In fact, evidence suggests that women with a history of CSA are more likely than non-abused women to associate sex with negative emotions (Rellini & Meston, 2007). Therefore, these women may be more alert, more likely to perceive and process sexual risk cues, and less likely to relinquish decision making to their partner.

Alcohol may act to relieve some of the negative emotions associated with the sexual situation and may reduce the individual's level of sexual caution. Therefore, the anxiolytic effect of alcohol may decrease perception of risky cues (Sayette, 1993). This would explain why intoxicated women with a more severe history of CSA were more likely to abdicate sexual decision making to their partner. While this explanation is speculative, these results are consistent with a study by Stoner and colleagues (2007). They found that when women were sober, sexual fear (as measured using the sexual aversion scale) was negatively related to sexual abdication. However, when intoxicated, sexual fear was positively related to sexual abdication; the same pattern of results we are seeing with CSA severity and sexual abdication. Stoner and colleagues suggest that alcohol may affect different types of individuals differently and that alcohol may foster sexual risk taking because it attenuates the fear and anxiety. Sexual fear and anxiety may play a role in the effect of CSA on the relationship between alcohol myopia and sexual risk taking. Future research should further examine the role of emotions in the

relationship between alcohol and sexual risk taking, focusing more specifically on this nexus in the context of CSA history.

Though these findings need to be replicated and expanded to other measures of sexual risk beyond sexual abdication, CSA history appears to moderate the relationship between alcohol myopia and risky sexual decision making. Therefore, alcohol intoxication may be a particularly risky state for women with more severe CSA histories. This study does have several limitations that future research should address. First, the abdication measure was a single item, which raises questions about its reliability. However, it is important to note that the findings obtained with this one item measure are in keeping with findings obtained using multi-item indicators of abdication (Eakins et al., in preparation; Masters et al., in press; Stoner et al., 2007; Zawacki et al., 2009). Furthermore, our abdication item may be confounded by the phrase "How likely are you to *relax*" preceding "and let Joe decide how far to go". Nevertheless, the current findings are in keeping both with findings that did (Stoner et al., 2007) and did not (Eakins et al., in preparation; Masters et al., in press; Stoner et al., 2007; Zawacki et al., 2009) include the "relax" element of this abdication item. Furthermore, we believe that this item has good external validity in that a man may actually say to a woman in a sexual situation "Just relax, and go with the flow". Another limitation of the current study is that sample characteristics may limit the generalizability of our findings. The women who participated in this study were all heavy episodic drinkers, single, and willing to volunteer for a study on sex (which involved erotica and genital measurement). Thus, our findings may not generalize to all women. Finally, our analyses were exploratory and future research should attempt to replicate our findings.

HIV and other STIs continue to be a major public health concern, and rates are especially high among women with a history of CSA who engage in risky sexual behaviors. It is important to

gain a better understanding of what occurs in the moment that risky sexual decisions are made in order to inform prevention and intervention efforts. Although further investigation is needed, these findings have implications for interventions targeting sex-related alcohol use, attention to risk cues, and abdication tendencies in women with a CSA history. Furthermore, these findings may be pertinent to understanding patterns of revictimization in this population. Child sexual abuse is the strongest predictor of adult sexual assault and women with a history of CSA are 2-3 times more likely than others to be revictimized (Messman-Moore & Brown, 2004). Theories attempting to explain revictimization often contain themes of learned helplessness, powerlessness, and impaired assertiveness (Marx, Heidt, & Gold, 2005; Zerubavel & Messman-Moore; in press), all of which appear to be similar constructs to sexual abdication. CSA women may abdicate when they don't really want to have sex, thus abdication may be an important mechanism between CSA and subsequent alcohol-related victimization. Future research should investigate sexual abdication as a mediator in the relationship between CSA and sexual revictimization as well as unprotected intercourse. While further research is needed, this study suggests that intoxicated women with a more severe history of CSA may be at increased risk of negative sexual outcomes.

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Table 1

Demographic characteristics

	M (SD)
Age	25.25 (4.53)
	N (%)
Education	
Currently a Student	
Yes	41(31.1)
No	88(66.7)
Some college or less	78(59.1)
College Graduate or more	47(35.5)
Income	
<$20,999	75(66.8)
$21,000-$40,999	35(26.5)
>$40,999	20(15.2)
Racial Identification	
Caucasion/White	89(67.4)
Black/African American	12(9.1)
Asian/Hawaiian/Pacific Islander	7(5.3)
Multi-Racial	17(12.9)
Other	5(3.8)
Hispanic or Latino	
Yes	9(6.8)
No	121(91.7)

Table 2

Means and standard deviations (SDs) of CSA severity and sexual abdication likelihood.

	High Conflict (*n*=73)			Low Conflict (*n*=59)		
	Control (*n*=34)	Alcohol (*n*=39)	Total (*n*=73)	Control (*n*=27)	Alcohol (*n*=32)	Total (*n*=59)
CSA severity	5.44(12.03)	12.03(16.99)	8.96(15.16)	$5.07(8.81)_a$	$14.72(16.98)_b$	10.31(14.58)
Abdication likelihood	2.76(1.30)	2.79(1.58)	$2.78(1.45)_b$	2.00(1.11)	2.22(1.39)	$2.12(1.26)_a$

Note. CSA = Childhood sexual abuse severity; Different subscripts in a row denote significant differences between groups, $p<.05$.

Table 3

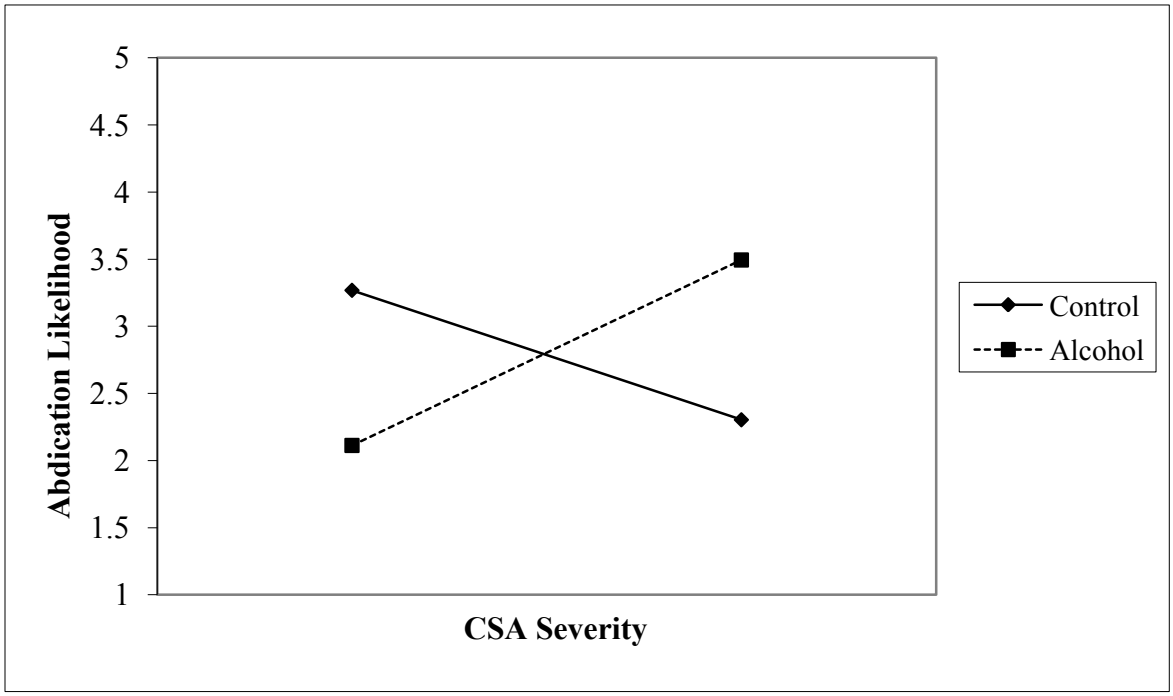
Summary of hierarchical regression analyses for abdication likelihood (N = 132)

			Abdication Likelihood		
	R^2	ΔR^2	β	p	s-r
Step 1:	.06				
CSA severity			-0.00	.96	-.00
Alcohol			0.04	.64	.04
Conflict			0.24	.01	.24
Step 2:	.11	.05			
CSA severity			-0.36	.04	-.17
Alcohol			0.08	.53	.05
Conflict			0.28	.03	.19
CSA X Alcohol			0.31	.02	.21
CSA X Conflict			0.17	.24	.10
Alcohol X Conflict			-0.06	.71	-.03
Step 3:	.16*	.06			
CSA severity			0.06	.80	.02
Alcohol			0.09	.49	.06
Conflict			0.28	.03	.19
CSA X Alcohol			-0.17	.40	-.07
CSA X Conflict			-0.30	.15	-.12
Alcohol X Conflict			-0.06	.69	-.03
CSA X Alcohol X Conflict			0.56	.00	.24

Note. CSA = Child Sexual Abuse Severity; s-r = semi-partial correlations, a measure of effect size. * $p < .01$

Figure 1

a. CSA X alcohol interaction on abdication likelihood in the high conflict condition



b. CSA X alcohol interaction on abdication likelihood in the low conflict condition