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Partner Pressure, Victimization History, and Alcohol: Women's Condom-Decision Abdication Mediated by Mood and Anticipated Negative Partner Reaction

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Abstract

Highly intoxicated versus sober women were evaluated using multi-group path analyses to test the hypothesis that sexual victimization history would interact with partner pressure to forgo condom use, resulting in greater condom-decision abdication – letting the man decide whether or not to use a condom. After beverage administration, community women (n=408) projected themselves into a scenario depicting a male partner exerting high or low pressure for unprotected sex. Mood, anticipated negative reactions from the partner, and condom-decision abdication were assessed. In both control and alcohol models, high pressure increased anticipated negative partner reaction, and positive mood was associated with increased abdication. In the alcohol model, victimization predicted abdication via anticipated negative partner reaction, and pressure decreased positive mood and abdication. In the control model, under high pressure, victimization history severity was positively associated with abdication. Findings implicate condom-decision abdication as an important construct in understanding how women's sexual victimization histories may exert sustained impact on sexual interactions.

Keywords

Partner Pressure; Sexual Victimization; Alcohol; Condom Decision Abdication

Women experience persistent health threats due to sexually transmitted infections (STIs), including HIV/AIDS. Infection risk can be reduced with male condoms. However, women's condom use depends on a male partner who may exert pressure to forgo it. Thus, women's potential susceptibility to partner pressure and their willingness to abdicate to it are

important to understand. To date, women's response to men's pressure to forgo condoms has received little scientific attention. Fragmented empirical findings from surveys and experiments reviewed below suggest that susceptibility to pressure would be associated with women's previous sexual victimization and related affective and cognitive mediators (1–3), particularly when drinking. Postulating accordingly, we investigated the influences of victimization history, partner pressure, and affective and cognitive mediators on women's condom-decision abdication – letting the partner decide about whether to use a condom – under sober versus intoxicated conditions.

Partner Pressure for Unprotected Sex

Pressure from a man to have sex without condoms has been identified as contributing to heterosexual women's sexual decisions (4). Consistent with this, men have reported that exerting verbal pressure to forgo condoms is acceptable and normative; and that they have done so in the past and intend to do so in the future (5,6). Thus, identifying and understanding how women respond to pressure for unprotected sex potentially represents a critical juncture in decisions about condoms. Yet scant science is available about the nature of women's responses to partner pressure.

This knowledge gap has particular relevance regarding steady partners, where it is commonly assumed that condom use is less necessary than with new or casual partners (7). In steady relationships where protected sex has been the norm, beginning to forego condoms is a critical decision point because it establishes precedence for future unprotected sex, thereby creating sustained elevation in STI transmission risk. Consistent, lasting condom use in young heterosexual couples has been difficult to achieve; high rates of condom discontinuation are common (8). Condom use patterns are related to relationship status in this population, with use being more likely in new or casual relationships than in established or serious ones (9). However, there is little research on the dynamics of ceasing condom use. Examining factors – such as alcohol, partner pressure, and sexual victimization history – that may be involved in women's in-the-moment decision to either advocate for condom use with a male partner or abdicate the decision may contribute to better understanding condom use continuation and cessation processes.

Previous research on “sexual pressure” has tended to conflate coercive pressure for sex with specific pressure for unprotected sex. For example, Teitelman, Ratcliffe, & Cederbaum (10) described sexual pressure as a form of social influence “toward having sex or having sex in a particular way (e.g., without condoms).” Similarly, Jones (11) conceptualized and operationalized sexual pressure as an internalized construct reflecting a woman's gender stereotypical concerns about adverse consequences resulting from not meeting a man's expectations for sex; again placing the emphasis on coercive pressure for sex generally. Although valuable for documenting women's subjective sense of feeling pressured to have sex, such research provides little illumination about men's pressure for unprotected sex with women who are willing to consent to protected sex and the role such pressure plays in their eventual risk decision.

Further, discussions of sexual pressure have been framed either by feminist discourse (e.g., gender-power theory, 12) and/or theories of HIV-related sexual risk taking (e.g., the theory of reasoned action, 13), which emphasize rational decision-making processes over emotional heat-of-the-moment processes. Lacking has been consideration of important naturalistic features of men's exertion of pressure. Specifically, exposure to such pressure occurs during heat-of-the-moment dyadic interchanges characterized by intense and dynamically shifting emotional states and social-cognitive perceptions, suggesting that affective and cognitive factors may mediate the effects of pressure.

Previous research indicates that a woman's anticipation of a man's response to her condom use insistence is an important cognitive factor. Anticipated negative partner reaction has predicted women's decreased sexual assertiveness (14) and condom self-efficacy (15), highlighting its importance to understanding women's responses to men's pressure. Because it is associated both with prior sexual victimization (14) and unprotected sex (16), anticipated negative partner reaction is especially relevant to understanding how women with victimization histories might respond. Moreover, the interplay of cognitive appraisal and emotional expression generally (e.g., 17) points to the likely involvement of mood states, as well.

Sexual Victimization History & Sexual Risk Taking

Victimized women report more sexual partnerships (18) and sexual risk taking (19) than non-victimized women. Surveys linking sexual risk behavior with previous childhood sexual abuse (CSA) (see reviews by 20,21) and adult sexual assault (ASA) (22,23) emphasize distal explanatory factors suggesting that post-victimization trauma symptoms and mood disturbances foster problematic coping styles and relational instability resulting in greater exposure to risk opportunities. However, growing evidence from experiments indicates that victimized women also respond differently than non-victimized women to sexual risk opportunities. In experiments potential mediators were evaluated using heat-of-the-moment scenarios in which women projected themselves into an eroticized consensual encounter with a casual partner. Focusing on behavioral mediators, Stoner et al. (24) found that women with a history of ASA were less sexually assertive than non-victimized women, resulting in less condom insistence and greater likelihood of unprotected sex. Focusing on sexual-emotional mediators, George et al. (25) found that both sexual victimization history severity and acute alcohol intoxication affected unprotected sex intention, and that these effects were mediated by positive mood and sexual desire. Focusing on cognitive mediators, Masters et al. (1) found that the effects of sexual victimization history severity and acute alcohol intoxication were mediated through a) perceptions of the partner's intoxication and STI risk, b) anticipated negative partner reaction to condom insistence; and c) willingness to abdicate the decision about having unprotected sex to him.

These experiments indicate that the well-established association between sexual victimization history and increased sexual risk taking is not exclusively a function of distal processes resulting in victimized women having increased exposure to risk taking opportunities. Instead, it appears that once in a sexual encounter, victimized women actually respond differently than non-victimized counterparts. Furthermore, these differences are

evident in in-the-moment mediators that make conceptual sense: decreased assertiveness, decreased positive mood, and increased perceptions of the partner as risky and as likely to respond negatively to condom use negotiation. “Sexual abdication” emerged as a relatively novel construct that may also be important in understanding how victimized women respond.

Sexual Abdication and Condom Decision Abdication

Sexual abdication refers to willingness to forsake decisional power in a sexual encounter by letting a partner decide what happens sexually. As operationalized in previous work, it constitutes a risky behavior because it subsumes allowing a partner to decide about condom use (26–28) and it predicts unprotected sex intentions (1). Sexual abdication may be an especially relevant outcome for victimized women who often feel powerless and unassertive in sexual situations and have difficulty refusing unwanted sexual advances (2,3,29). In experiments, victimized women have exhibited less assertiveness and more passivity than non-victimized women (24,27). Masters et al. (1) found that CSA increased sexual abdication indirectly via ASA and perceptions of the partner. Staples et al. (26) found that, compared to non-victims, CSA victims exhibited greater abdication when intoxicated and when subjected to high versus low inhibition conflict about having sex. Such findings suggest that women with increasingly more severe sexual victimization histories are more likely to abdicate sexually to a partner, especially when intoxicated. To gain a more precise account of abdication about condom use specifically, we modified our more general sexual abdication operationalization for the current study to capture condom-decision abdication specifically: willingness to allow a partner to decide whether a condom is used.

Mediation by Anticipated Partner Reaction and Mood

Cognitive and affective experiences unfolding in the heat of the moment should play mediating roles in links from both victimization history and partner pressure to abdication. In surveys, anticipating a negative partner reaction is an important cognitive factor, reliably associated with victimization history, more negative experiences with partners, decreased sexual assertiveness, decreased self-efficacy, and increased sexual risk taking (14,15). In a previous experiment, it mediated the link between victimization history and abdication (1). These findings pointed to formulating our hypothesis in the current study that anticipated partner reaction will be a significant mediator. Emotionally, decreased positive mood has mediated the association between victimization and sexual risk likelihood (25). Thus, this experiment considered both cognitive and emotional constructs simultaneously in characterizing how victimization history and pressure affect response to a hypothetical heat-of-the-moment sexual encounter.

Present Study

This is the first study to operationalize and manipulate partner pressure and evaluate its impact on women’s willingness to abdicate decisions about condom use. Without a pre-established theoretical rationale dedicated to predicting and explaining pressure effects, hypotheses were formed based on two considerations. First, gender-power theory (12)

suggests that victimized women may feel chronically disempowered in sexual encounters, resulting in them being more likely to abdicate to pressure regarding condom non-use. Second, aforementioned survey and experimental findings, while fragmented, clearly suggest that previous victimization fosters susceptibility to pressure by abdicating, that in-the-moment affective and cognitive processes mediate pressure effects, and that these effects vary with acute intoxication. We therefore hypothesized a) an interaction whereby victimization history would be more predictive of abdication under high versus low pressure and b) that heightened anticipation of a negative partner response, decreased positive mood, and increased negative mood would mediate between victimization history and partner pressure (see Figure 1).

Finally, alcohol continues to be important in understanding the role of sexual victimization history in sexual risk. Compared to non-victimized counterparts, victimized women generally tend to drink more heavily, more frequently, and more often before sex (e.g., 22,30). Also, alcohol is one of the strongest known contextual determinants of sexual risk behavior as evidenced by longitudinal surveys (e.g., 31) and rigorous experiments (e.g., see reviews by 32,33). Therefore, we examined the hypothesized model under two sets of conditions, alcohol and no alcohol, enabling us to evaluate whether victimization and pressure influence mediators and abdication differentially when women are highly intoxicated versus sober. We hypothesized that the effects of the cognitive and emotional mediators and the condom-decision abdication outcome would be similar in the alcohol and control groups and that the effects of partner pressure, victimization history, and their interaction would be different. Specifically, we expected both pressure and victimization to relate positively to condom-decision abdication when participants were highly intoxicated. Due to attentional effects laid out in alcohol myopia theory, intoxication should accentuate focus on salient situational cues like partner pressure, which itself should be more prominent among victimized women who have previously experienced disempowerment in sexual situations.

Method

Participants

Women were recruited from an urban community and were eligible if they were between the ages of 21 and 30, sexually active with men, had at least one occasion of heavy episodic drinking (HED, four or more drinks within two hours; 34) and one instance of unprotected sex in the past year with at least one additional HIV/STI risk factor. HIV/STI risk factors were defined as: a) new male sex partner in the past year; b) two or more male sex partners in the past year; c) having had an STI; or d) knowing or suspecting that a past year male sex partner had himself had a concurrent sexual relationship, an STI and/or HIV, a same-sex sexual encounter, ever used IV drugs, or been incarcerated in the last 12 months. Finally, women were excluded if they reported a medical condition or prescription drug use that contraindicated alcohol consumption, did not typically drink at least 5 drinks per week, or if they had a history of negative reactions to alcohol or problem drinking as assessed by the Brief Michigan Alcohol Screening Test (BMAST; 35). These final exclusion criteria are

based on the NIAAA's guidelines for ethical administration of alcohol to humans in research settings (36).

Four hundred and forty women initially participated in the study. Data for 21 women were removed from the sample due to an error in alcohol administration in which experimenters dosed them with lower proof alcohol (151 proof vs. 190). Another 7 participants became ill during alcohol administration and were unable to finish their beverages, and 4 participants did not ascend to the target blood alcohol concentration (BAC). Thus, the final analysis sample included 408 women ($M_{\text{age}} = 24.7$ years, $SD = 2.79$). The majority of the sample self-identified as Caucasian (65.3%), 9.4% self-identified as African American/Black, 6.7% as Asian/Pacific Islander, 8.3% as Hispanic/Latina, 1% as Native American, and 17.6% as Multiracial or other. Current full- or part-time employment was reported by 56.7% of women and 78.9% of women had at least some college education. Full- or part-time student status was reported by 37.7% of women and 72.8% of women reported a yearly income of \$30,999 or below; 18.2% of the women reported having been incarcerated. While most of the women reported never having been diagnosed with an STD (64.7%), the remainder reported one or more STD diagnoses with HPV (17.4% of the sample) and chlamydia (14.4%) the most commonly reported.

The average age of drinking onset was 14.14 years ($SD = 3.16$). On average, women consumed 12.95 drinks per week ($SD = 9.2$), 72.8% of women reported HED at least once a month in the past year. The mean consensual sexual debut for our sample was 16.65 years of age ($SD = 2.28$). Participants reported a mean of 16.03 ($SD = 12.09$; capped at 100) lifetime vaginal sex partners and a mean of 3.91 ($SD = 3.91$) vaginal sex partners in the past 12 months; 37.1% engaged in anal intercourse during the past year; 64.5% of women did not use a condom the last time they had sexual intercourse; and 61.3% reported using a condom during 50% or fewer of the times they had vaginal intercourse. Overall, 72% of the sample ($n=295$) reported having a history of ASA victimization.

Procedures

All procedures were approved by the university's human subjects institutional review board. We placed online and print ads and distributed flyers to recruit single women, aged 21 – 30, who were social drinkers to participate in a study on male-female interactions. Ads indicated that they would be paid \$15 per hour up to \$135. Interested women called in and were screened for eligibility by a trained female research assistant. Once they were determined to be eligible for the study, they were scheduled for an appointment. When participants arrived at the laboratory, a trained female research assistant verified that their blood alcohol concentration (BAC) was 0.00 using a handheld breathalyzer (Alco-Sensor IV, Intoximeters, Inc.) and then administered informed consent. Each participant was then weighed to calculate her alcohol dose and given a self-administered urine test to ensure she was not pregnant. Participants completed background questionnaires, which included demographics, sexual experiences, drinking habits, and history of sexual victimization. The background questions took approximately an hour to complete and participants entered all data into the computer in a private room. Once the background questions were complete, participants were block randomized based on victimization history into four conditions in which alcohol

consumption (no alcohol/alcohol) and pressure by the male character to have sex without a condom (high/low) were manipulated, creating a 2×2 (pressure by alcohol).

Participants were assigned to one of the alcohol conditions received beverages consisting of five parts cranberry juice and one part 190 proof grain alcohol, dosed at 1.0 ml per kg of body weight. Beverages were divided into three equal portions and consumed over a period of four minutes each for a total of 12 minutes. Breathalyzer tests were administered approximately every four minutes until a criterion BAC of .07 was reached. This ensured that participants would be on the ascending limb of the BAC. To control for individual differences in speed of alcohol absorption—and, consequently, elapsed time and number of breath samples to criterion—each alcohol participant was yoked to a control participant who drank only juice and was provided the same number of breath samples over the same number of minutes before beginning the experimental scenario (37). After reaching the criterion BAC (alcohol participants) or completing the yoked number of breathalyzers (controls), participants were left alone in the room to read the sexual scenario.

The sexual scenario was developed using data from focus groups on young women's experiences of casual sexual relationships, condom use, and relationship potential, as well as experience from the team's previous research. It was pilot tested to further ensure realism. The approximately 1600-word scenario was written in the second person to facilitate participants' projection into the storyline. Instructions read: "You are now going to read a brief scenario and answer some questions. Imagine that you are the person being described in the scenario and try and put yourself in the situation. When the scenario involves drinking, imagine that you have had a similar amount to drink as you have had today in the lab." For participants in the alcohol condition, the protagonist drank alcohol, while for those in the control condition, she drank soft drinks. The male character's moderate drinking was constant across conditions. Participants overall rated the scenario as very realistic ($M = 5.9$, $SD = 1.3$; 1 = *not at all realistic* to 7 = *extremely realistic*).

The scenario established that the protagonist had been in a steady relationship with the male character, Michael, for a couple of months, had previously had only protected sex with him, and was on the pill. She was very attracted to him. The characters went to dinner, then to Michael's place, where they began kissing and touching. Sexual activity became progressively more heated until both characters were undressed and approaching intercourse. Descriptions and dialogue were eroticized to increase the participant's sexual arousal.

The amount of pressure applied by Michael to have sex without a condom was varied according to experimental condition. In both low and high pressure conditions, it was made clear that condoms were available and that the female character/participant preferred to use one. She "ask[s] Michael if he has any condoms, while reaching over to open the drawer of the nightstand next to his bed where he usually keeps them. You open it and see that he has some in there." At this point in the low pressure scenario Michael states his desire not "to stop for that yet," leaving the door open for future condom use. In the high pressure scenario, Michael asks if "we need one," "closes the drawer" and says, "It will be so much hotter if there is nothing between us." Increasingly eroticized sexual activity occurs at this

point with Michael making one more attempt to have sex without a condom (i.e. “It would feel so good with nothing between us, but if you want to use one, we can” [low pressure] and “If we want to keep things going between us, it’s time we stopped using condoms” [high pressure]). At this point the mediating and outcome measures were assessed. Participants overall rated their/the female character’s desire to use a condom (“How much do you want to use a condom?”) as moderately high ($M = 4.6$, $SD = 2.0$; 1 = *not at all* to 7 = *extremely*).

Measures

Victimization history—We used the revised Sexual Experiences Survey (38), the gold standard in the field, to measure unwanted and nonconsensual sexual experiences since age 14. These questions were asked before participants were administered alcohol and read the scenario. Types of unwanted sexual behavior assessed included sexual contact (e.g., fondling) and attempted or completed oral, vaginal, or anal penetration. The tactics included verbal coercion (e.g., lies, verbal threats or pressure), intoxication, and force. Participants were asked to indicate the number of times each sexual act occurred by tactic used to obtain each act on 3 point response scales (0 = never; 3 = 3 or more times). ASA severity was calculated by multiplying a severity rank that represented a cross between the tactic and outcome (0 = no ASA, 1 = sexual contact by verbal coercion, 2 = sexual contact by intoxication, 3 = sexual contact by force, 4 = attempted or completed rape by verbal coercion, 5 = attempted or completed rape by intoxication, 6 = attempted or completed rape by physical force) by the frequency with which each tactic/outcome combination occurred (39). This sexual victimization severity score had a possible range of 0–63.

Partner pressure—Partner pressure to have sex without a condom was manipulated within the scenario as described above. It was coded as (0 = low pressure, 1 = high pressure).

Anticipated negative partner reaction—We measured participants’ anticipation of the scenario partner’s negative reaction to insistence on condom use with the mean of 5 items such as “If you refuse to have sex without a condom, how likely will Michael be to... lose interest in you? Become angry? Force you to have sex anyway?” The response scales were 1 (*not at all likely*) to 7 (*extremely likely*). Cronbach’s alpha for these 5 items was .80.

Negative mood—Negative mood was assessed at the end of the scenario using the following 7 emotions: Depressed, stressed, angry, afraid, irritated, worried, and upset. Participants were asked to “rate to what extent you have felt each of the following emotions during the past few minutes” on scale from 1 (*not at all*) to 7 (*extremely*). Reliability for these items was good with a Cronbach’s alpha of .82.

Positive mood—Positive mood was assessed at the same time as negative mood, with the same stem and response scales. There were also 7 positive mood items: Happy, cheerful, feeling good, enthusiastic, positive, relaxed, and interested. These items had excellent reliability ($\alpha = .92$).

Condom-decision abdication intention—Participants' intention to abdicate the condom use decision at the end of the scenario was measured by asking the following two items "At this point, how likely are you to... let Michael decide whether or not to use a condom? Go along with what Michael wants about not using a condom?" The response scales were from 1 (*not at all likely*) to 7 (*extremely likely*). We computed the abdication intention score as the mean of these 2 items, whose correlation was .81.

Analytic Approach

Before conducting the main analyses, we screened the data for skewness, kurtosis, and missingness. Less than 1% of data were missing on any variable, and we employed full information maximum likelihood (FIML), standard with Mplus, to handle rare instances of missing data. We computed means of model variables and tested for differences between Control and Alcohol groups, as well as bivariate correlations among model variables separately by group.

For the main analyses, we conducted a multiple group path analysis in MPlus version 7.11 (40) to examine differences between sober and intoxicated participants; the hypothesized model appears in Figure 1. We modelled the influence of victimization history severity, partner pressure for sex without a condom, and the interaction of these variables on participants' in-the-moment anticipation of negative partner reaction, negative mood, positive mood, and finally on their condom-decision abdication intentions. All paths between background and manipulated variables (i.e., victimization and partner pressure for sex without a condom) and mediating in-the-moment variables (i.e., anticipation of negative partner reaction, negative mood, and positive mood) were allowed to freely vary between the no alcohol and alcohol groups, as was the hypothesized path directly from partner pressure to abdication intention. In accordance with our hypothesis that relationships between the cognitive and affective mediators and the abdication intention outcome would be similar in both the alcohol and control groups, paths from mediating variables to the abdication intention outcome were constrained to equality between groups.

We also specified two alternative models. In the fully constrained model, all paths were constrained to equality across beverage condition groups. In order to compare a model with minimal equality constraints across alcohol and control groups, while avoiding a fully saturated model, we specified a second alternative model in which all paths were free to vary except the correlations among Anticipated Negative Partner Reaction, Negative Mood, and Positive Mood. We used χ^2 difference tests to compare goodness-of-fit between the hypothesized model and each of these alternative models.

Results

Preliminary Analyses

Means of model variables, compared among Partner Pressure x Alcohol Condition groups and between Control and Alcohol groups, appear in Table I. Positive mood and condom-decision abdication intention were both significantly higher in the Alcohol group; there were

no other significant mean differences between groups. Bivariate correlations among variables appear above (Control) and below (Alcohol) the diagonal in Table II.

Model Testing

Modified hypothesized model—Figure 1 shows the hypothesized model. In accordance with our hypothesis that paths between the cognitive and affective mediators and the condom-decision abdication outcome would be similar in both the alcohol and control groups, we constrained these paths to equality. Likewise, because we hypothesized that the effects of partner pressure, victimization history severity, and their interaction would be different in alcohol and control groups, we allowed these paths to vary freely. The hypothesized model was not a good fit for the data: $\chi^2(10) = 27.89, p = .002$; RMSEA (root mean square error of approximation) = .094 (90% confidence interval = .054, .136); CFI (comparative fit index) = .887; TLI (Tucker-Lewis index) = .594; SRMR (standardized root mean squared residual) = .048. Based on modification indices, we added a free direct path from the partner pressure by victimization history severity interaction to the abdication intention outcome (along with the victimization history severity to condom-decision abdication intention path necessary to test this interaction). The respecified model was a good fit: $\chi^2(6) = 4.90, p = .56$; RMSEA = .00 (90% CI = .00, .08; CFI = 1.00; TLI = 1.04; SRMR = .02). It accounted for 15% of the variance in abdication intention in the control group and 14% in the alcohol group.

Alternative models—The fully constrained model (all paths constrained to equality across beverage condition groups) was both a poor fit to the data ($\chi^2(18) = 29.06, p = .05$; RMSEA = .06 (90% CI = .01, .09; CFI = .93; TLI = .86; SRMR = .05) and a significantly worse fit than the modified hypothesized model (χ^2 difference test (12) = 24.16, $p = .02$). However, the alternative, mostly unconstrained model (all paths free except the correlations among Anticipated Negative Partner Reaction, Negative Mood, and Positive Mood) fit as well as the modified hypothesized model ($\chi^2(3) = 2.24, p = .52$; RMSEA = .00 (90% CI = .00, .11; CFI = 1.00; TLI = 1.06; SRMR = .02), with the χ^2 difference test indicating no significant difference in fit between these two models ($\chi^2(3) = 2.66, p = .45$). This alternative model accounted for 13% of the variance in abdication intention in the control group and 17% in the alcohol group. Because the modified hypothesized model and the minimally constrained alternative model fit the data equally well, and the alternative model was more theoretically informative, we present the alternative model below.

Direct and Indirect Effects

Figure 2a illustrates the final alternative model for the control group and Figure 2b, for the alcohol group. Figures display standardized coefficients for significant paths only. In both groups, high partner pressure to have sex without a condom increased anticipation of negative partner reaction to condom use insistence. Likewise, positive mood was related to increased condom-decision abdication intention in both groups.

In the control group, victimization severity and partner pressure interacted to directly affect condom-decision abdication intention. The direction of this interaction was such that in the low pressure condition, women's sexual victimization severity was not related to condom-

decision abdication intention, whereas in the high pressure condition, women with a less severe victimization history had lower abdication intention than women with a more severe history. For women who were not intoxicated, anticipated negative partner reaction did not significantly predict condom-decision abdication intention.

In the alcohol group, victimization severity and partner pressure did not interact significantly. Rather, victimization severity was related to increased anticipation of negative partner reaction, which in turn increased condom-decision abdication intentions. High partner pressure directly decreased both positive mood and abdication intention, and increased negative mood.

We also tested the significance of indirect effects of partner pressure, victimization history, and their interaction on abdication intention. In the alcohol group, but not in the control group, partner pressure had a significant indirect effect on condom-decision abdication intention, increasing it via anticipated negative partner reaction. No other indirect effects were statistically significant; complete results appear in Table III.

Discussion

This is the first study to manipulate partner pressure and alcohol systematically and evaluate women's condom-decision abdication as a function of sexual victimization history. Multi-group path analyses, across alcohol and non-alcohol control groups, revealed that both partner pressure and victimization history severity were associated with women's increased willingness to abdicate and let the man – depicted as a steady partner – decide about condom use. First, more severely victimized women were more susceptible to partner pressure effects on condom-decision abdication than less severely victimized counterparts, but only in the control group. Second, evaluating social-cognitive and emotional mechanisms simultaneously, we found that women's anticipated negative partner reaction mediated the effects of pressure on condom-decision abdication in the alcohol group but not in the control group. Unexpectedly, in the alcohol condition, partner pressure decreased condom-decision abdication directly. In research efforts to elucidate women's condom use decision making processes, these findings further substantiate the role of anticipated negative partner reaction and demonstrate the importance of two novel constructs lacking previous research attention: partner pressure to forgo condom use and condom-decision abdication.

High partner pressure consisted of both verbal and behavioral expressions of effort to influence the woman to forgo condom use. Our alternative minimally constrained model fit the data well and revealed that pressure affected condom-decision abdication in ways that differed based on alcohol. Without alcohol, the association between victimization severity and condom-decision abdication was evident only in the high pressure condition. This finding coheres with previous survey work showing that victimized women often feel powerless and unassertive in sexual situations (2,3) and with experimental work showing that, compared to non-victimized counterparts, victimized women exhibited less sexual assertiveness and greater passivity (24,27) and greater sexual abdication (doing what the man wants sexually) via anticipated negative reaction (1). The current finding extends earlier work in two important ways. First, it indicates that any tendency of victimized

women to be less empowered in sexual encounters and cede decisional power to a partner varies with the interpersonal dynamics of the situation. Second, by using a continuous severity index to quantify ASA based on the tactic, outcome, and frequency of earlier victimization experiences, our findings indicate that the degree of influence past victimization exerts on responding in present day sexual encounters varies with the severity of earlier victimizations.

In the alcohol model by contrast, pressure worsened the woman's emotional experience – decreasing positive mood and increasing negative mood – and, paradoxically, decreased condom-decision abdication directly. The reasons for this attenuation in condom decision abdication are not clear. Perhaps intoxication, via an alcohol myopia process, made the man's high pressure and subtle relationship threat ("If we want to keep things going between us, it's time we stopped using condoms") more salient thereby dampening her emotional warmth.

Interestingly, this abdication attenuation pathway was concurrent with an abdication enhancement pathway via anticipated partner negative reaction. Specifically, high pressure increased anticipation that the man would respond negatively to the woman's desire to use a condom. That this anticipation, in turn, increased willingness to abdicate can be seen as potentially instrumental in avoiding his negative reactions by instead yielding to his wish for unprotected intercourse. Such an avoidance-by-yielding response could be interpreted as disempowering because it is at the expense of women's own desire, agency, and sexual safety. Yet this pathway could also be self-protective, because it mitigates the prospect of being harmed by him (11,41), either psychologically or physically.

These contradictory pathways concurrently attenuating and fostering the likelihood of condom-decision abdication demonstrate the decisional complexity of such heat-of-the-moment sexual encounters when intoxicated. Conflicting social-cognitive and emotional processes appear to be weighing on women's willingness to go along with partner pressure.

Strengths and Limitations

The current study had both strengths and limitations. Victimization was operationalized as continuous severity index, thus providing more nuanced sensitivity to the impact of victimization than has been typically observed in this sexual victimization research. Alcohol factors, including dosage, BAC limb, and absorption times were tightly controlled through rigorous procedures involving consistent BAC monitoring, specific BAC criterion starting points, and yoked controls. To better approximate real-world risky sexual situations, the experimental scenario was eroticized to create a sexual ambiance during the sexual decision-making process. Although laboratory analogues of sexual situations can never fully capture all elements of real sexual situations, participants overall rated the scenario as very realistic and there is considerable evidence supporting both the internal (44–46) and external (47,48) validity of such analogues. Another strength was our sampling of predominantly urban community residents, broadening the base of sample characteristics beyond clinical and college samples. Finally, by using both survey and experimental methods, we were able to integrate distal and proximal factors and demonstrate their mutual influence on sexual risk.

This is consistent with recommendations that person and situation variables be examined simultaneously to promote a more comprehensive understanding of sexual risk-taking (31).

Limitations included the lack of an alcohol expectancy (placebo) condition, sample characteristics, and the prospect of volunteer bias. First, previous work has shown that expectancy set (the belief that one has been drinking) enhances self-reported and physiological arousal independent of low-dosage intoxication (49). Because of the difficulty of convincing placebo participants that they have received a high dose of alcohol (50), and our specific interest was high dosage effects, we did not manipulate alcohol expectancy set. Therefore, we cannot conclude that findings in the alcohol condition are strictly a function of alcohol pharmacological properties, independent of expectancy set effects. Second, sample characteristics limited the generalizability of our findings. Regarding alcohol use, abstainers, light drinkers, and heavy problem drinkers were excluded, while only heavy episodic drinkers were included. These inclusion/exclusion criteria prevent us from generalizing the observed relationships to women whose drinking habits do not fit the range reported by our participants. For example, women who do not engage in heavy episodic drinking may be less likely to drink to the intoxication level manipulated in our study; thus, these findings may not apply to their typical drinking levels. Moreover, because our alcohol administration paradigm required participants to be of legal drinking age (21 or over), it is unclear whether the current findings would generalize to underage drinking women whose contextual factors for sexual risk behavior may differ from those of their older peers. Similarly, our high rates of sexual victimization and our exclusion of women at lower risk for HIV/STI also limit our generalizability. In sum, because the alcohol consumption patterns, sexual risk indicators, and sexual victimization histories of this study's sample were high relative to the general population, care must be taken when generalizing the current findings to other groups of women. That noted, the participants in this study were recruited due to their elevated risk levels and thus they are an important focus of research in this area. Third, volunteers for sexuality research tend to have more sexual experience and liberal sexual attitudes than non-volunteers (51). Our findings should be interpreted in accordance with these sample limitations. Finally, our paradigm depicted a steady partner; thus it is unclear how these findings, particularly with respect to partner pressure, might apply to situation involving a new or casual partner.

Conclusions

Alcohol intoxication increased condom-decision abdication as observed previously with sexual abdication not specific to condom use (1). Regardless of intoxication, sexual victimization history was associated with differential responding to an analogue sexual encounter (1,24,25). Given that sexually victimized women generally drink more and engage in more frequent heavy episodic drinking than their nonvictimized counterparts, our findings demonstrate a clear risk nexus. By virtue of both their drinking quantity and style, sexually victimized women are at substantially elevated risk for behavior that can lead to STI/HIV infections. Thus, our findings continue to support the suggestions that prevention interventions should target drinking and should highlight victimization history as a factor. It appears from these and other findings (1,25,26) that women with varying degrees of sexual victimization history severity make different decisions when using and not using alcohol.

The current findings suggest that different decisions may place them at different kinds of interpersonal risk, e.g., disease risk and assault risk. A novel finding was that women's condom decision abdication – a seemingly direct pathway to unprotected intercourse (1) – was affected by partner pressure via anticipated negative partner reaction. Given that these are the first data demonstrating the impact of partner pressure, further research on this interpersonal factor and related cognitive and emotional mechanisms is warranted. Nevertheless, this initial finding coheres with suggestions that intervention strategies highlight issues and skills in sexual assertiveness, although not at the expense of personal safety.

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References

1. Masters NT, George WH, Davis KC, Norris J, Heiman JR, Jacques-Tiura AJ, et al. Women's unprotected sex intentions: Roles of sexual victimization, intoxication, and partner perception. *J Sex Res.* 2014 Jul; 51(5):586–98. [PubMed: 23718552]
2. Johnsen LW, Harlow LL. Childhood sexual abuse linked with adult substance use, victimization, and AIDS risk. *AIDS Educ Prev.* 1996 Feb; 8(1):44–57. [PubMed: 8703640]
3. Katz J, May P, Sorensen S, DelTosta J. Sexual revictimization during women's first year of college: Self-blame and sexual refusal assertiveness as possible mechanisms. *J Interpers Violence.* 2010 Nov; 25(11):2113–26. [PubMed: 20065312]
4. Gakumo CA, Moneyham LD, Enah CC, Childs GD. The moderating effect of sexual pressure on young urban women's condom use. *Res Nurs Health.* 2012 Feb; 35(1):4–14. [PubMed: 22033977]
5. Davis KC, Schraufnagel TJ, Kajumulo KF, Gilmore AK, Norris J, George WH. A qualitative examination of men's condom use attitudes and resistance: "It's just part of the game". *Arch Sex Behav.* 2014 Apr; 43(3):631–43. [PubMed: 23912776]
6. Davis KC, Stappenbeck CA, Norris J, George WH, Jacques-Tiura AJ, Schraufnagel TJ, et al. Young men's condom use resistance tactics: a latent profile analysis. *J Sex Res.* 2014; 51(4):454–65. [PubMed: 23548069]
7. O'Leary A. Women at risk for HIV from a primary partner: balancing risk and intimacy. *Annu Rev Sex Res.* 2000; 11:191–234. [PubMed: 11351832]
8. Braun V. "Proper sex without annoying things": Anti-condom discourse and the "nature" of (hetero)sex. *Sexualities.* 2013 May 10; 16(3–4):361–82.
9. Fortenberry JD, Tu W, Harezlak J, Katz BP, Orr DP. Condom Use as a Function of Time in New and Established Adolescent Sexual Relationships. *Am J Public Health.* 2002 Feb; 92(2):211–3. [PubMed: 11818293]
10. Teitelman AM, Ratcliffe SJ, Cederbaum JA. Parent--Adolescent Communication About Sexual Pressure, Maternal Norms About Relationship Power, and STI/HIV Protective Behaviors of Minority Urban Girls. *J Am Psychiatr Nurses Assoc.* 2008 Mar; 14(1):50–60. [PubMed: 21672881]
11. Jones R. Reliability and validity of the sexual pressure scale. *Res Nurs Health.* 2006 Aug; 29(4): 281–93. [PubMed: 16847908]
12. Wingood GM, DiClemente RJ. Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Educ Behav Off Publ Soc Public Health Educ.* 2000 Oct; 27(5):539–65.
13. Ajzen, I.; Fishbein, M. *Understanding Attitudes and Predicting Social Behavior* [Internet]. Englewood Cliffs, NJ: Prentice-Hall; 1980. [cited 2015 Jan 16]. Available from: <http://>

www.pearsonhighered.com/educator/academic/product/0,,0139364358,00%2ben-USS_01DBC.html

14. Morokoff PJ, Quina K, Harlow LL, Whitmire L, Grimley DM, Gibson PR, et al. Sexual Assertiveness Scale (SAS) for women: development and validation. *J Pers Soc Psychol.* 1997 Oct; 73(4):790–804. [PubMed: 9325594]
15. Quina K, Harlow LL, Morokoff PJ, Burkholder G, Deiter PJ. Sexual Communication in Relationships: When Words Speak Louder Than Actions. *Sex Roles.* 2000 Apr 1; 42(7–8):523–49.
16. Harlow LL, Quina K, Morokoff PJ, Rose JS, Grimley DM. HIV risk in women: A multifaceted model. *J Appl Biobehav Res.* 1993; 1(1):3–38.
17. Gyurak A, Gross JJ, Etkin A. Explicit and implicit emotion regulation: A dual-process framework. *Cogn Emot.* 2011 Apr; 25(3):400–12. [PubMed: 21432682]
18. Testa M, VanZile-Tamsen C, Livingston JA. Childhood sexual abuse, relationship satisfaction, and sexual risk taking in a community sample of women. *J Consult Clin Psychol.* 2005 Dec; 73(6): 1116–24. [PubMed: 16392972]
19. Testa M, Hoffman JH, Livingston JA. Alcohol and sexual risk behaviors as mediators of the sexual victimization-revictimization relationship. *J Consult Clin Psychol.* 2010 Apr; 78(2):249–59. [PubMed: 20350035]
20. Lalor K, McElvaney R. Child sexual abuse, links to later sexual exploitation/high-risk sexual behavior, and prevention/treatment programs. *Trauma Violence Abuse.* 2010 Oct; 11(4):159–77. [PubMed: 20679329]
21. Malow R, Dévieux J, Lucenko BA. History of childhood sexual abuse as a risk factor for HIV risk behavior. *J Psychol Trauma.* 2006; 5(3):13–32.
22. Brener ND, McMahon PM, Warren CW, Douglas KA. Forced sexual intercourse and associated health-risk behaviors among female college students in the United States. *J Consult Clin Psychol.* 1999 Apr; 67(2):252–9. [PubMed: 10224736]
23. Campbell R, Sefl T, Ahrens CE. The Impact of Rape on Women's Sexual Health Risk Behaviors. *Health Psychol.* 2004 Jan; 23(1):67–74. [PubMed: 14756605]
24. Stoner SA, Norris J, George WH, Morrison DM, Zawacki T, Davis KC, et al. Women's condom use assertiveness and sexual risk-taking: Effects of alcohol intoxication and adult victimization. *Addict Behav.* 2008 Sep; 33(9):1167–76. [PubMed: 18556139]
25. George WH, Davis KC, Masters NT, Jacques-Tiura AJ, Heiman JR, Norris J, et al. Sexual victimization, alcohol intoxication, sexual-emotional responding, and sexual risk in heavy episodic drinking women. *Arch Sex Behav.* 2014 May; 43(4):645–58. [PubMed: 23857517]
26. Staples JM, George WH, Stappenbeck CA, Davis KC, Norris J, Heiman JR. Alcohol myopia and sexual abdication among women: Examining the moderating effect of child sexual abuse. *Addict Behav.* 2015 Feb; 41:72–7. [PubMed: 25310825]
27. Stoner SA, Norris J, George WH, Davis KC, Masters NT, Hessler DM. Effects of alcohol intoxication and victimization history on women's sexual assault resistance intentions: The role of secondary cognitive appraisals. *Psychol Women Q.* 2007 Dec; 31(4):344–56.
28. Zawacki T, Norris J, Hessler DM, Morrison DM, Stoner SA, George WH, et al. Effects of Relationship Motivation, Partner Familiarity, and Alcohol on Women's Risky Sexual Decision Making. *Pers Soc Psychol Bull.* 2009 Mar 30; 35(6):723–36. [PubMed: 19332435]
29. Marx BP, Heidt JM, Gold SD. Perceived Uncontrollability and Unpredictability, Self-Regulation, and Sexual Revictimization. *Rev Gen Psychol.* 2005 Mar; 9(1):67–90.
30. Kendler KS, Bulik CM, Silberg J, Hettema JM, Myers J, Prescott CA. Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and cotwin control analysis. *Arch Gen Psychiatry.* 2000 Oct; 57(10):953–9. [PubMed: 11015813]
31. Cooper ML. Toward a person × situation model of sexual risk-taking behaviors: Illuminating the conditional effects of traits across sexual situations and relationship contexts. *J Pers Soc Psychol.* 2010 Feb; 98(2):319–41. [PubMed: 20085403]
32. Hendershot CS, George WH. Alcohol and sexuality research in the AIDS era: Trends in publication activity, target populations and research design. *AIDS Behav.* 2007 Mar; 11(2):217–26. [PubMed: 16897352]

33. Rehm J, Shield KD, Joharchi N, Shuper PA. Alcohol consumption and the intention to engage in unprotected sex: systematic review and meta-analysis of experimental studies. *Addict Abingdon Engl*. 2012 Jan; 107(1):51–9.
34. National Institute on Alcohol Abuse and Alcoholism (NIAAA). Recommended Alcohol Questions [Internet]. 2003. [cited 2014 Jun 3]. Available from: <http://www.niaaa.nih.gov/research/guidelines-and-resources/recommended-alcohol-questions>
35. Pokorny AD, Miller BA, Kaplan HB. The brief MAST: A shortened version of the Michigan Alcoholism Screening Test. *Am J Psychiatry*. 1972 Sep; 129(3):342–5. [PubMed: 5053717]
36. National Institute on Alcohol Abuse and Alcoholism (NIAAA). Administering Alcohol in Human Studies [Internet]. 2005. [cited 2014 Jun 3]. Available from: <http://www.niaaa.nih.gov/research/guidelines-and-resources/administering-alcohol-human-studies>
37. Schacht RL, Stoner SA, George WH, Norris J. Idiographically determined versus standard absorption periods in alcohol administration studies. *Alcohol Clin Exp Res*. 2010 May; 34(5):925–7. [PubMed: 20331574]
38. Koss MP, Abbey A, Campbell R, Cook S, Norris J, Testa M, et al. Revising the SES: A collaborative process to improve assessment of sexual aggression and victimization. *Psychol Women Q*. 2007 Dec; 31(4):357–70.
39. Davis KC, Gilmore AK, Stappenbeck CA, Balsan MJ, George WH, Norris J. How to score the Sexual Experiences Survey? A comparison of nine methods. *Psychol Violence*. 2014 Oct; 4(4): 445–61. [PubMed: 25512879]
40. Muthén, Muthén. Mplus. Los Angeles, CA: Muthén & Muthén; 2013.
41. Jones R, Gulick E. Reliability and validity of the Sexual Pressure Scale for Women-Revised. *Res Nurs Health*. 2009 Feb; 32(1):71–85. [PubMed: 18666222]
42. Mittal M, Senn TE, Carey MP. Fear of violent consequences and condom use among women attending an STD clinic. *Women Health*. 2013; 53(8):795–807. [PubMed: 24215273]
43. Zerubavel N, Messman-Moore TL. Sexual victimization, fear of sexual powerlessness, and cognitive emotion dysregulation as barriers to sexual assertiveness in college women. *Violence Women*. 2013 Dec; 19(12):1518–37.
44. George WH, Davis KC, Norris J, Heiman JR, Stoner SA, Schacht RL, et al. Indirect effects of acute alcohol intoxication on sexual risk-taking: The roles of subjective and physiological sexual arousal. *Arch Sex Behav*. 2009 Aug; 38(4):498–513. [PubMed: 18431618]
45. Masters NT, Norris J, Stoner SA, George WH. How does it end? Women project the outcome of a sexual assault scenario. *Psychol Women Q*. 2006 Sep; 30(3):291–302.
46. Noel NE, Maisto SA, Johnson JD, Jackson LA, Goings CD, Hagman BT. Development and validation of videotaped scenarios: a method for targeting specific participant groups. *J Interpers Violence*. 2008 Apr; 23(4):419–36. [PubMed: 18252938]
47. Kajumulo, KF.; Davis, KC.; George, WH. Experimental vignettes in assessing alcohol-involved risky sexual decision-making: Evidence for external validity. Presentation presented at: Annual meeting of the Society for the Scientific Study of Sexuality; 2009 Nov; Puerto Vallarta, Mexico.
48. Norris, J.; Kiekel, PA.; Purdie, MP.; Abdallah, DA. Using experimental simulations to assess self-reported sexual behavior: Further evidence of external validity. Presentation at a symposium on Alternative Conceptualizations of Assessing Sexual Behavior presented at: Annual meeting of the Society for the Scientific Study of Sexuality; 2010 Nov; Las Vegas, NV.
49. Wilson GT, Lawson DM. Effects of alcohol on sexual arousal in women. *J Abnorm Psychol*. 1976 Oct; 85(5):489–97. [PubMed: 965577]
50. Martin CS, Sayette MA. Experimental design in alcohol administration research: limitations and alternatives in the manipulation of dosage-set. *J Stud Alcohol*. 1993 Nov; 54(6):750–61. [PubMed: 8271813]
51. Strassberg DS, Lowe K. Volunteer bias in sexuality research. *Arch Sex Behav*. 1995 Aug; 24(4): 369–82. [PubMed: 7661653]

Figure 1. Hypothesized model

Note.

Dashed paths free to vary between control and alcohol groups; solid paths constrained to equality.

Figure 2a

Figure 2b

Figure 2. Figure 2a. *Alternative model, control group*

Note.

Standardized coefficients shown only for paths significant at $p < .05$.Figure 2b. *Alternative model, alcohol group*

Note.

Standardized coefficients shown only for paths significant at $p < .05$.

Table 1
Means of model variables compared between low and high partner pressure for condom non-use and Control and Alcohol groups

Variable (range)	Control			Alcohol			F (3)	Control (n=206)		Alcohol (n=202)		t (396)
	Low pressure (n=105)			High pressure (n=102)				Low pressure (n=100)		High pressure (n=100)		
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	
Victimization History (0–63)	17.14 (17.92)	17.13 (16.78)	17.36 (17.23)	18.29 (17.69)			.10	17.31 (17.36)	17.98 (17.44)			–.39
Anticipated Negative Partner Reaction (1–7)	2.96 (1.13) ^{a,b}	3.72 (1.32) ^{a,c}	2.96 (1.21) ^{c,d}	3.55 (1.23) ^{b,d}			10.60 ^{***}	3.34 (1.28)	3.25 (1.25)			.69
Negative Mood (1–7)	1.68 (0.89) ^a	2.08 (1.11) ^{a,b}	1.51 (0.77) ^{b,c}	1.93 (1.00) ^c			7.16 ^{***}	1.88 (1.03)	1.72 (0.92)			1.57
Positive Mood (1–7)	4.56 (1.61) ^{a,b}	4.12 (1.77) ^{a,c,d}	5.22 (1.48) ^{b,c}	4.79 (1.39) ^d			8.68 ^{***}	4.33 (1.70)	5.01 (1.44)			–4.35 ^{***}
Condom-Decision Abduction Intention (1–7)	2.86 (1.85) ^a	2.94 (1.93) ^b	3.93 (2.09) ^{a,b,c}	3.07 (1.95) ^c			6.53 ^{***}	2.88 (1.88)	3.50 (2.07)			–3.08 ^{**}

*
 $p < .05$,

**
 $p < .01$,

 $p < .001$.

Note. Where the omnibus test is significant, values in the same row that share a subscript differ significantly ($p < .05$) between Partner Pressure x Alcohol groups.

Table 2
Correlations between model variables in Control (above diagonal) and Alcohol (below diagonal) groups

	1	2	3	4	5	6
1. Victimization History	-	.00	.09	.18*	.13	.19**
2. Partner Pressure	.03	-	.29**	.21**	-.13	.02
3. Anticipated Negative Partner Reaction	.11	.24**	-	.31**	-.07	.10
4. Negative Mood	.08	.23**	.20**	-	-.26**	-.05
5. Positive Mood	-.12	-.15*	-.07	-.30**	-	.22**
6. Condom-Decision Abdication Intention	.17*	-.21**	.18*	-.11	.21**	-

* $p < .05$,

** $p < .01$.

Note.

Partner pressure was manipulated and coded as (0 = low pressure, 1 = high pressure).

Table 3

Indirect effects of model variables on condom-decision abdication intention

Indirect Paths	Control		Alcohol	
	Standardized estimate	SE	Standardized estimate	SE
Victimization History to Condom-Decision Abdication Intention (total indirect)	.076	.058	.032	.078
Via Anticipated Negative Partner Reaction	.002	.022	.106	.061
Via Negative Mood	-.001	.013	-.013	.020
Via Positive Mood	.075	.051	-.060	.047
Partner Pressure to Condom-Decision Abdication Intention (total indirect)	.010	.031	.029	.043
Via Anticipated Negative Partner Reaction	.029	.022	.086*	.034
Via Negative Mood	-.009	.012	-.016	.020
Via Positive Mood	-.010	.020	-.041	.024
Victimization History x Partner Pressure to Condom-Decision Abdication Intention (total indirect)	-.056	.058	-.038	.078
Via Anticipated Negative Partner Reaction	.009	.024	-.091	.062
Via Negative Mood	-.012	.020	.010	.018
Via Positive Mood	-.053	.050	.043	.047

* $p < .05$