Could you tell us a bit about your research background and interest in understanding sexual violence?

My interest in understanding sexual violence and coercion started on a personal level while attending Trinity University as an undergraduate psychology student. I had friends experience rape and attempted rape during this time and, through my work as an advocate at our local rape crisis center, I became passionate about this issue. The term “date rape” had just hit the national media scene, and only one nationwide study had been conducted on the topic. This study found that 1 in 4 women experienced rape or attempted rape while in college. As a rape prevention peer educator on my campus, I was frequently asked how often date rape occurred at our school. To answer this question, I conducted an anonymous survey of the student body and found that sexual assault rates on our campus were equivalent to the national rates, with 1 in 4 female undergraduates experiencing rape or attempted rape. Directly after graduation, I attended the University of Washington clinical psychology doctoral program where I conducted research on alcohol and sexual assault. When I realized I could craft a career based on my natural curiosity about and passion for sexual health and reproductive rights, I never looked back. Luckily for me it was a very organic, natural process.

Please give us some information about your new NIH research grant.

I am interested in the intersection of alcohol use, sexual violence, and sexual health, specifically why and how they are related. Typically, sexual health and sexual risk taking research focuses on sexually transmitted infections (STIs), while sexual violence has been studied separately. However, evidence demonstrates that they are related. Men who take more sexual risks tend to also be more likely to perpetrate sexual assault, and women who have been victimized sexually also have higher sexual risk tendencies. Our original study focused on how men with a history of sexual aggression might resist using condoms with partners who want to use one, also known as condom use resistance. We investigated if men who have a history of sexual aggression are more likely than non-aggressive men to resist condom use and whether alcohol influences those behaviors. This renewal project will build on the previous research to find out more about emotions and emotion-regulation processes in men’s condom use resistance. Specifically, do alcohol and emotional state affect men’s sexual risk decision-making?

What community needs do you see your research addressing?

Our previous research indicates that 80% of young men engage in condom use resistance, so this is a common, prevalent behavior. We want to motivate people to use condoms and negotiate for condom use effectively. In order to do so, we need to understand the different ways in which these dyadic processes unfold and why, in order to use that information to create intervention programming targeting the mechanisms underlying sexual risk behavior. In particular, I am most interested in the more coercive condom use resistance tactics. We found that to avoid using a condom, almost 1/3 of men reported using emotional manipulation, 20% reported deception and lying (for example, saying they’d been tested for STIs when they hadn’t), and almost 10% reported engaging in what we call “condom sabotage”, which includes tampering with a condom so that it breaks, and “stealthing”, which is non-consensual condom removal (i.e., removing the condom without the partner’s knowledge). Stealing is a particularly problematic behavior because the partner does not know she is at increased risk for STIs or unplanned pregnancies and thus may not seek prophylactic treatment options. Overall, we are trying to understand how alcohol affects these types of behaviors, who is more likely to engage in these types of behaviors, and whether men with better emotion-regulation skills are less likely to engage in these behaviors. Such information would allow us to target the individuals most in need of intervention, as well as specifically tailor such interventions to their needs. For example, emotion-regulation skills, which are effective for many different risk behaviors, could be taught to individuals deficient in these skills in order to reduce their coercive sexual behavior. By better understanding the mechanisms associated with these risk behaviors, we can improve the effectiveness of our interventions.

How do you feel this research project is innovative?

Currently, a very small amount of research focuses on condom use resistance and how consensual situations can become non-consensual during condom negotiation processes. In this project we are trying to understand how these situations unfold in “real time”. Data will be gathered from 420 men via online surveys, daily diaries, and in-lab alcohol administration sessions. By using multiple methods, we can get a more complete picture of the processes we are studying. It’s like the blind men feeling an elephant, describing only the part they feel individually. One feels a tree;
another feels a snake; no one feels an “elephant”. Multiple methods give us different perspectives on the same phenomenon, which ultimately gives us a better shot at seeing the whole picture. Also, when alcohol use is being studied, conducting alcohol administration experiments in the lab allows us to tightly control the drinking situation in order to get more precise data. Coupling the experiment data with the daily diary data will also allow us to see how in-lab responses correlate with real-world behavior.

**How do you feel the aims of this project fit with the CHPDP mission?**
Promoting safer sexual behavior will decrease the likelihood of STI transmission. Sexually aggressive men are more likely to have STIs and unplanned pregnancies (partner) as well. If emotions or emotion regulation skills are found to play a role, we can develop and implement emotion regulation interventions that could decrease the likelihood of coercive condom use resistance behaviors. Acknowledging that sexual coercion around condom use is a form of victimization is important. Studies show victims of sexual violence have worse mental and physical health, visit the doctor more often, and have higher rates of various reproductive concerns throughout the life course. If we help people engage in safer sexual behaviors, including the reduction of the coercive elements involved in condom negotiation processes, we can ultimately improve the sexual well-being of both partners.