

*“She was drunk! What did she expect?”* Predicting attitudes towards intoxicated sexual consent based upon demographic, psychological and attitudinal factors

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## **Abstract**

The definition of sexual consent is blurred, causing a reduction in victims reporting the offence and thus, perpetrators facing just punishments. Engaging in sexual activity whilst intoxicated is, by definition, illegal; laws in England and Wales state that alcohol causes individuals to lose the capacity to make such choices. This study investigates whether the belief that consenting to sexual activity whilst intoxicated is acceptable can be predicted through examining demographic, psychological and attitudinal factors. For this study, a community sample of 2,878 participants took part in a questionnaire that investigated demographic factors, levels of self-esteem, social dominance, hypermasculinity and their attitudes towards sexual consent whilst intoxicated. Hypermasculinity, social dominance orientation, self-esteem, education status, age and the existence of psychopathic traits were found to be predictive of an individual's attitudes towards intoxicated sexual consent. The study finds that implementing policies in bars, night clubs and other environments to advertise signs of problematic attitudes towards sexual consent that are likely indicators of sexual misconduct could be effective as a means of reducing sexual violence. Further reductions can be made through sex education classes being better informed in how to discuss situations in which sexual consent can and cannot be accepted.

**Key terms;** *Alcohol, Intoxication, Rape, Consent, Sexual Violence*

## **Introduction**

### **The pervasiveness of rape and sexual assault**

The Crime Survey for England and Wales (CSEW) (2018) highlights that between 2017 and 2018, 700,000 people reported experiences of sexual violence including rape to the police. There is a gender difference in sexual violence victimisation with 140,000 males and 560,000 females reporting the offence - women being nearly 4 times more likely to be victimised than men. Following this, the CSEW (2018) highlights victimisation from sexual violence differs also by age. For women, those aged between 10 and 24 were disproportionately more likely to be a victim of sexual violence including rape. For men, ages 5 to 19 were more likely to be victimised. However, this data arguably only shows a snapshot of how frequently sexual violence occurs. The dark figure of crime, crimes that are neither reported nor recorded by the police (Penney, 2014), is particularly relevant in cases of sexual assault and rape with only one in six cases actually being reported to the police (CSEW, 2018) meaning that the majority of cases do not enter the Criminal Justice System (Willmott et al, 2021). This is the case because victims avoid reporting such crimes for reasons such as embarrassment, believing that nothing will be done about the offence by authorities, or a having a lack of understanding that their experience is classifiable as sexual violence (CSEW, 2021; Willmott, 2016; Willmott et al, 2018). This causes difficulty when attempting to comprehend the true magnitude of sexual violence, as the behaviour frequently goes unrecognised.

### **The concept of sexual consent**

Sexual consent plays a significant role when talking of rape and sexual assault, as its absence is the defining factor in what constitutes the offence. However, its definition is often

brushed over within literature (Beres, 2007) and also seemingly in the real world (Harvey, 1932). It is defined in the England and Wales Sexual Offences Act 2003 as agreeing to sexual behaviours 'by choice, with the freedom and capacity to do so' (England and Wales Sexual Offences Act (2003:74). Whilst this appears to be a clear-cut definition, what is considered to be a choice, or a decision made freely, can be understood differently depending upon culture and place. For example, the definition of sexual consent in America differs between states, with some states having no definition at all (RAINN, 2020). This highlights that there is no universal definition as to what constitutes sexual consent, which becomes problematic when attempting to label an experience as sexual violence or not. It is difficult to define sexual consent due to the everyday person's poor understanding of the concept (Jozkowski et al., 2014). Padilla-Walker et al. (2020) found that adults avoid the topic of consent with their children as much as they avoid topics like reproduction. Their research showed that when talked about, parents often offer their own understandings of consent rather than factual information which can affect the clarity of what does and does not constitute sexual consent. Children and adolescents, therefore, do not receive adequate socialisation into to what is required when asking for consent to engage in sexual behaviour and, in turn, increases the likelihood of sexual assault and rape (Debowska et al, 2017; 2018; 2019; Padilla-Walker et al., 2020). As society has developed, what constitutes as sexual consent has evolved from simply "no means no"; there is now recognition that an individual may have said yes, but may have been coerced into agreeing, given consent whilst under the influence of drugs or alcohol or even not consented at all (Mellins et al., 2017).

## **Demographic influences**

Previous literature has identified age as influential on people's understandings of consent. For example, Graf and Johnson (2020) found a difference between young adult and middle-aged adults in their ability to expand on definitions of sexual consent. Both groups could provide an adequate definition, but upon being questioned about ambiguous situations, young adults were better able to identify whether the situation was consensual. This highlights that age can affect people's understanding of sexual consent, although it does not directly assess attitudes towards sexual consent in such ambiguous situations.

Research has found differences between genders in their support for sexual consent. Glace and Kaufman (2020) found that men were around 2.25 times more likely to report attitudes that were less supportive of sexual consent being offered in sexual encounters than their female and non-binary counterparts. Such findings are explained by Azjen's (1991) Theory of Planned Behaviour which poses that behaviour is based on how it is perceived by the individual, how others would perceive it and individual's level of control over the behaviour. Research has found there to be a relationship between men's conformity to hostile masculine norms and negative attitudes towards requesting consent (Hermann et al., 2018). This theory therefore gives evidence to gender having an influence on different attitudes towards sexual consent behaviours, as men are more likely to conform to hostile masculine beliefs and, in turn, behave in a way that disregards consent.

Research has not been conducted into the influence of ethnicity on attitudes towards sexual consent. However, it has been investigated in relation to Rape Myth Acceptance (RMA) (see Willmott, 2018; Willmott, Boduszek & Booth, 2017). RMA is a construct defined as

cultural beliefs that perpetuate male sexual violence against women (Brownmiller, 1975). Mulliken's (2005) study found that those who identified as Asian or Pacific Islanders had stronger RMA views than those who identified as White or Black. Such research suggests that this too, is the result of patriarchal values that are often endorsed in Asian culture. However, recent research into ethnicity's influence on RMA has yielded mixed results. Some literature regards race as the biggest influence of all demographic factors on levels of RMA (Suarez and Gadalla, 2010; Willmott & Boduszek, 2016). Yet in the same year, Morrow (2010) found race to have little influence on RMA views at all. The evident conflict in findings suggest that more research needs to be conducted to address ethnicity's influence on attitudes towards rape victims and consent.

There has also been no research addressing education's influence on attitudes towards sexual consent. Instead, the likes of Suarez and Gadalla (2010) looked at education level and its effect on RMA views. Their research found that those with higher education, i.e. more qualifications, reported lower adherence to RMA views. As well as level of education, literature has also found subject choice to be an influential factor. For example, students who studied Social Science subjects often had a deeper understanding of what rape myths were and therefore were more dismissive of rape myth views (Swope, 2014). Education status, i.e. whether the individual is currently in education or not, has not been assessed in relation to attitudes towards sexual consent.

It has not yet been researched whether sexual violence victimisation can influence people's attitudes towards intoxicated sexual consent. Research has, however, been conducted in its relation to the endorsement of RMA views (see Willmott, 2018). Early

research found that women who had strong RMA beliefs, were less likely to label their own experiences as rape (Peterson and Muehlenhard, 2004). This highlights that rape myths have some influence on the reporting of sexual violence, as those who more strongly endorse RMA beliefs are less likely to identify the event as sexual violence. Egan and Wilson's (2012) study found that rape victims who did not report their experiences to the police, held stronger RMA views. This is consistent with Peterson and Muehlenhard's (2004) findings and reaffirms that there is a relationship between victimisation and rape myths. It would therefore be wrong to suggest a relationship between victimisation and attitudes towards sexual consent does not exist due to its influence on RMA.

### **Attitudinal influences**

RMA has also been assessed in relation to attitudinal factors. For example, research has looked into whether homophobic attitudes can predict an increase in RMA. Kassing et al. (2005) found a strong relationship between male's RMA and negative attitudes towards gay men. This highlights that strong attitudes towards marginalised groups can play an important role in the endorsement of rape myths. Davies et al.'s (2012) research is supportive of these findings as it found individuals who adhere to male rape myth views, often hold negative views towards gay men.

A similar relationship was found with racist attitudes. Research conducted by Aosved and Long (2006) found that individuals who held strong racist attitudes – both traditional and modern – were associated with stronger RMA beliefs. This reinforces the notion that attitudinal factors can be strong predictors of rape myth views. It is not yet clear whether there is such a relationship with attitudes towards intoxicated consent, however.

Traits predisposing individuals to heavy alcohol consumption have also been investigated in relationship to RMA beliefs. Early research conducted by Seto and Barbaree (1997) found that factors such as impulsivity and delinquency, which often underlie individuals' desires to drink heavily, were also factors present in individuals who committed sexual assault. In relation to attitudes towards sexual consent, research conducted by Ward et al. (2012) developed a scale that assessed individuals' attitudes towards intoxicated sexual consent. Their research indicated that those who engaged in heavy drinking on the weekend, often scored highly on the Alcohol and Sexual Consent Scale (Ward et al., 2012) and so suggests that those who engaged in heavy drinking were likely to believe that intoxicated consent was acceptable.

### **Psychological Influences**

A large volume of literature exists that investigates psychological factors as predictive of RMA views, yet no research has been conducted regarding their influence on attitudes towards sexual consent.

Self-esteem is a person's overall view of their self-worth (Heatherton and Wyland, 2003). Rubinsky et al.'s (2018) research found that women who received messages from men that appeared beneficial and boosted their self-esteem, tended to have increased RMA. The literature explains that because their experiences were positive, they believe this should be the same for all other women and it is the woman's own fault if their experience with men is negative. They therefore believe the rape myth that women who are raped should blame

themselves for putting themselves in dangerous situations (Booth, Willmott & Boduszek, 2017; 2018).

Psychopathy is a term often used to characterise individuals with traits like deceitfulness, arrogance and impulsivity (Boduszek et al, 2017; 2019; Hare, 2003). Mouilso and Calhoun's (2013) research found that psychopathy scores were positively correlated with RMA scores. For example, deception and manipulation were characteristics linked with the rape myth that women lie about being raped. Reduced empathy and increased arrogance were linked with the rape myth that women actually want to be raped. These findings were supported in later research conducted by Debowska et al. (2015), whereby participants who scored particularly high on a callous affect subscale of psychopathy, often endorsed greater RMA. Thus, there is a recognised relationship between psychopathy and RMA. It is not clear though, whether such a relationship exists with attitudes towards intoxicated sexual consent.

Similar explanations were found in relation to hypermasculinity and RMA. Hypermasculinity entails characteristics that support the submission of women and dominance of men within society (Vokey, 2008). Suarez and Gadalla (2010) found that men who held hostile sexist beliefs were more likely to endorse rape myths that blamed the victim. Similar to the effects of increased arrogance in psychopaths, hypermasculine participants believed that women actually want to have sex despite not offering their consent – known as token resistance. This highlights that for hypermasculine participants, a lack of consent can often be regarded as playing hard to get rather than the individual stating that they do not want to engage in sexual behaviour.

Finally, researchers have addressed social dominance orientation (SDO) in relation to influencing rape myth endorsement. SDO refers to a desire for inequality between social groups (Pratto et al., 1994). Chapleau's (2010) research found that participants who believed the myth that consensual sex involves domination of the sexual partner, were also more likely to endorse rape myths. This suggests that higher disregard for equality can influence how individuals behave towards those deemed to be of lower status. This is supported by Chapleau and Oswald (2013) later research which found those who were more opposed to equality, endorsed stronger RMA if the perpetrator was of higher status than the victim, further promoting that the social status of those involved in an offence can affect how the incident is perceived i.e. whether consent was properly obtained or not.

### **Current study**

Previous literature has highlighted the spectrum of influences on rape myth acceptance, ranging from demographic factors like gender and ethnicity, to attitudinal factors like homophobia and attitudes towards alcohol. Psychological factors like hypermasculinity and social dominance orientation can also influence rape myth endorsement. Whilst such research offers sound evidence, there is little to no research that has attempted to directly test the role of these factors on people's attitudes towards intoxicated sexual consent. There is, therefore, a gap in research. The current study attempts to fill this gap through investigating whether attitudes towards intoxicated consent can be predicted through demographic, attitudinal and psychological factors. Some factors have been tested in previous research and so will be readdressed against the current concept; other factors' predictive value will be assessed for the first time.

The aims of the current study are to investigate factors including demographic (age, gender, ethnicity, education status and victimisation), psychological (social dominance orientation, hypermasculinity, self-esteem and psychopathy) and attitudinal (attitudes towards alcohol) and their predictive value of attitudes towards intoxicated sexual consent.

Based upon the small amount of previous research and intuitive links between factors, the following hypotheses are proposed:

1. demographic factors – particularly victimisation level – will be significant predictors of problematic attitudes towards consent in that those who identify as being a victim of sexual violence will show more problematic attitudes towards intoxicated sexual consent than their counterparts.
2. Psychological factors, namely social dominance orientation, psychopathy and hypermasculinity will be significant predictors of problematic attitudes towards intoxicated sexual consent in that those scoring higher on social dominance and strong sex role stereotypes will also score significantly higher in regard to support for intoxicated sexual consent.
3. No hypothesis is put forward surrounding attitudes towards alcohol as there is no previous literature providing evidence to suggest a predictive nature.

## **Method**

### **Design**

The current study was a quantitative, cross-sectional design. A regression analysis was conducted that aimed to investigate demographic, attitudinal and psychological factors as predictors of attitudes towards sexual consent – the outcome variable.

### **Participants**

A community sample of 2,878 participants took part in the questionnaire. They were recruited through a mixture of opportunistic and snowball sampling methods, whereby participants who took part via the study link advertised on social media were encouraged to share the study with anybody that they thought may be interested in taking part. This was deemed to be the most appropriate method of data collection allowing a large number of participants to be recruited whilst remaining in accordance with COVID-19 Government guidance that limited social contact. A total of 6,345 participants took part in the study, however, 3,467 participants' responses were removed as they had not completed the study in full and so had significant missing data.

### **Measures**

#### Alcohol and Sexual Consent scale

The Alcohol and Sexual Consent Scale (Ward et al., 2012) is a 12-item questionnaire used to measure attitudes towards consent when the situation involves alcohol. Example questions include "A person who is sexually assaulted after drinking alcohol should only blame him- or herself." (Item 2) and "Alcohol use makes a person more vulnerable to sexual

assault.” (Item 12). Participants indicated more approval for alcohol-involved sexual experiences through scoring higher on a 7-point Likert scale (1 = completely disagree, 7 = completely agree). Total scores could range from 12 to 84. The scale is unidimensional. Questions 4, 7, 8, 9 10 and 12 were all reverse scored. Chronbach’s alpha = .86 which indicated good reliability.

#### Rosenburg Self-esteem Scale

The Rosenberg Self-Esteem Scale (Rosenburg, 1965) is a 10-item questionnaire that was used to assess participants evaluation of their worth as a human. Total scores range from 10 to 40 with higher scores indicating higher global self-esteem. Participants scored on a 4-point Likert scale (1 = strongly disagree, 4 = strongly agree). The instrument is multidimensional with two subcategories: self-competence and self-liking. Questions 2, 5, 6, 8 and 9 were reverse scored. Reliability analysis yielded a Chronbach’s alpha = .86 indicating good internal reliability.

#### Psychopathic Personality Scale – Revised (PPTS – R)

The Psychopathic Personality Scale - Revised (Boduszek et al., 2018) is a 28-item self-report instrument that was used to measure psychopathic traits within the participants. The questionnaire is multidimensional with 4 subcategories: affective responsiveness which assessed emotional reactivity, cognitive responsiveness – understanding others’ emotional state, interpersonal manipulation which assessed deception and manipulation, and egocentricity – a focus on one’s own interests. Each subscale consists of 7 items that were scored using a 5-point Likert scale (1 = strongly agree, 5 = strongly disagree). Scores could range from 7 to 35 within each subscale, with higher scores in indicating elevated levels of

psychopathic personality traits. Reverse scoring was used in questions 10 and 22. Each subscale's internal reliability was assessed, and results suggest that all four subscales (affective responsiveness  $\alpha = .95$ , cognitive responsiveness  $\alpha = .86$ , interpersonal manipulation  $\alpha = .90$ , and egocentricity  $\alpha = .89$ ) demonstrate good internal reliability.

#### Short Hypermasculine Values Questionnaire

The Short Hypermasculine Values Questionnaire (Archer, 2010) is a 16-item questionnaire used to assess participants' endorsement of hypermasculine values. Higher scores on a 5-point Likert scale indicated more agreement with the statement (1 = strongly disagree, 5 = strongly agree). Total scores could range from 16 to 80. The instrument is unidimensional. Questions 4, 5, 7, 9, 10, 13, 14 and 15 were reverse scored items. Results demonstrated high internal reliability with Chronbach's alpha = .91.

#### Social Dominance Orientation scale – 16

The Social Dominance Orientation Scale-16 (Pratto et al, 1994) assessed the extent to which participants endorsed hierarchical attitudes between social groups. Total scores could range from 16 to 112, with higher scores on a 7-point Likert scale indicating more agreement with the statement (1 = strongly disagree, 7 = strongly agree). The questionnaire is unidimensional. Reverse scoring is used in questions 10 to 16. Internal consistency was good with Chronbach's alpha = .84.

#### **Study Procedure**

The study was conducted following the British Psychological Society's ethical guidelines. Ethical approval was granted by the Psychology Department at Manchester

Metropolitan University (See Appendix 1). The study questionnaire was advertised on different social media platforms including relevant Facebook groups and LinkedIn from the 19<sup>th</sup> November 2020 to 19<sup>th</sup> February 2021 (See Appendix 2). Participants were able to share the research study with their friends and family. Those who chose to complete the questionnaire were fully briefed (Appendix 3) and asked of their informed consent to take part (See Appendix 4). Participants then completed a questionnaire online via Qualtrics (See Appendix 5). Anonymity was maintained through the use of participant-made identification codes. The confidentiality of participant responses was ensured through holding the data on a password-protected device that only the researcher had access to. Participants were made aware of their right to withdraw their data from the study at any point up to two weeks after completing the questionnaire. They were made aware that their participation in the study was voluntary, with no reward or financial incentives. Participants were debriefed upon completing the study (Appendix 6) and reminded of their right to withdraw. The researcher respected the sensitive nature of the topic and so free and impartial helplines were identified during debriefing, should any of the participants have been affected by engaging in a questionnaire that talked of sexual violence and rape.

### **Analytical Procedure**

Data analysis was conducted on SPSS Version 26. The data output for the main regression analysis can be found in Appendix 7. Frequencies and percentiles of the participant sample were calculated. This was followed by calculating descriptive statistics – including the mean and standard deviation – for the sample and the study variables. Next, group differences in attitudes towards intoxicated sexual consent scores were calculated based on group demographics. This was done through the conduction of independent sample t-tests.

The effect size of the group differences was identified through the use of Cohen's (1988) effect size estimator. The t-tests output data also provided correlations between all of the study variables. Finally, a multiple regression analysis was conducted to calculate the predictive value of the variables and the model as a whole for attitudes towards intoxicated sexual consent.

## Results

### **Descriptive statistics and frequency distributions of all study variables**

The demographic profile of the participant sample is shown in Table 1 below. The final sample was predominately Caucasian (95.6%), female (89.4%), reported a level of education of above a university degree (51.7%) that they were not currently studying for (85.9%) and said that they had not been a victim of a serious sexual crime such as rape (96%).

Descriptive statistics including the Means (M) and Standard Deviations (SD) for all continuous variables including age, Alcohol and Sexual Consent Scale, Self-Esteem scale, four subscales of the Psychopathic Personality Traits Scale (Cognitive Responsiveness (CR), Affective Responsiveness (AR), Interpersonal Manipulation (IPM) and Egocentricity (EGO)), Hypermasculinity Scale and Social Dominance Orientation Scale are presented in Table 2 below.

**Table 1***Frequency Distribution and Percentiles for Participant Demographic Variables*

Variable	N (%)
Gender	
Female	2574 (89.4)
Male	304 (10.6)
Ethnicity	
White	2752 (95.6)
BAME	126 (4.4)
Education Level	
Below University Degree	1391 (48.3)
University Degree or Above	1487 (51.7)
Student Status	
Yes	406 (14.1)
No	2472 (85.9)
Sexual Victimization	
Yes	115 (4.0)
No	2763 (96.0)

*Note.* BAME = Black, Asian, Minority Ethnic; Degree Level or Above = Participants who have a University Degree or higher qualification.

**Table 2***Descriptive Statistics for all Continuous Study Variables.*

Variable	M	SD	Range	Minimum	Maximum
Age	37.61	12.14	60	18	78
ASCS	30.66	7.18	53.00	12.00	65.00
SES	28.50	5.68	30.00	10.00	40.00
AR	10.76	3.60	27.00	7.00	34.00
CR	13.55	3.45	27.00	7.00	34.00
IPM	14.71	5.02	28.00	7.00	35.00
EGO	13.44	3.57	28.00	7.00	35.00
Hypermasculinity	26.47	6.54	56.00	16.00	72.00
SDO	30.04	13.8	96.00	16.00	112.00

*Note.* ASCS = Alcohol and Sexual Consent Scale; SES = Self-Esteem Score; AR = Affective Responsiveness; CR = Cognitive Responsiveness; IPM = Interpersonal Manipulation; EGO = Egocentricity; SDO = Social Dominance Orientation.

### **Group differences in consent scores by participant demographics**

Group differences in ASCS scores between categorical demographic variables were tested using independent sample *t*-tests and are presented in Table 3 below. The results revealed that males ( $M = 33.19$ ,  $SD = 8.68$ ) displayed significantly higher ASCS scores than females ( $M = 30.36$ ,  $SD = 6.92$ ). With reference to Cohen's (1988) effect size estimator, there was a small difference found between male and female scores on the ASCS  $t(2864) = -6.56$ ,  $p < .001$ ,  $d = .36$ . Results also displayed a significant difference between participants that were not currently in education ( $M = 30.87$ ,  $SD = 7.18$ ) and those who were currently in education ( $M = 29.37$ ,  $SD = 7.03$ ) in ASCS scores. The difference between scores was small  $t(2864) = 3.90$ ,  $p < .001$ ,  $d = .21$ . There was no significant difference found between participants who identified as Caucasian ( $M = 30.62$ ,  $SD = 7.09$ ) and those identified as BAME ( $M = 31.51$ ,  $SD = 8.81$ ). The difference found between the scores of the two groups was small with  $t(2864) = 1.11$ ,  $p = .267$ ,  $d = .11$ . Results also indicated that there was no significant difference in ASCS scores between victims of sexual crimes ( $M = 30.03$ ,  $SD = 6.60$ ) and non-victims ( $M = 30.69$ ,  $SD = 7.20$ ). The effect size for the differences in scores was small with  $t(2864) = 3.95$ ,  $p = .298$ ,  $d = -.10$ .

**Table 3**

*Group Differences in ASCS Scores Between Gender, Ethnicity, Education Level, Education Status and Sexual Victimization*

Scale	Group	M	SD	<i>t</i>	Cohen's <i>d</i>
ASCS	Males	33.19	8.68	-6.56***	0.36
	Females	30.36	6.92		
	White	30.62	7.09	1.11	0.11
	BAME	31.51	8.81		
	Current Student	29.38	7.03	3.90***	0.21
	Not a Current Student	30.87	7.18		
	Victim	30.03	6.60	.996	0.10
	Non-Victim	30.69	7.20		

*Note.* ASCS = Alcohol and Sexual Consent Scale; BAME = Black, Asian, Minority Ethnic  
Cohen's *d*: 0.2 = small effect size; 0.5 = moderate effect size; 0.8 = large effect size (Cohen, 1998)

\**p* <.05; \*\**p* <.005; \*\*\**p* <.001.

### **Correlation between study variables**

Correlations between all study variables (Age, Gender, Ethnicity, Education Status, Victimization, Self-esteem, AR, CR, IPM, EGO, Hypermasculinity, Social Dominance Orientation and ASCS) are displayed in Table 4 below. Results display a weak to moderate correlation between most variables and constructs. The strongest correlation between a predictor variable and ASCS total score was Hypermasculinity, positively associated with consent attitudes ( $r(2864) = .35, p < .001$ ), followed by SDO ( $r(2864) = .31, p < .001$ ). CR showed a significant positive correlation with ASCS ( $r(2864) = .17, p = < .05$ ). This was also true of SES which showed a significant positive correlation ( $r(2864) = .08, p < .001$ ). Age had a significant, negative correlation with ASCS, ( $r(2864) = 0.20, p < .001$ ).

The strongest correlations between predictor variables in the study were observed between IPM and EGO, AR and EGO and Hypermasculinity and SDO. IPM showed a strong positive correlation with EGO ( $r(2864) = .60, p < .001$ ). This was then followed by AR which showed a strong positive relationship with EGO ( $r(2864) = .57, p < .001$ ). There was also a strong positive relationship found between AR and Hypermasculinity whereby  $r(2864) = .53, p < .001$ .

**Table 4**

*Correlations Matrix for ASCS, Age, Gender, Ethnicity, Education Level, Education Status, Victimization, Relationship Status, Self-esteem, AR, CR, IPM, EGO, Hypermasculinity and SDO*

Variable	ASCS	Age	Gender	Ethnicity	Education Status	Victimization	SES	AR	CR	IPM	EGO	Hypermasculinity	SDO
ASCS	-												
Age	-.02	-											
Gender	.12***	.05**	-										
Ethnicity	-.03	.11***		-									
Education Status			.12***		-								
Victimization	-.07***	-.33***	-.01	-.16***		-							
SES	-.02	-.05*	-.05**	-.03	-.00		-						
AR	.08***	.31***	.07***	-.04*	-.05**	-.06***		-					
CR	.20***	-.05**	.28***	-.07***	.04*	-.02	-.04*		-				
IPM	.17***	.04*	.16***	.03	-.02	.01	-.17***	.54***		-			
EGO	.13***	-.07***	.20***	-.04*	.07***	.00	-.04*	.46***	.22***		-		
Hypermasculinity	.17***	-.11***	.21***	-.03*	.07***	-.00	-.02	.57***	.40***	.60***		-	
SDO	.35***	-.06***	.22***	-.08***	.03	-.00	-.06***	.41***	.32***	.22***	.32***		-
	.31***	.05*	.23***	-.02	-.05*	-.01	.02	.38***	.24***	.34***	.37***	.53***	

*Note.* ASCS = Alcohol and Sexual Consent Scale; SES = Self-Esteem Score; AR = Affective Responsiveness; CR = Cognitive Responsiveness; IPM = Interpersonal Manipulation; EGO = Egocentricity; SDO = Social Dominance Orientation

\*p < .05; \*\*p < .005; \*\*\*p < .001.

## Regression Analysis

Before conducting the regression analysis, assumptions were tested to ensure that a multiple linear regression could be performed on the dataset. Outliers were removed, and checks for multicollinearity, homoscedasticity and linearity of data were undertaken. Analysis of standard residuals showed the data contained some outliers, but these were tightly clustered and so yielded little to no effect on the analysis (Std. Residual Min = -3.45, Std. Residual Max = 4.86). VIF and Tolerance figures were examined and displayed no problem with multicollinearity (Tabachnick and Fidell, 2014). Linearity and homoscedasticity were assessed based on a scatterplot of the standardised residuals and no assumptions were violated.

Multiple linear regression analyses were performed to test the extent to which the combination of 12 predictor variables (age, gender, ethnicity, education status, victimisation, self-esteem (SES), affective responsiveness (AR), cognitive responsiveness (CR), interpersonal manipulation (IPM), egocentricity (EGO), hypermasculinity, social dominance orientation (SDO)) predicted attitudes towards intoxicated sexual consent. A statistically significant model emerged,  $F(12, 2814) = 44.70, p < .001$ . No a priori hypothesis was made to determine the order of entry of the predictor variables and so a direct method of multiple linear regression was performed. The twelve predictor variables explained 16% of variance in attitudes towards sexual consent.

In the final model, there were six significant predictors shown in Table 5 below. Hypermasculinity exhibited the highest Beta value and was a significant predictor of attitudes towards intoxicated sexual consent ( $\beta = .24, p < .001$ ) meaning that participants who scored

higher in the Hypermasculinity scale, exhibited higher ASCS scores and thus had more support for intoxicated sexual consent. Social Dominance Orientation ( $\beta = .16, p <.001$ ) and self-esteem ( $\beta = .12, p <.001$ ) were also positively related with ASCS scores meaning that participants with increased self-esteem and social dominance orientation scores displayed higher ASCS scores. Education status was negatively related to attitudes towards sexual consent whereby ( $\beta = -.08, p <.001$ ) in that those who were not currently studying for their degree were likely to have higher ASCS scores. Age was negatively associated with attitudes towards intoxicated consent ( $\beta = -.07, p <.001$ ) with younger participants likely to have higher ASCS scores. Cognitive Responsiveness was positively associated with problematic attitudes towards consent ( $\beta = .06, p <.001$ ) meaning that higher scores in the cognitive responsiveness subscale, whereby participants lacked cognitive empathy, resulted in higher ASCS scores.

**Table 5***Summary of Regression Analysis to Predict Problematic Attitudes Towards Sexual Consent*

	<i>R</i>	<i>R</i> <sup>2</sup>	<i>B</i>	$\beta$	<i>SE</i>	<i>t</i>	CI 95% ( <i>B</i> )
<b>Model</b>	.40	.16***					
Age			-.04	-.07***	.01	-3.64	[-.07 / -.02]
Gender			.33	.01	.43	.75	[-.52 / 1.17]
Ethnicity			-.03	-.00	.63	-.05	[-1.26 / 1.20]
Education Status			-1.59	-.08	.38	-4.14	[-2.34 / -.84]
Victimisation			.49	-.01	.64	-.77	[-1.73 / .76]
SES			.15	.12***	.02	6.16	[.10 / .19]
AR			.01	.00	.05	.14	[-.09 / .10]
CR			.13	.06**	.05	-2.85	[.04 / .22]
IPM			.03	.02	.03	.83	[-.04 / .09]
EGO			-.01	-.01	.05	-.20	[-.11 / .09]
Hypermasculinity			.26	.24***	.02	10.93	[.21 / .31]
SDO			.08	.16***	.01	7.25	[.06 / .10]

*Note.* SES = Self-Esteem; AR = Affective Responsiveness; CR = Cognitive Responsiveness; IPM = Interpersonal Manipulation; EGO = Egocentricity; SDO = Social Dominance Orientation

\**p* < .05; \*\**p* < .005; \*\*\**p* < .001

## Discussion

The present study aimed to examine whether certain factors predict attitudes towards intoxicated sexual consent. Demographic (age, gender, ethnicity, education status and victimisation), psychological (psychopathy, hypermasculinity and social dominance orientation) and attitudinal (attitudes towards alcohol) factors were investigated.

The regression analysis results suggest that the present study's model is significant in predicting attitudes towards intoxicated sexual consent. Hypermasculinity and social dominance orientation (SDO) were found to be the most significant, positive predictors of the outcome variable, meaning that as scores of hypermasculinity and social dominance orientation increased, so too did participants' approval of intoxicated sexual consent. This was also true of cognitive responsiveness (a variable assessed within psychopathy). As cognitive responsiveness increased, so did participants' scores on the Alcohol and Sexual Consent Scale (Ward et al., 2012). Education status was a significant negative predictor of attitudes towards intoxicated consent; participants who were not currently in education had more approval for intoxicated consent. Age was a negative predictor of outcome variable. Results showed that the younger participants were, the more they endorsed the view that intoxicated sexual consent was acceptable. These results highlight the importance of considering people's age, their education, attitudes towards women and the presence of psychopathic personality traits when attempting to predict the possible rejection or acceptance of intoxicated consent.

In relation to previous research findings, the current study found that education plays a role in whether participants agree that sexual behaviour, despite being intoxicated, is acceptable. Such findings are fitting with that of Suarez and Gadalla (2010), who found that participants' level of education played a significant role when attempting to predict rape myth acceptance (RMA) beliefs. This is important, as education status (i.e. whether participants were currently studying or not) was a predictor variable investigated based upon intuitive links and previous literature that suggests education has a bearing on problematic attitudes towards sexual consent.

The current study found that hypermasculinity – a psychological factor – is predictive of the acceptance of intoxicated consent, which is fitting with that of previous literature. It found that those who endorse the belief that males should be dominant over females (Vokey, et al., 2012), are also likely to endorse the belief that sexual consent is acceptable when the individual is intoxicated. This is relevant to Hermann et al.'s (2018) link with the Theory of Planned Behaviour as it supports the proposition that males are less likely to value sexual consent as they often hold hostile, sexist attitudes towards women and so disregard the significance of sexual consent. Findings are also in line with Suarez and Gadalla's (2010) research which found men who held sexist and hostile attitudes towards women, were more likely to endorse rape myths. Whilst this is the case for the current study, Suarez and Gadalla's (2010) reasoning for such behaviour does not fit so well. They proposed that hypermasculinity led men to believe that women were engaging in token resistance behaviour, but the present study focussed on instances that involved intoxication, not ones whereby the consent – or lack of – was ambiguous. This is a limitation of the present study, as it does not address other instances in which sexual consent can be problematic.

It is also the case that self-esteem's predictive nature on attitudes towards sexual consent is in line with previous research that has investigated RMA. For example, research conducted into self-esteem as a predictor of RMA found that women who had increased self-esteem levels based on a man's comments, were more likely to endorse rape myths that suggest it is a woman's own fault if she is victimised (Rubinsky et al., 2018; Debowska, Boduszek & Willmott, 2018). The current study also found higher levels of self-esteem to be a predictor of problematic attitudes towards intoxicated sexual consent. It could be argued that the participants believed that sexual activity whilst under the influence of alcohol is acceptable because both parties are aware of the risk they are taking, and if they then fall victim to sexual violence, it is their own fault for engaging in sexual behaviour whilst drinking heavily.

Furthermore, research conducted into SDO's predictive nature of RMA views is reinforced by current findings. Chapleau and Oswald's (2013) research proposed that when participants held stronger attitudes towards the inequality of sexes during sexual encounters, they were more likely to endorse rape myths. The present study found that SDO is predictive of problematic attitudes towards intoxicated consent. It is arguable, then, that the current study reinstates the findings of previous literature. However, whilst Chapleau and Oswald (2013) concluded that SDO was predictive of RMA, the current study suggests that it is predictive of problematic attitudes towards intoxicated consent. Whilst similar, they are not directly measuring the same construct and situation; how relevant the current study results are to that of the previous research may not be so significant. This is not to say that the current study's findings lack value, but rather address a different issue.

In the current study, cognitive responsiveness, a subscale of psychopathy, (see Boduszek et al, In Press) had a positive relationship with attitudes towards intoxicated sexual consent meaning that higher scores were predictive of the acceptance of such consent. This is in line with previous literature from Mouilso and Calhoun's (2013) and Debowska et al. (2015) that states a lack of cognitive responsiveness is predictive of the endorsement of rape myths. The current study therefore reinforces the idea that low levels of empathy (affective versus cognitive – Bodszuek et al, 2019; 2021) can result in a disregard for others' feelings – particularly relevant in the case of intoxicated consent as the perpetrator is disregarding the victim's inability to consent freely.

The present study contradicts prior research conducted by Graf and Johnson (2020) which concluded that middle aged people were less able to identify whether sexual consent was given or not in ambiguous situations. The present study found that the older the participants were, the better their attitudes were towards intoxicated sexual consent, meaning that they had better recognition of the issues of consenting to sexual behaviour whilst intoxicated. Attitudes which at their most severe can have serious implications upon rape proclivity and perpetration (Debowska et al, 2021; Dlamini et al, 2017; Willmott et al, 2018). The present study may contradict the findings of previous research as it looked solely at alcohol-involved encounters, whilst Graf and Johnson's (2020) study addressed different situations. Older participants may have actually fared better when talking of intoxicated consent in the previous study, but performed worse, generally speaking, than younger people, hence concluding that their understanding of sexual consent in a given context is worse than younger participants. It would therefore be beneficial to use the current model

and apply it to different situations to see if it is generalisable. This would improve the external validity of the model and increase its significance in the real world.

### **Study Limitations**

Sexual violence often goes unreported by the victim (CSEW, 2018). The present study found 4% of respondents identified as a victim, which is unusually high given that previous estimates for the self-reporting of sexual violence suggests that between 1 and 3% of offences will be reported to police (Krebs et al., 2007). Also, given the nature of the topic, participants may have selected socially desirable responses within the questionnaire as though to fit in with the rest of the sample – suggesting the possibility of a social desirability effect. These issues mean that the data may be skewed and thus not accurately reflect the experiences nor the beliefs of the sample. Therefore, the extent to which the conclusions are applicable outside of the sample is questionable. However, instruments within the present study's questionnaire contained reverse scored questions in an attempt to account for the social desirability effect and so responses may, in reality, be more representative of the sample's actual beliefs than first thought.

Whilst the model was deemed significant in its predictive value of attitudes towards intoxicated consent, it has not been tested whether the model is as predictive of attitudes towards other consent related issues, for example, token resistance. The study is, however, able to comment on the predictability of each variable individually which is significant given that sexual behaviour whilst intoxicated is currently a leading form of sexual violence (Howard et al., 2008). It is also the case that the model's predictor variables were chosen by the researcher based upon engagement with previous literature, and so, the model may be

subject to researcher bias. However, given the weight of literature that addresses the links between the chosen predictors and sexual violence, it is arguable that the variables investigated were not the result of bias but rather based upon intuitive links between the predictor and outcome variables.

## **Implications**

The present study has identified factors that can predict attitudes towards intoxicated sexual consent and thus presents implications for policies attempting to prevent sexual violence. From being able to predict problematic attitudes towards sexual consent, i.e. believing that intoxicated consent is acceptable, policies against date raping and one-night stands (that are often fuelled by alcohol) can be better informed and implemented. The current study has been able to identify factors that are influential in predicting whether a person accepts or rejects that an individual cannot consent to sex whilst intoxicated and such factors should be addressed by the likes of bars and other establishments that encourage alcohol consumption. Pushing individuals to recognise the signs of someone likely to endorse such beliefs whilst in these establishments could reduce the likelihood of sexual violence occurring. As such the findings contribute to broader literature which has attempted explain motivations and psychosocial predictors of engaging in violent and sexual crime (Boduszek et al, 2017; Ryan et al, 2017; Sherretts et al, 2017; Willmott & Ioannou, 2017).

Other policy suggestions relate to sex education that often uses teachers' own understanding of consent to inform adolescents (Padilla-Walker, Mclean, Ogles and Pollard, 2020). Upon investigating attitudes towards intoxicated consent, the research has highlighted

the need for more factual and in-depth definitions to be taught to adolescents as though to ensure that they recognise when consent should and should not be accepted.

The study was conducted cross-sectionally and so cannot suggest direct causal relationships between predictor and outcome variables. It would thus be beneficial to conduct research that is longitudinal as though to account for temporal changes in the strength of the variables' predictability and in turn, increase its external validity. A randomised control trial design with experimental and control participant groups would allow for more detailed insight into how educational interventions ought to be designed to reduce such problematic belief systems (see Boduszek et al, 2019 as one example of such an approach and methodology). Furthermore, like other areas of forensic psychology where research has led to procedural reform and refinement within police and custodial settings (Debowska et al, 2018; McDermott & Willmott, 2018; Ryan et al, 2018; Thew et al, 2018; Willmott & Sherretts, 2016; Willmott, 2017), future research should also seek to examine how such attitudes among CJS professional may influence investigative and prosecutorial decision making as well as the treatment of offended sex offenders or those who allege victimisation experiences, within prison/victim services settings.

## **Conclusion**

Findings suggest that attitudes towards intoxicated consent can be predicted by age, education status and self-esteem, hypermasculine and social dominance orientation and psychopathic traits. It is concluded that sexual violence that results from intoxicated consent can be reduced through recognition of these features in an individual and acting upon these. It is hoped that interventions can be developed which would work towards educating those

who identify with such factors on the need for consent to sexual activity to be made freely and with the mental capacity to do so, of which intoxication does not allow for.

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## Appendices

### Appendix 1 – Ethics Application Approval

21/11/2020

**Project Title:** Examining Individual Differences in Attitudes Towards Consent

**EthOS Reference Number:** 27658

#### Ethical Opinion

Dear Cameron Nyland,

The above application was reviewed by Dr Dominic Willmott and on the 21/11/2020, was given a favourable ethical opinion. The approval is in place until six months after the end date recorded in your application documentation (10/05/2020).

#### Approved Documents

Document Type	File Name	Date	Version
Project Protocol	Cameron Nyland, 18024264, Reserch Ethics Protocol, V1.0	20/11/2020	V1.0
Information Sheet	Cameron Nyland, 18024264, Participant Information Sheet, V1.0	20/11/2020	V1.0
Consent Form	Cameron Nyland, 18024264, Consent Form, V1.0	20/11/2020	V1.0
Recruitment Media	Cameron Nyland, 18024264, Advert, V1.0	20/11/2020	V1.0
Additional Documentation	Cameron Nyland, 18024264, Questionnaire Booklet, V1.0	20/11/2020	V1.0
Additional Documentation	Cameron Nyland, 18024264, Debrief, V1.0	20/11/2020	V1.0

## Appendix 2 – Sample Population Recruitment Table

Source	Members in Group
LinkedIn	N/A
Facebook Group – PSYCHOLOGY STUDENTS NET	8,700 members
Facebook Group – PSYCHOLOGY UK	6,200 members
Facebook Group – Psychology Lovers	115,300 members
Facebook Group – Criminal and Forensic Psychology Research	5,200 members
Facebook Group – Forensic Advice	5,400 members
Facebook Group – Research Participation – Dissertation, Thesis, PhD, Survey Sharing	36,200 members
Facebook Group – Survey Exchange/Survey Group/Survey Participants – Dissertation, Thesis	9,700 members
Facebook Group - Psychology	140,000 members

### Participation Information Sheet

Examining individual differences in attitudes towards consent.

#### 1) Invitation to research

My name is Cameron Nyland and I would like to invite you to take part in a research project which is investigating attitudes towards sexual consent. This research forms part of my bachelor's degree dissertation research at Manchester Metropolitan University and is overseen by my project supervisor, Dr Dominic Willmott. Participants must be over the age of 18 and proficient at reading written English in order to be able to take part. In order for you to decide whether you want to take part I will present the details of the research project in more detail below. Please read through the information provided and feel free to contact me on the contact details provided if you require more information.

#### 2) Do I have to take part?

It's up to you whether you want to take part or not, you haven't been specifically approached but rather we would like you take part if you feel you have the time and are interested in doing so. In this information sheet you will be informed with what the study will involve and the sort of questions you will be answering. Before deciding whether to take part in the study, you will be presented with a series of statements to make sure you understand what the study involves, which you must read carefully and agree to within a consent form (this is on the next page). If you decide to take part, you are free to withdraw from the study at any time without having to give a reason. If you are not proficient at reading written English, please do not take part in the study, as you may be unaware at what is being asked of you.

#### 3) What will I be asked to do?

If you decide to take part, you will be provided with a series of questionnaires which should take around 20 minutes in total to complete. The questionnaires will ask you about your opinions surrounding sexual consent, attitudes towards sexuality and alcohol, as well as your feelings and thoughts about yourself. You will be asked to decide on a scale whether you agree or disagree with these statements. After completing the questionnaires, you will be provided with a study debrief which will provide you with a summary of the study and will also repeat the contact information and support service helplines listed at the bottom of this document in case you would find such information useful.

#### 4) Are there any risks if I participate?

This study will ask you a series of questions assessing your opinions and attitudes towards sexual consent, sexuality and alcohol. The questionnaire will also ask you questions about

how you feel about yourself. Due to the sensitive nature of this topic, there may be questions or statements which you will find distressing, though the questions in this study have been carefully selected to try to minimize the risk of harm or upset. However, inevitably for some people, questions may be upsetting or distressing. It is advisable that you do not take part if you feel this topic may cause you to become upset after taking part.

Should you decide to take part, please refer to the contact information below also listed at the end of the study on the debrief sheet. Here free and impartial support service information is provided. If you wish to withdraw from the study, you can do this at any time during the study by simply closing the browser, or up to two weeks after taking part by emailing the lead researcher using the contact details at the end of this sheet. You will need to quote the unique participation code that you will be asked to create at the start of the questionnaire, that allows the researcher to link back to your answers, otherwise they are entirely anonymous.

**5) Are there any advantages if I participate?**

There are no direct advantages for participation, however your responses will be very useful in helping us better understand what factors influence public perceptions of sexual consent.

**6) What will happen with the data I provide?**

If you agree to participate in this research, we will collect information from you, but it is important to note that no personally identifiable information will be collected.

The University is registered with the Information Commissioner's Office (ICO) and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will destroy the information about you that we have already obtained.

Personal data collected in this study may be shared, such as age and gender, however these will not be personally identifiable, and you will remain anonymous throughout. We may share your personal data with Manchester Metropolitan University and possible future publishers in order to fulfil the purposes set out above but it will always be anonymous.

If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written

consent to be identified in the research. **The University never sells personal data to third parties.**

We will only retain your personal data for as long as is necessary to achieve the research purpose. Data will be kept on a password secured service, which will allow for protection from any possible data breaches. None of this data will contain any personal information relating to you, as all data will be anonymous. Data will be stored for the duration of the project, until the final piece of research is handed in as part of a bachelor's degree research project and will be securely stored up to one-year post submission/completion of the research project.

For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages (<https://www2.mmu.ac.uk/data-protection/>).

#### **7) What will happen to the results of the research study?**

The results of this research will be used to form the basis of an BSc Forensic Psychology dissertation that will be submitted to Manchester Metropolitan University. There is also the possibility of publication of this research within a scientific journal. However, your data will be merged with other participant's data, and so you will never be singled out or identifiable as an individual. To be clear, you will be fully anonymised at all times in this study.

On the completion of the study, in the case that you wish to ask for the outcome of the study, you can email the lead researcher on the contact information provided below. Please note only the overall findings of the study can be provided, not those that relate to you specifically.

#### **8) Who has reviewed this research project?**

This research has been reviewed by the project supervisor (Dr Dominic Willmott) and has gained ethical approval after being reviewed by the Manchester Metropolitan University ethics committee.

#### **9) Who do I contact if I have concerns about this study or I wish to complain?**

- Project Supervisor – Dr Dominic Willmott – [d.willmott@mmu.ac.uk](mailto:d.willmott@mmu.ac.uk)

If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the [legal@mmu.ac.uk](mailto:legal@mmu.ac.uk) e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see: <https://ico.org.uk/global/contact-us/>

**Support service information**

**Rape Crisis England and Wales**

National Helpline: 0808 802 9999

Web: <https://rapecrisis.org.uk/>

**Victim Support**

Web: <https://www.victimsupport.org.uk/more-us/contact-us>

Telephone: 0808 16 89 111

**Samaritans:**

Telephone: 116 123

Email: [jo@samaritans.org](mailto:jo@samaritans.org)

Web: <https://www.samaritans.org/?nation=wales>

**THANKYOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT**

## Appendix 4 – Participant Consent Form



### Consent Form

This project is investigating attitudes surrounding sexual consent. Before consenting to take part, we ask that you read through the participant information sheet carefully and agree to each of the statements that you are consenting to below. If you have any queries before signing the consent form, please email the principal investigator, Cameron Nyland, [18024264@stu.mmu.ac.uk](mailto:18024264@stu.mmu.ac.uk), or the project supervisor, Dr Dominic Willmott, [d.willmott@mmu.ac.uk](mailto:d.willmott@mmu.ac.uk).

1. I confirm that I have read the Participant Information sheet and fully understand what is expected of me within this study.
2. I confirm that I have had the opportunity to ask any questions and to have them answered where asked.
3. I understand that my participation is voluntary and that I am free to withdraw up to the 31<sup>st</sup> March 2021 without giving any reason, and without my legal rights being affected in any way.
4. I understand that I will be shown content and asked questions that may be disturbing or distressing.
5. I understand that in order for my data to be withdrawn, I will need to contact the researcher via email within two weeks of completing the survey, with the inclusion of the code I have created as part of my participation.
6. I understand that failure to provide a valid code will not allow the researcher to trace my responses and remove them and they will still be included in the analysis and write up of the project.
7. I understand that the information from my responses will be pooled with other participants' responses and may be published but that I will remain anonymous throughout.
8. I consent to the data generated as part of this research to be used in reports, conferences, and publications on the basis that I am always anonymised.
9. I understand that information I give will remain strictly confidential and anonymous.
10. I consent to take part in this study.

Pressing 'continue' below is equivalent to giving your consent to take part. Thank you.

- Continue

EthOS ID: 27658, Consent Form V1.0, Student no: 18024264, 20/11/2020