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J Sex Res. Author manuscript; available in PMC 2016 June 01.

Published in final edited form as:

J Sex Res. 2015 June ; 52(5): 580–589. doi:10.1080/00224499.2014.931336.

Sex-Related Alcohol Expectancies among African American Women Attending an Urban STI Clinic

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Abstract

African American women are disproportionately affected by HIV/AIDS and sexually transmitted infections (STIs). Alcohol use is a significant risk factor for HIV/STI acquisition. Sex related alcohol expectancies (SRAE) may partially account for alcohol related risky sexual behaviors. Using qualitative interviews we explored the link between alcohol use and risky sex among 20 African American women attending an STI clinic who had consumed ≥4 alcoholic drinks per drinking day (binge drinking) and/or reported vaginal or anal sex while under the influence of alcohol. Four SRAE emerged which we named: drink for sexual desire, drink for sexual power, drink for sexual excuse, and drink for anal sex. While the desire SRAE has been documented, this study identified three additional SRAEs not currently assessed by expectancy questionnaires. These SRAEs may contribute to high-risk sex when under the influence of alcohol, and suggests the importance of developing integrated alcohol-sexual risk reduction interventions for high-risk women.

Keywords

sex related alcohol expectancies; sexual risk behavior; alcohol use; African American women; sexually transmitted infection; STD clinic

African American women are disproportionately affected by HIV/AIDS and sexually transmitted infections (STIs) in the US. In 2010, African American women accounted for approximately 64% of the estimated 9500 new HIV Infections (CDC, 2014). Their HIV

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incidence rate was 4.8 and 20 times greater than the rate for Hispanic and white women. In that same year, young black women (aged 20-24) had the highest rates of gonorrhea and chlamydia compared with young Hispanic and white women (CDC, 2013). Their gonorrhea rate was more than 8 and 12 times higher than Hispanic and white women respectively; their chlamydia rate was more than 2 and 5 times higher than Hispanic and white women.

A significant risk factor for both HIV infection and STIs among women is alcohol use (Baliunas, Rehm, Irving, & Shuper, 2010; Boden, Fergusson, & Horwood, 2011; Buffardi, Thomas, Holes, & Manhart, 2008; Cook & Clark, 2005; Eriksen & Trocki, 1994; Hutton, McCaul, Santora, & Erbelding, 2008; Seth, Wingood, DiClemente, & Robinson, 2011). Alcohol use, particularly binge drinking ≥4 drinks/occasion for women (Wechsler, Dowdall, Davenport, & Rimm, 1995) is correlated with HIV/STI risk behaviors which include: unprotected vaginal and anal sex, multiple sex partners, coerced or forced sex, and sex with high- risk partners (Cooper, 2002; Hutton et al., 2008; Jenness, Beier, Neaigus, Murrrill, Wendel, & Hagan, 2011; Rehm, Shield, Joharchi, & Shuper, 2012; Scott-Sheldon, Senn, Carey, Urban, & Carey, 2013; Seth et al., 2011; Stockman, Campbell, & Celentano, 2010). Among African American women, even non-abuse levels of consumption are associated with HIV/STI risk behaviors and STIs (Sales, Brown, Vissman, & DiClemente, 2012; Seth et al., 2011). While African American women have lower prevalence rates of alcohol use and binge drinking than white or Hispanic women, they experience more adverse medical and social outcomes from their alcohol use (Boyd, Mackey, & Phillips, 2006; Caetano, Schafer, & Cunradi, 2001; Mulia, Ye, Greenfield, Zemore, 2009; Sales et al., 2012; Sempos, Rehm, Wu, Crespo, & Trevisan, 2003).

A compelling link between alcohol use and risky sexual behavior is sex-related alcohol expectancies (SRAE; Dermen, Cooper, & Agocha, 1998; George & Stoner, 2000; George, Stoner, Norris, Lopez, & Lehman, 2000; Gilmore, George, Nguyen, Heman, Davis, & Norris, 2013; Norris, Masters, & Zawacki, 2004). SRAEs are defined as the individual's beliefs about the physiological, emotional, and behavioral effects of alcohol consumption on sexual behavior. A common SRAE in Western culture is that “alcohol improves sexual pleasure” (Brown, Goldman, Inn, & Anderson, 1980; George et al., 2000). Women holding this SRAE are more likely to consume higher quantities of alcohol before sex and more likely to engage in risky sex after drinking (Crowe & George, 1989; Fromme, D'Amico, & Katz, 1999; Gilmore et al., 2013; Hendershot, Stoner, George, & Norris, 2007). Compared with women who have no or weak enhancement expectancies, women with strong enhancement SRAEs more often report intentions to have and/or history of: 1) sex with a casual partner (Abbey, Saenz, & Buck 2005; Cooper, 2002; George & Stoner, 2000; Parks, Hsieh, Collins, Levonyan-Radloff, & King, 2009); 2) sex with a new partner (Gilmore et al., 2013); 3) substance-impaired sex (Leigh, 1990; Weinhardt, Otto-Salaj, Brondino, Norberg, & Kalichman, 2002; White, Fleming, Catalano, & Bailery, 2009); 4) unprotected sex (Corbin & Fromme, 2002; Maisto, Carey, Carey, Gordon, & Schum, 2004); and 5) a greater number of sex partners [Hendershot et al., 2007; Stappenbeck, Norris, Kiekel, Morrison, George, Davis, Zawacki, Jacques-Tiura, & Abdallah, 2013; Weinhardt et al., 2002). Women with enhancement SRAEs are also more likely to report a history of sexual victimization (Marx, Nichols-Anderson, Messman-Moore, Miranda, & Porter, 2000; Testa & Dermen, 1999), which may occur as a consequence of engaging in risky sexually behaviors.

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Enhancement SRAEs, therefore, may help identify women who are at increased risk for engaging in unsafe sexual behaviors and/or experiencing sexual victimization.

There are two potential limitations of these studies. The expectancy scales that were used to measure SRAEs queried the sexually enhancing, sexually disinhibiting, or sexual risk promoting properties of alcohol (George, Frone, Cooper, Russell, Skinner, Windle, 1995; Dermen, Cooper, Agocha, 1998). There may be other potent SRAEs that influence decision making which are not identified by these scales. Second, in the majority of studies, participants were drawn from white adult or college student populations. It is unclear, therefore, to what extent the SRAEs from these studies can be extrapolated to understanding the risks faced by at risk African American women. It may be more beneficial, to use open-ended methods that allow for exploration of SRAEs that may be specific to African American women. Qualitative interviewing has been effective in identifying SRAEs of high-risk groups of adolescent and adult men who have sex with men (MSM; Coleman & Cater, 2005; Mutchler, McDavitt, & Gordon, 2013; Parsons, Vicioso, Punzalan, Halkitis, Kutnick, & Velasquez, 2004).

By definition, African American women who attend STI clinics either engage in, or have sexual partners who engage in, risky sexual behaviors (Hutton et al., 2008; Norris et al., 2004; Scott-Sheldon, et al., 2013). They also have a high frequency of hazardous alcohol use that exceeds that reported by the general population of African American women (Naimi, Nelson, and Brewer, 2010). SRAEs may increase their likelihood of drinking in sexual contexts and their HIV/STI risk. The purpose of this study, therefore, was to qualitatively explore SRAEs of African American women attending an urban STI clinic. The goal was to identify SRAEs that could inform the development of an integrated alcohol and sexual risk reduction intervention for African American women attending an STI clinic.

Method

Study design, setting, and participants

We performed semi-structured interviews among women presenting for care at the Baltimore City Health Department. We chose not to use alcohol expectancy scales that were developed and used largely with white and college populations because of concerns about relevance to our population. Instead we chose to use qualitative interviewing which has been used effectively to explore the specific SRAEs expectancies of high-risk groups of young and adult MSMs and adolescents (Coleman & Cater, 2005; Mutchler et al., 2013; Parsons et al., 2004). The study was conducted between December 2009 and August 2010. Women were purposively sampled and eligible if they were at least 18 years old, seeking treatment at the clinic, able to speak English, and in the last 6 months had consumed 4 or more alcoholic drinks per drinking day (binge drinking) and/or reported vaginal or anal sex with a male while under the influence of alcohol. Sexual orientation was not queried.

Procedure

Clinic health care providers referred potential participants who met study eligibility criteria. For women wishing to participate, written informed consent was obtained. No participant

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withdrew from the study. Participants were reimbursed $35.00 for their time and transportation costs.

Twenty one-on-one interviews were conducted by a female clinical psychologist or a female physician in private offices at the Health Department. Interviews were conducted using semi-structured guides, which allowed for probing and clarification to query women about their alcohol use and sexual activity (Bernard & Ryan, 2010). The guide asked about their first experience drinking alcohol, situations or moods that increase the likelihood of drinking alcohol, alcohol's effect on sexual behaviors, body experience when drinking, sex partners, and condom use. The interviews were typically completed in about 60 minutes and were audio-recorded and transcribed verbatim.

Following the interviews, participants completed the Alcohol Use Disorders Identification Test, (AUDIT; Allen, Litten, Fertig, & Babor, 1997), a widely used and well-validated screening questionnaire to identify hazardous or harmful alcohol use. They also answered brief, investigator-generated questions about vaginal or anal sex, alcohol or drug use before sex and whether a condom was used: with main, casual, and/or new sex partners. All audio recordings, transcripts, and files were labeled with a code, and any identifying information was removed from interview transcripts. Participants were continuously enrolled until thematic saturation was obtained. Saturation was defined as the point at which no new information or themes were observed in the data (Guest, Bunce, & Johnson, 2006). The institutional review boards at the Johns Hopkins University School of Medicine and the Baltimore City Health Department approved the study.

Data Analysis

The transcripts were analyzed in an iterative process using thematic analysis guided by grounded theory (Charmaz, 2006; Guest, MacQueen, & Namey, 2011; Guest et al., 2006). Data were organized in ATLAS-ti (2010) qualitative data analysis software (Atlas.ti, 2010). Concepts were viewed as grounded in the data, leading successive phases of analysis to identify themes as they emerged through a process of coding (Lincoln, 1995). Emergent themes were related by the research team to those found in the literature concerning alcohol use and sexual behavior (Glaser, 2002).

Two graduate-level research assistants (RAs) with advanced training in qualitative interviewing coded the data. To begin, the RAs independently coded a sub-sample of four of the twenty interview transcripts to determine whether there was adequate interrater reliability between the coders. To create provisional codebooks, a process of open, axial, and selective coding was used (Guest et al., 2006) wherein the transcripts were considered line by line in order to identify concepts and patterns among them. Codes were applied and categorized. The research team then examined these provisional codebooks and collapsed and reordered them to create a representative codebook for use in the entire analysis. Inconsistencies were examined and resolved through consensus to arrive at an agreed-upon coding scheme (Maxwell, 2012; Patton, 2002). This sub-sample of interviews was then re-coded according to the joint codebook. Remaining interviews were coded in the same fashion. Domains that emerged across cases subsequent to the development of the initial codebook were considered by the research team with additions and alterations to the

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codebook identified and agreed upon by the team. In the final phase, we focused on connecting themes and finding links in the data. We re-examined the data and assigned excerpts that illustrated the final themes.

Results

The 20 participants were African American women with a mean age of 24.5 years. Ninety-five percent (95%) had completed high school or the equivalent. Their average AUDIT score was 7.1 (SD=2.81), the established cut-off score for women as an indicator of hazardous and harmful alcohol use (Reinert & Allen, 2007). In the preceding 3 months, 95% (19/20) of the women reported having “unprotected vaginal or anal sex when high on alcohol” and 50% (10/20) reported “using drugs before or during sex.” Most women had a main partner (19/20) and 50% had concurrent partners (10/20). Of those women with main partners, 26% (5/19) always used condoms; of those with concurrent partners, 30% (3/10) always used condoms.

Qualitative interviewing enabled in-depth exploration of the link between alcohol use and sexual behavior. Four expectancies emerged from the interviews which we have named: drink for sexual desire, drink for sexual power, drink for sexual excuse, and drink for anal sex. Verbatim quotations are listed below with participant identification number and age in parentheses.

1) Drink for sexual desire

Every participant expressed the belief that drinking stimulated their sex drive as well as increased their sexual satisfaction. Alcohol can “intensify and intensify and intensify… [sex]” (Participant 13, age 21).

They also believed that alcohol could expand the variety of sexual activities they engaged in--even riskier ones—because of the increased pleasure they derived and the intensified desire to give pleasure to their sex partner. Participant 2 (age 32) explained,… [alcohol] “raises sex drive tremendously and for doing basically anything. All you feel is pleasure.”

Participant 17 (age 23) corroborated:

> They got a song about it. Get loose as a goose, like the goose, drink goose you get loose.* Like it just make you feel open, just like how [the] guy singing [the] music, it just make you different, act a different way. I'm sober, I'd just lay there and like, oh, come on, let's just get it over with or something like that. But if I drink, I'd be all extra. I'd want to do extra stuff. And, so I'd drink just because it'd make the sex more fun…*[Goose refers to Grey Goose Vodka in song by actor Jamie Foxx called, “Blame it (On The Alcohol)”].

In addition to altering choices about sexual behaviors, the women perceived that alcohol also had a significant impact on their choice of potential sex partners. For instance, they indicated that men whom they would not have considered for a sexual partner when they were sober change into an attractive partner with alcohol. Although the arousal from alcohol was positively portrayed, women recognized that its effects could be deceiving.

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> Well, some [women] drink above their limit, and then, they be on the prowl. They go find their man - - and [alcohol] just change your eye sight. Just like—God, forgive me—a cancer patient will look like Vin Diesel (Hollywood action actor) in your eyes. (Participant 6, age 31).

Women expected alcohol to be a source of sexual arousal and once under alcohol's influence, they also expected that their perception of a potential sex partner could be significantly altered. Inherent in this perception of a seriously ill person appearing to be a robust movie actor was a sense of danger obscured by the illusion alcohol creates. As Participant 2 (age 32) summarized, “My whole thing with women drinking before sex, it can be a good thing, but then it don't.”

2) Drink for sexual power

In addition to increasing sexual desire, women also believed that alcohol increased feelings of power and aggression. And Participant 4 (age 36) explained:

> When you're under the influence [of alcohol], you feel more powerful and more bold, I would say. You are more outspoken when you drink….get more aggressive and outspoken… [Women] feel like they can stand up for themselves more than they could if they were sober.

For Participant 20 (age 24) alcohol's effect was seen as even more compelling,

> For me, [alcohol] is liquid courage.. I just feel like invincible. I just have a sense of power, like you can't tell me anything. You say something to me; I'm going to shut you down.

The increased sense of power from drinking also translated into increased sense of sexual power and parity with men in the bedroom. Participant 20 (age 24) observed:

> The script flips sometimes. Like you can maybe last longer before you climax or whatever. It's like, hey, I can keep up with him now. I don't have to say, well, stop, give me a minute, or whatever. It's like I can be on his level.

Participant 4 (age 36) agreed:

> I think because when you're always under the influence, the more you drink, the more aggressive you get. And that's in all areas, definitely in the bedroom.

Alcohol also increased a woman's ability to handle a sexually difficult situation. One woman observed that drinking alcohol enabled her to “handle” anal sex even though it may have been difficult for her. Participant 8 (age 26) shared that:

> Alcohol makes you more aggressive like you can handle things a little bit more, well certain things I mean when I say handle I mean like if I was having anal sex, I couldn't do it - - like once I start drinking I can handle it but I can really handle it like I have never handled it before in my life…stuff like that.

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3) Drink for sexual excuse

Another expectancy cited by all of the women was that alcohol provided an excuse for sexual behavior that was either desired but prohibited at night, or sexual behavior that was regretted the next morning. The word ‘blame’ was cited frequently in the interviews, Participant 1 (age 21) described:

> I think some women want to try some stuff, different stuff sexually, but may not be inclined to, may feel embarrassed that they want to ask to do something that might be considered overly erotic, like being taped, when they're sober opposed to when they're not sober. It's like, “You want to try this?” And then, when they begin to drink, it's like I'll try it now, and then blame it on the alcohol later.

Participant 16 (age 27) used a metaphor of having anesthesia to block the pain of childbirth to describe alcohol's role in mediating the association between sexual desire and sexual culpability. Drinking alcohol functioned as an anesthetic to relieve the pain of guilt about engaging in sex. Once this pain was blunted, it became easier to engage in sex, all kinds of sex.

> Just like when you're going for surgery. Some procedures you could take without anesthesia, but you're going to take it because you don't want to go through the pain, so it's like childbirth. You can do childbirth without epidural, but to avoid that pain you're going to take the epidural. Just like I can go and have sex with this random person…but to make it, to make it okay in my mind I'm going to get drunk first so I can say I can't believe I did that. So it's not going to take away your consequences, ..still have to pay the consequences but I think it just takes away some of the guilt. You say, well, “Oh, honey, I did it because I was drinking. I will never drink again.

Women claimed intoxication as an excuse for behavior that they desired but were afraid or too inhibited to do sober. Participant 17 (age 23):

> Because they can just use that like I was drunk, I don't remember that. People use it to act like they don't remember stuff that they did so that they can act out the way they want to act without having to deal with the consequences from it. Some of them want to do it, and they don't want to be held responsible for it…so they do it while they're drunk.

Alcohol provided an excuse for behavior that was either regretted or not remembered the next morning. Participant 2 (age 32) stated:

> Why, ‘cause when she wake up the next day [after drinking], she may or may not remember. She may wake up and say wait a minute, who are you? And then he there looking dumb, like, huh? Yeah, but some don't. Some wake up and say “who are you,” but know who they are, but play it dumb because they embarrassed about what they did.

Participant 16 (age 27) corroborated,

> Participant 17 (age 23): Yeah. And then some, um, I got some friends who like they want to do anal so they'll drink—and so they'll make them be with it even more like

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> that person and—make you do stuff that you don't normally do. Some girls don't even do oral sex. But if they drink, then they'd be like..oh well, I'm gonna drink and then people also use it to say like I'll forget about it the next day. Like I won't remember. They use that as an excuse.

The primary reason for wanting the alcohol excuse was to protect their reputations. Women worried about public opinion, especially those of men, when they ventured beyond their usual sexual boundaries. Alcohol provided the necessary cover for the episode. Participant 11 (age 27) explained:

> Someone can really like a man and don't want to be called a name by their friends or whatever, so they consume some alcohol, go chill with this guy, then they will have sex and then they can go tell that friend, well I do not remember, you know what I'm saying, or maybe because I was drunk, I did that, but if I was sober, I wouldn't have done that. Even though that is not a good excuse, blame it on the alcohol. But that is what I mean about excuses. So it is an excuse to be sexual in some ways…. Like she has sex with this dude, girls would get called all these names and that will hurt someone. A lot of people say words do not hurt but that will scar a female if they be called this, especially by a male, so they would use that alcohol. Instead of being called a bitch, a whore, or a slut, they prefer to be called, "I was just drunk that night."

4) Drink for anal Sex

Engaging in anal sex under the influence of alcohol appeared in the three expectancies of drink for desire, drink for power, and drink for excuse. It was also a pervasive theme on its own. As a high risk STI/HIV behavior, we examined it separately. Women believed that alcohol consumption was a necessary precursor to engaging in anal sex. They were often hesitant about it, believing that it was a non-normative, even exceptional, behavior. By drinking alcohol they eased such concerns and inhibitions.

> A lot of women have got to get drunk to do anal. Women that do anal, they still have to get drunk to do anal because it, I guess, makes it easier…the effect that alcohol has on you, you get lightheaded and you're more go with the flow…. Girl, I had to get wasted you know. (Participant 8, age 26)

Participant 18 (age 50) corroborates:

> Because [the guy says] hey I want to anal and you're saying, yeah, because you're drunk. Whereas though when you're not drunk, you're like, what now? Oh, hell no. If you want to do the anal s--t, no, go on about your business, whereas though, you drunk, yeah, come one, let's go.

Alcohol also impaired awareness so that women were no longer cognizant of what they were doing in the heat of the moment and became more likely to have anal sex. It was understood that it was a type of sex that could occur under alcohol's influence and without their consent.

> Participant 11 corroborated: Some people may not want that to happen but if you drunk and the guy already in there, he might just go ahead and put it in there. You probably don't even know the difference anyway and they ain't going to stop

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> because you're under the heat of the moment so you may lose your virginity on your anal just from being drunk, you know what I'm saying?
>
> I don't know how much they drunk. They might try anything. Like I never did anal sex until I was drunk one time. (Participant 16, age 27)
>
> Participant 6 (age 31): : It doesn't matter who it is, what's going on, it doesn't even matter. The more I drink, the more I'm willing to do everything; anal sex, all that stuff. While I'm drinking, it doesn't matter.

The final motivation for consuming alcohol before anal sex was to raise the threshold for physical pain. Women typically would not consider having anal sex unless they had been drinking because of discomfort.

> Participant 2, age 32: because say a female tries anal sex and it's for the first time. She tries it and it hurts her. If she drinks enough liquor, that pain is not going to register fully. It's going to be painful, but then it's going to be enjoyable. But then, the next morning when she wake up, she going to want to know what's wrong. Why do I feel like I got to go to the doctor's?
>
> Okay so, I'll do the regular kind of sex and then the oral thing, but the anal thing--like, that is the worst thing ever to do and --I can't do it unless I have like a whole lot to drink, because it hurts. (Participant 12, age 21)

Discussion

At an urban STI clinic, we used qualitative interviewing to explore the sex-related alcohol expectancies of 20 African American women. Four themes emerged which characterized their beliefs about the effect of alcohol on sex. Women described drinking for: 1) sexual desire, 2) sexual power, 3) sexual excuse, and 4) anal sex. Within each of these expectancies, we examine their potential influence on sexual risk behaviors. Finally, we provide recommendations for intervention development. Drinking for sexual desire was the SRAE that alcohol fueled sexual appetites and altered the perception of partner attractiveness. The women viewed alcohol as increasing their sex drive and therefore the likelihood of engaging in and deriving pleasure from sex. Women also viewed alcohol as inducing the desire to engage in a broader range of sexual risks. This ‘desire’ SRAE also appears across gender and race in western culture (George & Stoner, 2000; Leigh, 1990) and the stronger it is, the greater the likelihood of engaging in risky sex (Davis, Hendershot, George, Norris,& Heiman, 2007; Davis, Norris, Hessler, Zawacki, Morrison, & George, 2010; Gilmore et al., 2013; Hendershot et al., 2007). The women also believed that drinking alcohol enhanced the allure of a potential sex partner by transforming “a cancer patient into Vin Diesel.” These beliefs corroborate empirical studies showing that alcohol consumption increased the ratings of perceived attractiveness of faces (Attwood, Penton-Voak, Goodwin, Munafò, 2012; Jones, Jones, Thomas, & Piper, 2003; Halwsey, Huber, Bufton, & Little, 2010) and as such ratings increased, so did the reported intentions of engaging in unprotected sex [Halsey et al., 2010; Jones et al., 2003; Agocha & Cooper, 1999). Enhancement SRAEs are also associated with increased risk of unwanted sexual contact. When compared to those who have not been victimized, college women who have been

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victims of unwanted sexual contact also report increased alcohol-related outcome expectancies for sexual enhancement (Corbin & Fromme, 2002; Marx et al., 2000). For example, Corbin, Bernat, Calhoun, McNair, and Seals (2001) found that women with the most severe histories of victimization expressed increased alcohol outcome expectancies involving sexual enhancement that was associated with higher drinking rates, more sexual partners, and more sexual activity, all of which could place them at high risk for re-victimization.

Drinking for sexual power was the expectation that alcohol could make women feel "invincible," particularly in relation to men. While it is often nicknamed 'liquid courage' in our culture (Fromme, Stroot, & Kaplan, 1993; Stoner, George, Peters, & Norris, 2007), our interviews indicated that women believed they derived more than courage from alcohol; they derived "boldness" and "invincibility." In sexual contexts, they drank alcohol to attain the power, aggression, and stamina of men, as one woman described to sexually "flip the script." Women may seek power through alcohol because their sexual behavior often occurs in a context of unequal power (Amaro, 2000; Amaro & Raj, 2000; Campbell, Tross, Dworkin, Hu, Manuel, Pavlicova, & Nunes, 2009). Unequal power can hinder the ability to initiate or negotiate safer sex through condom use (Campbell et al., 2009; Amaro & Raj, 2000; Pulerwitz, Amaro, Jong, Gortmaker & Rudd, 2002; Rosenthal & Levy, 2010; Wingood & DiClemente, 2000) and the ability to refuse sex in coercive situations (El-Bassell, Gilbert, Wu, Go, & Hill, 2005; Testa & Livingston, 2000).

Women who hope to achieve sexual power through alcohol may instead increase their risk of adverse sexual outcomes associated with hazardous drinking. Although there has not been a direct assessment of this SRAE on sexual outcomes, drinking for courage in general appears to put young adults at increased sexual risk. Students who have stronger expectancies that alcohol will give them courage also report more unwanted sexual contact than their counterparts who do not have courage expectancy (Palmer, McMahon, Rounsaville, & Ball, 2010; Crawford & Popp, 2003). Similarly, women who reported coerced sexual contact (ranging from forced kissing to rape) while under the influence of alcohol or drugs had alcohol outcome expectancies for increased power and sexual enhancement and these expectancies were associated with higher quantity and frequency of alcohol use (Marx et al., 2000). However, this study used the Alcohol Effects Questionnaire which measured power but not sexual power so it is not possible to parse whether sexual power was also part of the expectancy, a subject for future study.

Drinking for sexual excuse was the women's belief that alcohol provided "cover" for engaging in sex that was considered taboo. Blaming sex on alcohol dissociated women from negative emotions, such as embarrassment and guilt about sexual desires. Morning after guilt and regret about sex was in the words of one participant "anesthetized" by alcohol. Drinking alcohol also allowed women to dissociate themselves from sexual behaviors that they considered proscribed. They believed that their reputations could remain unsullied when they attributed sexual behaviors to the influence of alcohol. This sexual double standard, different standards of sexual permissiveness for women and men, is widely internalized by women (Crawford & Popp, 2003), as it was in our sample. Importantly, women who expected drinking to resolve the dissonance between their sexual desire and

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their prohibitions against it have placed themselves in risky sexual situations where they could become impaired by alcohol's effects and experience adverse consequences (Cho & Span, 2010; Crowe & George, 1989; Fromme et al., 1999; Hendershot et al., 2007).

Drinking to facilitate anal sex was thematically ubiquitous and appeared in the other three expectancies as well. Anal sex was perceived as “the worst thing ever,” and a Rubicon that women did not cross without the assistance of alcohol. Women believed that anal sex was not normative but would occur after alcohol had increased sexual desire and sexual aggression. In quantitative studies, alcohol is frequently associated with anal sex among women (Hutton et al., 2008; Seth et al., 2011), although the reasons for the association have been largely speculative (Gross, Holte, Marmor, Mwatha, Koblin, & Mayer, 2000; Wingood & DiClemente, 1997). Our interviews indicated that women believed that alcohol had a numbing effect so that physical pain and personal taboos were dulled. This SRAE could be associated with an increased likelihood of engaging in anal sex, a very high risk behavior for STI/HIV because women. Women are less likely to use condoms during anal sex than during vaginal sex (McBride & Fortenberry, 2010) and HIV/STI transmission is more effective for anal sex than for vaginal sex (Vargese, Maher, Peterman, Branson, Steketee, 2002).

Finally, within the SRAEs of drinking for sexual excuse and drinking for anal sex, women reported having sexual experiences that they did not remember or did not want. Women's SRAEs may influence certain sexual behaviors which subsequently place them in situations where nonconsensual sex can also occur. This may account for the reported association between enhancement SRAEs and unwanted/forced/coerced sex (Marx, Nichols-Anderson, Messman-Moore, Miranda, & Porter, 2000; Testa & Dermen, 1999). Future research may examine this.

The SRAEs of African American women attending an STI clinic may result in high risk sex and also in unwanted/forced/coerced sex, and suggests the importance of developing integrated alcohol -sexual risk reduction interventions for high risk women (Sales et al., 2012; Stappenbeck et al., 2013). First, we recommend that such interventions increase self-awareness and self-monitoring by helping women identify their SRAEs. Current expectancy measures focus on the sexually enhancing, sexually disinhibiting, or sexual risk promoting properties of alcohol (George et al., 1995; Dermen et al., 1998). By using qualitative inquiry, we have identified three more SRAEs that may influence sexual risk behavior, and there are likely others among other populations of women. For women, understanding their SRAEs may increase their opportunity to make alternative choices or develop self-protective behaviors. This is particularly critical for women whose SRAEs are associated with heavy alcohol use (Brown et al., 1980). As outlined by Testa and Livingston (2000), reducing binge drinking is central to reducing sexual vulnerability. Among women whose SRAEs also involve risky sexual behaviors, decreasing heavy drinking would be especially critical. Second, we recommend that interventions address the discrepancy between goals, as defined by SRAEs, and actual sexual outcomes. Women who expect, for example, that alcohol will increase their sexual power with men may actually increase their likelihood of sexual victimization (Palmer, McMahon, Rounsaville, & Ball 2010) and sexual revictimization (Bedard-Gilligan, Kaysen, Desai, & Lee, 2011]. This recommendation aligns with

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expectancy challenges (EC) that use either didactic or experiential challenges to alter alcohol expectancies. In a meta-analytic review of EC interventions, college students, receiving ECs to global positive alcohol expectancies or to specific sexual enhancing effects of alcohol, showed greater reductions in these expectancies as well as in quantity and frequency of alcohol consumption compared with students receiving no EC intervention at one month follow-up (Scott-Sheldon, Terry, Carey, Garey, Carey, 2012). We recommend further EC testing to controvert or diminish other SRAEs, such as the expanded SRAEs identified here. Women can challenge their own expectations and goals for drinking alcohol to numb either their bodies or their regrets so that they can engage in sexual behaviors. Finally, we recommend altering SRAEs by strengthening opposing behaviors and experiences. For example, interventions aimed at women could challenge the sexual double standard [80], the necessity to consume alcohol to justify having sex (Cho & Span, 2010; Leigh, 1990) or the reliance on alcohol to enhance the sexual experience (Messman-Moore, Ward, & DeNardi, 2013).

This study has a number of limitations. We documented the SRAEs of purposively sampled African American women attending treatment at an urban STI clinic. Our findings therefore may not be generalizable to populations of other female hazardous drinkers with different demographic characteristics. Second, expectancies are just one component in a series of cognitive appraisals and behavioral choices that occur before a risky sexual encounter (Norris et al., 2004). We cannot determine whether these expectancies affected their cognitive appraisal of sexual situations or if these expectancies influenced choices about alcohol use or risky sexual behaviors. Quantitative research is required to examine these expectancies and their potential impact on sexual decision making and behavioral outcomes. Finally, our interviews exploring the SRAEs of women do not mean that the burden of reducing risky behavior falls upon changing the SRAEs of women only. We examined SRAEs as part of overall intervention development to assist women to make considered choices about alcohol use and sexual risk behaviors. It would also be useful to explore the SRAEs of adult heterosexual men as others have done for adolescent and adult MSM (Coleman & Cater, 2005; Mutchler et al., 2013; Parsons et al., 2004).

Our study provides insight into the link between alcohol use and risky sex from the viewpoint of urban African American women attending an STI clinic. Women expressed four expectancies about alcohol's role in sex: drink for sexual desire, drink for sexual power, drink for sexual excuse, and drink for anal sex. While desire/enhancement SRAEs have been previously documented, this qualitative study identified three additional SRAEs not currently assessed by expectancy questionnaires. Expanded quantitative investigation of SRAEs, beyond sexual enhancement, may improve the understanding of alcohol-related risky sexual behaviors among women. This information can be used in risk reduction interventions for women and by women as they seek ways to improve their choices and safety in alcohol-related sexual situations.

Acknowledgments

Funding Source: This work was funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA R01AA018632).

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