# THE INFLUENCE OF FEMINIST IDENTITY ON THE SEXUAL HEALTH BEHAVIOR OF EMERGING ADULT WOMEN

By

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Bachelor of Science in Health Education & Promotion

Oklahoma State University

Stillwater, Oklahoma

2018

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF PUBLIC HEALTH
July 2020

THE INFLUENCE OF FEMINIST IDENTITY ON

THE SEXUAL HEALTH BEHAVIOR OF

EMERGING ADULT WOMEN

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# ACKNOWLEDGEMENTS

I would like to thank my committee members for everything they have done to help me on this journey. Dr. Rhoads has provided me with her advice, support, and honesty when I needed it most, and I am so grateful that she was my office neighbor for two years. Dr. Bailey challenged me to think more deeply than I ever had before, and she opened my eyes to the ways in which compassion and equality can guide research. Dr. Hubach has truly shaped my academic and career path by inspiring me to work in the field of public health, and he has always empowered me to keep going during the most difficult of times. I am incredibly fortunate to have been mentored by the faculty that I have.

I also want to thank my parents, Lisa and Kevin, for being so supportive of my academic and career choices. Without their love and enthusiasm, I could not have made it through these last few years - and certainly not this thesis! They are the reason I am able to continue furthering my education, and they will be the first people I will miss once I move. I cannot thank them enough for their love and the values they instilled in me!




Acknowledgements reflect the views of the author and are not endorsed by committee members or Oklahoma State University.

Name: KORI RAE MORGAN

Date of Degree: JULY 2020

Title of Study: THE INFLUENCE OF FEMINIST IDENTITY ON THE SEXUAL HEALTH BEHAVIOR OR EMERGING ADULT WOMEN

Major Field: PUBLIC HEALTH

Abstract: The purpose of this study is to explore the influence of a woman's feminist identity on her sexual health behavior, experiences, and perspectives. Thirteen women (ages 18 – 24) were recruited through Oklahoma State University and were interviewed between the months of April and June of 2020. The primary topics addressed with participants were: 1) contraceptive use and negotiation; 2) power dynamics within relationships; 3) history of sexual health behavior; 4) perceptions of feminism, sex, and sexual health; 5) sexual experiences; and, 6) reproductive healthcare provider experiences. This inquiry established five main conclusions: 1) feminist women place great importance upon bodily autonomy; 2) feminist women largely reject patriarchal power dynamics within sexual and romantic relationships; 3) feminist women have a heightened awareness of widespread sexism towards women; 4) feminist women realize that sexual health is more than physical health; and 5) feminist women experience many barriers towards reaching optimal sexual health. The results of this study illustrate how life experiences and identity have the capacity to shape one another, particularly in cases of trauma. Instilling feminist values or using feminist methods to educate students may prove to be useful in encouraging them to see sexual health from a more holistic perspective.

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# CHAPTER I

## INTRODUCTION

Feminism is historically defined as the movement advocating for women's rights in order to ultimately achieve political, social, and economic equality. This liberational epistemology has produced waves of unrest over the course of the past century, resulting in mass social and political demonstrations. The first wave of feminism took place during the early 1900's. This movement became powerful enough to pressure the United States federal government into amending the constitution and giving women the right to vote. Women's suffrage leaders like Susan B. Anthony and Elizabeth Cady Stanton remain feminist icons to this day; their headstones becoming covered with, "I voted!" stickers on election days from politically active women wishing to pay their respects. 1920 was the first time women were given this right on a national scale - however, black women would continue to be denied their rights until the Voting Rights Act of 1965.

The importance of constitutional legislation and Supreme Court decisions cannot be overstated when exploring the history of feminist movements and their goals. Prior to the 1965 case of *Griswold v. Connecticut*, married women could be legally barred from accessing and utilizing birth control. The Supreme Court ruled that this was in fact, unconstitutional, citing the 5th amendment and an individual's right to privacy in sexually

intimate settings. The original law that prevented couples from using contraceptives was never practical in nature; as Justice William O. Douglas wrote of the court's decision, "Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship ("The Identity of", 2010)." It was not until 1972, seven years after *Griswold v. Connecticut*, that *Eisenstadt v. Baird* set the precedent of single women's right to use contraceptives. Laws and practices dismantled by these court judgements have existed for the primary purpose of controlling women's bodies and their sexual behavior. This patriarchal intent was also addressed in the infamous *Roe v. Wade* case of 1973. This Supreme Court decision remains the standard that upholds a woman's right to an abortion in the United States, having withstood multiple attempts of dismantlement and abolition. A woman's right to choose may be limited depending on where she resides however, with nearly 39% of American women currently living in states that do not have a single abortion provider (The Lancet, 2018).

Today's feminist movement is still focused largely on the reproductive rights of women, as well as confronting the rape culture and sexual assault that has become endemic throughout the nation. An example of how the fight against rape culture has become mainstream can be seen in the #MeToo movement. The original MeToo campaign, created in 2006 by Tarana Burke, was intended to raise awareness of the vulnerability of African American children. In 2017, following the high profile sexual assault cases against Hervey Weinstein, #MeToo gained popularity when it was used across social media as a means of demonstrating widespread sexual violence against women (Mendes, Ringrose, & Keller, 2018). Fears of *Roe v. Wade* being overturned have

also plagued feminist communities, especially after the confirmation of conservative Supreme Court Justice Brett Kavanaugh in 2018.

Trends of women fighting against systems of oppression for their reproductive rights may be easily identifiable throughout the last century, but the reproductive health behaviors of these feminist women are largely still unknown. Studies have shown that feminist women are generally more assertive than non-feminists in sexual scenarios, they have higher levels of self-esteem, and they show positive coping skills when facing gender-based discrimination (Yoder, Perry, & Saal, 2007; Watson, Flores, Grotewiel, Brownfield, Aslan, & Farrell, 2018). A review of the literature exposes a gap of knowledge surrounding one's feminist identity and actual sexual health behaviors. Although reproductive rights are the subject of many feminist demonstrations, there is a lack of inquiry into whether or not feminist women actually utilize the reproductive services that they are fighting to protect. This study will employ the use of Grounded Theory (Glaser & Strauss, 1967) in order to identify and understand the ways in which one's feminist identity is manifested through their sexual health behaviors.

## Statement of the Problem

While identifying as a feminist has been connected to possessing various positive traits, such as having increased self-confidence, prioritizing egalitarianism in intimate relationships, and being more comfortable being their authentic selves (Yoder, Perry, & Saal, 2007; Calver-Dawe & Gavey, 2017), there is a lack of literature surrounding the sexual health behaviors that these women engage in. The women who take part in this inquiry lie within the age range of 18 and 24 – coinciding with the cohort most heavily affected by new diagnoses of sexually transmitted infections. Nearly half of all new STI

diagnoses impact adolescents between 15 – 24, and 25% of all sexually active adolescent and young adult females have an STI (Satterwhite et al., 2013; Forhan et al., 2009).

## Purpose of the Study

The purpose of this thesis study is to use grounded theory methodology and a feminist lens to explore the influence of a feminist identity on the sexual health behaviors of emerging adult women (18 – 24 years of age) who reside in Oklahoma.

## Hypothesis

As an inductive explorative study, no hypothesis will be tested during the course of this thesis inquiry.

## Significance

Reproductive health is an issue that affects every woman in America. The feminist movement may be the underlying force and collective group that pushes a progressive agenda forward in order to attain equality, but it takes millions of individuals to come together and create change. In January of 2017, one of the largest worldwide demonstrations took place in the name of women's rights. An estimated 5 million Americans took part in this Women's March (Chenowith & Pressman, 2017) – a massive public expression of defiance and disapproval against the newly elected president and his administration's overt sexism. Since these marches, the Supreme Court has become particularly conservative leaning, putting abortion rights at significant risk. The implications of this study would be significant not only for women who already identify as feminist, but also for those who do not. The truths uncovered through this inquiry can be used to dispel sexist stereotypes against women who have used contraceptives and/or abortion services, empower all women to make reproductive decisions for themselves,

and also shed light on the inequities that feminist women have experienced when attempting to express their reproductive rights.

## Delimitations

Delimitations for this study include geographic location, recruitment location, identifying as a woman, identifying as a feminist, and falling within the age range of 18 – 24. This inquiry will include participants recruited via online outreach as well as local organizations near and on the Oklahoma State University campus. Self-identification as a feminist woman will be determined by the respondent prior to enrolling in the study, and no other instruments will be used to assess the varying degrees of feminism that each woman demonstrates. The results of this study may not generalize well to other locations or populations.

# CHAPTER II

## LITERATURE REVIEW

Accessing reproductive healthcare is a fundamental component of achieving and maintaining optimal health throughout communities in the United States. The role of clinics offering reproductive healthcare is to take preventative measures to decrease the number of unwanted pregnancies, sexually transmitted infections (STI's), and other negative sexual health outcomes that have been outlined in Healthy People 2020. Although the Department of Health and Human Services has set the goal of decreasing STI rates, the rates for bacterial infections chlamydia and gonorrhea have respectfully increased by 6.9% and 18.6% since the previous CDC surveillance report in 2016. These discrepancies have largely been due to an increase in STI diagnoses among young adults, ages 18 – 24. This cohort is also the typical age range for those attending college, where STI transmission is notoriously higher when compared to the general population. Often before university students are ever exposed to this environment, they receive sexual health education through a variety of sources – with public schools being a primary point of access for health educators.

### Sex Education in Schools & Sexual Health

Although sexual health education programs are becoming increasingly common, only half of the states require their school systems, by law, to provide them (Blackman, Scotti, & Heller, 2016). The curriculum that is followed often endorses abstinence above comprehensive sex education, and abstinence-only programs have been shown to spread false information regarding sex and condom usage (Johnson, 2016). This renders the programs ineffective and, at times, counterproductive. Abstinence-based education that also uses fear tactics in efforts to prevent sexual intercourse from happening has been shown to connect with higher rates of unplanned pregnancy (Trenholm et al., 2007).

In order to lay the foundation for optimal reproductive health, adolescents and young adults need access to comprehensive sex education. By educating on topics such as contraceptives, STI's, sexual orientation, gender identity, and healthy communication, students become better equipped to handle sexual situations and potential problems in the future. These programs, whether in-person or online, have been linked to lower rates of unplanned pregnancy and decreased incidence of adolescent sexual experiences (Raghupathy, Klein, & Card, 2013; Stanger-Hall & Hall, 2011). These findings suggest that increasing access to sex education could potentially decrease the number of people impacted by STI's and unintended pregnancy. This could become a primary channel of reaching younger populations before they become a part of the 18 – 24-year range currently associated with higher rates of negative reproductive health outcomes.

Unwanted Pregnancy & Sexual Health

Unintended pregnancy is a topic rife with controversy over abortion legislation and funding for reproductive services, especially under the current federal administration. As nearly half of all women are likely to experience an unplanned pregnancy in their

lifetime, with forty percent of those ending in abortion (Finer & Zolna, 2011), fighting back against opposing forces has become routine for abortion providers and advocates. One of the greatest hurdles that abortion providers must now overcome is the 2019 withdrawal of Title X grant funding by the Department of Health and Human Services. Reproductive health agencies, such as Planned Parenthood, are no longer permitted to either give information regarding abortion procedures or refer patients to somebody who performs them (Steven Ros, 2018). This enactment has forced a multitude of clinics that receive federal monies to either stop offering abortion services or refuse the funding needed to keep their organizations functioning. By cutting the flow of funds to these agencies, all types of reproductive services become less available. Potential areas that could be impacted include access to contraceptives, pregnancy testing, prenatal care, STI testing and treatment, and more. These recent policy developments only further demonstrate the dire need for comprehensive reproductive healthcare, particularly for women.

Abortion rights are an integral part of women's reproductive justice, their health, and their ability to have control over their bodies. While the topic of abortion remains highly contested in both political and spiritual realms, this medical procedure is viewed as both a normal and necessary option from a public health perspective. With some studies finding that up to a third of American women will undergo an abortion in her lifetime (Ostrach & Cheyney, 2014), it is apparent that a legal and safe path towards ending unwanted pregnancies must remain available for women of all backgrounds. The rates of unintended pregnancy vary by race and ethnicity, with African American women having the highest likelihood (67%), followed by Hispanic women (53%) (Finer & Zolna,

2011). Health disparities based on race often continue into treatment and quality of care provided to people of color. A recent study was conducted to assess the reproductive health outcomes of young black and Latina women based upon their individual experiences (Gomez & Wapman, 2017). Researchers found that not only did the perception of a negative appointment experience impact women's adherence to treatment, but also their overall attitude towards healthcare and practitioners (Gomez & Wapman, 2017). If public health professionals hope to decrease unwanted sexual health outcomes in the future, racial inequities will have to be addressed on a grand scale.

Race, Policy, & Sexual Health

Changes in United States policy have the potential to drastically alter the health of entire populations – particularly for people of color. One example can be seen in the passing of the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA was intended to increase access to healthcare through a variety of means – including Medicaid expansion (Andrews, 2014). Through this expansion, populations of lower socioeconomic status would have their health insurance covered through the government, regardless of pre-existing conditions or parental status. After the Supreme Court decision in *National Federation of Independent Business vs. Sebelius* however, the step to undergo Medicaid expansion became optional, and the choice was left to state governments. Of the 24 states that have chosen not to expand Medicaid, the majority are located in the Southern region of the country – along with the majority of African American individuals (Andrews, 2014; Kaiser Commission on Medicaid and the Uninsured, 2014). The lack of coverage for people of color is not a new phenomenon, as past studies have shown a pattern of federal agencies providing substantially less funding for health programs and

social assistance within states that have a higher proportion of black citizens (Grogan, 1994; Grogan & Park, 2013). If African American communities have generally less access to healthcare than others, then African American women are at a particular disadvantage when they require reproductive services.

Women of color are disproportionately affected by sexual health problems not only due to healthcare discrimination – they also face higher rates of intimate partner violence (IPV) and a lower than average socioeconomic status from generations of systemic oppression. One grim example of how African American women receive lower quality reproductive care than white women can be seen in the United States' maternal mortality rates. From 2011 – 2015, the rates of maternal deaths were 42.8 per 100,000 live births for black mothers and 11.4 deaths per 100,000 live births for white mothers (CDC). Maternal mortality can be linked to one's quality of care as well as one's exposure to violence. Risk of mortality increases with exposure to abuse, which is reflected in the reporting that 4 out of 10 black women have been victims of domestic violence (Black et al., 2011).

Intimate Partner Violence & Sexual Health

Intimate partner violence is a form of domestic violence that can manifest itself through patterns of physical, sexual, verbal, emotional, social, and/or economic abuse. IPV is more common amongst black women than any other ethnic group (Catalano, Smith, Snyder, & Rand, 2009). IPV has been linked to higher rates of sexually transmitted infections, including HIV, a virus that has more new diagnoses among black women than any other racial group (Mathew, Smith, Marsh, & Houry, 2013). Those who experience abuse from either a past or present partner are more likely to be exposed to

situations that increase their risk of being exposed to STI's, such as being sexually assaulted or becoming dependent upon substances like drugs and alcohol to cope with trauma. Intravenous drug use could become a potential means through which an individual might come in contact with viruses like hepatitis C and HIV. Instances of sexual assault are all too common amongst those who have an abusive partner. With 15.8% of American women reporting that they have experienced sexual violence at the hands of an intimate partner (Breiding, 2015), this public health and personal safety issue must continue to be addressed and fought against.

## Stigma, Gender Roles, & Sexual Health

An important factor to consider when regarding a woman's choice to access reproductive health services is stigma. Stigma can influence who chooses to access reproductive healthcare services by imposing a negative stereotype onto those who use do. Whether judgement is actually present or imagined does not change the effect that this stigma has – perceived stigma and internalized stigma both have the ability to alter behavior and negatively influence one's self-image (Van Brakel, 2006). Social norms often dictate the expected behavior of women, especially in relation to sexual activity. Before a woman can utilize reproductive services, she must first overcome the gender roles imposed upon her by society. Gender roles are the traditional behaviors, attitudes, and activities that are bestowed upon someone and expected to be carried out depending on their gender. Women have been traditionally described as meek, submissive, gentle, and polite, while men should be strong, dominant, and outspoken. The heteronormative assertion that women should leave the decision-making to their male counterparts is a

common theme throughout history, and support of these traditional values still exist in many regions.

<u>Religion, Policy, & Sexual Health</u>

Religiosity has been linked to increased support of gender roles, as expectations based on gender are written throughout many religious texts. For example, in the Bible, Ephesians 5:22 – 24 reads, "**22** Wives, submit yourselves to your own husbands as you do to the Lord. **23** For the husband is the head of the wife as Christ is the head of the church, his body, of which he is the Savior. **24** Now as the church submits to Christ, so also wives should submit to their husbands in everything." If religion is an important facet of a woman's life, the enforcement of gender roles could serve as a potential barrier against her expression of reproductive plans and choices. Religiosity has also been linked to an increased likelihood of endorsing rape myths and victim blaming, possibly due to heightened pressure to remain submissive within a relationship (Barnett, Sligar, & Wang, 2018). The patriarchal nature of Abrahamic religions not only influences the power dynamics of romantic relationships, but also the ability for women to retain their bodily autonomy.

Religion has the potential to shape ideas surrounding pre-marital sex and abortion, and it also impacts the quality and kind of reproductive services that women can access. Women may choose to not seek an abortion out of fear of retribution from the protestors that can often be found outside of the clinics, or agencies themselves may be forced to close due to conservative legislation (Castle, 2011). Policies that are labeled as Targeted Regulation of Abortion Providers (TRAP laws) can have enormous consequences (Jones, Daniel, & Cloud, 2018). These regulations function in ways that declare completely safe

abortion clinics as not being able to pass necessary inspections. For example, these laws may require that hallways be a certain width in order to compensate for the moving of multiple hospital beds. While this may sound appropriate for a hospital, abortions clinics oversee out-patient procedures, meaning there are no long hospital hallways or even numerous patients under anesthesia simultaneously, rendering policies like these inapplicable and unnecessary (Jones, Daniel, & Cloud, 2018).

Other TRAP laws will not allow a physician to perform abortions unless they are directly affiliated with and have an office at a nearby hospital. Once again, laws like these initially sound well-meaning. Upon closer inspection, one will find that large hospital corporations – that are often religiously affiliated – do not want to be involved with the controversy surrounding abortions, and they also do not want to have TRAP laws implemented within their facilities. (Jones, Daniel, & Cloud, 2018). With the number of TRAP laws increasing, many clinics have had to dramatically increase their prices or shut their doors. Especially within conservative states, many abortion-providing physicians have had to give up their practice due to regulations gradually dismantling their clinics.

Crisis Pregnancy Centers (CPC's) serve as another potential barrier to abortion (Castle, 2011). CPC's are places where women go to seek assistance when facing an unplanned pregnancy and receive the medically accurate, unbiased opinion of a professional on how to move forward. These agencies advertise themselves to be facilities that provide information, support, and references for those finding themselves experiencing an unplanned pregnancy. This image is often a façade however, as these agencies function with one purpose in mind: to discourage and prevent the termination of

pregnancy. Since CPC's are funded through religious organizations, churches, or donations, regulations are few and far between. Technicians operating ultrasound machines utilize the images as a means of convincing women not to abort. In order for women to able to establish trust with reproductive service provider, there cannot be judgement against her sexual history or reproductive decisions. This allows for women to make well-educated choices surrounding their bodies as well as feel empowered to continue receiving reproductive care.

Patient-Provider Interactions & Sexual Health

Healthcare practitioners have the ability to not only influence their patients' perceptions of reproductive health, but also shape their sexual behavior after they leave the clinic. One potential area of improvement could be condom usage. According to a study conducted among college students in Texas, having a general understanding of condoms and how they function is not necessarily linked to proper usage (Tilford et al., 2013). As previously discussed, sex education programs offered in public schools are typically abstinence-based or not required. If schools cannot be relied upon to depict reproductive health in a nonbiased format, condom utilization might not even be included in the curriculum. This exacerbates the need for there to be healthcare professionals available to train patients on how to properly use a condom, as well as assert their desire to use one. Supporting and encouraging patients' in their condom use, especially among women, can increase the likelihood of them insisting upon having protected sex. Other factors that play a role in determining whether or not a woman will use a condom are her levels of self-esteem and confidence, knowledge and perception of the sexual health

risks, alcohol use, and a feminist identity (Auslander, Baker, & Short, 2012; Stoner et al., 2008; Yoder, Perry, & Saal, 2007).

Feminism & Identity

Broadly defined, feminism is a movement and manner of thought that supports political, social, and economic equality among the sexes. The Model of Feminist Identity as outlined by Downing and Rousch (1985) explains the process of how women evolve towards accepting feminist ideology. *Passive acceptance* is the state in which a woman exists before discovering feminist epistemology; she may endorse a patriarchal family structure, avoid situations that defy stereotypical gender roles, and fail to acknowledge societal systems of oppression that continue to quell the potential of women. Stage II, *revelation*, is characterized by a readiness to change her frame of reference to one that does not view men as superior to herself. This shift often takes time for someone to adapt to, and many women may describe a feeling of anger and of having been used or tricked by society (Downing & Rousch, 1985). The gradual realization of living in a misogynistic world looks different for every woman, but denying one's status of oppression is a commonly manifested defense mechanism. The next stage, *embeddedness-emanation*, is described as a period during which a woman creates bonds with others, especially other women, based upon their similar ideologies. This phase may also cause difficulties to arise within relationships that have patriarchal foundations (Downing & Rousch, 1985). The final stages, *synthesis* and *active commitment*, are characterized by a synthesis of feminist thought into one's daily actions and a feeling of purpose in pursuing social change towards equality.

Downing and Rousch's Model of Feminist Identity is not without its flaws; some feminist scholars argue that the stages should be expressed as simultaneous dimensions within an individual rather than consecutive phases that are dependent upon the successful completion of another (Hyde, 2002). The 1985 model is effective at describing the varying degrees of adopting a feminist manner of living however, and it has been used extensively as the basis of identifying feminists versus non-feminists in empirical studies (Yoder, Perry, & Saal, 2007). Research has shown that women who score higher in the *passive acceptance* dimension have lower expectations for intimate relationships and sexual experiences when compared to women who rated themselves as having higher scores in *synthesis* and *active commitment*. If these groups are further broken down into the assumed categories of "non-feminist" and "feminist", data shows that feminists are more likely to be assertive when defining their sexual needs (Yoder, Perry, & Saal, 2007). Egalitarianism has also been found to be a common characteristic of feminist women, as they expect their partners to share responsibilities and chores rather than assign tasks on the basis of outdated gender roles.

Feminism & Intimate Relationships

Feminist researchers have long sought to find understanding in how power dynamics play a role within sexual and romantic relationships. There are studies that have shown heterosexual sexual experiences are typically male-focused, and male and female sexuality are positioned as opposites of one another (Holland, Ramazanoglu, Sharpe, & Thomson, 1998). This discourse unveils the potential for there to be unequal influences of power when making choices that affect sexual health. Making decisions that could potentially have significant implications for a woman's health, such as wearing condoms

or utilizing contraceptives, can be understood as negotiations between partners with unequal amounts of power (Holland, Ramazangolu, Sharpe, & Thomson, 1991; Pearson, 2006). Women who report that they have been in a relationship that followed conservative gender roles also express that they rarely initiated sexual encounters, and they did not always feel comfortable asserting their preferences (Pearson, 2006).

Theoretical Underpinnings & Conclusion

Research surrounding the development and impact of a feminist identity has been covered on various fronts. College-age women who have experienced gender-based violence are more likely to develop a feminist identity (Valentine, Gefter, Bankoff, Rood, & Pantalone, 2017), while teenage feminist women often describe their identities as having always been present, but not always uncovered (Calder-Dawe & Gavey, 2017). Feminist-identified women are more likely to describe actively seeking out romantic partners that do not strongly conform to traditional gender norms (Backus & Mahalik, 2011), and possessing a feminist identity also increases the likelihood that a woman will intervene during acts of sexism in everyday life (Weis, Redford, Zucker, & Ratliff, 2018). One area of literature that is currently absent surrounds the development of a feminist identity and how that process influences and intertwines with sexual health behaviors. Both the acts of participating in sexual health behaviors and identifying as a feminist depend on a number of preceding factors and determinants, but neither have been explored at length among emerging adult women.

This study's purpose is to interpret the realities of college-age, feminist-identified women through their own words, so that public health professionals, educators, and policymakers can better understand how the empowerment of women influences their

reproductive health. Access to abortion, contraceptives, and other reproductive services is a common cause that the feminist community is known to support, in an effort to create healthcare equality among all genders. This inquiry will delve into how support for these feminist policies align with actual behavior, and how women's internalization of feminist beliefs thereby influences their sexual health practices.

# CHAPTER III

# METHODOLOGY

## Study Design

Throughout the course of this inquiry, a qualitative approach based in grounded theory was utilized to construct epistemological narratives and conclusions based on the responses of the women who participated. This form of intuitive qualitative methodology is ideal for piecing data together and creating a theory to describe the observed phenomena. One-on-one interviews were conducted with each member of the sample, guided by a semi-structured script. This format allowed for participants to express their thoughts and responses in detail, and they could also clarify their answers and ask questions as needed. Examining this study's evolution through a feminist lens was an integral step in identifying the influence of power dynamics and structures within the data collected. In order to illustrate the ways in which a feminist identity manifests itself in the sexual health behavior of emerging adult women, a theoretical model grounded in interview data was produced.

## Participants and Recruitment

Purposeful, voluntary sampling was utilized for participants to be recruited as part of the study. It is during this recruitment phase that participants were inducted into

the sample on the basis of fulfilling the study's eligibility criteria: 1.) was between 18 and 24 years of age; 2.) identified as a female or woman; 3.) identified as a feminist; 4.) resided in Oklahoma; and 5.) has had a sexual experience within their lifetime. Being that this study's aim was to discover the importance of a feminist identity in women's motivations to carry out sexual health behaviors, initial screenings purposely did not: 1.) define what it means to be a feminist; 2.) list inclusion criteria of specific feminist beliefs; or 3.) provide a definition of "sexual experience". These omissions allowed for each individual woman to define their unique feminist identity within the context of their own lives, as well as prevent heteronormative limitations on what may be perceived as a sexual experience. Female participants were sought out through the use of fliers and leaflets. Paper advertisements were to be placed in areas that are frequented by all genders (coffeeshops, Edmon Low Library), as well as places that are more curated towards women (women's dorm bulletin boards, Department of Women and Gender Studies). University email was also be utilized as a means to reach a larger sample of feminist students. Participants would respond to recruitment efforts via email, during which time they were screened for eligibility.

## Procedures

If the inclusion criteria had been met by an individual and they wished to participate in the study, they were scheduled to take part in an interview. Each interview was to be conducted in my office, located in 428 Willard at Oklahoma State University. If this space was unavailable or inconvenient, the videoconferencing application, Zoom, was to be utilized, or another private location could be allocated to provide the participant with confidentiality and ease for transportation. The study's interview format was semi-

structured through the assistance of a script, developed and conducted by the principal investigator. Before the interview process began, each participant was given an informed consent document that required their signature. This form outlined their rights of confidentiality, an outline of the upcoming interview process, a description of how their information was to be used by the investigator, as well as asked for permission to record their spoken responses for later transcription.

Following the informed consent, participants completed a demographic questionnaire. This asked about each participant's age, sexual orientation, ethnicity, marital status, work / student status, education level, and income. During the subsequent interview, each woman was prompted to gradually create a narrative through the responses elicited from the script's outlined questions. These narratives were ultimately coded into separate pieces of data categorizing their sexual risk behaviors (i.e. having sex while intoxicated, not using condoms), preventative sexual health behaviors (i.e. obtaining necessary medical screenings regularly, enforcing the use of condoms / appropriate contraceptives), affiliation with the feminist movement and community, application of feminist ideology to everyday behaviors, and support of traditional gender roles and patriarchal power structures within relationships.

Due to the COVID-19 pandemic, all interviews were conducted via Zoom video calls. Interviews generally lasted anywhere from 25-40 minutes, with the longest interview concluding at an hour. The majority of the women expressed an interest in speaking with the primary investigator as part of their role as feminist women, and many saw the interview as a means to take action against the patriarchy and sexual violence. The tone of each interview was friendly, honest, and one of compassion. The interviewer

would often extend words of comfort if a participant recounted a traumatic experience. The interviewer was cognizant to not interject her own views into the questions and responses, but words of encouragement and understanding were given in order for each woman to feel heard and validated. Even while discussing instances of sexual violence or stigma, the women exuded an air of positivity and resiliency. Extra time was always offered in case someone may need a moment to collect themselves or get a drink of water, but each time, the women stoically retained their composure and were readily prepared for the next question. At the end of the interviews, participants were thanked for their time and energy, particularly in this instance – where they are asked about intimate details of sexual and relational histories. The women often replied that they were happy to help, and they would be available for follow-ups if deemed necessary.

Following the Zoom interviews, audio recordings were transcribed with the use of Otter.ai transcription technology. Once typed out, the individual transcripts were evaluated by the primary investigator by simultaneously reading the interview and listening to its recording. Revisions were made as needed. Copies of each transcript were printed and analyzed for common themes. When identified, a theme or sub-theme was highlighted in a specific color, and these colors were consistently utilized throughout. Using the highlighting colors as a key for the thematic analysis of each of the women's words, multiple patterns emerged.

## Measures

### Interview Guide

A semi-structured interview guide was developed to elicit a narrative from each participant. Pre-determined interview questions as well as probe questions were asked in

an order deemed appropriate based upon the judgement of the principal investigator. Probes were used only to motivate additional participation or explanation, in an effort to not insert unnecessary bias.

Demographic Questionnaire

A questionnaire instrument (SurveyMonkey) was used to collect participants' demographic data. Some of the information that was obtained are participants' age, sexual orientation, and education. Although this study has inclusion criteria of identifying as a female / woman, there was not discrimination between cis-women or trans-women. Other data collected was on education and income levels, marital status, work status, and race / ethnicity. Questions regarding sexual health experiences briefly asked for a recent history of past STI / HIV testing, pap smear screenings, regular physicals, and a list of prescribed contraceptives or reproductive hormones.

## Data Analysis

### Interview Data Analysis

Grounded inductive analysis, as first described by Glaser and Strauss in *The Discovery of Grounded Theory*, is a method of qualitative analysis that constructs a theoretical model through the interpretation of narrative data (1967). This methodology uses the knowledge gained from interviews and other qualitative sources as a foundation to build a theory that explains the underlying mechanisms and patterns of specific behavior and thought. The first step of data interpretation is theoretical sampling – wherein the researcher collects the data, codes it, and analyzes it. Raw data was continuously broken down and compared to other participants' responses (open coding) – ultimately leading to the identification of common themes. The constant comparative

method of data was used in order to detect recurrent thought patterns or thematic elements among the study participants, as well as group together similar categories of data. These groupings were continually analyzed until an overarching pattern within the dataset emerged, and the key relationships between categorical groups were unveiled (axial coding).

Demographic Variable Analysis

Descriptive statistics were used to interpret the demographic data. Mean and standard deviation was calculated for the sample's age, while frequencies were assessed for all other categorical variables.

# CHAPTER IV

# RESULTS

## Descriptive Statistics of the Sample

In total, 13 interviews were conducted. Table 1 displays the descriptive statistics of the sample. Participants ranged in age from 18 to 24 ($\bar{x}$=21.31, *SD*=3.312) and all participants identified as female (100.0%). In terms of race and ethnicity, eleven (84.6%) identified as White/Caucasian, one (7.7%) as Latino/Hispanic, and one (7.7%) as American Indian/Alaska Native. Two (15.4%) participants reported to be married, while one (7.7%) lived with their significant other. The remaining 10 women (76.9%) were not married and did not live with a partner. Sexual orientation varied among the women, with two (15.4%) stating they were bisexual, two (15.4) were pansexual, one woman (7.7%) identified as queer, and the remaining eight (61.5%) were straight/heterosexual. All 13 (100%) participants confirmed that they had engaged in sexual behavior with another person at least once in their lifetime.

Over one third (38.5%) of the participants had completed some college, and another 38.5% had earned their bachelor's degree. Two (15.4%) women reported having earned their GED or completed high school, while another (7.7%) had finished their Associate's degree. While the employment status of each woman varied, none (0%) of

the participants worked full-time. Nine (69.2%) stated that they worked part-time, and four (30.8%) were not working at the time of their interviews. Of these four women, three (23.1%) were actively looking for work and one (7.7) was not. The most commonly reported annual household salary was below $24,999 (30.8), followed by the next income bracket, $25,000 – 49,999 (23.1%). Two women (15.4%) each reported household incomes between $50,000 – 74,999, $75,000 – 99,999, and $100,000 – 149,999. None (0%) of the participants had children.

Table 1

*Demographic and Other Characteristics of Study Participants, Feminist Identity & Sexual Health Behavior (n = 13)*

| | $\bar{x}$ | SD |
|---|---|---|
| Age | 21.308 | 1.932 |
| | F | % |
| Gender | | |
| Female | 13 | 100.0 |
| Sexual Orientation | | |
| Heterosexual/Straight | 8 | 61.5 |
| Bisexual | 2 | 15.4 |
| Pansexual | 2 | 15.4 |
| Queer | 1 | 7.7 |
| Ethnicity | | |
| Latino(a)/Hispanic | 1 | 7.7 |
| American Indian/Alaska Native | 1 | 7.7 |
| White/Caucasian | 11 | 84.6 |
| Marital Status | | |
| Single | 10 | 76.9 |
| Single & Cohabiting with Significant Other | 1 | 7.7 |
| Married | 2 | 15.4 |
| Parental Status | | |
| No Children | 13 | 100.0 |
| Education | | |
| High School Diploma/GED | 2 | 15.4 |
| Some College, No Degree | 5 | 38.5 |
| Completion of Associate's Degree | 1 | 7.7 |
| Completion of Bachelor's Degree | 5 | 38.5 |
| Employment Status | | |
| Employed Part-Time | 9 | 69.2 |
| Not Employed & Looking for Work | 3 | 23.1 |
| Not Employed & Not Looking for Work | 1 | 7.7 |
| Annual Household Income | | |
| $0 – 24,999 | 4 | 30.8 |
| $25,000 – 49,999 | 3 | 23.1 |
| $50,000 – 74,999 | 2 | 15.4 |
| $75,000 – 99,999 | 2 | 15.4 |
| $100,000 – 149,999 | 2 | 15.4 |
| Student Status | | |
| Full-Time Undergraduate | 10 | 76.9 |
| Full-Time Graduate | 3 | 23.1 |

## Influence of Feminist Identity on Sexual Health Behaviors

Table 2 lists the themes and sub-themes of the study. These were constructed through the use of Grounded Theory and interview transcripts from conversations with thirteen women. The five main themes (codes) expressed through participants' responses are as follows: 1) feminist women's endorsement of bodily autonomy affects their sexual health choices; 2) participants reject traditional patriarchal power dynamics within sexual and romantic partnerships; 3)feminist women report having a heightened sense of awareness for sexism, inequality, and injustice; 4) for all respondents, sexual health extended far beyond the use of condoms and birth control pills; and 5) there are a multitude of barriers that interfere with a woman's ability to maintain optimal sexual wellness.

To expand upon and provide further insight into the emergent themes and their interactions, relevant passages from the thirteen interviews are highlighted below. Pseudonyms are used in order to preserve confidentiality, and quotes remain unchanged for maximum accuracy for data analysis.

### Feminism Definition

When asked to define what feminism means to them, participants often described a set of values and beliefs that they ascribe to, such as support for equality, reproductive justice, and empowerment for those who have been oppressed. For the majority of these women, being a feminist is a means in which to advocate on behalf of oneself and others – especially in the face of injustice. From many women's perspectives, feminism is intersectional, requiring those who identify to become increasingly conscious of multiple sources and manifestations of inequity. Carmen (22 years old) stated that she, "would

define feminism as advocating for other women, regardless of whether you agree with their choices or circumstances, and regardless of sexual orientation, race, socioeconomic status". Supporting and empowering women, even when they look or behave differently than oneself, was a commonly expressed sentiment of the women who took part in the study. By identifying as a feminist, one participant advised to, "make sure that you're being like a true sister to all other women. No matter who they are, what their beliefs are, or anything like that (June, 23 years old)." Some participants spoke of the underlying mechanisms of feminism and the need to examine inequality from all levels. Rose (22 years old) stated that part of being a feminist is:

> Understanding societal dynamics and moving in a way that brings equality to all people involved – that allows them to be heard and validated … amplifying the voices of those who are marginalized, validating and understanding the issues and experiences of people who I like and respect, but do not have the same experiences as.

Expressing the desire to advocate for others, treat all people equally, and dismantle systems of oppression and privilege were common codes among all thirteen participants.

Sexual Health Definition

For nearly all of the participants, the first subject that came to mind when asked about their definition of sexual health was protection against sexually transmitted infections. Physical health was the most prevalent category of definition, with many women listing off contraceptive methods, pap smears, and regular testing as being the typical meaning of the term. Nine (69%) of the feminist participants said that consent was also of great importance. As will be broken down later in the chapter, sexual health had a much broader meaning and level of importance to these thirteen woman than physical wellness alone.

Bodily Autonomy

A common code found throughout all thirteen conversations was bodily autonomy, or the freedom to make one's own decisions about their body. This was often expressed through: 1) participants' support of a woman's right to choose; 2) the utmost important placed upon consent; and 3) respondents' desire to use contraceptives of their choice.

A Woman's Right to Choose. When asked if their identity as a feminist impacted their views of sexual and reproductive health, every participant emphatically agreed that it had. Carmen, 22 years old, answered: "Oh definitely, because I'm pro-choice. And I want birth control to be affordable and accessible – free, even." Supporting the right to an abortion was one of the strongest values for some participants, even withstanding other major belief system changes. June (23 years old) discussed her experience with such a transition: "Even if my political background has changed over the years, like from high school into college kind of switch, I've always been very pro-choice, because I think that's just generally important to feminism and the power of women."

Consent. This sub-theme was discussed by every participant. Many women spoke of either being or knowing a sexual assault survivor, and consent only became more relevant following the trauma. Kaylee (24 years old) talked about how she no longer feels timid in situations where she wants to say no: "…just because you are more physically able than I am or whatever, I don't have to just keel over and take it. I don't want it, then I won't take it." Consent is the ultimate manifestation of bodily autonomy, as it requires explicit permission before any contact may occur. Francesca (21 years old) summed up her meaning of consent with four words: "My body is mine."

Freedom of Choice for Contraceptive Use. A common idea expressed by the participants was freedom to use the contraceptives they wanted. Nearly every woman stated that they used condoms, unless they were in a committed relationship. Those who did not use condoms used another form of birth control, such as the birth control pill, IUD, NuvaRing, and Depo Provera injection. One respondent had an allergy to latex, so she rarely used them. Erin (20 years old) stated that she would "always ask if they have a condom … before anything gets started, because, I mean, I feel like it's out of respect for myself and that person." Winona (21 years old) said of her condom negotiation technique: "I'll straight up be like, 'yeah, I'm on this birth control, and we're using condoms. Like, if you have a problem with that, then nice knowing you'."

For several women, their methodology for getting partners to wear condoms is to give an ultimatum: either they wear a condom, or else they will not have sex. Luna (21 years old) described how she would act in such a scenario:

> It's up to you if you want to use protection, but I'm just saying, I'm not going to go through this [sex] without it. So, regardless of if I'm on birth control, because, you know, some people are like, 'well you're on the pill!' And I'm like, 'it's still not protecting me from anything else!

Rejection of Patriarchal Power Dynamics within Sexual Interactions / Relationships

The thirteen feminists who took part in the study all relayed their disdain for patriarchal systems of power – especially within sexual encounters and intimate partnerships. The most prevalent sub-themes from the women's conversations that connected with this main theme are: 1) the rejection of male-centered intimate relationships; 2) sexual satisfaction is for all genders – not just men; 3) the rejection of stereotypical gender roles; and 4) the rejection of heteronormativity.

Rejection of Male-Based Intimate Relationships. Participants often commented on the tendency for sexual encounters to be based upon the man and his desires. As Erin (20 years old) stated: “it [sex] tends to be centered towards the male perspective – that it’s for men to enjoy, and women are just objects within that.” Over half of the women spoke about the ways in which they had adjusted to being either neutral or woman-centered during sex. Carmen (22 years old) discussed how she came to discover that sexual pleasure was also for women:

> I definitely don't focus on male pleasure as much as I used to… Emma Watson actually, like launched this website and it was all about like female sex - like orgasms for females, how to like, masturbate - stuff like that. And I was just like, wait a damn minute, like maybe I could actually like, focus on myself when I'm in those, you know, like, in those scenarios…like it’s not selfish of me.

Sexual Satisfaction is Not Only for Men. Erin, 20 years old, had her perspective influenced by a former partner who held feminist views of his own. This was Erin’s first sexual relationship with another feminist, and she stated that, “the way he talked to me about sex and the way that he approached it kind of gave me the sense that, hey – maybe this isn’t all that bad. This isn’t something to get through. It’s something to be a part of and enjoy.” Negative sexual experiences were described by some participants as taking place when their needs were neglected by their partner. When asked what made her encounter an unpleasant one. Luna (21 years old) said, “he didn’t really care [about my needs] as long as he got what he wanted.”

In contrast, positive sexual encounters were most often felt when participants could freely enjoy their sexual nature. For many of the thirteen women, their feminist identity helped shape their perceptions of sex and feelings of empowerment through their sexual choices. When discussing the ways in which her views may have been affected by

feminism, Carmen (22 years old) said that she believed it helped make her a more sex positive person. "I never felt ashamed for having several partners… So I think that's how [being a feminist has shaped my perceptions of sex] – just feeling empowered to make your own choices." Some women spoke of their journeys in learning to embrace masturbation, as well:

> As a feminist, I am happy to be the woman that takes other women to go buy their first vibrator. That is one of my most proud moments, because so many of my friends have never had fucking orgasms! And they don't even know what they feel like; they don't know what they're supposed to feel like; they don't know how to have them. And they're embarrassed to talk about them, like, 'why, this must be dirty!' and it's not. It's not. Men do it, like all the time. (Janelle, 23 years old)

Rejection of Stereotypical Gender Roles. When each of the thirteen women were asked how being a feminist has impacted the ways they approach sex, many described their increased comfort with asserting dominance. These insights were also often followed with comments on societal perceptions and gender roles where women are meek and timid. Marlena (19 years old) said, "I feel like sex is looked at as kind of like, a man's world, and like, you know, women are just kind of… submissive." Kaylee (24 years old) agreed with Marlena's statement, but also believed that being a feminist helped her break away from those boundaries. "I think it definitely gives you the power to say, 'I can step outside of my role as somebody who is supposed to be submissive in the bedroom."

Rejection of Heteronormativity. Several women talked about their belief in a gender and sexuality spectrum – directly contradicting the binary nature of heteronormative values. Seven (54%) participants spoke about having transgender or non-binary loved ones. Winona (21 years old) shared how she makes a conscious effort

to be gender non-specific in her speech. “Recently, I’ve been using a lot of like, they/them pronouns instead of like, he or she, like when I’m just talking about anyone… men and women, and like, non-binary, we’re all equal.” One respondent (Kaylee, 24 years old) also discussed her perspective on sexual behaviors that may not fit into the traditional heteronormative value system (i.e. women in dominant positions and men in submissive ones).

> I think that being a feminist, you have to say that, ‘okay, yes – this might be out of the norm because it challenges these traditional patriarchal [and heteronormative] views – and it’s okay!’ Like, it doesn’t force you into a category. It doesn’t change who you are. It’s just what you like.

Heightened Awareness of Widespread Sexism towards Women.

A feminist identity was found to be connected to an increased awareness of the unequal treatment of women on various fronts. The thirteen women discussed: 1) their experiences with body and slut shaming; 2) the prevalence of rape myths and victim blaming; 3) the objectified portrayal of women and their bodies in media; and, 4) the ways in which they combat acts of sexism and inequality.

Body / Slut Shaming. Body shaming and unrealistic expectations of women’s bodies were common sub-themes expressed by participants. Janelle (19 years old) recalled overhearing a conversation between two male acquaintances where they loudly compared a former sex partner’s labia minora to roast beef. Janelle shared that prior to this encounter, she had already felt insecure about the appearance of her vulva. This feeling of abnormality and humiliation stuck with her for years following the conversation.

Some participants also described a culture of slut-shaming within schools they attended. Examples of slut-shaming – stigmatizing women for taking part in sexual behavior – can often be found throughout sex education programming. Jessica (24 years old) recounted her middle school sex ed experience, and how the educator used a band-aid as a synonym for girls who choose to have sex. After sticking the band-aid to multiple students around the room (analogous for having multiple sex partners), the educator showed how the band-aid was no longer sticky. Just as the band-aid would no longer stick to people, individuals with more than one sex partner would struggle to find a good mate for themselves (according to this instructor).

Sources of slut shaming in schools were not just adults, but students often also adopted the perception that women should remain virgins until marriage – and anything outside of this was abnormal. June (23 years old) shared her story of being marginalized by male classmates due to her relationship with sex:

> I was always pretty sex positive… and people can perceive that as being easy or something. And so, something that would happen is like, they take me on dates. Take me out and expect something, like on the first date, and like, be kind of upset if I said no…they just threw a fit about it.

Rape Myths. Each of the women who brought up the subject of sexual assault also mentioned some form of rape myth or another. These statements place blame upon the victim, whether it be for the attack itself or for the circumstances leading up to it. Janelle (23 years old) gave her perspective on victim blaming: "Ultimately, it's not the victim's fault – it's the attacker – and we don't need to teach out girls how to protect themselves. We need to teach our men to not hurt girls." Savannah (19 years old) also provided an example of rape myths being used:

> If someone ends up getting raped, some people would say, 'well, she had it coming to her. That was her fault. She should have stopped it.' And I don't think it's like that. So, from a feminist perspective, I feel like at any time, she could say no, and has the right to leave. But if the man doesn't allow that, then you know, it, it could definitely affect her and traumatize her.

Winona (21 years old) shared a personal story of when she was confronted by an intoxicated man who wanted sex – and had to argue against a rape myth endorser face-to-face:

> "He ended up getting really mad at me and was like, 'consent doesn't matter. It's not even a real thing. Like, we're just going to do this [have sex].' And I was like, 'hang on, hold up.' And so I kind of like went off on him and like, went on this big like, feminist rant about like, 'no, this is important. This is real, like, you can't just ignore it.'"

<u>Portrayal of Women and Their Bodies in Media.</u> Several women brought up examples of comparing themselves to photoshopped models and celebrities in magazines. One participant shared that she needed social media breaks in order for it to not impact her self-esteem. Janelle (19 years old) spoke of how she believed she had "weird-ass genitals" due to the way women's bodies appeared in pornography. It was not until she was in college that she had a conversation with a friend and realized she was normal.

<u>Actively Creating Environment of Inclusivity.</u> In order to combat against a culture of sexism and inequality, feminist women actively create inclusive spaces around themselves. Janelle (23 years old) shared how her home became a sex-positive place for herself and her roommates: "We didn't have to pretend that we didn't have sex, and we didn't have to pretend that we didn't masturbate. Like we could discuss it, like a normal topic in our house, and it was wonderful. And when you come to our house, that's the culture that we have there." The feminist women interviewed for this inquiry also made it

clear that they are not only wanting equality for themselves, but also for all people of color. Francesca (21 years old) spoke of her relationship to advocacy:

> I stand up for the African American community and I stand up for the LGBTQ community - I may only be a member of certain communities, like I'm part of the LGBTQ. And I am middle class. I can't speak for anybody who's African American or who grew up in a lower poverty. But I'm going to work as hard as I possibly can to understand your side of the story so that we can fight better together.

<u>Sexual Health Extends Beyond Protection from STI's and Pregnancy.</u>

Although the majority of participants discussed frequent STI testing, like Rose (22 years old) "we [my partner and I] get tested pretty regularly", and June (23 years old) "there's been times I just switch partners, and so of course I get an STI check", several other layers of sexual health were also revealed. The thirteen women shared that it is also important to: 1) be respected and treated positively by healthcare providers; 2) know that hormonal contraceptive methods have multiple health purposes; 3) establish open communication and trust with partners; 4) always get consent; and, 5) strive for self-awareness and acceptance of one's sexuality.

<u>Respect and Positive Treatment from Providers.</u> One common complaint against the healthcare providers these women had encountered were that they elicited judgement without prompting. According to Erin (20 years old), going to the OB/GYN would be much easier if they would "listen instead of passing judgement" Winona (21 years old) told a similar story of how she was seeking out birth control, and the physician began to chastise her for becoming sexually active. Adversely, positive experiences with one's provider can have great benefits. Rose (22 years old) said of her gynecologist: "She is so informative about like, legislation that could affect the way that she can, like, help me with sexual health. And it's really nice to know that my doctor goes above and beyond to

make sure that I'm going to be taken care of." This kind of treatment not only reassures the patient that they are cared for, but they are also gaining knowledge from a reputable source.

Multiple Uses for Contraceptives. As previously discussed regarding positive treatment from providers, women may have judgement passed onto them by even a healthcare professional. This directly contradicts the fact that many women use contraceptive methods for purposes outside of preventing pregnancy. Erin (20 years old) spoke of her experience with hormonal contraceptives:

> I started taking birth control long before I started having sexual experiences to manage my own health… I started using the pill whenever I was in high school to manage my periods, but I am terrible at remembering to take stuff like that. So switching to the Depo was more of a convenience for me.

June (23 years old ) also confirmed that hormonal birth control helped with her reproductive health: "I got on the pill because of my sporadic periods and it did help."

Communication and Trust. Nearly every respondent discussed the importance of open communication with one's partner and the feeling of trust and comfort when being intimate together. Communicating about testing, STI status, and contraceptives were listed off as being requirements by many of the participants prior to them agreeing to have sex with a partner. Jessica (24 years old) also expressed her frustration in lack of communication because it ultimately leads to repeated negative interactions – often without one side acknowledging it.

Consent. The subject of consent was so prevalent, it was found to connect not only with the theme of bodily autonomy, but also overall sexual and mental health. When asked about her definition of sexual health, Savannah (19 years old) said, "Sexual health

is… consent. So knowing that at any time you can say no, at any time you can stop. And if it doesn't, it is considered rape. And knowing how to seek help if that does happen.” Knowing where to seek help in the case of sexual assault is key to a survivor reaching justice, but it is not always a clear-cut path. June (23 years old) recounted an experience where she was unable to give consent:

> I was severely dehydrated. And I just am like, in and out of consciousness and I feel the doctors open my legs and swab me, and I like didn't have the energy to be like what's going on? You know? It just didn't make sense to me why that happened. And I think I never got like an answer. I think they had mixed up patient charts or something. Because I was in there for dehydration. And they told me that I had an STD. And so I went back to my OB/GYN and she was like, you don't have an STD.

Self – Awareness and Acceptance of Sexuality. The majority of the women interviewed discussed having come to terms with both their sex drives and sexual orientations, and 38% of participants identified as being either pansexual, bisexual, or queer. These women shared how it required self-awareness and integrity to acknowledge their sexual orientation and eventually come out. One respondent shared that it was not until a few years into her marriage that she realized she was bisexual. June (23 years old) spoke about her journey to self-acceptance, and how she needs no justification for equality:

> Being a feminist, I've always been really sex positive with myself from young age. Like, I wasn't ashamed of masturbating… guys get to talk about their dicks, you know, like, it's always been in the back of my mind is like, they get to talk about it - I get to talk about it. So yeah, so being a feminist, I've always been like, I can talk about sex whenever I want to, I can sleep with whoever I want, whenever I want. And I won't feel ashamed about my sex history or anything like that.

Self-awareness was also apparent in the women who recounted experiences of their boundaries being crossed. These encounters, traumatic at times, certainly resulted in a

heightened awareness of one’s sexual limits and desires. Seven (54%) participants described instances of feeling uncomfortable or violated during a sexual experience, with the majority stating how they now have increased awareness of their boundaries and reproductive rights.

Barriers for Women’s Optimal Sexual Health.

While speaking to each of the thirteen women, multiple stories about negative sexual experiences were shown to have common themes and occurrences. Participants seemed to be very aware of societal shortcomings regarding women’s health, and they identified multiple barriers towards reaching and maintaining optimal sexual wellness. These barriers are: 1) the sex education quality in the region is poor; 2) sexual assault and violation of boundaries are common for many women; 3) patients often do not feel like they are listened to or taken seriously by healthcare providers; and, 4) pressure from others can impact the choices feminist women make.

Education Quality in the Region is Poor. Several of the feminist respondents brought up their distaste for the sex education programs they were exposed to in school. These programs were described as primarily abstinence-based, and shame/fear-based tactics were prevalent in each example given (i.e. chewing gum and tape being analogous for having multiple sex partners). Jessica (24 years old) also discussed how there is a substantial gap in education for those who do not identify as cisgender and heterosexual:

> I have become like increasingly aware of the, like the lack of sexual health resources for people that don't fall into just like, ‘Oh, I am a straight cis-person having sex with another straight cisgender person’. Yeah, I have plenty of friends that are trans and like… they were never taught, like how to do any of the stuff that like women are taught to do for their sexual health when they're growing up. Or like, for like queer people.

For many feminist women, their primary sources of sexual health education became like-minded family members or friends. When asked if there were any people who had influenced her sexual health decisions, Luna (21 years old) said:

> My mom, for sure. She's always been, since as long as I can remember, it's always been' protection, protection, protection, and like, take care of your body, respect your body. And she's always been for birth control…my grandma also like, 'protection, protection'. I guess it was passed on to my mom just the same! Definitely those people have had a major impact on my sexual life.

Sexual Assault and Violation of Boundaries is Common. Throughout a majority of the conversations had with participants, situations where sexual boundaries were crossed were shared. Of the thirteen women, five (38%) explicitly recounted their experiences of sexual assault or rape. From Luna's (21 years old) perspective, non-feminists may be at an even higher risk of having their boundaries ignored. "[Non-feminists] are less likely to kind of speak up and demand what they deserve in that situation [a sexual encounter]." Not feeling safe or comfortable enough to express one's dislikes and limitations during a sexual encounter was common amongst participants. These occurrences were typically described as a sort of turning point in recognizing their need for direct consent. Carmen (22 years old), described her feelings about having her sexual boundaries violated: "I just went along with it. I don't believe I was raped – I never said no. I mean, yeah, you're supposed to have a verbal and enthusiastic, 'yes'. But like, I just went along with it." Rose (22 years old) also discussed her feelings regarding her past negative sexual encounters:

> I didn't feel confident enough to enforce my boundaries, I didn't feel like I would be listened to. I let things go that I should not have… And I definitely have some experiences of that where I was too uncomfortable to say anything. And in the end, it hurt me more in the long run than had I been able to, you know, enforce my boundaries… I think back on those

> moments, and it's just like, I wish I had the confidence and the foundation… so I could have shut it down. (Rose, 22 years old)

Just as sexual assault was common (38%) amongst study participants, multiple women expressed their concern over loved ones' who had also been traumatized. Janelle (23 years old) shared her perspective on the prevalence of sexual violence:

> It is something that every woman in my life has faced to some extent. You know, it is infuriating and heartbreaking. Just to talk to my friends and realize the number of my friends that have faced sexual assault in some form, or, you know, any kind of assault. I can't think of one, frankly, who hasn't been taken advantage of in some form or fashion…And they have to live with it for the rest of their life and the consequences of that. And I, frankly, don't think any of these men that have committed these crimes have been persecuted.

Patients Often Do Not Feel Listened to by Providers. A common statement on behalf of the participants was that providers have ignored them in the past. Numerous women described a lengthy journey towards finding compassionate treatment, and Janelle (23 years old) expressed her frustration with her former doctor: "I do trust their medical opinion over mine. But I am an informed individual, and it is my body and ultimately, no one knows my body better than me. And if I'm telling you that these things are happening, and I have medical records to back it up, hmm, that is something that needs to be considered." Luna (21 years old) recounted a similar story of how she was ignored by a male physician: "I've had some experiences with male doctors being less open minded. They don't want to listen to what's going on. They kind of just, okay, well, that shouldn't be happening. And it's like, well, yeah, it shouldn't, but it is happening… They don't want to listen."

Healthcare providers should also listen to feedback from patients regarding their comfort within their clinic. Kaylee (24 years old) discussed how she felt more uncomfortable than was necessary during her IUD insertion: "The guy who put my IUD

in, he, like, didn't talk too much. But he had a picture of horses on the ceiling. I laid back, and I was like… 'No. This is not doing it.'"

Pressure from Others Influences Choices. Throughout the course of their answers, multiple women claimed to have been pressured by a former partner to not use a condom. This could potentially lead to serious health consequences for her – particularly when compared to most men's experiences with STI's and pregnancy. Sexual partners are not the only individuals with the capacity to influence someone into making reproductive choices they may not otherwise make. Carmen (22 years old) said that when going to her OB/GYN's office, "sometimes, like a lot of times, I get pressured into, like, birth control options and things that I don't even want to hear about." While it is standard for a provider to list multiple options for treatment, feeling pressured is never a comfortable experience – compounded by the discomfort of a gynecological appointment.

Table 2

*Emergent Themes and Sub-Themes for Study*

| Theme | Sub-Theme |
| --- | --- |
| Feminism Definition | |
| Sexual Health Definition | |
| Endorsement of Bodily Autonomy | Supporting Women's Right to Choose<br>Importance of Consent<br>Freedom of Choice for Contraceptive Use |
| Rejection of Patriarchal Power Dynamics within Sexual Interactions / Relationships | Rejection of Male-Centered Relationships<br>Sexual Satisfaction is Not Only for Men<br>Rejection of Stereotypical Gender Roles<br>Rejection of Heteronormativity |
| Heightened Awareness of Widespread Sexism towards Women | Body / Slut Shaming<br>Rape Myths<br>Portrayal of Women & Their Bodies in Media<br>Creating Environment of Anti-Sexism |
| Sexual Health Extends Beyond Protection from STI's & Pregnancy | Respect & Positive Treatment from Providers<br>Multiple Uses for Contraceptives<br>Communication & Trust<br>Consent<br>Self-Awareness / Acceptance |
| Barriers for Women's Optimal Sexual Health | Education Quality in Region is Poor<br>Sexual Assault / Violation of Boundaries<br>Patients Do Not Feel Listened to by Providers<br>Pressure from Others Influences Choices |

# CHAPTER V

## DISCUSSION

This study uncovered a multitude of thematic trends among the thirteen feminist women who were interviewed. Not only were these women's perceptions of sex and relationships explored, but shared sexual health behaviors and barriers to optimal health were also found between them. While the personal meaning of feminism was slightly different for each participant, all thirteen women believed their identities represented a sense of purpose through equality, justice, and compassion. This thesis was an attempt to identify the connections between the intrapersonal factor of a feminist identity and the sexual health behaviors and perceptions that emerging adult women take part in. The different experiences shared have shaped these women into becoming the feminists they are today, and as such, now largely advocate for the well-being and equality of other women. Events expressed to the primary investigator fall all along the emotional spectrum, from traumatic times to moments of intimacy and joy. It has been the goal of this research to not only shed light on the underlying mechanisms of a feminist identity's influence on sexual health behavior, but also to share the important stories of the feminist women who participated.

The aim of this inquiry was to explore the influence and connections between

emerging adult women's feminist identity and their sexual health behaviors. Among the sample of Oklahoman women, multiple areas of influence were identified through their recounting of experiences.

Overall, findings from this inquiry suggest that feminist women are conscious of their sexual health and make an effort to advocate for their own well-being. Positive experiences, both with healthcare providers and sexual partners, occurred when each woman was listened to, respected, & their needs were made a priority. Just as Yoder, Perry, and Saal (2007) found that feminist women were more assertive during sexual encounters than those who did not identify as feminist, I spoke to multiple feminists who were indeed very assertive with their sexual boundaries. This could be found amongst participants who said they would automatically refuse to have sex and/or continue dating a person who would not wear a condom. Every one of the thirteen women who took part in this study also brought up the topic of consent. For this group of women – and likely feminists in general – retaining and asserting control over one's own body is an enormous element of their sense of freedom and reproductive justice.

Participants from this study were not only assertive with their sexual partners in regards to their needs and boundaries, but also with health providers. Nearly every woman interviewed spoke of a negative experience with a reproductive healthcare professional. During these appointments, it is not uncommon for women to feel ignored, shamed, pressured, and objectified. After repeated misdiagnoses due to a lack of either compassion or concentration, several women reported going through multiple reproductive healthcare providers until they happen to find one that treats them and their bodies with respect.

In previous studies, like the one conducted by Holland and colleagues (1998), researchers found that heteronormative assumptions and sexual interactions dominate much of American society. Based on the interviews completed throughout this inquiry however, that is not the case for feminist women. As shown in Table 2, a common manner that these women expressed rejection for patriarchal power dynamics in their relationships was by disagreeing with heteronormative beliefs and the gender binary construct. Sexual practices varied among each woman, as did their sexual orientations. All thirteen women also spoke of their unhappiness with male-centered sexual encounters being a societal norm. With sex being so heavily associated with men and their behavior, it is little surprise that slut-shaming also was evident in many of the participants' experiences. For the majority of the women, it was not until they became feminists that they fully came to accept and take pride in their own sexuality.

Prior to identifying as a feminist, some women recounted that they did not have the confidence or communication skills to get out of an unwanted sexual situation. This realization aligns with findings from Pearson's 2006 study: women who find themselves falling into traditional gender roles are less likely to feel comfortable asserting their sexual needs and preferences. Many participants of my study stated how they wish they had known their rights and their value at the time that they had been assaulted or had boundaries violated – but internalized self-blame only slows the healing process after a traumatic event.

Of the seven women who described having their sexual boundaries broken, five directly confirmed they had been sexually assaulted or raped. These women have shown profound strength and growth through their dedication towards healing. These traumatic

experiences were sometimes described as being a sort of catalyst for change within these feminist women, eventually leading them onto a path towards self-acceptance and a greater commitment to the fight for equality. This trend was also found in a 2017 study by Valentine and colleagues. According to their findings, college-age survivors of sexual violence were more likely to develop a feminist identity than those who did not experience similar trauma. Feminist women have also been found to be more sex positive than those who are not. Several participants spoke of how they have taken charge of their sexual pleasure, and they feel no shame in that. Justification for having an active, diverse sex life was typically just, "if men can do it, why can't I?" Using one's bodily autonomy as a means to express love, endorse equality, and squash double standards was something that multiple women described.

## Limitations

Due to the small sample size of this study (n = 13), interpretation of these findings and evaluation of their significance and application should be made within the context of the inquiry's limitations. Although not a large study, the results are applicable to furthering the understanding of the connections between elements of identity and specific health behaviors. Due to the recent global COVID-19 pandemic and university campus closures, advertising for recruitment was made a challenge. All participants who were ultimately interviewed had received word of the study via email. It would have been preferred to have a greater opportunity to recruit through the use of fliers and leaflets to increase exposure, but the health of students always comes first.

Another potential limitation concerns the demographics of the sample. Although Oklahoma is a predominantly white state, having the perspectives of at least a few black women would have been enormously insightful and helpful. Particularly in the world we live in currently, more black voices need to be heard and represented in academia as a whole. As a result of the study demographics, findings may not be as applicable to communities of color, older women, or lesbian women. Each person who took part in this inquiry also had a history sexual experiences with men, and this is not always the case for all women.

As with any study, this inquiry is likely not completely free of bias. As a feminist and health educator, my presence as their interviewer may have influenced the participants' responses. The COVID-19 pandemic also interfered with the manner in which interviews were conducted. By using Zoom to communicate, there were occasional moments of technical difficulties and glitches that may have distorted sound and video. Comfort level with the interviewer, as well as the software being used, may have also impacted the statements made by respondents.

## Study Implications

While this inquiry was exploratory in nature, the findings can be applied to future feminist or sexual health behavioral studies and programming. The results of this study show that feminist women are generally self-sufficient, knowledgeable and assertive when it comes to their rights, and heavily prioritize their sexual health and overall well-being. While it is not exactly clear which comes first, feminism or a holistic view of sexual health, it is apparent that many feminist women are aware that sexual health is

more than simply physical. In future sex education programming, the connection between sexual health and other dimensions of wellness should be made clear. Several of the women interviewed for this study recounted stories of embarrassingly poor quality of sex education that they endured in school. Based on their suggestions, sex education should be taught at an earlier age, and resources need to be more widely available for students.

This inquiry helps highlight the continuing struggle for reproductive justice and equality in America. Legislative changes may have been made to advance women's rights in the 1900's, yet there are still laws being enacted today that operate solely to dismantle them. This study shows that there is, and will continue to be, the support and the need for reproductive healthcare and justice for women of all backgrounds. Future studies may be necessary to understand the connections between one's background and identity as a feminist. For many, identifying as a feminist is seen a political statement. This facet should be explored in order to untangle the political underpinnings and alignments of those who do and do not identify as feminists. Are feminist ideals and values shared by those without a shared identity? What happens to a person's identity when conservative political and religious beliefs collide with progressive sexual and gender identities also should be looked at. This was a common occurrence among the women who took part in this study, and it may have played a role in their positions currently as advocates and supporters of women.

## Conclusion

To summarize, the impact that a woman's feminist identity has upon her sexual health decisions, experiences, and perspectives is multi-faceted and interconnected. The

thirteen interviewed women shared how being a feminist not only affects their sexual health choices, but also the kinds of relationships they choose to be a part of, the way they engage with others as equals, and how it serves as a sort of moral compass for identifying injustices.

Although Downing and Roush (1985) created a model to help describe the process of identifying as a feminist, future research needs to be done into the evolution of feminist beliefs compared to personal identification. Exploring potential sources of feminist epistemology in people's lives may also prove useful in the event of coordinating a feminist sex education program.

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# APPENDICES

## APPENDIX A

## ELIGIBILITY SCREENER

Thank you so much for reaching out! If you'd like to be a part of the study, you just need to meet the following criteria:

- Do you identify as a woman?
- Do you identify as a feminist?
- Have you had a sexual experience (with another individual) within your lifetime?
- Are you between the ages of 18 and 24?

If these all apply to you, I will just need the attached informed consent document to be completed (2 questions at the bottom) and signed.

I am also including the link to our demographic survey. This short questionnaire should take less than 5 minutes. Once you have completed the survey and completed the forms, we can schedule an interview session! Let me know if you have any questions or concerns!

## APPENDIX B

## DEMOGRAPHIC QUESTIONNAIRE

**Q1: What is your age (in whole numbers)?** ____________

**Q2: Which of the following best describes your sexual orientation?**

a. Straight / Heterosexual
b. Gay / Lesbian / Homosexual
c. Bisexual
d. Pansexual
e. Asexual
f. Other (please specify) ____________

**Q3: Which of the following best describes your race / ethnicity?**

a. White / Caucasian
b. Black / African American
c. American Indian / Alaska Native
d. Asian
e. Latina / Hispanic
f. Multiple Races

**Q4: Which of the following best describes your current marital status?**

a. Married
b. Widowed
c. Divorced
d. Separated
e. Never married, cohabiting with a partner
f. Never married, not cohabiting with a partner

**Q5: Do you have any children?**

a. Yes
b. No

**Q6: What is the highest level of school you have completed or the highest degree you have received?**

a. High school degree or equivalent (e.g., GED)
b. Some college, but no degree
c. Associate’s degree
d. Bachelor’s degree
e. Graduate degree

**Q7: Which of the following categories best describes your employment status?**

a. Employed, working 40 or more hours per week
b. Employed, working 1 – 39 hours per week
c. Not employed, looking for work
d. Not employed, NOT looking for work
e. Disabled, not able to work

**Q8: How much total combined money did your household earn last year?**

a. $0 – 24,999
b. $25,000 – 49,999
c. $50,000 – 74,999
d. $75,000 – 99,999
e. $100,000 – 149,999
f. $150,000 – 249,999
g. $250,000+
h. Prefer not to answer

**Q9: How would you describe your student status?**

a. Undergraduate, part-time
b. Undergraduate, full-time
c. Graduate, part-time
d. Graduate, full-time
e. Other (please specify) __________________

<u>ABBENDIX C</u>

INTERVIEW GUIDE

<u>Interview Questions</u>

I. What is feminism?

II. What does it mean to *be* a feminist?

III. What does sexual health mean to you?

  a. How does your feminist identity influence the way you define sexual health?

  b. How might your definition of sexual health differ from others on campus?

IV. What does it mean to live in a way that is sexually healthy?

  a. Sexually unhealthy?

V. Have you ever used contraceptives?

  a. If so, what kinds?

  b. What factors influenced your decision to use/discontinue those types?

  c. What originally motivated you to seek out contraceptives?

  d. Do you currently use contraceptives?

    i. If so, why?

  e. How do you address the topic of contraceptives with sexual partners?

    i. Examples?

VI. In what ways do you believe your feminist identity has influenced your perceptions of sex?

VII. Describe a sexual experience that you have had that was positive.

  a. What made this experience a good one?

VIII. Describe a sexual experience that you have had that was negative.

  a. What made this experience a bad one?

IX. Have you ever received STI testing?

  a. What motivated you to seek testing?

X. Have you ever seen a physician/health professional for reproductive health services?

a. What are characteristics that you look for in a healthcare provider?

b. If so, for what? (pap test, birth control, STI testing, abortion, etc.)

c. Describe a positive experience you have had with a reproductive health professional

d. Describe a negative experience you have had with a reproductive health professional

XI. Has anyone in your life influenced the reproductive/sexual health choices you make?

a. If so, who?

b. In what way?

APPENDIX D

RESEARCH STUDY INFORMED CONSENT

**INFORMED CONSENT DOCUMENT (PRESCREEN)**

IRB STUDY # IRB-20-167

OKLAHOMA STATE UNIVERSITY STUDY INFORMATION SHEET & INFORMED CONSENT

**SEXUAL HEALTH & FEMINISM: INTERVIEW**

You are invited to participate in looking at women's sexual health and the intersection with a feminist identity. We are recruiting women between the ages of 18-24 who are a student at Oklahoma State University. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Kori Morgan a MPH student and her advisor Randolph D. Hubach, PhD, MPH at Oklahoma State University.

**STUDY PURPOSE**

The purpose of this study is to better understand the experiences of college-aged women related to sexual health, their perceptions/attitudes, and to what extent these are shaped by a feminist identity.

**PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will do the following things:

Complete a one-time interview, taking approximately 60 minutes. Some of the questions in this study will ask about sexual health, sexual behaviors, and partner preferences. No identifying information will be collected and the records of the study will be kept private.

**RISKS OF PARTICIPATION**

There are no risks that are anticipated from your participation in the study. Some of the questions may make you feel uncomfortable, but you are free to decline to answer any questions you do not wish to answer or stop participation in the study.

**BENEFITS OF PARTICIPATION**

The anticipated benefit of participation is to provide insight into preferences for sexual health programming.

**CONFIDENTIALITY**
This study includes the collection of data related to your experiences, attitudes, and preferences; as such the records of this study will be kept private. Research records will be stored on a password-protected computer in a locked office and only researchers and individuals responsible for research oversight will have access to the records.
Note that Qualtrics has specific privacy policies of their own. If you have concerns, you should consult this service directly. Qualtrics' privacy statement is provided at: http://qualtrics.com/privacy-statement.

**PAYMENT**
Participants completing the questionnaire can elect to receive an Amazon gift certificate in the amount of $20.

**DATA USE**
Data collected during this study will be utilized for the development of public health programming. This includes the dissemination of findings through academic and community presentations, publications, and reports. All data are de-identified. As such, your name or other identifiers will not be collected. Only members of the research team will have access to the information you provide us. All de-identified data will be retained for 3 years; however, data will only be utilized by the research team to meet the project objectives as described within this document.

**CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study, contact the researchers, Kori Morgan at korirm@okstate.edu or Randolph D. Hubach, PhD, MPH (faculty advisor) at randolph.hubach@okstate.edu.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IRB Office at 223 Scott Hall, Stillwater, OK 74078, 405-744-3377 or irb@okstate.edu

**VOLUNTARY NATURE OF STUDY**
Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with Oklahoma State University.

**CONSENT DOCUMENTATION:**

I have been fully informed about the procedures listed here. I am aware of what I will be asked to do and of the benefits of my participation. I also understand the following statements:

I affirm that I am 18 years of age or older:

Yes
No

I have read and fully understand this consent form.  I hereby give permission for my participation in this study.

Yes
No

VITA

Kori Rae Morgan

Candidate for the Degree of

Master of Public Health

Thesis: THE INFLUENCE OF FEMINIST IDENTITY ON THE SEXUAL HEALTH BEHAVIOR OF EMERGING ADULT WOMEN

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Education:

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Completed the requirements for the Bachelor of Science in your Health Education & Promotion at Oklahoma State University, Stillwater, Oklahoma in 2018.

Experience: Graduate Teaching Assistant – Total Wellness – 2018-2020

Professional Memberships: Phi Kappa Phi