

SAFER, BETTER SEX THROUGH FEMINISM: THE ROLE OF FEMINIST IDEOLOGY IN WOMEN'S SEXUAL WELL-BEING

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Feminists have argued that traditional gender norms can obstruct women's sexual well-being (Amaro, 1995; Morokoff, 2000; Tolman, 2006; Walker, 1997). Therefore, we expected feminist ideology, by virtue of this critique, to be associated with women's sexual subjectivity and sexual well-being. To test this model, we analyzed data from a survey of college-age women ($N = 424$) using structural equation modeling. As hypothesized, feminist ideology was indirectly related to condom-use self-efficacy and sexual satisfaction via sexual subjectivity, and sexual motivation was directly related to sexual satisfaction. In an alternative model, feminist ideology was directly related to sexual motivation. This research indicates that feminist ideology may play a role in the promotion of women's sexual well-being.

Since the emergence of HIV/AIDS in the early 1980s as a major public health threat, over 175,000 women have been infected with HIV in the United States (Centers for Disease Control and Prevention, 2005). Heterosexual sexual activity is believed to be the most probable cause of infection in approximately 75% of these cases (Centers for Disease Control and Prevention, 2002). In 2005 the federal government dedicated approximately \$900 million in funding to the prevention of HIV transmission (Kates & Leggoe, 2005), including the promotion of condom use, the only safer sex measure that protects against the transmission of the virus. Despite these efforts, rates of condom use

in coitus remain low: Among one sample of racially diverse, low-income women, only 11.7% of participants reported being "consistent" condom users (Soler et al., 2000), and among a sample of male and female undergraduates, less than one third of participants reported consistent condom use over the past month (Parsons, Halkitis, Bimbi, & Borkowski, 2000). Condom-use self-efficacy, the confidence in one's ability to negotiate for and employ a condom, has been found to predict condom use consistently (Cecil & Pinkerton, 1998; DiIorio, Maibach, O'Leary, Sanderson, & Celentano, 1997; Levinson, Wan, & Beamer, 1998; Wulfert & Wan, 1993). As a result, a common recommendation is that preventive interventions designed to increase condom use focus on cultivating condom-use self-efficacy (Soler et al., 2000).

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Earlier versions of this article were presented at the 28th annual meeting of the International Society for Political Psychology in Toronto, Ontario, Canada, July 2005 and the 31st annual meeting of the Association of Women in Psychology in Ypsilanti, MI, April 2006. We are thankful for Eileen L. Zurbriggen's feedback on the data analyses. We also appreciate the assistance of Jaime Abraham and Jacqueline Servais with the data collection and contributions of Sapan D. Donde, Maureen M. Kentoff, Laura J. Landry, Andrea E. Mercurio, Veronica H. Moreno, and Natalie J. Sabik to the data preparation.

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Alongside this discourse of how to make heterosexual sex safer by increasing condom use is evidence that many Americans, particularly women, are unhappy and dissatisfied with their sexual lives. Laumann, Paik, and Rosen (1999) reported that 43% of women experience sexual dysfunction, the symptoms of which include (but are not limited to) diminished arousal, painful coitus, and infrequent orgasm. Tiefer (2004) claimed that we are in the midst of "a modern epidemic of insecurity and worry" (p. 8) with regard to sexuality, but vigorously disputed that these worries and so-called "sexual dysfunction" can be attributed solely to innate biological causes. Instead, she and other feminist researchers and theorists (e.g., Amaro, 1995; Amaro & Raj, 2000; Gavey & McPhillips, 1999; Gavey, McPhillips, & Doherty, 2001; Tolman, 2006) view the redress of gender norms, particularly those that circumscribe women's sexual subjectivity, as a key step toward safer (in relation to condom-use self-efficacy) and better (in relation to

satisfaction) sexual experiences for women. In this article, we review existing studies of the relation of gender norms to women's sexual well-being and use this literature as a foundation for the hypothesis that feminist ideology, with its critique of gender norms and support of women's sexual subjectivity, empowers women in the sexual realm, making them both more efficacious with regard to condom use and more satisfied sexually.

Gender Norms and Sexual Well-Being

Many feminist scholars argue that dominant constructions of women's sexual roles (e.g., as passive recipients or responsible gatekeepers) are barriers to women's sexual well-being (e.g., Amaro, 1995; Amaro & Raj, 2000; Gavey, 2005; Impett, Schooler, & Tolman, 2006; Morokoff, 2000; Walker, 1997). With regard to condom use, many aspects of advocating for safer sex with a male partner are in sharp contrast with normative expectations that women will be sexually pleasing and acquiescent to men. First, given that condoms are commonly believed to decrease sexual pleasure, especially men's (Gavey et al., 2001), women advocating for condom use must operate directly against the norm that male pleasure should supersede female self-interest (Gavey, 2005; Walker, 1997). In addition, women who negotiate for condom use can be vulnerable to accusations of sexual promiscuity and infidelity, because sexually chaste and monogamous women would be "clean" (Amaro, Raj, & Reed, 2001; Hillier, Harrison, & Warr, 1998; Kirkman, Rosenthal, & Smith, 1998; Wingood & DiClemente, 1998). Impett et al. (2006) explained the association they discovered between adolescent girls' body objectification and condom use at first intercourse by suggesting that women who are distanced from their embodied experiences may be less inclined to advocate for condom use on behalf of their sexual health. Finally, given that condom use is entirely dependent on male compliance, it requires a degree of interpersonal negotiation on the part of women that is unnecessary in many forms of contraception (e.g., the pill). As Amaro (1995) pointed out, for men, condom use involves wearing the condom whereas for heterosexual women, it involves persuading a man to wear a condom. In each of these cases, traditional norms of female sexuality appear to undermine women's interest in and self-efficacy regarding condom use.

Gender norms may not only inhibit women's condom-use self-efficacy but also impinge on their sexual satisfaction. Fredrickson and Roberts (1997) proposed that one of the consequences of women's self-objectification is diminished capacity for embodied sexual arousal and pleasure. Morokoff (2000) argued that the norm of female sexual passivity interferes with women's ability to assert their sexual preferences and interests and that the role of sexual gatekeeper, in which women are typically cast, "makes full sexual expression difficult because a woman who must constantly evaluate the appropriateness of a sexual interchange

(because her partner may at any moment direct the action into an unacceptable area) cannot immerse herself in the experience" (p. 306). In a recent study of the link between gender norms and sexual satisfaction, Sanchez, Crocker, and Boike (2005) found that, among both female and male undergraduates, greater investment in gender norms was related to diminished sexual satisfaction.

Sexual satisfaction has also been linked to one's motivation for engaging in sexual behavior. Impett and Tolman (2006) found that, among adolescent women, satisfaction was associated with both positive sexual self-concept and approach motives (i.e., engaging in sexual behavior as a means of attaining something positive and desirable, rather than avoiding something negative and unappealing). In his study of sexual motivation among undergraduates, Jenkins (2004) found evidence that intrinsic motivation for sexual behavior (e.g., physiological arousal) was related to greater sexual satisfaction, whereas the inverse was true when engaging in sexual behaviors for extrinsic reasons (e.g., to please a partner). Although Jenkins did not find robust evidence of gender differences among participants' sexual motivation, others have argued that women feel more susceptible to extrinsic influences (e.g., partner pressure; Walker, 1997) and less entitled to intrinsic ones (e.g., sexual desire; Tolman, 2002).

Importantly, one common thread among these studies of sexual satisfaction is the significant role played by sexual subjectivity (Horne & Zimmer-Gembeck, 2006; Martin, 1996; Tolman, 2002), a particular aspect of sexual self-concept that encompasses (a) awareness of one's embodied sexual desires and responses, (b) a sense of entitlement to those sensations, and (c) the agency necessary to advocate for one's sexual safety and pleasure. As such, sexual subjectivity runs counter to the internalized forces (e.g., objectification), roles (e.g., gatekeeper), and norms (e.g., being a passive, pleasing woman) that have been found to jeopardize women's sexual well-being. In this sense, sexual subjectivity consists of knowing what one wants and how to get it as well as knowing what one does not want and how to stop it. In the present study, we propose feminist ideology as one means of cultivating sexual subjectivity.

Feminist Ideology and Sexual Well-Being

Although contemporary feminism is a pluralistic, complex, and dynamic movement, it does have some dominant and enduring themes, including two that may be especially relevant to the cultivation of sexual subjectivity and women's sexual well-being. The first, consciousness raising, consists of both recognizing external structures of oppression as well as unlearning internalized norms of sexism (hooks, 2000). The second is sexual liberation, which hooks (2000) envisioned as a function of consciousness raising. She asserted that feminist efforts to end female sexual oppression should not only redress sexual violation and moralist restrictions but also liberate women and men from "a socially

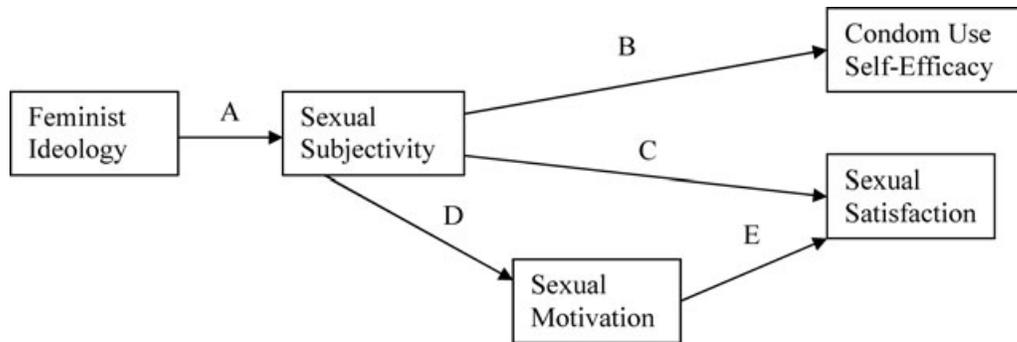


Fig. 1. Theoretical model of women's sexual well-being.

constructed sexuality based on biologically determined definitions of sexuality: repression, guilt, shame, dominance, conquest, and exploitation” (p. 151). This critical underpinning of feminist ideology may help women resist the gender norms that impede female sexual subjectivity, thus enabling women who hold feminist beliefs to feel more sexually self-efficacious (with regard to condom use) as well as more sexually satisfied.

In the present study, we test the relation of feminist ideology to condom-use self-efficacy and sexual satisfaction in a multivariate model (Figure 1). In this model, we propose that the endorsement of feminist beliefs will be associated with greater sexual subjectivity (Path A). Sexual subjectivity, in turn, will be related to increased confidence in one's ability to advocate for condom use with male partners (Path B) and to greater sexual satisfaction both directly (Path C) and indirectly via increased intrinsic motivation to engage in intercourse (Paths D and E).

METHOD

Participants and Procedure

Female undergraduate students over the age of 18 who were enrolled in an introductory psychology course were invited to volunteer for the study through the psychology subject recruitment pool. A final sample of 430 female undergraduate students completed the survey in exchange for course credit. Data were gathered using an online survey that participants completed at a computer of their choice. To be included in the sample, participants must have reported either past sexual experience with a man or intentions to have such experience in the future. Six women were excluded on the basis of this criterion, resulting in a final sample of 424 participants. Participants reported engaging in sex with an average of 5.01 partners ($SD = 4.97$) within their lifetime. Participants were primarily 1st-year students (47%) with an age range from 18 to 30 ($M = 19.17$, $SD = 1.62$). They were predominantly white (72%) and self-defined as “well to do” or “extremely well to do,” with 69% of the population reporting an annual family income over \$100,000.

Measures

Feminist ideology. Feminist ideology was measured using the liberal feminism subscale of the Feminist Perspectives Scale (FPS3; Henley, Spalding, & Kosta, 2000). In their delineation of different feminist perspectives, Henley, Meng, O'Brien, McCarthy, and Sockloskie (1998) identified liberal feminism as the most common, particularly among well-educated women, and as representing a “baseline feminist” position that emphasizes gender equality and the protection of equal rights, opportunities, and resources. To complete the FPS3, participants were asked to rate their endorsement of five statements such as “The government is responsible for making sure that all women receive an equal chance at employment and education” on a 7-point Likert scale. Item responses were summed, as recommended by Henley et al. (1998, 2000), with higher scores indicating greater support for the belief. The alpha (.61) was consistent with those found in previous studies: between .46 and .62 in the original study (Henley et al., 1998) and .53 in a subsequent study (Henley et al., 2000).

Sexual subjectivity. Participants' degree of sexual subjectivity was measured by combining items from the subscales of two existing measures: the sexual consciousness subscale of the Sexual Awareness Questionnaire (SAQ; Snell, Fisher, & Miller, 1991) and the assertiveness and “say no” (referring to one's ability to reject unwanted sexual advances) subscales of the Sexual Self-Efficacy Scale (SSE; Rosenthal, Moore, & Flynn, 1991).

The sexual consciousness subscale of the SAQ measured participants' awareness of their sexual desire and responses. Six items, such as “I'm very alert to changes in my sexual desires,” were rated on a 5-point Likert scale ranging from 0 to 4, with higher scores indicating greater recognition of sexual desire. This subscale has been found to have high internal consistency with alpha scores ranging from .86 to .88 (Snell et al., 1991).

Each of the two SSE subscales, assertiveness and say no, used a 6-point scale, ranging from 0 (*can't do*) to 5 (*absolutely certain*), to assess a participant's confidence in her ability to perform certain behaviors related to sexual assertiveness (e.g., “Tell your partner how to treat you

sexually”) and saying “no” to unwanted sexual encounters (e.g., “Have a sexual encounter without feeling obligated to have intercourse”). Previous literature has found that both the say no and assertiveness subscales have internal reliability coefficients ranging from .72 to .75 and .66 to .77, respectively (e.g., Akinsulure-Smith, 1997).

The three subscales were modestly correlated. However, when a factor analysis was constrained to one factor, it produced a solution where all but four standardized items met the fair factor loading criterion, which was identified as above .45 (Comrey, 1973). Additionally, Cronbach’s alpha on the combined subscales was .88. Therefore, a composite score was created using the mean of the remaining 14 items, such that higher scores indicated greater sexual subjectivity.

Condom-use self-efficacy. A subscale from Brafford and Beck’s (1991) Condom Use Self-Efficacy Scale (CUSES) was used to assess participants’ confidence in their ability to assert their desire to use a condom with a partner. Using a 5-point Likert scale, participants rated the degree to which they agreed with three statements about condom use, such as “I feel confident in my ability to suggest using condoms with a new partner.” Item scores were summed in accordance with the authors’ suggestion; higher scores indicated an increased perception of condom-use self-efficacy. Brafford and Beck (1991) reported a test-retest correlation of .81 and a Cronbach’s alpha of .91 for the assertiveness subscale. This value was consistent with the internal reliability of CUSES items in the current study ($\alpha = .90$).

Sexual motivation. Participants’ sexual motivation was measured using the Perceived Locus of Causality for Sex (PLOC-S; Jenkins, 2004), a 77-item scale that assesses participants’ motives for engaging in sexual intercourse. Participants used a 5-point Likert scale to rate the extent to which each of the items influenced their decision to engage in partnered sexual activity. The PLOC-S consists of eight subscales that measure both extrinsically motivated reasons (e.g., “The last time I engaged in sex was because my partner insisted on it”) and intrinsically motivated reasons (e.g., “The last time I engaged in sex was because I thought that it would feel good”) for engaging in sexual intercourse. In the current study, scale items had a Cronbach’s alpha of .83. A participant’s overall sexual motivation score was obtained by weighting the intrinsic motivation items positively and the extrinsic motivation items negatively. Higher scores indicated stronger motivation to engage in sexual intercourse for intrinsic reasons.

Sexual satisfaction. Participants’ current sexual satisfaction was assessed using a subscale of Snell and Papini’s (1989) Sexuality Scale (SS). The participants were given 10 items from the sexual depression subscale and asked to rate the extent to which they agreed with items pertaining to their current sexual perceptions (e.g., “I feel pleased

with my sex life”) on a 7-point Likert scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). The authors’ instructions for reverse coding were inverted so that, when individual item ratings were summed, a higher score indicated increased sexual satisfaction. The Cronbach’s alpha found in the present study ($\alpha = .89$) was consistent with Snell and Papini’s (1989) findings ($\alpha = .85$ –.93).

RESULTS

Preliminary Analysis

Results of correlational analyses are presented in Table 1. All variables were significantly and positively related to one another with correlation coefficients ranging from .16 (feminist ideology and sexual satisfaction) to .61 (sexual motivation and sexual satisfaction).

Path Analysis

We conducted path analysis using structural equation modeling to test the hypothesized model (Figure 1). All variables in the model are manifest indicators, rather than latent variables, because we did not have sufficient power to test the factor model simultaneously with the path model. The path analysis was tested using Amos 5.0 (Arbuckle, 2003). The original statistical model, including standardized coefficients, is presented in Figure 2. All paths were significant, with feminist ideology associated with sexual subjectivity, which was positively related to greater condom-use self-efficacy, sexual motivation, and sexual satisfaction. Sexual motivation was also directly related to sexual satisfaction. We used three goodness-of-fit measures: the root mean square error of approximation (RMSEA), the comparative fit index (CFI), and the incremental fit index (IFI). The RMSEA indicates a good fit of the data if the value is under .05 and a poor fit if it is over .10 (Kenny, 2003). Additionally, a model is recognized as an adequate fit of the data if the CFI and/or IFI values are above .90; the model is considered to be a good fit of the data if the CFI/IFI value is above .95. In addition to the fit indices, a nonsignificant chi-square indicates that the model fits the data (Byrne, 2001). Although both the CFI = .97 and the IFI = .97 indicated an adequate fit, the RMSEA = .08 and significant

Table 1
Intercorrelations for Measures of Feminist Ideology and Sexual Well-Being

Measure	1	2	3	4	5
1. Feminist ideology	-	.30**	.23**	.26**	.16*
2. Sexual subjectivity	-	-	.55**	.53**	.52**
3. Condom use self-efficacy	-	-	-	.28**	.26**
4. Sexual motivation	-	-	-	-	.61**
5. Sexual satisfaction	-	-	-	-	-

* $p < .05$. ** $p < .001$.

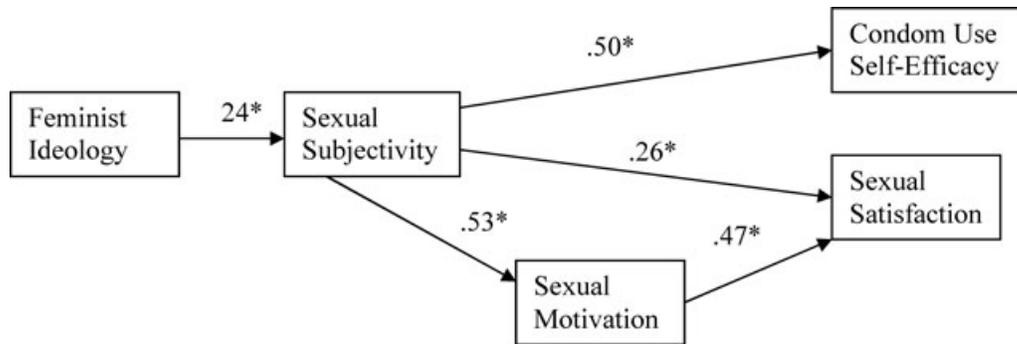


Fig. 2. Standardized coefficients for the original model of women's sexual well-being.* $p < .05$.

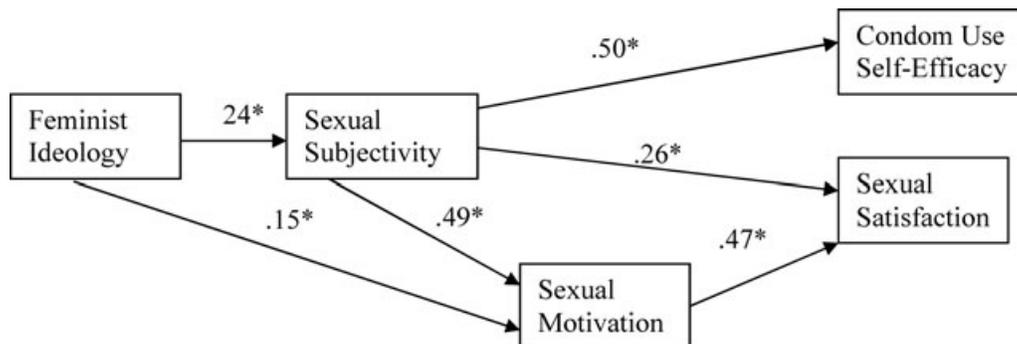


Fig. 3. Standardized coefficients for the alternative model of women's well-being.* $p < .05$.

chi-square value, $X^2(5, 424) = 20.07$, $p = .001$, indicated that it was not the best fit of the data.

To improve the fit of the model, we explored possible changes through the removal or addition of paths. An alternative model was constructed based on our examination of the modification indices. Given the statistical significance of all paths in the original model, none were removed in constructing the alternative model. Instead, a path linking feminist ideology to sexual motivation was added. All paths in the alternative model were significant (see Figure 3), and all indices suggested that the model was a good fit: CFI = .99; IFI = .99; RMSEA = .04. In addition, unlike the original model, the chi-square value in the alternative model was nonsignificant, $X^2(4, 424) = 7.32$, $p = .12$; this indicated that the alternative model was a superior fit of the data. The difference between the χ^2 values for the two models was 12.75 with one degree of freedom. The critical value of χ^2 with one degree of freedom at $p = .05$ is 3.84. Thus, the change in χ^2 was significant, indicating that the model in Figure 3 was significantly different from the model in Figure 2.

DISCUSSION

Our analyses lend further support to previous findings regarding links between sexual subjectivity and condom-use self-efficacy (Gavey & McPhillips, 1999; Gavey et al., 2001), sexual motivation and sexual satisfaction (Impett & Tolman, 2006; Jenkins, 2004), and sexual subjectivity and sexual sat-

isfaction (Impett & Tolman, 2006; Sanchez et al., 2005). The most notable and original contribution of this research, however, is evidence of the role of feminist ideology in supporting women's sexual well-being. Women who endorsed feminist beliefs more strongly felt a greater sense of sexual subjectivity and were more inclined to have sex as a result of their own sexual interests and wishes rather than in response to extrinsic forces (e.g., their male partners). Although we hypothesized that feminist ideology, with its critique of sexually disempowering gender norms, would be linked to sexual subjectivity, analyses indicated that it is directly related to sexual motivation as well. Although we did not anticipate this association, we find it plausible that the critical consciousness associated with feminist ideology would be related to women's motives for engaging in partnered sexual activity—when they want to for their own benefit and pleasure but not out of fear or subservience to their partners' wishes. Given the relations of sexual subjectivity and sexual motivation to condom-use self-efficacy and sexual satisfaction, these findings suggest that young women who endorse feminist beliefs may be sexually safer—insofar as condom-use self-efficacy is predictive of actual condom use—as well as more satisfied with their sexual experiences.

Although our analyses are correlational in nature and therefore cannot be used to make definitive conclusions regarding causality, they lead us to believe that efforts to promote women's sexual well-being may be strengthened by a feminist critique of gender norms. This is a compelling supplement to Impett et al.'s (2006) findings that femininity

ideology (i.e., inauthenticity in relationships and body objectification) was associated with lower sexual self-efficacy, which was associated with less frequent condom and contraceptive use. By challenging and attempting to dismantle norms of femininity, such as that of female sexual passivity, feminist ideology can clear the way for women's sexual agency to flourish. However, practical approaches to increase individual women's sexual assertiveness may be compromised if the larger context of sexism and sexist norms remains intact and unquestioned. This can leave women with ambiguous and contradictory understandings of their sexual rights, as evidenced by the following set of findings: Although 78% of adolescent and young adult female participants reported that they felt they "always" had the right "to make their own decisions about sexual activity, regardless of their partner's wishes," only a little more than half felt this translated into the rights "to stop foreplay at any time, including at the point of intercourse," "to tell a partner he is being too rough," and "to tell a partner 'I want to make love differently'" (Rickert, Sanghvi, & Wiemann, 2002). In addition, although popular discourse is replete with depictions of women's increased sexual freedom, scholars and critics have raised serious doubt that this apparent liberty has translated into healthier or more rewarding sexual experiences for women (Levy, 2005; Phillips, 2000). In her reflection on the beginning of second-wave feminism, hooks (2000) noted the limitation of sexual liberation in the absence of a critique of gender inequalities:

Advocating genuine sexual liberty was positive and women learned from experience that the freedom to initiate sexual relationships; to be non-monogamous; to experiment with group sex, sexualized sado-masochism, etc. could sometimes be exciting and pleasurable; *it did not, however, deconstruct the power relations between men and women in the sexual sphere* (pp. 148–149, emphasis added).

In accordance with hooks's (2000) assertion, we offer the current findings as support for the value and importance of feminist critique in advocacy for women's sexual well-being.

Although these findings may have important implications for women's sexual well-being, the study did have several methodological limitations. To begin, the relative homogeneity and material privilege of the sample constrain the generalizability of the findings. In addition, sample homogeneity makes it impossible to ascertain if there are race- or class-based differences in the relation of feminist ideology to sexual well-being. This issue is important to pursue, given both feminism's history of marginalizing and excluding the concerns and participation of women of color and/or low income (hooks, 2000; Hurtado, 1989) as well as the disproportionate sexual health risks faced by women of color and/or lower socioeconomic status (Centers for Disease Control and Prevention, 2005). Furthermore, our single measure of feminist ideology does not capture the diverse and dynamic character of feminism (Henley et al., 1998;

hooks, 2000). It is important to note that the measure employed in the present study assessed women's endorsement of one perspective of feminism (liberal feminism), rather than women's explicit identification as "feminist." Previous studies indicate that attitudes and behaviors among those who endorse feminist norms differ depending on whether they also embrace a feminist identity (Bay-Cheng & Zucker, 2007; Zucker, 2004). In addition, the study is limited by the relatively low reliability of the scale used to measure feminist ideology.

With regard to the sexuality measures used in the study, we are aware that, although condom-use self-efficacy has been found to be predictive of actual condom use (Cecil & Pinkerton, 1998; DiIorio et al., 1997; Levinson et al., 1998; Wulfert & Wan, 1993), this is not a perfect association. Therefore, increased condom-use self-efficacy should be interpreted as increasing the chances for safer sex, not as translating into safer sex. In addition, we did not have data regarding relational factors (e.g., length or type of relationship, perceptions of closeness and trust) that may affect several aspects of sexuality. For instance, relationship length has been found to be inversely related to condom use as participants introduce alternative methods of birth control and develop trust in their partner over time (Corbin & Fromme, 2002). The measure of sexual motivation asked participants to reflect on their most recent sexual intercourse; however, in the absence of empirical evidence that sexual motivation is stable over time and context, this construct is of limited value as a proxy for general sexual motivation. Finally, the study's cross-sectional design precludes any firm conclusions regarding the causal relations among variables. For example, although we speculate that embracing norms of gender equality and women's rights leads one to use condoms more frequently, the direction of this relation may be the inverse: frequent, positive, and successful experiences of advocating for condom use may encourage one to believe that women and men are and should be mutual partners with equal rights and responsibilities. Longitudinal analysis is necessary to ascertain if feminist ideology is a source of safer and better sex or its outcome.

Future research that corrects these limitations and further probes the relation between feminist ideology and women's sexual well-being has the potential to make both scholarly and practical contributions. For instance, if a causal link that leads from feminist critique to greater sexual subjectivity (and in turn to greater self-efficacy and satisfaction) can be discerned, especially among diverse communities of women, this finding could be used to call for a stronger programmatic and practical emphasis on helping women critique dominant gender norms and inequalities. At present, efforts to improve women's sexual well-being are largely focused on individual-level skill building and the need for more numerous and more accessible sexual health promotion programs (e.g., Rickert et al., 2002). Although we emphatically support such recommendations, we also concur with Tolman (2003) that efforts to promote women's

sexual well-being will be of limited use as long as the larger context of gender inequality remains intact:

In a patriarchal society where women's and girls' sexuality is still met with discomfort and denigration, and in which boys and men continue to believe that women and girls are sexual objects who have no sexual rights or needs, it is often unsafe for women to be sexually assertive. What girls and women need to have unencumbered access to their sexual rights is a society that rejects the belief that males are natural sexual predators who cannot be held responsible for dominating women and that embraces women's access to all forms of power (p. 48).

The findings of the present study suggest that feminism, with its emphasis on gender equality and women's sexual rights, has a role to play in the progress toward safer and better sexual experiences for women.

Initial submission: September 18, 2007

Initial acceptance: January 23, 2008

Final acceptance: March 10, 2008

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