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Religion and sex-guilt: Implications for women

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Abstract

In the therapeutic environment, clients present issues of sexuality at continually increasing rates (Bruess & Greenberg, 1988; Gordon, 1976). Current research supports the hypothesis that religion influences sexuality across a wide range of attitudes and behaviors (Bullis & Harrigan, 1992). The mental health professional, in order to create effective interventions, must be prepared to understand and address clients' religious and sexual issues (Bullis & Harrigan, 1992; Gray & House, 1991).

RELIGION AND SEX-GUILT:
IMPLICATIONS FOR WOMEN

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In the therapeutic environment, clients present issues of sexuality at continually increasing rates (Bruess & Greenberg, 1988; Gordon, 1976). Current research supports the hypothesis that religion influences sexuality across a wide range of attitudes and behaviors (Bullis & Harrigan, 1992). The mental health professional, in order to create effective interventions, must be prepared to understand and address clients' religious and sexual issues (Bullis & Harrigan, 1992; Gray & House, 1991).

The relationship between religion and sex-guilt has permeated the literature since the early 1970s (Bruess & Greenberg, 1988). Several researchers have taken the position that religion is an intervening variable to sex-guilt (Gunderson & McCary, 1979; Ogren, 1974). However, Ellis (1971, 1980) has taken the position that religion in the extreme has a profound negative impact on mental and sexual health. This review of the literature will examine the influence of Western religions on sexuality, specifically sex-guilt and the implications for women's sexuality.

Knox, Walters, and Walters (1991) reported that the literature includes over 160 articles on sex-guilt, and McCarthy (1987) stated that sex-guilt has a variety of sources. In this review, the section concerning sex-guilt

will contain a focus on the issues of premarital sex, contraception, and masturbation as sources of sex-guilt. This section will also examine the impact that sex-guilt has on these issues and the implications for women.

Concerns for the mental health professional is a section that examines the role of the therapist as a sex educator. This section also examines several factors that the mental health professional may chose to consider when working with couples, individuals, families, and groups.

In this review of the literature, the author will explore trends in the relationship between religion and sex-guilt.

Religion

Byer, Shainberg, and Jones, (1988) and Katchadourian, (1985) stated that the historical Judeo-Christian position regarding human sexuality has been considered a sex-negative position. The tenets of Western religions concerning human sexuality are rooted in this historical Judeo-Christian position. Western religions, (e.g., Catholicism and mainline Protestant religions), are those that dominate the religious cultures of Western civilization. Western religions profoundly influence people's behaviors, attitudes, thoughts, and feelings concerning their sexuality (Byer et al., 1988; Ellis, 1971; Gordon & Snyder, 1989; Katchadourian, 1985).

Western religions are an incessant influence on women's sexual choices and experiences. Tomm (1990) listed several factors that influence these choices and experiences, including gender domination and the militaristic structure of Western religions. He also identified the major symbols concerned with sexuality as derivatives of classical Greek philosophy and the Bible. This author stated that these symbols fit into two major themes: "the activity of males and passivity of females and the evil of sexuality in general, particularly female sexuality" (p. 221).

The tenets of many Western religions incorporate an exhaustive list of sexually proscribed behaviors, thoughts, and attitudes. These proscriptions include abstinence from all: sexual behaviors before marriage, extramarital sex, oral sex, anal sex, sodomy, masturbation, and homosexuality (Gordon & Snyder, 1989). Many of these tenets include the mandate that sex should occur exclusively within the confines of marriage for procreative purposes (Byer et al., 1988; Cochran & Beeghley, 1991; Gordon & Snyder, 1989; Gunderson & McCary, 1979; Kassorla, 1980; Woodroof, 1985).

This expansive proscriptive and limited prescriptive religious doctrine concerning human sexuality impacts the psychological dimensions of women's sexual and mental

health (Ellis, 1971, 1980; Richards, 1991). Whether that impact has negative or positive consequences is an on-going debate. Ellis (1971, 1980) takes the position that religiosity in the extreme has a profound negative psychological effect on sexual and mental health. On the other side of the debate authors Bergin (1983), Masters, Bergin, Reynolds, and Sullivan (1991), Richards (1991), and Richards, Smith, and Davis (1989) disagree with Ellis' position.

Ellis (1971) developed a hypothesis concerning the negative psychological impact of religion. This author stated that the dogmatic inflexibility of religion is wrought with devout "shoulds," "oughts," and "musts." For Ellis, this idea fit well with his Rational Emotive theory, and he hypothesized that religiosity in the extreme has a significant correlation with emotional disturbance and other forms of pathology. He defined religiosity "in the extreme" as being exceptionally conservative. According to Ellis (1980), the conservative nature of religiosity in the extreme eliminates individual freedom, impedes all aspects of self-acceptance, and creates a pathological intolerance of self and others.

In order to test Ellis' hypothesis, Bergin (1983), performed a meta-analysis of the research through 1979 on the relationship between religiosity and various indices

of psychopathology. Of the 30 effects obtained, Bergin found that "23 outcomes showed no significant relationship, 5 showed a positive relationship, and 2 showed a negative relationship" between psychopathology and religion (p. 176). The final conclusion from this analysis was that there was no support in the existing literature for Ellis' hypothesis that religiosity in the extreme has a significant correlation with emotional disturbance and other forms of pathology (Bergin, 1983).

Richards and his colleagues (1989) conducted a study on the relationship between religiosity and psychopathology. These authors investigated the differences in psychological and religious variables between 49 Mormon psychotherapy clients and 51 Mormon non-clients. The subjects in this study were administered the following scales and tests: the Religious Orientation Scale (ROS), a measure of intrinsic and extrinsic religious orientation; the Spiritual Well-Being Scale (SWBS), a measure of healthy religious belief or attitude; the SWBS subscale Existential Well-Being (EWB), a measure of an individual sense of life direction and satisfaction; the Shame-Guilt Test A (SGTA), a measure of shame (an unhealthy response) and guilt (a healthy response); the Defining Issues Test (DIT), a measure of individual moral reasoning development; and the Marlowe-Crowne Social

Desirability Scale (MCS), a measure of individual tendencies to respond to questions in a socially desirable manner. The researchers found no evidence that the religiosity variables of religious beliefs, attitudes, and/or motivations caused or contributed to subjects' psychopathology. However, they observed that the women in this study scored considerably higher than the men on measures of shame and guilt (Richards et al., 1989).

Masters and his research partners (1991) conducted a study to test Ellis' hypothesis that religiosity in the extreme has a significant correlation to emotional disturbance and other forms of psychopathology. These authors selected for their study people who previously had participated in religious missionary experiences. The subjects of this study completed the Minnesota Multiphasic Personality Inventory (MMPI) and the ROS. The researchers found no evidence to support the hypothesis that religiosity has a negative impact on a person's psychological functioning and mental health.

Richards (1991) also investigated the relationship between religiosity and mental health. The subjects, 268 undergraduate students, responded to: the ROS; the Center for Epidemiological Studies Depression Scale (CES-D), to measure the frequency and duration of depressive episodes; the SWBS subscales of EWB and

Religious Well-Being (RWB) , to measure the belief that God loves them and whether their relationship with God is fulfilling and meaningful; the short form of the Bealle Shame Guilt Test (SGT-RW), to measure the inclination for shame and guilt; and the Psychological Separation Inventory (PSI), to measure four dimensions of psychological separation and independence from parents. Richards found no support for Ellis' hypothesis on the relationship between religiosity and mental health. He observed that more religiously devout subjects were increasingly likely to experience higher levels of guilt than the less religiously devout. Richards concluded that religion may impact personality functioning, an important subject for future studies.

Based on the previously cited studies, there is little data to support evidence of a relationship between religiosity and pathology in general terms (Bergin, 1983; Masters et al., 1991; Richards, 1991; Richards et al., 1989). However, when researchers define pathology as a specific concrete variable, such as sex-guilt, the results of studies demonstrate a relationship (Darling, Davidson, & Passarello, 1992; Gunderson & McCary, 1979; Knox, Walters, & Walters, 1991; Mosher, 1979; Mosher & Vonderheide, 1985; Ogren, 1974; Strassberg & Mahoney, 1988; Wyatt & Dunn, 1991).

Sex-Guilt

According to Katchadourian (1985), guilt is a psychological mechanism that originates and develops in early childhood (Katchadourian, 1985). The origins of guilt in early childhood are experiences resulting from interactions with external forces (Thomas, 1992). According to Freud, as consciousness develops so does the superego. The superego, an internalized mechanism of self monitoring, changes the origins of guilt from an external locus of control to an internal locus of control (Corsini & Wedding, 1989).

Mosher and Cross (1971) applied Freud's developmental approach to guilt in their definition of sex-guilt. These authors defined sex-guilt as "a personality disposition that is manifested by resistance to sexual temptation, inhibited sexual behavior, or the disruption of cognitive processes in sex-related situations" (p. 28).

Katchadourian (1985) and Tangney (1990) defined sex-guilt as a painful emotion that can fall within a continuum from mild psychological discomfort to an overwhelming pathology. Gordon and Snyder (1989) defined the two end points of this continuum of sex-guilt. On one end of the continuum sex-guilt is a mature, rational, and healthy response when an individual has violated her or his personal standards for sexual conduct. This response

can serve as a frame of reference when the individual makes future choices about sexual conduct (Gordon & Snyder, 1989). On the other end of the continuum is irrational, immature sex-guilt. Characteristics of this irrational sex-guilt are the absence of a constructive purpose and an external locus of control. Irrational sex-guilt frequently occurs when an individual perceives herself or himself as violating codes of sexual conduct and this violation becomes known to significant others (Gordon & Snyder, 1989; Tangney, 1990).

According to Hartman and Fithian (1972), individuals who experience irrational sex-guilt are more likely to accept sexual myths as facts and/or accept inaccurate information concerning sexuality. These authors take the position that most individuals who experience irrational sex-guilt do not have access to accurate sexual knowledge.

Mosher (1979) studied the endorsement of sexual myths as a function of sexual experience and sex-guilt. Subjects in this study were college students who responded to inventories measuring sex myths, sex experiences, and sex-guilt. Mosher found that the males in this study subscribed to significantly more sexual myths than their female peers. He also found that sex-guilt negatively correlated with sex experience and positively correlated with belief in sex myths. Mosher suggested that

experiencing sex-guilt can inhibit sexual behavior, as well as the acquisition of accurate information about sexuality.

Gunderson and McCary (1979) investigated the relationship between religion and sex-guilt as a predictor of three sex variables: (a) sex information obtained, (b) sexual attitudes, and (c) sexual behaviors. The subjects, 327 college students, responded to a four part 173-item sex questionnaire. Women in this study who reported strong religious interests and frequent church attendance also reported significantly less accurate sex information and fewer sexual experiences, were conservative in their sexual attitudes, and experienced higher levels of sex-guilt than other subjects. These authors found sex-guilt to be more powerful than religion in predicting the three sex variables. They concluded that religion, an intervening variable, can influence the level of sex-guilt which strengthens the predictive value of sex-guilt.

Consistent with these findings were the results of Ogren's (1974) study on the variables of sex-guilt and religion. He studied these variables in order to identify which one was the more powerful predictor of sexual behaviors. The sample of 207 college students completed questionnaires that measured sex-guilt, accurate

information about sexuality, range of sexual experiences, and the level of religiosity. Ogren used subjects' frequency of church attendance, present religious interest, and religious experiences to measure the level of religiosity. He found that those with higher levels of sex-guilt had limited sexual knowledge, information, and experiences with no correlation with religiosity. He concluded that, although some religious training may result in sex-guilt, those with little or no religious training have the same potential to develop and maintain differing levels of sex-guilt as those with more intense religious involvement (Ogren, 1974).

According to McCarthy (1987), it is not the sexual incident or behavior that results in sex-guilt. Her position is that sex-guilt is the result of cognitive processes and subsequent emotional reactions concerning sexual behaviors. McCarthy identified numerous universal sources of sex-guilt. This review of the literature will focus on three of these sources: premarital sex, contraception, and masturbation.

Premarital Sex

Premarital sexual behaviors are long-standing concerns of society and religious cultures. Experts in the field believe that the proscription of premarital sexual behaviors is understandable given the continually

increasing rates of sexually transmitted diseases (STDs), unplanned pregnancies, and abortions (Bruess & Greenberg, 1988; Gerrard, 1982; Katchadourian, 1985; Woodroof, 1985). Numerous authors take the position that forbidding, attempting to control, and/or chastising individuals and groups are ineffective methods of reducing the rates of premarital sexual behaviors (Bruess & Greenberg, 1988; Chilman, 1990; Gerrard, 1982; Gordon & Snyder, 1989; Kinsey, Pomeroy, Martin & Gebhard, 1953; Mosher & Cross, 1971).

Several experts explored the time periods identified with an increase in premarital sexual activity (Bruess & Greenberg, 1988; Reiss, 1973). Bruess and Greenberg (1988) conducted a review of longitudinal data and reported that the most marked increases in premarital sex occurred in the early 1900s. The data from this review indicated that approximately 35% to 45% of women engaged in premarital sexual intercourse from 1900 to 1965. These authors concluded that if a sexual revolution did occur, it began in the early part of the century as opposed to being a more recent development (Bruess & Greenberg, 1988).

Reiss (1973) conducted a study on the incidence of premarital sexual intercourse across a number of life stages. He identified life stages as pre-adolesence,

young adult, adult, middle-age, and older, while designating "premarital" sex as any partnered sexual experiences before the first and between subsequent marriages. The subjects in this study responded to questionnaires identifying their premarital sexual experiences at all stages of life. Reiss found that the highest number of increases in premarital sexual behaviors occurred in the earliest 1900s and later in the 1960s. As a result, Reiss formulated the following observations:

> (a) the basic shift in the partners of men in the twentieth century is away from small select groups and toward women irrespective of their social status, (b) premarital sexual ethics during the past century has been from an orthodox double standard to a modified version of the double standard that allows women to have premarital coitus, although not quite as freely as men, (c) women are more oriented to affectionate sexual behavior and men more to body centered sexual behavior, (d) it is recognized that there is a choice to be made and the appropriate decision is not necessarily assumed to be abstinence, and (e) whether or not to participate in premarital sex is no longer a choice made secretively or with a great sense of guilt. (Reiss, 1973)

Although the results of numerous studies indicated an increase in premarital sexual intercourse (Bruess & Greenberg, 1988; Cochran & Beeghley, 1991; Darling, Kallen, & VanDusen, 1984; Jensen, Newell, & Holman, 1990; Katchadourian, 1985; Kantner & Zelnick, 1972; Kinsey, et al., 1953; Mosher & Cross, 1971; Tavris & Sadd, 1977; Vener & Stewart, 1974; Wilson & Medora, 1990), there was not always agreement among researchers concerning the rates of this increase. For instance, Kinsey and his colleagues (1953) reported that 18% of the women in their study had experienced premarital intercourse by the age of nineteen. Vener and Stewart (1974) conducted a study with a high school population in the same community in 1970 and again in 1973. The 50-item questionnaire administered to subjects was identical for both years. These authors found that in 1970 13% and in 1973 24% of the 15 year old girls reported they had engaged in sexual intercourse.

Darling, along with his research partners (1984), analyzed the results of 35 studies conducted between 1903 and 1980. These studies investigated the sexual behaviors of adolescents and young adults who had never been married. The authors identified two major trends: (a) a major increase in the number of adolescents and young adults reporting premarital sexual experiences and (b) a more rapid increase in the premarital sexual experiences

of females than that of males. Prior to 1970, approximately twice as many college men as women reported having premarital sex. Since 1970, the proportion of college men and women reporting premarital sexual experiences are about equal (Darling et al., 1984).

Tavris and Sadd (1977) published the results of a survey conducted by Redbook magazine. More than 100,000 women responded to a questionnaire concerning a wide range of sexual experiences. These researchers found that 96% of the women under age 20 reported having engaged in premarital sex, and 91% of the women between the ages of 20 and 24 reported having premarital sex. They also reported that 89% of the nonreligious married women had engaged in premarital sex, compared to 61% of the strongly religious married women (Tavris & Sadd, 1977).

Several authors studied the relationship between religion and premarital sexual behaviors (Byer et al., 1988; Daugherty & Burger, 1984; Jensen et al., 1990; Kinsey et al., 1953; Mahoney, 1980; McCormick, Izzo, & Foleik, 1985; Mosher & Cross, 1971; Sack, Keller, & Hinkle, 1984; Tavris & Sadd, 1977; Woodroof, 1985; Wyatt & Dunn, 1991; Young, 1981). Young (1981) conducted a study to determine the relationship between religiosity and the sexual experiences of women. Subjects were eighty-two college women from a private southern university who

responded to the Faulkner and DeJong Religiosity in five Dimensional Scale. Young found that the five religiosity items on this scale divided the subjects into three groups: (a) had not participated in premarital intercourse in the last year, (b) had participated in premarital intercourse with one partner in the last year, and (c) had participated in premarital intercourse with more than one partner within the last year. They concluded that an inverse relationship exists between premarital sexual behaviors and the degree to which a subject is religious (Young, 1981).

Jensen and his associates (1990) conducted a study to test the relationship between the frequencies of premarital sex and church attendance. Subjects for this study, 423 single college students between the ages of 17 and 25, responded to a 170-item questionnaire. These authors found that the subjects in their study who reported attending church once or twice a month had higher rates of premarital sexual activity than those subjects who attended weekly. Cochran and Beeghley (1991) replicated the findings of this study while Kinsey and his colleagues (1953), Mahoney (1980), Mosher and Cross (1971), Tavris and Sadd (1977), and Woodroof (1985) previously found similar results. Kinsey and his colleagues (1953) reported that, although less religious

women had higher incidences of premarital sexual experiences, they also experienced less sex-guilt.

Several authors who studied the relationship between religiosity and premarital sex found religiosity to be unrelated to premarital sexual behaviors (Daugherty & Burger, 1984; McCormick et al., 1985; Sack et al., 1984). McCormick and his fellow researchers (1985) studied this relationship. The subjects in this study were 284 single college students who responded to a 120-item questionnaire concerning sexual behaviors and attitudes. The only measure of religiosity on this questionnaire was the denominational preference of the subjects' families. These authors found no relationship between religiosity and premarital sexual behaviors. They concluded that there is a relationship between sex-guilt and premarital sex and identified this relationship as a focus for future research (McCormick et al., 1985).

Daugherty and Burger (1984) conducted a study to determine if a relationship exists between religiosity and premarital sex. They administered a questionnaire that measured sexual behaviors, attitudes, and level of church related activities to 213 college students. They found that the level of involvement in church activities was unrelated to sexual behaviors and attitudes. Sack and his research partners (1984) replicated these findings when

they conducted a study on this relationship. Although these experts found no relationship between religiosity and premarital sex, they did detect indications of a relationship between sex-guilt and premarital sex which they believe needs to be empirically researched.

Unplanned pregnancies, a possible consequence of premarital sex, are positively correlated with sex-guilt. Gerrard (1977) administered the Mosher True-False Sex Guilt Inventory to 92 college women: 45 were single and pregnant, 47 were single, sexually active, and non-pregnant. She found that high sex-guilt was related to unplanned pregnancies in this unmarried college population (Gerrard, 1977).

In a later study, Gerrard (1982) examined the relationship between the variables of sex-guilt, premarital sexual activity, and contraceptive use. She administered the Mosher True-False Sex Guilt Inventory and questionnaires to 109 and 111 college women in 1973 and 1978 respectively and compared the results from these two samples. She found that an increase in premarital sexual activity and a decrease in effective contraceptive use occurred between 1973 and 1978. Gerrard concluded that "the level of sex-guilt sufficient to inhibit premarital sexual activity in 1973 was no longer sufficient in 1978" (p. 158).

Contraception

The development and availability of contraceptive methods and devises are well documented in the literature (Bruess & Greenberg, 1988; Burger & Inderbitzen, 1985; Darling et al., 1992; Gerrard, 1977, 1982; Gunderson & McCary, 1979; Katchadourian, 1985; Mosher & Vonderheide, 1985; Schwartz, 1973; Strassberg & Mahoney, 1988; Tavris & Sadd, 1977), yet the pregnancy rate for unmarried adolescents and young adults has exceeded one million per year (Bruess & Greenberg, 1988; Katchadourian, 1985). Bruess and Greenberg (1988) reported that the majority of women do not employ any form of contraception with their first sexual intercourse experience. They also stated that the average delay between first intercourse and first use of contraception is eight months, with many women using contraception after a pregnancy occurs.

Katchadourian (1985) stated that a variety of factors influence the ineffective use of contraception or the abstinence from contraception. These factors include: (a) the lack of accessible and accurate contraceptive knowledge and use; (b) the psychosocial factors concerning contraceptive knowledge and use; and (c) the relationship between sex-guilt, contraceptive knowledge and use.

Schwartz (1973) attempted to identify variables that influence the acquisition of contraceptive knowledge and

effective contraceptive use. He formulated and tested the hypothesis that contraceptive behaviors have a positive correlation with the anxiety generated by sex-guilt. In this study, the subjects were a group of college women who responded to a questionnaire that divided them into two groups: those with high sex-guilt and those with low sex-guilt. All the subjects in this study listened to the same lecture on contraceptives and then took an examination based on the information presented. This researcher found that those in the high sex-guilt group retained less information from the lecture, while those in the low sex-guilt group retained more information.

Mosher and Vonderheide (1985) studied the relationship between sex-guilt and masturbation guilt as influences on contraceptive attitudes and use. They identified sex-guilt as occurring within the general context of sexuality because it is related to diverse sexual experiences and masturbation guilt as occurring within a limited context of sexuality because it is erotic self-stimulation. The subjects in this study were 186 college women who responded to a variety of inventories and questionnaires. The respondents divided into four groups: (a) non-contraceptors, those who abstain from any contraceptive behaviors; (b) high risk coitus-dependent contraceptors, those who used foam, suppositories, and

condoms; (c) low risk coitus-dependent contraceptors, those who used the diaphragm; and (d) coitus-independent, those who used the pill or IUD. These researchers found that sex-guilt had a significant inverse correlation to the measures of contraceptive attitudes and use. The highest level of sex-guilt was associated with the non-contraceptors group and the lowest level of sex-guilt was associated with the coitus-independent group. When they removed the sex-guilt variable, they found that the coitus-dependent group who use the diaphragm scored lower on masturbation guilt than the three remaining groups. These authors concluded that masturbation guilt appeared to account specifically for reluctance to use the diaphragm for contraception. They reasoned that masturbation guilt would inhibit the use of the diaphragm as a contraceptive choice because it involves the handling of the genitals for insertion (Mosher & Vonderheide, 1985).

Masturbation

Masturbation has perhaps been the least talked about, most frequently condemned, and universally practiced sexual activity that exists (Byer et al., 1988; Davidson & Darling, 1988; Gagnon, 1985; Gordon & Snyder, 1989; Kassorla, 1980; Kinsey et al., 1953; Patton, 1985; Tavris & Sadd, 1977; Wilson & Medora, 1990). The word

masturbation has its origins in Latin and literally translated means to defile by hand. Within that context alone is the connotation of corruption and wickedness (Byer et al., 1988; Gordon & Snyder, 1989; Katchadourian, 1985; Patton, 1985).

Historically, Judaism and Christianity condemned masturbation as the "secret sin" (Patton, 1985, p. 133). Most communities accepted the belief that masturbation was the annihilation of life, that ejaculate was viable human life rather than the potential for human life. The roots of this Judeo-Christian heritage established the foundation for the proscription of masturbation in Western religions (Gordon & Snyder, 1989; Patton, 1985).

The Bible was, and in many instances remains, the identified source that justifies the proscription of masturbation (Patton, 1985). The reference most often cited in the Bible is in Genesis 38:7-10, which concerns Onan who ejaculated on the ground and was punished with death. As recently as the Salem witch hunts of the 1700s, many persons accused of masturbation were put to death (Katchadourian, 1985; Patton, 1985).

The traditions concerning masturbation existed for nearly two millenia (Patton, 1985). These proscriptive traditions had been so deeply ingrained that the medical profession, as well as most religious denominations,

subscribed to the pathology of masturbation (Byer et al., 1988; Gagnon, 1985; Gordon & Snyder, 1989; Katchadourian, 1985; Kinsey et al., 1953; Patton, 1985; Tavris & Sadd, 1977). Medical professionals and religious leaders believed that masturbation caused diseases and ailments such as: epilepsy, demonic possession, headaches, red nose, breast tenderness, any form of trouble with reproductive organs, painful menstruation, acne, odor of women's skin, insanity, mania, depression, and neurosis, to name a few. The theory of masturbation, as a pathological phenomenon, lacked scientific support.

In the mid 1930s through the 1940s, a few professionals in the scientific community began to seriously, yet cautiously, challenge the pathology of masturbation theory (Gordon & Snyder, 1989; Katchadourian, 1985; Patton, 1985). As a result, today most professionals in the medical, psychiatric, social, and educational communities believe masturbation is a normal component of psychosexual development (Katchadourian, 1985), and some professionals use masturbation as a therapeutic intervention (Hartman & Fithian, 1977; Kassorla, 1980). Social acceptance of this change in attitudes and beliefs about masturbation did not occur until the 1970s. In spite of these changes, numerous religious denominations continue to maintain their

proscriptive position concerning masturbation (Katchadourian, 1985).

The data is limited regarding the prevalence of masturbation (Bruess & Greenberg, 1988; Davidson & Darling, 1988; Gagnon, 1985; Hunt, 1975; Kinsey et al., 1953). It appears that most experts rely on the data collected by Kinsey and his associates (1949, 1953) for information on the prevalence of masturbatory behaviors.

Kinsey and his associates (1953) reported that 62% of the women in their study had masturbated at some time in their lives, and 58% of the women reported experiencing orgasm as a result. Hunt (1975) reported similar results. He found that 63% of women, compared to 94% of men, engaged in masturbation. Davidson & Darling (1988), in their review of the literature, reported that the range for masturbatory behaviors is from 46% to 81% for women.

The guilt a woman experiences as a result of masturbation can have many sources. For instance, several Western religions continue to condemn this activity and often refer to it as impure touch, rendering it as a potential source of guilt (Byer et al., 1988). Kinsey and his associates (1953) reported that those who were religiously devout masturbated less than those who were religiously inactive. They also found that 44% of those who reported they had never masturbated also reported they

did not because they felt it was morally wrong. Hunt (1975) found that the more religious people are the less likely they are to masturbate and that if they do, it begins at a later age. He also indicated that the effect of religion on this sexual activity is more profound for women than for men.

Katchadourian (1985) studied the relationship between masturbation and guilt. The subjects in this study were college women who responded to questionnaires concerning masturbatory behaviors, attitudes, and feelings. He found that sexually active women in this sample were more likely to masturbate than their nonsexually active peers. This author reported that 10% of those who engaged in masturbation identified feelings of guilt, and 25% identified feelings of depression (Katchadourian, 1985). Greenberg (1973) found that more than 50% of the women in his sample reported feelings of guilt following masturbation.

Many experts take the position that masturbation guilt has the propensity to interfere with physiological and psychological fulfillment (Bruess & Greenberg, 1988; Byer et al., 1988; Davidson & Darling, 1988; Gordon & Snyder, 1989; Greenberg, 1973; Hartman & Fithian, 1977; Kassorla, 1980; Katchadourian, 1985; Kinsey et al., 1953; Tavris & Sadd, 1977). It is likely that as this guilt

concerning masturbation occurs, it can restrict a woman's healthy sexual response, inhibiting future experiences (Hartman & Fithian, 1972; Kinsey et al., 1953). Numerous experts have stated that for preorgasmic and/or anorgasmic women, masturbation is most often their first choice for intervention (Hartman & Fithian, 1972; Kassorla, 1980; Kinsey et al., 1953).

Davidson and Darling (1988) investigated the effects, if any, on college level sex education and the impact on women's masturbatory attitudes and behaviors. In the pretest phase of this study, both the experimental and comparison groups responded to questionnaires concerning their masturbatory attitudes and behaviors. In the two-year follow-up phase, all remaining subjects responded to the same questionnaire. Members of the experimental group took a course on human sexuality. These authors found that those who participated in the human sexuality course were, at the two-year follow-up, more likely to perceive masturbation as an acceptable healthy behavior and more likely to initiate this activity. Davidson and Darling (1988) concluded that a college education tends to, over time, have a liberating effect on masturbatory attitudes and behaviors of women.

Many experts agree that education can positively influence healthier attitudes and behaviors concerning

sexuality (Bruess & Greenberg, 1988; Byer et al., 1988; Gagnon, 1985; Gordon & Snyder, 1989; Katchadourian, 1985). Gagnon (1985) conducted a study of 1,482 parents concerning their attitudes toward masturbatory behaviors and their preadolescent children. He found that parents with more liberal attitudes about sexuality and higher levels of education demonstrated a more accepting attitude concerning their children's masturbatory behaviors. He also found that parents who were more religious were less likely to demonstrate acceptance concerning their children's masturbatory behaviors. Less than half the parents in this study wanted their children, as adolescents, to have a positive attitude toward masturbation (Gagnon, 1985).

The knowledge and acceptance of masturbation has an intense impact on psychosexual development (Katchadourian, 1985). Many experts, within the last two decades, have taken the position that masturbation is a healthy, normal, and even beneficial sexual activity, yet not a necessary activity for sexual health (Bruess & Greenberg, 1988; Byer et al., 1988; Gagnon, 1985; Gordon & Snyder, 1989; Hartman & Fithian, 1972; Katchadourian, 1985). Some experts stated that the only identified mental health risks concerning masturbation are: (a) the development of masturbation as a compulsive/obsessive pathology and/or

(b) the development of masturbation as an exclusive sexual behavior (Bruess & Greenberg, 1988; Byer et al., 1988, Gordon & Snyder, 1989; Katchadourian, 1985; Tavris & Sadd, 1977).

Concerns for the Mental Health Professional

Sexuality is a fundamental dimension of human awareness, an expression of the total personality (Fyfe, 1980). The mental health counselor, in order to create effective and appropriate interventions, must be proficient in the area of human sexuality (Gray & House, 1991). Several researchers reported that religion influences sexuality in various ways (Bullis & Harrigan, 1992; Kinsey et al., 1953). Religious attitudes and beliefs regarding sexuality are critical considerations for the mental health professional (Bullis & Harrigan, 1992).

According to Bullis and Harrigan (1992), understanding clients' religious values in the counseling environment is essential to the counseling process. These authors stated that it is important for the clinician to gain a general understanding about religious denominations and the commonalities among them. When the therapist understands these religious influences from the clients' perspective, then the therapist gains a more profound understanding of the relationship between the clients'

religious values and their sexuality issues (Bergin, 1980; Bullis & Harrigan, 1992). These issues of religion and sexuality are crucial components of therapeutic assessment and intervention (Bruess & Greenberg, 1988; Gordon & Snyder, 1989; Katchadourian; 1985; Reed & Munson, 1976;).

Sex Education

Many times, within the counseling process, the mental health professional takes on the role of sex educator (Young, 1981). In this position of influence, the professional has a particularly important responsibility (Gordon, 1976). Reed and Munson (1976) stated that the counselor/educator must gain a positive self-resolution toward her or his own sexuality in order to effectively assist others in this highly sensitive area of humanity. This process of self-resolution must include: the acceptance of one's sexuality as a gift of life, the acceptance of life styles that are different from one's own, and the acceptance and expression of sexuality in a sharing, enhancing, and nonexploitive manner. These authors identified several categories designed to foster and achieve healthy "sexual concept, growth, and self-resolution: knowledgeability; trustability; acceptability; possibility; moveability; changeability; and, authenticity" (Reed & Munson, 1976, p. 33).

According to Gray and House (1991), clients in the 1990s must learn to make responsible sexual decisions, change familiar sexual patterns that are self-destructive, and learn new and safer sexual behaviors. In order to actively assist clients with these changes, the authors developed a five stage model for the mental health counselor/sex educator:

> (a) counselor comfort with sexuality, the most critical aspect of sexual intervention where counselors must first examine their own limitations surrounding sexual comfort; (b) sexuality assessment tools, the most important aspects being a family/self sexual history and current sexual status; (c) societal values about sexuality, the context must include religious and other cultural perspectives; (d) treatment approaches to clients' sexual issues, the most necessary components are sexual knowledge, values and decision making, and behavioral change; (e) incorporation of safer-sex guidelines into counseling, the most critical factor is that the counselor be as explicit and specific as possible when identifying risky and safer sexual behaviors. (pp. 293-301)

A critical component of this model is the counselor's awareness, understanding, and acceptance of her or his

limitations, comfort, and attitudes concerning sexuality. This model is conducive to the development of effective work concerning sexual issues when working with couples, individuals, families, or groups (Gray & House, 1991).

Couples and Individuals

Hartman and Fithian (1972) reported that, in their work with couples and individuals, a sex history can be extremely beneficial to the counseling process. These authors employ an extensive assessment form when taking a sex history. They stated that their form cycles through emotionless material, to emotion filled material, to neutral material several times. Within this cycle, clients' become more comfortable and freer in discussing all aspects of their sexual experiences. These authors concluded that gathering a sexual history can be a time of learning for the client and counselor, and that this process will assist the counselor in determining interventions, educational needs, and referral possibilities.

According to Davidson and Darling (1988), sex education is the key component in reducing sex-guilt. McCarthy (1987) identified a sex-guilt cycle characterized by the acceptance and belief of sexual myths, misconceptions, and assumptions. These characteristics can elicit feelings of sex-guilt that reduces sexual

self-esteem. With reduced levels of sexual self-esteem, an individual is more likely to repeat self-defeating sexual behaviors. When these behaviors are repeated, levels of sex-guilt increase and the cycle persists. McCarthy (1987) found that a cognitive-behavioral model, as an intervention for clients who present a sex-guilt cycle, works well with couples and individuals.

Families

Couples and individuals are subsystems of the larger family system, and to a large extent it is the family that makes the determination concerning sex education and counseling (Chilman, 1990). Sexuality is a normal part of the family process. Maddock (1989) defined healthy family sexuality as "the balanced expression of sexuality in the structures and functions of the family, in ways that enhance the personal identities and sexual health of the individual members and the coherence of the family as a system" (p. 135).

Frequently, when sexual education occurs within a family it is the result of the woman's efforts (Gagnon, 1985). Gagnon (1985) found in his study of 1,482 parents that 20% of the mothers discussed masturbation with their sons, compared to 14% of the fathers. He identified this in terms of "domestic sexual knowledge" and concluded that mothers are more responsible than fathers for informing

their children about sex. When working with families, the mental health professional must be prepared to address sexuality issues within a family system (Maddock, 1989). A focus on sexual development, appropriate developmental behaviors, and the dissemination of accurate information are interventions that can assist the family system with the development of healthy family sexuality (Fyfe, 1980; Maddock, 1989; McCarthy, 1987).

Groups

Being an involved member of a group can have a decisive impact on individual sexual behaviors and choices (Woodroof, 1985). Woodroof (1985) found in his study that group characteristics are important factors in shaping an individual's sexual attitudes and behaviors. He concluded that the mental health professional can be more effective in the group process, as opposed to individual therapy, when working with sexuality issues.

Daugherty and Burger (1984) conducted a study to investigate the influences on college students' sexual behaviors. They found that parents are more reluctant to discuss sexuality concerns with daughters than they are with sons, and that parents do not influence sexual attitudes and behaviors as profoundly as a peer group. This is especially true for adolescent women and young adult women. These authors concluded that basic

information about sexuality, contraception, and health related issues might best be approached by working with groups. Exploring and identifying values, attitudes, and feelings about sexuality in the peer group can maximize the effectiveness of the mental health professional, especially when working with women (Daugherty & Burger, 1984).

Sexuality is a fundamental component of being human (Byer et al., 1988; Chilman, 1990; Fyfe, 1980; Gagnon, 1985; Maddock, 1989), and the sexual needs and concerns of clients are increasingly being presented in a variety of counseling environments (Bruess & Greenberg, 1988; Gordon, 1976). Professional mental health services that promote healthy sexuality enhance the sexual functioning of couples, individuals, families, and groups. It is imperative that professional training include a comprehensive component that will prepare the mental health professional to be effective when presented with issues of sexuality (Bullis & Harrigan, 1992; Chilman, 1990; Fyfe, 1980; Gray & House, 1991).

Conclusion

The literature is filled with studies on the subjects of religion and sex-guilt (Wyatt & Dunn, 1991). However, there are two major reasons for caution in applying the results of the studies in this review to the general

population. First, the majority of studies concerning sex-guilt and religion include results from college populations. These populations are generally Anglo, protestant, and under 25 years of age. This fact alone limits the applicability of these research findings to the general population (Knox et al., 1991). The second limitation is the volunteer bias that occurs in all areas of human psychological research (Morokoff, 1986). Morokoff (1986) compared volunteers to nonvolunteers in a college sample to identify significant differences between these two groups. She found that volunteers have greater noncoital sexual experience, greater masturbatory experience, less sexual inhibition, and more experience with unusual sex. She concluded that volunteers are not an accurate representation of the general population. The researcher must consider the limitations of research findings when applying results to the general population.

The influence of religion on people's behaviors, attitudes, thoughts, and feelings concerning their sexuality is supported by this review of the literature (Byer et al., 1988; Cochran & Beeghley, 1991; Ellis, 1971, 1980; Gordon & Snyder, 1989; Gunderson & McCary, 1979; Katchadourian, 1985; Kassorla, 1980; Tomm, 1990; Woodroof, 1985). Katchadourian (1985) stated that

although the official Christian position on human sexuality appears to be moving away from the sex-negative position, the influence of this position is likely to persist for some time to come. Kinsey, and his research partners (1953), stated that the pressures and taboos extolled by religious communities regarding sexuality impact women more intensely than men.

Ellis (1971) hypothesized that religion in the extreme has a significant correlation with emotional disturbance and other forms of psychopathology. Bergin (1983), Masters and his associates (1991), Richards (1991), and Richards along with his research partners (1989) tested Ellis' hypothesis and found no support for Ellis' contention. Although the literature does not support the pathology of religion, it does support the influence religion has on one's sexuality, which is especially true for women. It appears that this influence on women is particularly evident in relationship to experiences of sex-guilt.

A trend identified in this review of the literature is the relationship that seems to exist between religion and women's sex-guilt (Darling et al., 1992; Gunderson & McCary, 1979; Knox et al., 1991; Mosher, 1979; Mosher & Vonderheide, 1985; Ogren, 1974; Strassberg & Mahoney, 1988; Wyatt & Dunn, 1991). Whether or not sex-guilt is a

positive influence on sexual decisions and behaviors for women appears to be dependent on whether the sex-guilt is rational or irrational.

The literature supports the relationship of religion and sex-guilt to premarital sex, contraception, and masturbation. Another trend identified in this review is that women who experience increased levels of sex-guilt tend to be: more religious, less likely to engage in premarital sex, less likely to use contraception if they engage in premarital sex, and less likely to masturbate (Byer et al., 1988; Daugherty & Burger, 1984; Davidson & Darling, 1988; Gerrard, 1977; Greenberg, 1973; Hartman & Fithian, 1977; Hunt, 1975; Jensen et al., 1990; Kassorla, 1980; Katchadourian, 1985; Kinsey et al., 1953; Mahoney, 1980; McCormick et al., 1985; Mosher & Cross, 1971; Mosher & Vonderheide, 1985; Sack et al., 1984; Schwartz, 1973; Tavris & Sadd, 1977; Wyatt & Dunn, 1991; Young, 1981). Religion and sex-guilt appear to be strong influences on women's sexuality. The strength of that influence was not examined in this review.

Mental health counselors are addressing issues of sexuality at continually increasing rates (Bruess & Greenberg, 1988; Gordon, 1976). The most crucial concerns for counselors regarding issues of sexuality are: understanding and accepting their personal limitations

regarding sexuality; exploring their personal attitudes and comfort about sexuality; and seeking a positive self-resolution concerning their sexuality (Gray & House, 1991; Reed & Munson, 1976).

The purpose of this review of the literature was to explore the relationship between religion and sex-guilt in order to discover the implications for women. The literature suggests that a relationship exists. This relationship appears to be one of influence, that is sex-guilt can develop from the sexual proscription of religious tenets pertaining to such issues as premarital sex, contraception, and masturbation. This relationship can have a profound influence on women's sexuality. For some, this can be positive, and for others, it can be negative.

However, there is hope for women who perceive and/or experience the negative impact of this relationship. As previously stated, religious tenets appear to be moving away, no matter how slowly, from the sexually proscriptive position. This move has the potential for women to experience their sexuality more fully and with less guilt. Katchadourian (1985) crystalized this idea in his statement: "there is hope, providing we are truly in the process of liberating women's sexuality."

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