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The Effects of Sex Guilt and Communication on Condom Use

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The Effects of Sex Guilt and

Communication on Condom Use

(TITLE)

BY

Renee M. Souva

1973

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
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IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
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Abstract

The purpose of this study was to determine whether sex guilt and communication were related to condom use. Past research has examined variables that affect condom use and has found that individuals who communicate more about sexual matters, and individuals who have low sex guilt, have been found to use condoms/contraceptives more consistently. This study examined sex guilt and communication and how they predict condom use. The participants were 80 female undergraduates recruited from psychology classes at Eastern Illinois University. Mosher's revised Sex Guilt Inventory and Catania's Health Protective Communication Scale were administered along with a question that assessed condom use. An interview was conducted to find explanation for the results. Bivariate correlational analyses revealed no relationships between sex guilt, communication, and condom use. A step-wise multiple regression revealed that sex guilt and communication did not predict condom use. Twelve females who completed the questionnaire volunteered to participate in the interview session. Of the twelve interviewees, seven did not use condoms because they used another type of birth control (none of which protected against HIV), nine were in a serious, long-term relationship, and only three used

condoms as disease prevention. The interviews suggest that it might be useful to look at the length of the relationship between partners and how it is related to sex guilt, communication and condom use. Condom use is a complicated behavior and reasonable assumptions do not seem to explain this complex interpersonal behavior. Further research should be directed towards sorting these variables out so that condom promotion programs can increase the use of condoms and decrease the number of new HIV and STD cases.

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Twenty to twenty-nine year olds make up 21% of all Acquired Immune Deficiency Syndrome (AIDS) cases (CDC, 1988). Gayle et al. (1990) found that one in every 500 blood samples collected from college infirmaries tests positive for human immunodeficiency virus (HIV, the virus that leads to AIDS). College students as a group are more at risk for HIV because they are more likely to experiment with alcohol, which has been linked to risky behaviors such as unprotected sex, and to experiment sexually (Lear, 1995).

In order to protect oneself against the threat of AIDS, a person must engage in certain behaviors (Poppen, 1994). One recommended behavior is to use condoms during any type of sexual act: oral, vaginal, or anal. Not engaging in intravenous (IV) drug use is another way to reduce the likelihood of getting the AIDS virus. Open discussion between sexual partners is also recommended. Partners should discuss their sexual history, such as the number of past sexual partners, risky behaviors (i.e. IV drug use or unprotected anal sex), and if they have been tested for HIV in the last six months.

The best prevention for sexually active people is to use condoms consistently and to limit the number of sexual partners (Poppen, 1994). However, college students, in general, have not been found to be

consistent users of condoms (DiClemente, 1991) and have also been reported to have multiple partners (Lear, 1995).

Seal and Palmer-Seal (1996) found that less than one third of the college students they questioned reported consistent condom use. In another study, only nine percent of unmarried male respondents between the ages of 20 and 44 always used condoms while those with multiple sexual partners and those in monogamous relationships used them six percent and twelve percent, respectively (Catania et al., 1992). Interestingly, only six percent of college age condom users in a study by Freimuth et al. (1992) reported that disease prevention was their sole reason for the behavior, while 20% used it for birth control. Another 71% of condom users indicated that they used a condom for both birth control and disease prevention. Given the lack of condom use among college students and the potential consequences for non-use, it is important to study this age group. To address this issue, we need to discern the social and psychological determinants of condom use for college students.

Anxiety and fear of HIV, attitudes about risks other than HIV, and how safe one intends to be have not been found to be significantly related to consistent condom use in adolescents (Brown et al.,

1992). Freimuth et al. (1992) listed several factors that have been found to be related to infrequent condom use in college students. These variables include negative attitudes toward condoms, lack of personalization of risk, inhibition due to alcohol and drug use, lack of personal efficacy, low self-esteem, sexual phobias and reliance on other forms of birth control.

In most studies involving condom use in college students, researchers have found that students do have sufficient knowledge about contraceptives, AIDS, and HIV risk factors. Moreover, increased knowledge does not predict increased condom use (Basen-Engquist, 1992). DiClemente (1991) concluded that HIV knowledge, in and of itself, is not sufficient to motivate the adoption and maintenance of HIV preventive behaviors. By the time most people reach the college level, information about sexually transmitted diseases (STDs), HIV specifically, has been obtained. However, Oswalt and Matsen (1993) found that only 20% of college students always used a condom, and 44% used condoms less than 50% of the time. Therefore, college students have the knowledge of how to protect themselves but do not engage in the preventive behavior. When inquiring further about college students' reasons for not using a condom in the Oswalt and Matsen (1993)

study, the most common answers given were that they felt secure about their partners' sexual history, or they used some other type of birth control. Less frequently given reasons were that the sexual encounter was not planned or condoms were unavailable at the time.

Another variable that may be related to condom use is sex guilt. Contraceptive use, in general, has been found to be inversely related to sex guilt (Gerrard et al., 1993). Sex guilt is the generalized expectance of self-monitored punishment for violating, or anticipating violating, standards of proper sexual conduct (Mosher, 1966). High sex guilt is also related to less sexual activity (Gerrard & Gibbons, 1982). Ninety-six percent of low sex guilt participants had intercourse compared to 79% of high sex guilt participants in a study of college students by Berger et al. (1985). However, when high sex guilt individuals do engage in sexual activity, they use contraceptives inconsistently (Gerrard et al., 1993). In the study by Berger et al. (1985), one out of five high sex guilt individuals failed to employ birth control. It seems reasonable to assume that individuals with high sex guilt are more likely than individuals with low sex guilt to have sex spontaneously in casual relationships as compared

to intimate relationships because they do not plan on engaging in sex. If sex was planned, their sex guilt might lead them to not engage in sexual activity.

A variable that may be related to sex guilt and condom use is communication. Edgar et al. (1992) reported that many women may not feel comfortable enough with their own sexuality to communicate openly about giving and receiving physical pleasure. DiClemente (1991) and Catania et al. (1992) report that communication is a powerful predictor of condom use. Condom use is an interactive process, especially for females, because the sexual partners should agree and cooperate in using them (Freimuth et al., 1992). Discussion about contraception and intercourse is necessary because effective contraception requires planning prior to intercourse (Burger & Inderbitzen, 1985). Talking about sex in general, safer sex in particular, has been found to predict condom use in males (Catania et al., 1992), and Burger and Inderbitzen (1985) found the same results with females. Catania et al. (1989) found that willingness to request a condom was a powerful predictor of condom use in adolescent women. Weisman et al. (1989) reported that when adolescent females asked any of their previous partners at least once to wear a condom,

they had higher levels of use.

Lowe and Radius (1987) and Poppen (1994) found that adolescents who were more skillful interpersonally used effective contraception. It may be that some college students lack the necessary communication skills to use condoms (Brafford & Beck, 1991). Freimuth's et al. (1992) results indicated that among college students who did not use a condom during a recent first-time sexual encounter, none had discussed condom use prior to intercourse.

A study by Edgar et al. (1992) examined ways in which potential sexual partners seek information about one another and persuade their partners to use condoms. It was found that few respondents tried to assess the HIV risk of their partner. But when participants did attempt to use a condom, they were not met with resistance. Also, female non-users of condoms were less likely to communicate their wishes because they were embarrassed or uncomfortable, feared that it may ruin the moment, or another type of contraceptive was used. Therefore, it was concluded that college students have not personalized the AIDS risk.

In addition to communication, several researchers have looked at stage models to understand the adoption of safer sex practices. These models include the

AIDS Risk Reduction Model (Catania, Coates, & Kegeles, 1994), Byrne's five-step model (Burger & Inderbitzen, 1985), and Freimuth's three-step model (Freimuth et al., 1992). These models are similar in that they explain the process of condom use and include a communication stage. The communication stage received the most research support which indicates that this stage is critical in all of the models. Also, high levels of condom use were related to high levels of communication in all three of the models.

Despite the fact that it seems obvious that sex guilt and communication are related, there has been no evidence that this relationship exists. From the previously mentioned study by Edgar et al. (1992) which examined the concept of communication, the participants indicated that when they felt uncomfortable or embarrassed, they were less likely to communicate with their partners. This discomfort and embarrassment seems to be related to the concept of sex guilt. Are college students with high sex guilt less likely to communicate about sex in general and condom use in particular?

Gender has also been found to be important when examining condom use. Men usually use a condom without consulting with their partner or put the responsibility on the female by asking her preference (Edgar et al.,

1992). In addition, females' contraceptive preferences and sexual attitudes have been found to be more influential than males (Gerrard et al., 1990). Therefore, it is especially important to examine females' condom use.

As stated before, researchers have not looked at the concept of health protective communication and sex guilt together as they effect condom use in females. In order to explore this relationship, several hypotheses will be tested:

1. There will be a replication of the direct relationship between communication and condom use.
2. Sex guilt will be inversely related to communication.
3. An inverse relationship will be found between sex guilt and condom use.
4. A multiple regression will find that condom use will be predicted by sex guilt and communication with communication being the major predictor of condom use.

An interview will also be done in order to further explain the results that will be obtained. It will get at the reasoning behind the use or non-use of

condoms and why the participants choose to communicate or not to communicate.

Method

Participants

Eighty college age females in psychology classes were recruited. Ages ranged from eighteen to forty-two with a median age of 19.96. Number of sex partners ranged from one to eleven with a median of 1.30. They received class credit for completing the questionnaires. Only heterosexual respondents who reported having at least one partner in the last 12 months were included. Heterosexual was defined as having only sexual partners of the opposite sex for the past two years.

Materials

In order to preserve the extended interview, a tape recorder was utilized.

Experimental measures that were used include the Mosher's (1988) Revised Sex Guilt Inventory (MSGI), Catania et al.'s (1994) Health Protective Sexual Communication Scale (HPSC), and self-reports of the number of condom used with their last sexual partner.

The MSGI (Mosher, 1988) is fifty items arranged in pairs of responses to sentence completion stems such as:

"Dirty" jokes in mixed company...

1. do not bother me.
2. are something that make me very uncomfortable.

Masturbation...

3. is wrong and will ruin you.
4. helps one feel eased and relaxed.

The responses for each item are rated on a 7-point Likert scale ranging from zero, which means not at all true for the respondent, to six, which means extremely true of the respondent. The items are arranged in pairs of two to permit a limited comparison since people frequently agree with only one item in a pair. A single sex guilt score is obtained by adding the responses of the guilty items and reverse scoring nonguilty alternatives. Scores can range from 0 to 300. Higher scores indicate more scripted guilt.

This scale has been used in recent research, including Walker, Rowe, and Quinsey's (1993) study of authoritarianism and sexual aggression. The original and revised scales still have the same items, but the original has a forced-choice format while the revised version has a Likert scale format. Therefore, the original version's reliability and validity data can be generalized to the revised

version. In past research, the original inventory's corrected split-half reliability was very good (Cronbach's alpha = .97). Mosher (1979) has reviewed 100 studies supporting the construct validity of the measure of guilt. It continues to be a valid measure of guilt as a personality disposition (Mosher, 1988).

The HPSC (Catania et al., 1994) is a revised ten-item Likert rating scale. For example:

How often in the past 12 months have you...

1. Asked a new partner how he felt about using condoms before you had intercourse.
2. Asked a new partner/sex partner about the number of past sex partners he had.

This self-report scale assesses people's perceptions of verbal interactions with a new (first time) sexual partner concerning safe sex and sexual histories relevant to HIV transmission.

Each item is rated on a four point scale (4=always, 1=never). Total scores are obtained by summing across items. Its internal reliability is good (Cronbach's alpha = .67). Validity has not been studied as of yet for this scale because it is an expanded form, but the original version has good validity for predicting condom use (Catania, Coates, & Kegeles, 1994). The original version only contained

three items.

Condom use was assessed by asking each participant the following question and scoring their answer from zero to four respectively:

In the past 12 months, my partner(s) and I used a condom when we had sex...(never, rarely, occasionally, almost every time, always).

Procedure

Questionnaires were given to 80 female students who completed the consent form. Additional class credit was given, along with a certificate for a free movie rental, to twelve participants who attended an interview session at a different assigned date.

The questions were:

1. You indicated in your survey that you always/sometimes/rarely/never use condoms. Why?
2. You indicated in your survey that you do/do not communicate with your partner. Why?

It was made known to the participants prior to the interview that the sessions would be recorded anonymously, and would consist of follow-up responses concerning their responses to the questionnaires. The interview was done to support the numerical or

quantitative results. A sign up sheet was posted in the classroom so they could sign up after they turned in their completed questionnaires.

Results

Table 1 presents levels of condom use and birth control methods.

Insert Table 1 here

Sex guilt scores ranged from 15 to 237 with a mean of 87.19 (SD = 43.38). Communication scores ranged from 0 to 40 with a mean of 16.14 (SD = 8.19).

Table 2 presents the correlations between sex guilt, communication, and condom use. These variables were not correlated with each other.

Insert Table 2 here

A step-wise multiple regression revealed no significant relationship between sex guilt, communication, and condom use as shown in Table 3.

Insert Table 3 here

Twelve females who completed the questionnaire volunteered to participate in the interview session.

Discussion

The results did not support my hypotheses. I predicted that I would find a direct relationship between communication and condom use, an inverse relationship between sex guilt and communication, and an inverse relationship between sex guilt and condom use. Another unsupported hypothesis was that, of the variables, condom use would be best predicted by communication.

These findings are contrary to previous research. Several researchers have found that people who talk about sexual matters used condoms more often (Burger & Inderbitzen, 1985, Catania et al., 1989, Catania et al., 1994, Diclemente, 1991, Dolcini et al., 1995, Lowe & Radius, 1987, & Weisman et al., 1989). Perhaps my results are due to the fact that the participants used another type of birth control and/or both partners had gotten tested for sexually transmitted diseases such as AIDS or herpes. Therefore, the participants may have felt that there was no need for disease prevention because there was no risk. Interestingly, Oswalt and Matsen (1993) found that college students who did not use condoms either perceived knowledge of their partner's sexual history or used another method of contraception.

Perhaps communication was not found to be related

to condom use because of the communication scale (HPSC) used. The questions in the HPSC (Catania et al., 1994) assume that the participants have recently had several short-term sexual relationships. Moreover, someone in a long-term relationship may get a low communication score even though they talked about condoms once and decided to use condoms every time they had sex.

During the interview, several (7 out of 12) females explained that they did not use condoms because they were using another type of birth control, and most (9 out of 12) were in a serious, long-term relationship. Previous research has also found that reliance on other forms of birth control is related to infrequent condom use (Freimuth et al., 1992, & Oswalt & Matsen, 1993). Only three interviewees used condoms as disease prevention. These interviewees did, however, talk about sexual matters in the beginning of their relationship and several indicated that they felt they were open and comfortable enough with their partner to discuss sexual matters. Only one interviewee indicated that sexual matters were "not something you discuss."

These findings suggest that the interviewees perceived condoms as birth control, not as disease prevention. Safety was not an important issue.

Perhaps most of the interviewees were in long-term relationships and were not worried about disease prevention because they knew their partner's sexual history. Future research could examine long-term and short-term relationships and how they each differ in sex guilt, communication and condom use.

Other findings from research involving condom use and sex guilt also differ from my results. Low sex guilt has been found to be related to higher levels of contraceptive use (Berger et al., 1985, Gerrard et al., 1993, & Rimberg & Lewis, 1994). The present study looked at condom use, not contraceptive use. Perhaps this could explain one of the reasons why the expected results were not found. Another reason the results were not found might be that previous research used the original Mosher Sex Guilt Inventory while the revised form was used for the present study.

Interestingly, Edgar et al. (1992) indicated that if women are not comfortable with their sexuality, they will not talk about sexual matters. Despite this, a relationship between communication and sex guilt was not found in this study.

The mean sex guilt score was rather low at 87.19 and the scores ranged from 15 to 237. The Mosher Sex Guilt Inventory (Mosher, 1988) that was used is a recently revised scale, therefore little is known

about average scores. The scores have a possible range of 0 to 300 and a mean of 150. Perhaps, there were no significant results found because the range of scores was constrained. Contrasting groups or performing t-tests could be done to examine further the high and low sex guilt groups as they are related to condom use and communication.

A more psychometrically sound measure of condom use or better assessment of safe sex could result in more reliable and valid findings. The condom use measure only included one question. However, DiClemente (1991) and Basen-Engquist (1992) found significant results involving predictors of condom use in adolescents with the same measure of condom use. Catania et al. (1994) perhaps used a better measure because they computed the average proportion of vaginal or anal contacts in which condoms were used across sexual partners. Further research utilizing Catania's measure could possibly better examine the relationship between communication, sex guilt, and condom use.

Cohen and Dent (1992) found that self-reported condom use may in fact be an invalid measure. First, Cohen and Dent found that good communication had little predictive value for long-term safer sexual behavior. Second, they found that there was a strong self-report

bias because people who report more positive communication overreport their use of condoms.

In conclusion, it is not clear that there is a relationship between sex guilt, communication, and condom use. However, further research could help resolve this dispute. For instance, a better measure of condom use such as Catania et al.'s (1994) averaging the number of times condoms were used across all sexual partners could be employed. Also, the original Mosher Sex Guilt Inventory and/or a better measure of communication could be utilized.

Moreover, the interviews suggest that it might be useful to look at the length of the relationship between partners and how it is related to condom use. Most of the interviewees were in long-term relationships and felt that there was little risk for AIDS. They felt that birth control was more important than disease prevention.

Perhaps sex guilt and/or communication is related to contraceptive use but not condom use. Therefore, a replication of this research might measure contraceptive use as a whole rather than just condom use. However, contraceptive use looks at birth control rather than protection from HIV which was where this research began.

Also, further analysis of the data might be useful.

For example, analyses that contrasted individuals with extremely low and extremely high sex guilt may reveal relationships to communication and condom use.

There seems to be many variables that may be related to condom use and protecting oneself from AIDS. Researchers have looked at several variables that appeared to predict condom use, but in actuality, did not predict condom use such as knowledge of HIV/AIDS (DiClemente, 1991) and anxiety or fear of HIV/AIDS (Brown et al., 1992). Therefore, condom use is a complicated behavior and reasonable assumptions are not going to easily explain this complex interpersonal behavior. Further research should be directed towards sorting these variables out so that condom promotion programs can increase the use of condoms and decrease the number of new HIV and STD cases.

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Table 1
 Reported Use of Condoms and Birth Control (N = 80)

<u>Condom Use</u>	<u>Number</u>	<u>Percent</u>
Never	13	17.3
Rarely	10	13.3
Occasionally	15	20.0
Almost Every Time	14	18.7
Always	23	30.7
<u>Birth Control</u>		
Condom	24	34.3
Pill	34	48.6
Diaphragm	1	1.4
Rhythm Method	3	4.3
Other	8	11.4
None	0	0.0

Table 2
 Pearson Coefficients for Sex Guilt, Communication,
 and Condom Use (N = 80)

	Sex Guilt	Communication	Condom Use
Sex Guilt	1.000	.064	-.063
Communication	.064	1.000	-.137
Condom Use	-.063	-.137	1.000

Table 3
Multiple Regression Analysis with Condom Use as the
Dependent Variable and Sex Guilt and Communication as
Independent Variables (N = 80)

<u>Independent Variables</u>	<u>Beta</u>	<u>t</u>	<u>Significance</u>
Sex Guilt	-.051	-.429	.669
Communication	-.126	-1.070	.288