Handbook of Sexuality-Related Measures

Third Edition

Edited by
Terri D. Fisher
Clive M. Davis
William L. Yarber
Sandra L. Davis

HANDBOOK OF SEXUALITY-RELATED MEASURES

THIRD EDITION

This classic and invaluable reference Handbook of use to sex researchers and their students worldwide has now been completely revised in a new edition complete with its own companion website. It remains the only easy and efficient way for researchers to learn about, evaluate, and compare instruments that have previously been used in sex research. In this third edition of the *Handbook*, 218 scales, complete with full descriptions and psychometric data, are made available, with additional information provided at the companion website for this volume.

Terri D. Fisher has been on the psychology faculty of The Ohio State University since 1982. She has conducted research on various aspects of sexual behavior and is Past-President of the Midcontinent Region of the Society for the Scientific Study of Sexuality, and Consulting Editor for *The Journal of Sex Research*.

Clive M. Davis taught at Syracuse University. Davis' research was focused on sexuality and communications. He was Editor of *The Journal of Sex Research* and President of the Society for the Scientific Study of Sexuality. He was the founding president of the Foundation for the Scientific Study of Sexuality.

William L. Yarber is professor of applied health science and professor of gender studies at Indiana University, Bloomington. He is also a senior research fellow at The Kinsey Institute for Research in Sex, Gender, and Reproduction and the senior director of the Rural Center for AIDS/STD Prevention at Indiana University. He is a Past-President of the Society for the Scientific Study of Sexuality.

Sandra L. Davis was an Executive Assistant in the New York State Assembly for 15 years. From 1983-1988, she was Managing Editor of *The Journal of Sex Research* and then served as Assistant Editor for the *Annual Review of Sex Research* for 10 years. She currently edits the online series "What Sexual Scientists Know About…" published by the Society for the Scientific Study of Sexuality.

Summaries of all scales, additional information regarding some of the scales, and complete versions of several others may be found at the companion website to the *Handbook*: http://www.routledge.com/textbooks/9780415801751

Routledge Titles of Related Interest

Sex For Sale, *Second Edition*
Ronald Weitzer

Global Gender Research
Bose and Kim

Regression Analysis for the Social Sciences
Rachel Gordon

GIS and Spatial Analysis for the Social Sciences
Robert Parker and Emily Asencio

State of Sex: Tourism, Sex, and Sin in the New American Heartland
Barbara Brents, Crystal Jackson, and Kathryn Hausbeck

Gender Circuits: Bodies and Identities in a Technological Age
Eve Shapiro

HANDBOOK OF SEXUALITY-RELATED MEASURES

THIRD EDITION

Edited by

Terri D. Fisher

Clive M. Davis

William L. Yarber

Sandra L. Davis

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

For important resources associated with this text please visit the companion website:
www.routledge.com/textbooks/9780415801751

First edition published 1988
by Clive M. Davis, William L. Yarber, and Sandra L. Davis

Second edition published 1998
by Sage Publications, Inc.

This edition published 2011
by Routledge
270 Madison Avenue, New York, NY 10016

Simultaneously published in the UK
by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

© 1988 Clive M. Davis, William L. Yarber, and Sandra L. Davis
© 1998 Sage Publications, Inc.
© 2011 Taylor & Francis

Typeset in Times New Roman by Swales & Willis Ltd, Exeter, Devon
Printed and bound in the United States of America on acid-free paper by Sheridan Books, Inc.

All rights reserved. No part of this book may be reprinted or reproduced or utilised in any form or by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.

Trademark Notice: Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

Library of Congress Cataloging in Publication Data
Handbook of Sexuality related measures / edited by Terri D. Fisher ... [et al.]. — 3rd ed.
p. cm.
Includes bibliographical references and index.
1. Sexology—Research—Handbooks, manuals, etc. 2. Birth control—Research—Handbooks, manuals, etc.
3. Hygiene, Sexual—Research—Handbooks, manuals, etc. 4. Sexual behavior surveys—Handbooks, manuals, etc.
5. Questionnaires. I. Fisher, Terri D.
HQ60.H36 2010
3067072—dc22
2009048685

ISBN13: 978–0–415–80174–4 (hbk)
ISBN13: 978–0–415–80175–1(pbk)

Contents

Preface xxi

Abuse

Childhood Sexual Abuse Scale 1
M. C. Aalsma and J. D. Fortenberry

Early Sexual Experiences Checklist 2
R. S. Miller and J. A. Johnson

What-If-Situations-Test 5
A. G. Nemerofsky and D. T. Carran

Empathy for Children Scale 7
G. A. Schaefer and S. Feelgood

Unwanted Childhood Sexual Experiences Questionnaire 12
M. R. Stevenson

Activity (see Behavior)

Adjustment

Sexual History and Adjustment Questionnaire 13
R. J. Lewis and L. H. Janda

Adolescents

Sexual Knowledge and Attitude Test for Adolescents 16
W. Fullard and L. M. Scheier

Mathtech Questionnaires: Sexuality Questionnaires for Adolescents 18
D. Kirby

Worry About Sexual Outcomes Scale 30
J. M. Sales, R. R. Milhausen, J. Spitalnick, and R. J. DiClemente

Adolescent Perceived Costs and Benefits Scale for Sexual Intercourse 32
S. A. Small

Affect (also see Erotophobia-Erotophilia)

Multidimensional Measure of Comfort With Sexuality 34
P. Tromovitch

Aggression

Attraction to Sexual Aggression Scale 39
N. M. Malamuth

Aggressive Sexual Behavior Inventory 42
D. L. Mosher

Aging

Senior Adult Sexuality Scales 44
E. Weinstein

Aging Sexual Knowledge and Attitudes Scale 49
C. B. White

AIDS (see HIV/AIDS)

Anxiety (also see Guilt)

Sex Anxiety Inventory 52
L. H. Janda

Arousal/Arousability

Sexual Arousability Inventory and Sexual Arousability Inventory–Expanded 55
E. F. Hoon and D. Chambless

Multiple Indicators of Subjective Sexual Arousal 59
D. L. Mosher

Assault (see Aggression, Rape)

Assertiveness (also see Initiative/Initiation)

Hurlbert Index of Sexual Assertiveness 62
D. F. Hurlbert

Intimate Relationships Questionnaire 63
G. Yesmont

Attitudes (also see Behavior, Beliefs and Cognitions, Emotions, Ideology, Knowledge, and Permissiveness; also see specific attitude topics)

Attitudes Toward Sexuality Scale 66
T. D. Fisher

Trueblood Sexual Attitudes Questionnaire 68
R. Hannon, D. Hall, V. Gonzalez, and H. Cacciapaglia

Sexual Attitudes Scale and Brief Sexual Attitudes Scale 71
S. S. Hendrick and C. Hendrick

Sexual Attitude Scale 75
W. W. Hudson and G. J. Murphy

Revised Attitudes Toward Sexuality Inventory 77
W. Patton and M. Mannison

Attitudes Toward Unconventional Sex Scale 80
C. A. Wenner, V. M. Russell, and J. K. McNulty

Attraction

Assessing Multiple Facets of Attraction to Women and Men 81
L. M. Diamond

Awareness

Sexual Awareness Questionnaire 84
W. E. Snell, Jr., T. D. Fisher, and R. S. Miller

Behavior

Sexual Activity Questionnaire 87
E. S. Byers

Cowart–Pollack Scale of Sexual Experience 93
D. Cowart-Steckler and R. H. Pollack

Human Sexuality Questionnaire 95
M. Zuckerman

Beliefs and Cognitions (also see Attitudes, and Fantasy)

Sexual Dysfunctional Beliefs Questionnaire 102
P. J. Nobre and J. Pinto-Gouveia

Sexual Modes Questionnaire 106
P. J. Nobre and J. Pinto-Gouveia

Sexual Cognitions Checklist 110
C. A. Renaud and E. S. Byers

Birth Control (see Contraception)

Bisexuality (see Attraction, and Homosexualities)

Body Image

Attitudes Toward Women's Genitals Scale 114
D. Herbenick

Male Body Image Self-Consciousness Scale 116
L. K. McDonagh, T. G. Morrison, and B. E. McGuire

Children, Childhood Sexual Experience (also see Abuse, Education, and Family)

Questionnaire on Young Children's Sexual Learning 117
P. B. Koch and P. Brick

Coercion (also see Harassment, and Rape)

Sexual Coercion Scale 121
M. C. Aalsma and J. D. Fortenberry

Survey of Unwanted Sexual Attention in University Residences 123
K. V. Cairns and J. Wright

Sexual Coercion in Intimate Relationships Scale 125
A. T. Goetz and T. K. Shackelford

Sexual Beliefs Scale 127
C. L. Muehlenhard and A. S. Felts

Communication

Dyadic Sexual Communication Scale 130
J. A. Catania

Weighted Topics Measure of Family Sexual Communication 132
T. D. Fisher

Female Partner's Communication During Sexual Activity Scale 134
A. McIntyre-Smith and W. A. Fisher

Partner Communication Scale 137
R. R. Milhausen, J. M. Sales, and R. J. DiClemente

Parent-Adolescent Communication Scale 139
J. M. Sales, R. R. Milhausen, and R. J. DiClemente

Family Sex Communication Quotient 140
C. Warren

Compatibility

Hurlbert Index of Sexual Compatibility 143
D. F. Hurlbert

Compulsion

Compulsive Sexual Behavior Inventory 144
E. Coleman and R. E. Swinburne Romine

Sexual Compulsivity Scale 146
S. C. Kalichman

Cognitive and Behavioral Outcomes of Sexual Behavior Scale 148
K. R. McBride, M. Reece, and S. A. Sanders

Sexuality Scale 151
W. E. Snell, Jr.

Condoms

Condom Use Errors/Problems Survey 153
R. A. Crosby, C. A. Graham, R. R. Milhausen, S. A. Sanders, and W. L. Yarber

Correct Condom Use Self-Efficacy Scale 160
R. A. Crosby, C. A. Graham, R. R. Milhausen, S. A. Sanders, and W. L. Yarber

UCLA Multidimensional Condom Attitudes Scale 162
M. Helweg-Larsen

Condom Fit and Feel Scale 164
M. Reece, D. Herbenick, and B. Dodge

Condom Embarrassment Scale 166
K. Vail-Smith, T. W. Durham, and H. A. Howard

Conflict

Sexual Situation Questionnaire 169
E. S. Byers and L. F. O'Sullivan

Consent

Sexual Consent Scale, Revised 173
T. P. Humphreys

Reasons for Consenting to Unwanted Sex Scale 176
T. P. Humphreys and D. J. Kennett

Contraception (also see Condoms)

Contraceptive Attitude Scale 179
K. J. Black

Contraceptive Utilities, Intention, and Knowledge Scale 180
L. Condelli

Contraceptive Self-Efficacy Scale 186
R. A. Levinson

Deception (see Self-Disclosure and Deception)

Desire

Decreased Sexual Desire Screener 189
A. H. Clayton, E. R. Goldfischer, I. Goldstein, L. R. Derogatis, D. J. Lewis-D'Agostino, and R. Pyke

Hurlbert Index of Sexual Desire 191
D. F. Hurlbert

Sexual Desire Inventory 192
I. P. Spector, M. P. Carey, and L. Steinberg

Double Standard

Double Standard Scale 195
S. L. Caron, C. M. Davis, W. A. Halteman, and M. Stickle

Indicators of a Double Standard and Generational Difference in Sexual Attitudes 196
I. L. Lottes and M. S. Weinberg

Sexual Double Standard Scale 199
C. L. Muehlenhard and D. M. Quackenbush

Drive (see Desire, and Excitability/Excitation)

Dysfunction (also see Functioning, and Satisfaction)

Sexual Interest and Desire Inventory—Female 201
A. H. Clayton, D. Goldmeier, R. E. Nappi, G. Wunderlich, D. J. Lewis-D'Agostino, and R. Pyke

Female Sexual Distress Scale—Revised 203
L. R. Derogatis, R. Pyke, J. McCormack, A. Hunter, and G. Harding

Attitudes Related to Sexual Concerns Scale 205
P. B. Koch and C. R. Cowden

Sexual Problems Self-Assessment Questionnaire 207
E. R. Larson and M. H. McKay

Sexual Dysfunction Scale 211
M. P. McCabe

Education

Family Life Sex Education Goal Questionnaire II 213
S. Godin and K. Razzano

Egalitarianism

Global Measure of Equity and Multi-Trait Measure of Equity: Measuring Equity in Close Relationships 216
D. M. Young and E. Hatfield

Ejaculation

Female Sexual Response Patterns: Grafenberg Spot/Area and Ejaculation 220
C. A. Darling and J. K. Davidson, Sr.

Elderly (see Aging)

Emotions (also see Attitudes, and specific emotions)

Emotional Promiscuity Scale 226
D. N. Jones

Equality (see Egalitarianism)

Erotica (see Sexually Explicit Material)

Erotophobia-Erotophilia (also see Affect)

Sexual Anxiety Scale 228
E. E. Fallis, C. Gordon, and C. Purdon

Sexual Opinion Survey 231
B. J. Rye, G. J. Meaney, and W. A. Fisher

Excitability/Excitation

Sexual Inhibition/Sexual Excitation Scales—Short Form 236
D. L. Carpenter, E. Janssen, C. A. Graham, H. Vorst, and J. Wicherts

Sexual Excitation/Sexual Inhibition Inventory for Women 239
C. A. Graham, S. A. Sanders, and R. R. Milhausen

Hurlbert Index of Sexual Excitability 242
D. F. Hurlbert

Sexual Inhibition/Sexual Excitation Scales 243
E. Janssen, J. Bancroft, C. A. Graham, and D. L. Carpenter

Sexual Excitation/Sexual Inhibition Inventory for Women and Men 247
R. R. Milhausen, C. A. Graham, and S. A. Sanders

Experience (see Behavior)

Extramarital/Extrarelational

Extramarital Behavioral Intentions Scale 250
B. Buunk

Intentions Towards Infidelity Scale 251
D. N. Jones, S. G. Olderbak, and A. J. Figueredo

Reiss Extramarital Sexual Permissiveness Scale 253
I. L. Reiss

Family

Parenting Outcome Expectancy Scale 255
C. DiIorio

Parenting Self-Efficacy Scale 257
C. DiIorio

Fantasy

Sexual Daydreaming Scale of the Imaginal Processes Inventory 260
L. M. Giambra and J. L. Singer

Hurlbert Index of Sexual Fantasy 262
D. F. Hurlbert

Female Sexuality

Women's Sexuality Questionnaire 263
D. L. Chambless and D. DeMarco

Self-Perceptions of Female Sexuality Survey Instrument 268
J. K. Davidson, Sr. and C. A. Darling

Sexuality of Women Survey 272
C. R. Ellison and B. Zilbergeld

Sexual Self-Schema Scale—Women's Version 287
A. O. Levin and B. L. Andersen

Brief Index of Sexual Functioning for Women 289
R. C. Rosen, J. F. Taylor, and S. R. Leiblum

Functioning (also see Satisfaction)

Changes in Sexual Functioning Questionnaire 290
A. H. Clayton and E. L. McGarvey

Global Sexual Functioning: A Single Summary Score for Nowinski and LoPiccolo's Sexual History Form (SHF) 295
L. Creti, C. S. Fichten, R. Amsel, W. Brender, L. R. Schover, D. Kalogeropoulos, and E. Libman

Derogatis Interview for Sexual Functioning 302
L. R. Derogatis

Derogatis Sexual Functioning Inventory 304
L. R. Derogatis

Garos Sexual Behavior Inventory 306
S. Garos

Jewish General Hospital Sexual Self-Monitoring Form: Diary Evaluation of Sexual Behavior and Satisfaction 309
E. Libman, I. Spector, Y. Binik, W. Brender, and C. S. Fichten

Sexual Function Scale 312
M. P. McCabe

Personal Sentence Completion Inventory 313
L. C. Miccio-Fonseca

Sexual Interaction System Scale 315
J. D. Woody and H. J. D'Souza

Gender Identification

Masculine Gender Identity Scale for Females 317
R. Blanchard

Guilt

Revised Mosher Guilt Inventory 321
D. L. Mosher

Harassment

Index of Sexual Harassment 325
A. L. Decker and W. W. Hudson

Peer Sexual Harassment Victimization Scale 326
J. Petersen and J. S. Hyde

Likelihood to Sexually Harass Scale 328
J. B. Pryor and E. D. Wesselmann

Sexual Harassment Attitudes Questionnaire 333
J. E. Stake and N. J. Malovich

Health

Sexual Health Services Questionnaire 335
S. M. Butler, D. R. Black, G. H. Avery, J. Kelly, and D. C. Coster

Sexual Health Survey 340
H. Eastman-Mueller, D. Carr, and S. Osterlind

Sexual Health Practices Self-Efficacy Scale 345
P. B. Koch, C. Colaco, and A. W. Porter

Pediatric Penile Perception Score 348
V. Schönbucher, M. A. Landolt, R. Gobet, and D. M. Weber

Herpes

Herpes Attitude Scale 350
K. Bruce and J. McLaughlin

Herpes Knowledge Scale 352
K. Bruce and J. McLaughlin

Genital Herpes Perceived Severity Scales 354
J. Mirotznik

Heterosexual Preferences

Inventory of Dyadic Heterosexual Preferences and Inventory of Dyadic Heterosexual Preferences—Other 356
D. M. Purnine, M. P. Carey, and R. S. Jorgensen

HIV/AIDS

The Meharry Questionnaire: The Measurement of Attitudes Toward AIDS-Related Issues 359
F. A. Ernst, R. A. Francis, J. Perkins, Q. Britton-Williams, and A. S. Kang

HIV/AIDS Knowledge and Attitudes Scales for Teachers 360
P. B. Koch and M. D. Singer

HIV/AIDS Knowledge and Beliefs Scales for Adolescents 364
C. Koopman, H. Reid, E. McGarvey, and A. C. Castillo

Attitudes About HIV/AIDS for Hispanic College Students 368
R. R. Luquis and P. B. Koch

Nurses' Attitudes About HIV/AIDS Scale—Version 2 370
D. B. Preston, E. W. Young, P. B. Koch, and E. M. Forti

AIDS Attitude Scale 373
J. Shrum, N. Turner, and K. Bruce

AIDS Discussion Strategy Scale 375
W. E. Snell, Jr.

Multidimensional AIDS Anxiety Questionnaire 378
W. E. Snell, Jr. and P. D. Finney

Stereotypes About AIDS Scale 381
W. E. Snell, Jr., P. D. Finney, and L. J. Godwin

Alternate Forms of HIV Prevention Attitude Scales for Teenagers 385
M. R. Torabi and W. L. Yarber

Sexual Health Knowledge Questionnaire for HIV+ MSM 388
P. A. Vanable, J. L. Brown, M. P. Carey, and R. A. Bostwick

Adolescent AIDS Knowledge Scale 390
G. D. Zimet

Homophobia

Modern Homonegativity Scale 392
M. A. Morrison and T. G. Morrison

Index of Homophobia (Index of Attitudes Toward Homosexuals) 395
W. A. Ricketts and W. W. Hudson

Homophobic Behavior of Students Scale 397
P. Van de Ven, L. Bornholt, and M. Bailey

Internalized Homophobia Scale 399
G. J. Wagner

Self-Identified Lesbian Internalized Homophobia Scale 400
S. Weibley and M. Hindin

Homophobia Scale 402
L. W. Wright, Jr., H. E. Adams, and J. Bernat

Homosexualities (also see Attraction)

Gay Identity Questionnaire 405
S. Brady

Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale 407
F. R. Dillon and R. L. Worthington

Sexual Correlates of Female Homosexual Experience 410
E. Goode

Attitudes Toward Lesbians and Gay Men Scale 415
G. M. Herek and K. A. McLemore

Component Measure of Attitudes Toward Homosexuality 417
M. E. Kite

Gay Peer Crowds Questionnaire 420
B. S. Lai, B. L. B. Willoughby, N. D. Doty, and N. M. Malik

Power Sharing in Lesbian Partnerships 424
J. M. Lynch and M. E. Reilly

Identification and Involvement with the Gay Community Scale 430
P. A. Vanable, D. J. McKirnan, and J. P. Stokes

Perceived Parental Reactions Scale 432
B. L. B. Willoughby, N. D. Doty, E. B. Braaten, and N. M. Malik

Identity (also see Attraction, Experience, Gender Identification, and Homosexualities)

Measure of Sexual Identity Exploration and Commitment 434
R. L. Navarro, H. B. Savoy, and R. L. Worthington

Ideology (also see Attitudes, and Knowledge)

Sexual Ideology Instrument 437
I. L. Lottes

Sexual Rights Instrument 442
I. L. Lottes

Sexual Polarity Scale 446
D. L. Mosher and J. Sullivan

Initiative/Initiation

Sexually Assertive Behavior Scale 450
P. B. Anderson and M. Newton

Intimacy (see Satisfaction)

Involvement

Depth of Sexual Involvement Scale 453
M. P. McCabe and J. K. Collins

Sexual Path Preferences Inventory 455
D. L. Mosher

Jealousy

Anticipated Sexual Jealousy Scale 460
B. Buunk

Knowledge (also see Adolescents)

Sexual Knowledge, Experience, Feelings, and Needs Scale 462
M. P. McCabe

Locus of Control

Dyadic Sexual Regulation Scale 464
J. A. Catania

Love

Juvenile Love Scale: A Child's Version of the Passionate Love Scale 466
E. Hatfield and D. Young

Passionate Love Scale 469
E. Hatfield and S. Sprecher

Male Sexuality

Gender Identity and Erotic Preference in Males 473
K. Freund and R. Blanchard

Stereotypes About Male Sexuality Scale 484
W. E. Snell, Jr.

Masculinity (see Male Sexuality)

Masturbation (also see Attitudes, Behavior, Female Sexuality, and Self-Stimulation)

Negative Attitudes Toward Masturbation 487
D. L. Mosher

Attitudes Toward Masturbation Scale 489
C. D. Young and C. L. Muehlenhard

Molestation (see Abuse)

Motivation (see Sexual Motivation)

Myths (see Attitudes, Beliefs and Cognitions, and Knowledge)

Narcissism

Hurlbert Index of Sexual Narcissism 495
D. F. Hurlbert

Sexual Narcissism Scale 496
L. Widman and J. K. McNulty

Orgasm (also see Female Sexuality)

Causal Attribution for Coital Orgasm Scale 498
J. W. Critelli, C. F. Bridges, and V. E. Loos

Orgasm Rating Scale 500
K. Mah and Y. M. Binik

Female Orgasm Scale 503
A. McIntyre-Smith and W. A. Fisher

Paraphilia (also see Compulsion, and Transvestism)

Paraphilia Scales From Kurt Freund's Erotic Preferences Examination Scheme 506
R. Blanchard

Pedophilia (see Abuse)

Permissiveness (also see Attitudes)

Sexual Socialization Instrument 507
I. L. Lottes and P. J. Kuriloff

Reiss Premarital Sexual Permissiveness Scale (Short Form) 509
I. L. Reiss

Premarital Sexual Permissiveness Scale 511
S. Sprecher

Personality (also see Assertiveness, Erotophobia-Erotophilia, Narcissism, Sensation Seeking, and Sexual Perfectionism)

Need for Sexual Intimacy Scale 513
W. D. Marelich and E. Shelton

Pornography (see Sexually Explicit Material)

Power (see Locus of Control)

Premarital (see Attitudes, and Permissiveness)

Rape (see also Coercion)

Rape Supportive Attitude Scale 515
I. L. Lottes

Sexual Assault Treating/Reporting Attitudes Survey 517
V. L. S. Thompson and S. W. Smith

Relationships

Multidimensional Sexual Approach Questionnaire 518
W. E. Snell, Jr.

Sexual Relationship Scale 520
W. E. Snell, Jr.

Safer-Sex Behaviors (see Sexual Risk)

Satisfaction (also see Functioning)

Index of Sexual Satisfaction 523
W. W. Hudson

Interpersonal Exchange Model of Sexual Satisfaction Questionnaire 525
K. Lawrance, E. S. Byers, and J. N. Cohen

The New Sexual Satisfaction Scale and Its Short Form 530
A. Štulhofer, V. Buško, and P. Brouillard

Self-Concept (also see Female Sexuality)

The Meaning of My Sexual Self 533
A. L. Cotten

Sexual Self-Concept Inventory 534
L. F. O'Sullivan, H. F. L. Meyer-Bahlburg, and I. McKeague

Multidimensional Sexual Self-Concept Questionnaire 537
W. E. Snell, Jr.

Self-Disclosure and Deception

Sexual Self-Disclosure Scale 540
J. A. Catania

Sexual Self-Disclosure Scale 543
E. S. Herold and L. Way

Sexual Deception Scale
W. D. Marelich and R. I. Slaughter 544

Sexual Self-Disclosure Scale 547
W. E. Snell, Jr.

Self-Efficacy

Sexual Self-Efficacy Scale for Female Functioning 551
S. Bailes, L. Creti, C. S. Fichten, E. Libman, W. Brender, and R. Amsel

Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory 554
F. R. Dillon and R. L. Worthington

Sexual Self-Efficacy Scale—Erectile Functioning 557
C. S. Fichten, J. Budd, I. Spector, R. Amsel, L. Creti, W. Brender, S. Bailes, and E. Libman

Self-Stimulation (also see Masturbation)

Clitoral Self-Stimulation Scale 561
A. McIntyre-Smith and W. A. Fisher

Sensation Seeking

Sexual Sensation Seeking Scale 564
S. C. Kalichman

Sex Education (see Education)

Sexual Consciousness

Sexual Self-Consciousness Scale 566
J. J. D. M. van Lankveld, H. Sykora, and W. E. H. Geijen

Sexual History

Sexual History Questionnaire 568
C. Cupitt

Sexual Motivation

Affective and Motivational Orientation Related to Erotic Arousal Questionnaire 572
C. A. Hill

Sexual Wanting Questionnaire 575
Z. D. Peterson and C. L. Muehlenhard

Age, Gender, and Sexual Motivation Inventory 582
D. Quadagno

Sexual Perfectionism

Multidimensional Sexual Perfectionism Questionnaire 586
W. E. Snell, Jr.

Sexual Risk

Sexual Risk Behavior Beliefs and Self-Efficacy Scales 588
K. Basen-Engquist, L. C. Mâsse, K. Coyle, D. Kirby, G. Parcel, S. Banspach, and J. Nodora

Health Protective Sexual Communication Scale 591
J. A. Catania

Safe Sex Behavior Questionnaire 594
C. DiIorio

Risk Behavior Assessment 596
D. G. Fisher, L. E. Napper, G. L. Reynolds, and M. E. Johnson

Sexual Risk Survey 600
J. A. Turchik and J. P. Garske

Sexually Explicit Material

Attitudes Toward Erotica Questionnaire 602
I. L. Lottes and M. S. Weinberg

Sexual Scripts Overlap Scale—Short Version 604
A. Štulhofer and I. Landripet

Sexually Transmitted Infections (see also specific diseases)

STI Education Efficacy Survey 606
P. B. Koch, A. W. Porter, and C. Colaco

STD Attitude Scale 609
W. L. Yarber, M. R. Torabi, and C. H. Veenker

Signaling (see Initiative/Initiation)

Situations

Female Sexual Resourcefulness Scale 612
T. P. Humphreys and D. J. Kennett

Questionnaire of Cognitive Schema Activation in Sexual Context 614
P. J. Nobre and J. Pinto-Gouveia

Sociosexual Orientation

Women's Nontraditional Sexuality Questionnaire 618
R. F. Levant, K. B. Smalley, T. J. Rankin, A. Colbow, K. David, and C. M. Williams

Revised Sociosexual Orientation Inventory 622
L. Penke

Sociosexual Orientation Inventory 625
J. A. Simpson and S. W. Gangestad

Tactics

Tactics to Obtain Sex Scale 628
J. A. Camilleri

Token Resistance

Token Resistance to Sex Scale 631
S. L. Osman

Transvestism

Cross-Gender Fetishism Scale 633
R. Blanchard

Variations (also see Gender Identification, and specific variations)

Attitudes About Sadomasochism Scale 635
M. R. Yost

Victimization (see Abuse)

Virginity and Virginity Loss

Virginity Beliefs Scale 638
J. Eriksson and T. Humphreys

First Coital Affective Reaction Scale 640
I. M. Schwartz

Women (see Female Sexuality)

Credit Lines 643

About the Editors 651

Index 652

This page intentionally left blank

Preface

Research is fundamental to increasing the understanding of individual and societal sexual expression. Reliable and valid measurement is fundamental to sound research. Although there have been many questionnaires, scales, inventories, interview schedules, etc. developed to measure a myriad of sexuality-related states and traits, attitudes and behaviors, variations and deviations, in the past, relatively few of these were used sufficiently for their reliability and validity to have been firmly established. Instead, there was a tendency for researchers to reinvent the wheel when they had need of a sexuality-related measure.

For an instrument to be used, it must be available to the community of professionals in the field. In order to solve the problem of accessibility of scales, Clive M. Davis, William L. Yarber, and Sandra L. Davis edited and published *Sexuality-Related Measures: A Compendium* in 1988. Prior to the publication of this compendium, there was no easy or efficient way for researchers to learn about, evaluate, and compare instruments that had been previously used in sex research. Although this task has become easier with the advent of the Internet, tracking down available sexuality-related measures has remained a challenge.

The first edition, which consisted of 110 scales, was revised in 1998 by Davis, Yarber, and Davis, with the assistance of Robert Bauserman and George Schreer. The second edition, published by Sage, contained 225 scales. Since the previous edition, sex research has progressed, expanded, and transformed, but despite the increase in physiologically based measures there is still a great need for sound psychometric instruments.

In this third edition of the *Handbook*, we have included 218 scales, with some additional ones at the companion website for this volume, which may be found at http://www.routledge.com/textbooks/9780415801751. However, because of the large expansion of the field, we have made the decision that this edition will focus more directly on solid sexuality-related measures. Therefore, we have eliminated a few categories of measures that were included in the previous two editions; for example, we have not included measures of abortion attitudes or of sex-role behavior. We have also eliminated a number of obsolete measures. This edition consists of 87 new scales, 43 revised entries from the previous edition, and 88 entries from the previous edition for which we did not receive a revision but which we chose to retain nonetheless.

Notable entries in this edition of the *Handbook* include revisions and updates of some well-established measures, scales that reflect expansions into sexual medicine, scales that have resulted from new theoretical constructs, and scales that reflect societal changes in attitudes toward women and toward homosexuality. As with the previous editions, there are a few instruments that are described only briefly, primarily because the author of the instrument was not able to provide us with a more complete paper. In some instances, we have been able to include only a sampling of items from the instrument. In most cases, this is because the instrument is sold commercially and restricted by copyright regulations. In these instances, details about how to obtain the instrument are included. Also, there are some instruments that will be known to many readers that are not mentioned at all. These are not included, unfortunately, because we were unable to obtain a response from the author(s) to our request for a paper or the necessary information. We welcome suggestions from readers about other instruments to include in future editions, and we invite authors to submit material without invitation. As this project has grown, it has become increasingly difficult to identify all of the available instruments and to track down the authors, so assistance from the community of sexual scientists and practitioners is most welcome.

Acknowledgments

We wish to thank all of those who have contributed to the third edition of this handbook. Without the authors of the more than 200 separate chapters contained herein, this edition could not have been produced. We also want to thank the many people who reported to us that they had found the first two editions very useful and encouraged us to undertake a revision. Without that support, it is unlikely we would have taken on the task again. We need to single out for special thanks Paul J. Loeber, who served as an editorial assistant and copyeditor on this project for an extended period of time, with little compensation other than his pride in a job well done. We also wish to acknowledge the support of The Ohio State University at Mansfield in providing workspace and supplies. Finally, we want to thank all of those at Routledge who have provided support and assistance in completing this project, most notably Steve Rutter and Leah Babb-Rosenfeld.

Terri D. Fisher
Mansfield, Ohio

Clive M. Davis
Syracuse, New York

William L. Yarber
Bloomington, Indiana

Sandra L. Davis
Syracuse, New York

Childhood Sexual Abuse Scale

Matthew C. Aalsma[1] **and J. Dennis Fortenberry,** *Indiana University School of Medicine, Indianapolis*

The Child Sexual Abuse Scale (CSAS; Aalsma, Zimet, Fortenberry, Blythe, & Orr, 2002) is a self-report instrument that was developed to measure the occurrence of childhood sexual abuse in adolescent and adult populations. The measurement of childhood sexual abuse varies widely from brief, single-item measures to lengthy clinical interviews. The scale was developed with two issues in mind. First, a benefit of the current measure is it is very brief (four items) and can therefore be utilized in a wide variety of studies. For instance, many measures of childhood sexual abuse are interviews or are lengthy self-report inventories, which are difficult to incorporate into studies assessing many areas of sexual functioning and behavior. Second, because the CSAS is a multiple-item rather than single-item measure, internal reliability can be assessed.

Description

The CSAS consists of four items. Participants are instructed that the items refer to events that may have occurred prior to age 12. The use of this particular age cutoff was based, in part, on focus groups with adolescents in which the participants reached a consensus that the term childhood sexual abuse involved events occurring up to 12 years of age. We also wanted the CSAS to address an age range during which consensual sexual experiences were less likely. In order to maintain brevity, the CSAS did not include items regarding the specific nature of the abuse (e.g., whether penetration was involved) or the participant's relationship with the perpetrator. Given that the age range for childhood sexual abuse is set at below 12, as well as the reading level of this scale, it is most appropriate for adolescent and adult populations.

Response Mode and Timing

The participants are asked to circle *Yes* or *No* to each statement.

Scoring

The total score for this scale is calculated by summing across items and can range from zero to four.

Reliability

The CSAS was originally utilized in a study of female adolescent and young adult subjects (14 to 24 years of age) recruited from urban health clinics and a sexually transmitted disease clinic in a large midwestern city. The scale, measuring a single construct, demonstrated excellent internal reliability at baseline (alpha = .81) and 7-month follow-up (alpha = .84; Aalsma et al., 2002).

Validity

The content validity of this scale was established by exploring other childhood sexual abuse scales. When compared to other scales, the current CSAS demonstrates strong face validity. Support for the construct validity of the CSAS is demonstrated by its relationship with other variables. In the original study assessing the role of consistent reporting of childhood sexual abuse, consistent nonreporters of childhood sexual abuse were compared to inconsistent (endorsed at least one item at one time point and not at another time point) and consistent reporters of childhood sexual abuse. We found that reporters (either inconsistent or consistent) endorsed marked increases in measures of pathology (i.e., depression) and health-compromising behavior (i.e., sexual coercion and lifetime sexual partners). Moreover, a linear trend was evident with lifetime number of sexual partners and depression. Consistent reports of childhood sexual abuse reported the highest number of sexual partners and increased depression. Lastly, we conducted a logistic regression in order to predict membership in the consistent or inconsistent reporting group. The results indicated that adolescents who endorsed at least two items on the CSAS were over five times more likely to be consistent childhood sexual abuse reporters. The results of this analysis demonstrate the utility and importance of using a scale to measure childhood sexual abuse rather than a single-item measure. The above findings were extended in an additional analysis with the same sample (Fortenberry & Aalsma, 2003).

[1]Address correspondence to Matthew C. Aalsma, Section of Adolescent Medicine, Indiana University School of Medicine, 575 N. West Dr., Rm. 070, Indianapolis, IN 46202; e-mail: maalsma@iupui.edu

The CSAS was also employed in a study of homeless youth (Rew, Whittaker, Taylor-Seehafer, & Smith, 2005). Significant differences among homeless youth by sexual orientation categories on the CSAS were found. Specifically, gay and lesbian youth were more likely to have left home due to sexual abuse than heterosexual and bisexual youth. The authors of the study utilized the full scale as well as individual items in the analysis.

References

Aalsma, M. C., Zimet, G. D., Fortenberry, J. D., Blythe, M. J., & Orr, D. P. (2002). Report of childhood sexual abuse by adolescents and young adults: Stability over time. *The Journal of Sex Research, 39,* 259–263.

Fortenberry, J. D. & Aalsma, M. C. (2003). Abusive sexual experiences before age 12 and adolescent sexual behaviors. In J. Bancroft (Ed.), *Sexual Development in Childhood* (pp. 359–369). Bloomington, IN: Indiana University Press.

Rew, L., Whittaker, T. A., Taylor-Seehafer, M. A., & Smith, L. R. (2005). Sexual health risks and protective resources and gay, lesbian, bisexual, and heterosexual homeless youth. *Journal for Specialists in Pediatric Nursing, 10,* 11–19.

Exhibit

Childhood Sexual Abuse Scale

Instructions: These next questions are about activity before you were 12 years old.

1. Someone tried to touch me in a sexual way against my will.
2. Someone tried to make me touch them in a sexual way against my will.
3. I believe that I have been sexually abused by someone.
4. Someone threatened to tell lies about me or hurt me unless I did something sexual with them.

Early Sexual Experiences Checklist

Rowland S. Miller[1] **and James A. Johnson,** *Sam Houston State University*

Self-report biases and definitional problems have plagued studies of sexual abuse of children. Various investigators have forced respondents to label themselves as "sexually abused" (e.g., Kercher & McShane, 1984) or to make subtle distinctions among vague categories (e.g., "kissing or hugging in a sexual way"; Kilpatrick, 1986) in order to be counted as victims of deleterious, unwanted childhood sexual experiences. Miller, Johnson, and Johnson (1991) created the Early Sexual Experiences Checklist (ESEC) to provide an efficient, accessible procedure for detecting such experiences that avoids these methodological and conceptual problems. The ESEC merely asks respondents to check any specific, overt sexual behaviors that occurred when the respondents did not want them to. Coupled with reports of (a) the respondent's age during the events, (b) the age of the person who initiated the events, or (c) any coercion, the ESEC allows diverse operationalizations of unwanted sexual experience that span the existing literature on sexual abuse (Kendall-Tackett, Williams, & Finkelhor, 1993). The straightforward, mechanical checklist method eschews evaluative, pejorative terminology and is thus relatively noninvasive. It is also simple and direct and very inexpensive, making it practical for use with large heterogenous populations.

Description

The ESEC contains nine items listing explicit sexual behaviors and two additional items that allow respondents either to describe a further sexual event or to pick *none of the above*. The checklist ordinarily includes additional questions—which may vary according to investigators' needs—that obtain (a) the respondent's sex, (b) the respondent's age at the time of the most bothersome event, (c) the age of the other person involved, (d) the identity (e.g., "stranger") of the other person, (e) the frequency and duration of the most bothersome experience, and (f) the presence and type of any coercion. Items using a 1 (*not at*

[1]Address correspondence to Rowland Miller, Division of Psychology and Philosophy, Sam Houston State University, Huntsville, TX 77341–2447; e-mail: psy_rsm@shsu.edu

all) to 7 (*extremely*) Likert-type format also obtain various ratings of the most bothersome event (e.g., "How much did it bother you then?" "How much does it bother you now?").

Response Mode and Timing

Respondents are ordinarily instructed to indicate with a check any sexual behaviors that were unwanted and that occurred before they were 16 years old. (This age limit may be changed for different applications of the checklist.) Thereafter, because many respondents will have encountered more than one type of sexual experience, respondents are typically asked to circle the experience that bothered them the most and to answer any further questions with regard to that specific event. The checklist and any additional questions usually fit on two sheets that take only 4 or 5 minutes to complete.

Scoring

Respondents who report unwanted sexual experiences can readily be distinguished from those who do not, and the percentage of the sample reporting each type of unwanted experience is easily calculated. A useful distinction can also be made, however, between those who have encountered relatively severe events, such as oral-genital contact or anal or vaginal intercourse, and those who have encountered less severe events, such as the exhibition of, or fondling of, sexual organs. Miller et al. (1991) showed that such distinctions are made by lay judges, and Anderson, Miller, and Miller (1995) demonstrated that the two different types of experiences are linked to different adult outcomes.

The results obtained by the ESEC resemble those obtained by the laborious, much costlier face-to-face interviews often advocated by methodologists (Wyatt & Peters, 1986). Anderson et al. (1995) found that 9% of the women and 3% of the men in a heterogenous college sample reported a youthful history of severe victimization by another person 5 or more years older than themselves. An additional 15% of the women and 6% of the men reported less severe experiences that were initiated by substantially older partners. Remarkably, if all such experiences are counted—regardless of the age of the partner—nearly half of the sample (48%) had some unwanted sexual experience during childhood or young adolescence.

Reliability

Using Cohen's kappa, a conservative statistic that corrects for chance agreement among diverse categories, the average 1-month test-retest reliability of the ESEC is .92 (Miller & Johnson, 1997).

Validity

Importantly, the ESEC captures reports of childhood sexual abuse that escape other paper-and-pencil techniques. Using the ESEC, Miller and Johnson (1997) found that 56% of a college sample who reported abuse in the form of unwanted, bothersome childhood experiences with partners 5 or more years older than themselves nevertheless specifically reported that they had *not* been "sexually abused." Thus, fewer than half of those who had encountered sexual abuse actually labeled themselves as "abused." Nonetheless, their experiences were detected by the ESEC. Anderson et al. (1995) have also found that adult respondents reporting any unwanted experiences on the ESEC evidenced more depression and neuroticism, and lower self-esteem, than did those who had encountered no such experiences. Furthermore, those reporting relatively severe experiences (i.e., unwanted oral-genital contact or anal or vaginal intercourse) were more impulsive, used more alcohol and other drugs, and were less secure and more anxious and avoidant in their interpersonal relations than were those who had not had such severe experiences. The ESEC methodology thus replicated the findings of other techniques for assessing abuse, but also extended those findings by allowing comparison of the sequelae of different types of abuse experiences.

References

Anderson, J. H., Miller, R. S., & Miller, G. A. (1995, August). *Adult sequelae of unwanted childhood sexual experiences*. Paper presented at the meeting of the American Psychological Association, New York.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*, 164–180.

Kercher, G., & McShane, M. (1984). Prevalence of child sexual abuse victimization in an adult sample of Texas residents. *Child Abuse and Neglect, 8*, 495–501.

Kilpatrick, A. (1986). Some correlates of women's childhood sexual experiences: A retrospective study. *The Journal of Sex Research, 22*, 221–242.

Miller, R. S., & Johnson, J. A. (1997). *Abuse victims don't always feel "abused": Using checklists to detect childhood sexual abuse*. Unpublished manuscript.

Miller, R. S., Johnson, J. A., & Johnson J. K. (1991). Assessing the prevalence of unwanted childhood sexual experiences. *Journal of Psychology & Human Sexuality, 4*, 43–54.

Wyatt, G. E., & Peters, S. D. (1986). Methodological considerations in research on the prevalence of child sexual abuse. *Child Abuse and Neglect, 10*, 241–251.

Exhibit

Early Sexual Experiences Checklist

Your sex: _____ Male _____ Female

Early Sexual Experiences

When you were under the age of sixteen (16), did any of these incidents ever happen to you *when you did not want them to?*

Please check those that occurred:

_____ Another person showed his or her sex organs to you.
_____ You showed your sex organs to another person at his or her request.
_____ Someone touched or fondled your sexual organs.
_____ You touched or fondled another person's sex organs at his or her request.
_____ Another person had sexual intercourse with you.
_____ Another person performed oral sex on you.
_____ You performed oral sex on another person.
_____ Someone told you to engage in sexual activity so that he or she could watch.
_____ You engaged in anal sex with another person.
_____ Other (please specify): _____
_____ None of these events ever occurred.

If any of these incidents ever happened to you, please answer the following questions by *thinking about the one behavior that bothered you the most.*

In addition, please *circle* the behavior above that bothered you the most.

1. How old were you when it happened? _____
2. Approximately how old was the other person involved? _____
3. Who was the other person involved?

   ____ relative ____ friend or acquaintance ____ stranger

4. If the other person was a relative, how were they related to you? (i.e., cousin, father, sister, etc.) _____
5. How many times did this behavior occur?

   ____ just once ____ twice ____ 3 or 4 times ____ 5 times or more

6. Over how long a period did this behavior occur?

   ____ just once ____ a month or less ____ several months ____ a year or more

7. How much did the experience *bother* you at the time?

1	2	3	4	5	6	7
not at all			moderately			extremely

8. How much does the experience *bother* you *now*?

1	2	3	4	5	6	7
not at all			moderately			extremely

9. What kind of psychological pressure or physical force did the person use, if any? *Please check all that apply:*

   _____ They tried to talk you into it.
   _____ They scared you because they were bigger or stronger.
   _____ They said they would hurt you.
   _____ They bribed you.
   _____ They pushed, hit, or physically restrained you.
   _____ You were afraid they wouldn't like or love you.
   _____ They physically harmed or injured you.
   _____ They threatened you with a weapon.

_____ They drugged you or got you drunk.
_____ Other (please specify): _____
_____ None of these occurred.

What-If-Situations-Test

Alan G. Nemerofsky,[1] *Community College of Baltimore County*
Deborah T. Carran, *Johns Hopkins University*

The What-If-Situations-Test (WIST; Nemerofsky, 1986) was developed to measure performance of preschool-age children in sexual abuse prevention programs. The WIST is constructed from the learning objectives of the Children's Primary Prevention Training Program (Nemerofsky, Sanford, Baer, Cage, & Wood, 1986) and is composed of situations that require the child to determine how he or she would respond. The test items measure the skills and concepts taught in the prevention program and address skills and concepts thought to be essential in reducing the risk of sexual victimization (Conte, Rosen, & Saperstein, 1986; Wurtele, 1987). The WIST can be used as a pretest measure, as well as a measure of performance in sexual abuse prevention programs.

Description

The WIST consists of 29 items addressing (a) the names and location of the child's "private parts," (b) appropriate requests to touch or to examine the child's genitals by physicians, (c) requests for touching of the child's genitals by others, (d) requests for the child to touch another individual's genitals, (e) the child's right to refuse to be touched, (f) appropriate requests to touch (hug/kiss) the child by others, (g) requests to keep secrets, (h) requests to keep secrets about genital touching, (i) attempts to provide gifts/bribes/presents/incentives to touch child's genitals or have the child touch the genitals of another person, (j) actions to be taken if the child was afraid and/or uncomfortable, and (k) the child's role in potential abuse situations.

Eleven items require the child to make a determination about the appropriateness of an action or situation (e.g., If someone touches a child's private parts, should the child tell?). Seventeen items deal with actions that a child should take in abuse situations (e.g., What would you do if someone touched your private parts?). One item addresses the names and locations of the child's private parts.

Response Mode and Timing

The WIST is administered, on an individual basis, by the child's teacher. The child's responses are written down verbatim and scored by comparison to a key. The test requires approximately 15 minutes to complete.

Scoring

Scores can range from 0 to 64, with higher scores indicating greater understanding of child sexual abuse prevention skills and concepts. WIST items are differently keyed according to the nature of the item. The 11 WIST items requiring the child to make a determination about the appropriateness of an action or situation are scored 0 points for a wrong answer and 1 point for a correct response. The 17 items addressing actions a child could take in abuse situations receive 1 point for an assertive or motoric response, 2 points for disclosure, and 3 points for both an assertive and a disclosure response. The WIST item that requires the child to name and locate his or her private parts receives 0 points for a wrong answer, 1 point for a partial answer (e.g., child names only one private part), and 2 points for a complete correct answer (e.g., a girl's private parts are her vagina, buttocks, and breasts).

Reliability

In a sample of 1,044 3- to 6-year-old children (Nemerofsky, 1991), the Cronbach's alpha for the WIST was .83, indicating good reliability.

Validity

In a study using the WIST pretest mean score as the covariate, WIST posttest mean scores of children who had completed a sexual abuse prevention training program were compared to the control group of children who had not received the training. A significant difference was found between groups, with the experimental group of children scoring significantly higher on the WIST posttest following participation in the sexual abuse prevention training program than the control group of children who had not received the training (Nemerofsky, Carran, & Rosenberg, 1994).

[1]Address correspondence to Alan G. Nemerofsky, CCBC Essex, 7201 Rossville Blvd., Baltimore, MD 21237; e-mail: ANemerofsky@ccbcmd.edu

References

Conte, J. R., Rosen, C., & Saperstein, L. (1986). An analysis of programs to prevent the sexual victimization of children. *Journal of Primary Prevention, 6,* 141–155.

Nemerofsky, A. G. (1986). *The What-If-Situations-Test.* Baltimore, MD: Author.

Nemerofsky, A. G. (1991). *Child sexual abuse prevention: Teacher and child variables affecting the learning of skills and concepts in a sexual abuse prevention program.* Unpublished doctoral dissertation, The Johns Hopkins University, Baltimore, MD.

Nemerofsky, A. G., Carran, D. T., & Rosenberg, L. A. (1994). Age variation in performance among preschool age children in a sexual abuse prevention program. *Journal of Child Sexual Abuse, 3,* 85–102.

Nemerofsky, A. G., Sanford, H. J., Baer, B., Cage, M., & Wood, D. (1986). *The children's primary prevention training program.* Baltimore, MD: Author.

Wurtele, S. K. (1987). School-based sexual abuse prevention programs: A review. *Child Abuse and Neglect, 11,* 483–495.

Exhibit

What-If-Situations-Test

Child Code Number:

Circle: Pretest Posttest

1. Tell me the names of your private parts.
2. What would you do if someone touched you in a way you did not like?
3. What would you do if someone touched you in a way that you liked?
4. What would you do if someone asked you to keep a secret?
5. What would you do if someone tried to touch your private parts?
6. What would you do if someone touched you in a way that made you feel uncomfortable?
7. Is it OK for a mom or dad to give you a hug if you want one? (Circle) Yes No
8. Do you have to let anyone touch you on your private parts? (Circle) Yes No
9. What would you do if someone touched your private parts?
10. What would you do if someone said they would give you a present if you would keep a secret?
11. If someone makes a child touch their private parts:
    a. Did the child do anything wrong? Yes No
    b. Is it the child's fault? Yes No
    c. Should the child tell? Yes No
    d. Should the child ask for help? Yes No
12. What would you do if someone asked you to touch their private parts?
13. What would you do if someone asked you to keep a secret about touching private parts?
14. What would you do if someone said they would give you a present if you would touch their private parts?
15. What would you do if someone made you touch their private parts?
16. If someone touches a child's private parts:
    a. Did the child do anything wrong? Yes No
    b. Is it the child's fault? Yes No
    c. Should the child tell? Yes No
    d. Should the child ask for help? Yes No
17. Would it be OK for your doctor to look at your private parts if you were hurt there? Yes No
18. What would you do if you were scared or confused or felt uncomfortable?
19. What would you say if someone asked you to touch their private parts?
20. What should a child do if someone touched his/her private parts and promised not to do it again?
21. If someone touched your private parts:
    a. What would you say?
    b. What would you do?
    c. Who would you tell?

Empathy for Children Scale

Gerard A. Schaefer,[1] *Institute of Sexology and Sexual Medicine, Charité—Universitätsmedizin Berlin, Freie und Humboldt-Universität zu Berlin, Germany*
Steven Feelgood, *Clinical Psychology and Psychotherapy, Technical University, Dresden, Germany*

Empathy can be defined as one individual's reactions to the observed experiences of another (Davis, 1983). A four-stage model of empathy by Marshall, Hudson, Jones, and Fernandez (1995) includes emotion recognition, perspective taking, emotional response, and appropriate action. Several measures have been developed to assess general empathy, such as the Interpersonal Reactivity Index (IRI; Davis,1983), Hogan's Empathy Scale (Hogan, 1969), or the Emotional Empathy Scale (Mehrabian & Epstein, 1972).

Sexual offenders typically display a lack of empathy for their victims (Marshall, 1997). Child sexual abuse offenders' empathy deficits are greatest for their own victims compared to nonsexual offenders (Marshall, Hamilton, & Fernandez, 2001). Contact sexual offenders score lower than child pornography offenders in victim empathy (Bates & Metcalf, 2007; Elliott, Beech, Mandeville-Norden, & Hayes, 2009).

The Empathy for Children Scale (ECS) was developed to measure an individual's cognitive and emotional empathy for child victims. Three scenarios are used, assessing empathy with respect to an "accident victim," a "stranger child sexual abuse victim," and "(fantasized) own child sexual abuse victim." The ECS can be used as a research tool in examining respective empathy deficits of various subsamples. It can also serve as a clinical tool for therapists in treatment planning and treatment outcome assessment.

Description

The ECS is based on the Child Molester Empathy Measure (CMEM; Fernandez & Marshall, 2003; Fernandez, Marshall, Lightbody, & O'Sullivan, 1999), in that it uses the same three scenarios to assess empathy for child victims using two subscales (cognitive and emotional empathy) for each scenario. However, as the ECS was specifically developed for administration with pedophilic nonoffenders, the original "own child sexual abuse victim" scenario was modified to offer a fantasized own victim. Changes to the scenarios also improved the comparability of the scenarios. Furthermore, the ECS assesses data regarding age and gender of (fantasized) own victim and imagined general sexual abuse victim. With 75 items rated on 5-point Likert-type scales, the ECS is less complex to rate for the respondents, as well as more economic to administer (the CMEM has 150 items and uses 11-point Likert-type scales). Higher scores indicate more empathy. Owing to its design, it may be used in both forensic and nonforensic settings. Therefore, its use is not limited to individuals with known victims, such as convicted sexual offenders. The instrument is available in English, French, and German (Feelgood & Schaefer, 2005).

Response Mode and Timing

For each item, respondents are to circle the number (0–4; 0 = *Not at all*; 4 = *Very Much*) that best describes how, in their opinion, the child might feel (cognitive empathy) and how they feel when imagining what the child experienced (emotional empathy). It typically takes 20 to 30 minutes to complete the instrument.

Scoring

The items for each subscale are added to form total scores. Items 4 and 7 are reverse scored for cognitive empathy, and Items 1, 8, and 9 are reverse scored for emotional empathy. It is possible to have an overall empathy score for each scenario by simply adding the total scores for cognitive and emotional empathy for the respective scenarios.

Reliability

One hundred and fifty men (83 reporting sexual contacts with children, 67 "potential" perpetrators) who volunteered for a treatment program for individuals with a sexual interest in minors, the Berlin Prevention Project Dunkelfeld (PPD), completed the ECS as part of an assessment battery (Beier, Ahlers et al., 2009; Beier, Neutze et al., 2009). Cognitive distortion and social desirability were controlled using the Bumby MOLEST Scale (BMS; Bumby, 1996) and the Balanced Inventory of Desirable Responding (BIDR-20; Paulhus, 1991; German version: Musch, Brockhaus,

[1]Address correspondence to Gerard A. Schaefer, Institute of Sexology and Sexual Medicine, University Clinic Charité Campus Mitte, Freie und Humboldt-Universität zu Berlin, Luisenstraße 57, D-10117 Berlin-Mitte, Germany; e-mail: gerard.schaefer@charite.de

& Bröder, 2002). Significant correlations with the BMS-cognitive distortion scale were found (−.42 to −.50) and only one small correlation with social desirability (−.19 for accident victim). Internal consistency (Cronbach's alpha = .96) supports the structure of the scale (Schaefer & Feelgood, 2006).

Validity

Comparing child sexual abuse offenders diagnosed with pedophilia, no differences were found between undetected and detected offenders concerning emotional empathy regarding their own victims (Schaefer, Neutze, Mundt, & Beier, 2008). Similar profiles to those found in samples of detected offenders (Marshall et al., 2001) were identified in a sample of PPD offenders (i.e., undetected child sexual abuse offenders). They displayed less empathy for their own victim than for other victims of child sexual abuse and the greatest empathy for a child car accident victim (Schaefer & Feelgood, 2006). Differences between these groups support discriminant validity. The lack of social desirability responding relative to the ECS supports divergent validity.

Other Information

When using the instrument to assess empathy deficits within a population of known (e.g., convicted) offenders, the text passages in italicized uppercase letters must be deleted.

Steven Feelgood is also affiliated with the Social Therapy Unit, Brandenburg an der Havel Prison, Brandenburg, Germany.

Copies of the instrument and information regarding revisions of any part of the instrument may be requested by e-mail to the first author.

References

Bates, A., & Metcalf, C. (2007). A psychometric comparison of Internet and non-Internet sex offenders from a community treatment sample. *Journal of Sexual Aggression, 13,* 11–20.

Beier, K. M., Ahlers, C. J., Goecker, D., Neutze, J., Mundt, I. A., Hupp, E., et al. (2009). Can pedophiles be reached for primary prevention of child sexual abuse? First results of the Berlin Prevention Project Dunkelfeld (PPD). *Journal of Forensic Psychiatry and Forensic Psychology*, *20*, 851–867.

Beier, K. M., Neutze, J., Mundt, I. A., Ahlers, C. J., Goecker, D., Konrad, A., et al. (2009). Encouraging self-identified pedophiles and hebephiles to seek professional help: First results of the Berlin Prevention Project Dunkelfeld (PPD). *Child Abuse and Neglect, 33,* 545–549.

Bumby, K. M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. *Sexual Abuse: Journal of Research and Treatment, 8,* 37–54.

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44,* 113–126.

Elliott, I. A., Beech, A. R., Mandeville-Norden, R., & Hayes, E. (2009). Psychological profiles of Internet sexual offenders: Comparisons with contact sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 21,* 76–92.

Feelgood, S., & Schaefer, G. A. (2005). *German version of the Empathy for Children Scale (ECS)*. Unpublished manuscript.

Fernandez, Y. M., & Marshall, W. L. (2003). Victim empathy, social self-esteem and psychopathy in rapists. *Sexual Abuse: A Journal of Research and Treatment, 15,* 11–26.

Fernandez, Y. M., Marshall, W. L., Lightbody, S., & O'Sullivan, C. (1999). The Child Molester Empathy Measure. *Sexual Abuse: A Journal of Research and Treatment, 11,* 17–31.

Hogan, R. (1969). Development of an empathy scale. *Journal of Consulting and Clinical Psychology, 33,* 307–316.

Marshall, W. L. (1997). The relationship between self-esteem and deviant sexual arousal in non-familial child molesters. *Behavior Modification, 21*, 86–96.

Marshall, W. L., Hamilton, K., & Fernandez, Y. (2001). Empathy deficits and cognitive distortions in child molesters. *Sexual Abuse: A Journal of Research and Treatment, 13,* 123–130.

Marshall, W. L., Hudson , S. M., Jones, R., & Fernandez, Y. M. (1995). Empathy in sex offenders. *Clinical Psychological Review, 15,* 99–113.

Mehrabian, A., & Epstein, N. (1972). A measure of emotional empathy. *Journal of Personality, 40,* 525–543.

Musch, J., Brockhaus, R., & Bröder, A. (2002). Ein Inventar zur Erfassung von zwei Faktoren sozialer Erwünschtheit [An inventory for the assessment of two factors of social desirability]. *Diagnostica, 48*(3), 121–129.

Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (pp. 17–41). San Diego, CA: Academic Press.

Schaefer, G. A., & Feelgood, S. (2006, September). *Validation of a new scale for measuring victim empathy in pedophiles: The Empathy for Children Scale (ECS)*. Paper presented at the 9th International Conference of the International Association for the Treatment of Sexual Offenders (IATSO), Hamburg, Germany.

Schaefer, G. A., Neutze, J., Mundt, I. A., & Beier, K. M. (2008, October). *Pedophiles and hebephiles in the community: Findings from the Berlin Prevention Project Dunkelfeld (PPD)*. Paper presented at the 27th Annual Meeting of the Association for the Treatment of Sexual Abusers, Atlanta, GA.

Exhibit

Empathy for Children Scale

Instructions: In the following you will find three short stories. You will be asked to indicate at first how you believe the *child* in the story feels, and afterwards how *you* feel when thinking about the child.

Story 1:

Imagine a child that was badly injured in road traffic and had to spend some time in hospital. The child is now out of hospital and will live with a permanent disability.

In your opinion, how may the child feel or have felt, what may it experience or have experienced while in hospital and afterwards? For each of the following descriptions, please circle the number that best indicates ***the child's experience***.

The child	*Not at all*				*Very Much*
1. feels guilty.	0	1	2	3	4
2. feels sad.	0	1	2	3	4
3. feels angry.	0	1	2	3	4
4. is self-confident.	0	1	2	3	4
5. has nightmares.	0	1	2	3	4
6. has suicidal thoughts.	0	1	2	3	4
7. is successful in school.	0	1	2	3	4
8. has sleep disturbances.	0	1	2	3	4
9. feels lonely.	0	1	2	3	4
10. is withdrawn from others.	0	1	2	3	4
11. has psychological problems.	0	1	2	3	4
12. feels helpless.	0	1	2	3	4
13. is suffering.	0	1	2	3	4
14. is tense.	0	1	2	3	4
15. feels ashamed.	0	1	2	3	4

Now please circle the number that best indicates ***how you feel*** when imagining what the child experienced.

I feel . . . / I am . . .	*Not at all*				*Very Much*
1. cheerful.	0	1	2	3	4
2. furious.	0	1	2	3	4
3. disturbed.	0	1	2	3	4
4. distraught.	0	1	2	3	4
5. devastated.	0	1	2	3	4
6. helpless.	0	1	2	3	4
7. upset.	0	1	2	3	4
8. good.	0	1	2	3	4
9. stimulated.	0	1	2	3	4
10. shocked.	0	1	2	3	4

How old was the child you imagined? Ca. _____ years

Of what gender was the child you imagined?

○ female
○ male

Story 2:

Now imagine a child that had sex with an adult male. *(THE RELATIONSHIP WITH THE CHILD AS WELL AS THE NATURE AND FREQUENCY OF SEXUAL CONTACT MATCH YOUR OWN SEXUAL EXPERIENCE WITH CHILDREN. IF YOU HAVE NOT HAD ANY SEXUAL EXPERIENCE WITH CHILDREN, THEN IMAGINE THE STORY MATCHED YOUR USUAL SEXUAL FANTASIES OF CHILDREN.) In your opinion*, how may the child feel or have felt, what may it experience or have experienced while this sexual contact was occurring and afterwards?

For each of the following descriptions, please circle the number that best indicates ***the child's experience***.

The child . . .	*Not at all*				*Very Much*
1. feels guilty.	0	1	2	3	4
2. feels sad.	0	1	2	3	4
3. feels angry.	0	1	2	3	4
4. is self-confident.	0	1	2	3	4
5. has nightmares.	0	1	2	3	4
6. has suicidal thoughts.	0	1	2	3	4
7. is successful in school.	0	1	2	3	4
8. has sleep disturbances.	0	1	2	3	4
9. feels lonely.	0	1	2	3	4
10. is withdrawn from others.	0	1	2	3	4
11. has psychological problems.	0	1	2	3	4
12. feels helpless.	0	1	2	3	4
13. is suffering.	0	1	2	3	4
14. is tense.	0	1	2	3	4
15. feels ashamed.	0	1	2	3	4

Now please circle the number that best indicates ***how you feel*** when imagining what the child experienced.

I feel . . . / I am . . .	*Not at all*				*Very Much*
1. cheerful.	0	1	2	3	4
2. furious.	0	1	2	3	4
3. disturbed.	0	1	2	3	4
4. distraught.	0	1	2	3	4
5. devastated.	0	1	2	3	4
6. helpless.	0	1	2	3	4
7. upset.	0	1	2	3	4
8. good.	0	1	2	3	4
9. stimulated.	0	1	2	3	4
10. shocked.	0	1	2	3	4

How old was the child you imagined? Ca. _____ years

Of what gender was the child you imagined?

○ female
○ male

Story 3:

Now think of a child with whom *you* have had sexual contact. *(IF YOU HAVE NOT HAD ANY SEXUAL CONTACT WITH CHILDREN, PLEASE IMAGINE A CHILD YOU HAD OR HAVE SEX WITH IN YOUR FANTASIES.) In your opinion*, how may the child feel or have felt, what may it experience or have experienced while this sexual contact was occurring and afterwards?

For each of the following descriptions, please circle the number that best indicates ***the child's experience***.

IF YOU HAVE NOT HAD ANY SEXUAL CONTACT WITH CHILDREN PLEASE TICK THE BOX TO THE RIGHT. ☐

The child . . .	*Not at all*				*Very Much*
1. feels guilty.	0	1	2	3	4
2. feels sad.	0	1	2	3	4
3. feels angry.	0	1	2	3	4
4. is self-confident.	0	1	2	3	4
5. has nightmares.	0	1	2	3	4
6. has suicidal thoughts.	0	1	2	3	4
7. is successful in school.	0	1	2	3	4
8. has sleep disturbances.	0	1	2	3	4
9. feels lonely.	0	1	2	3	4
10. is withdrawn from others.	0	1	2	3	4
11. has psychological problems.	0	1	2	3	4
12. feels helpless.	0	1	2	3	4
13. is suffering.	0	1	2	3	4
14. is tense.	0	1	2	3	4
15. feels ashamed.	0	1	2	3	4

Now please circle the number that best indicates ***how you feel*** when imagining what the child experienced.

IF YOU HAVE NOT HAD ANY SEXUAL CONTACT WITH CHILDREN PLEASE TICK THE BOX TO THE RIGHT. ☐

I feel . . . / I am . . .	*Not at all*				*Very Much*
1. cheerful.	0	1	2	3	4
2. furious.	0	1	2	3	4
3. disturbed.	0	1	2	3	4
4. distraught.	0	1	2	3	4
5. devastated.	0	1	2	3	4
6. helpless.	0	1	2	3	4
7. upset.	0	1	2	3	4
8. good.	0	1	2	3	4
9. stimulated.	0	1	2	3	4
10. shocked.	0	1	2	3	4

How old was the child you imagined? Ca. _____ years

Of what gender was the child you imagined?

○ female
○ male

Unwanted Childhood Sexual Experiences Questionnaire

Michael R. Stevenson,[1] *Ball State University*

The Unwanted Childhood Sexual Experience Questionnaire can be used to document the age and extent of respondents' unwanted childhood sexual experiences with adults. Instructions intentionally refer to *unwanted* childhood sexual experiences rather than abusive sexual experiences or experiences of sexual *victimization* in an attempt to avoid unintended bias in reporting. It defines an adult as someone who is at least 5 years older than the respondent.

Description

Each of the 13 items refers to a different set of behaviors that can be categorized as minimal contact (Items 1–3), moderate contact (Items 4–8), or maximal contact (Items 9–13). Items were drawn from a larger questionnaire designed by Finkelhor (1979) and have been used in other studies (e.g., Fromuth, 1986; Stevenson & Gajarsky, 1992).

Response Mode and Timing

Respondents simply indicate in the space provided the age or ages at which any of the unwanted sexual behaviors occurred. The scale can be completed in less than 5 minutes.

Scoring

The questionnaire allows for the reporting of the frequency with which each of the behaviors occur in the sample, and the ages at which the behaviors occurred.

Reliability

The intention of this questionnaire is to document whether specific unwanted behaviors have occurred, and the items are not intended to constitute a scale. Reliability has not been assessed directly.

Validity

Using this measure, Stevenson and Gajarsky's (1992) sample of college students reported frequencies of unwanted sexual experiences that were consistent with earlier reports (e.g., Finkelhor, 1979, 1984; Groth, 1979). Although the percentage of men reporting unwanted sexual experiences was somewhat higher than some previous estimates, it was quite consistent with others (e.g., Popen & Segal, 1988).

References

Finkelhor, D. (1979). *Sexually victimized children*. New York: Free Press.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: Free Press.

Fromuth, M. E. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. *Child Abuse and Neglect, 10*, 5–15.

Groth, N. A. (1979). Sexual trauma in the life histories of rapists and child molesters. *Victimology: An International Journal, 4*(1), 10–16.

Popen, P. J., & Segal, H. J. (1988). The influence of sex and sex-role orientation on sexual coercion. *Sex Roles, 19*, 689–701.

Stevenson, M. R., & Gajarsky, W. M. (1992). Unwanted childhood sexual experiences relate to later revictimization and male perpetration. *Journal of Psychology & Human Sexuality, 4*, 57–70.

Exhibit

Unwanted Childhood Sexual Experiences Questionnaire

It is now generally realized that most people have sexual experiences as children and while growing up. By "sexual" it is meant any behavior or event that might seem "sexual" to you. Please try to remember the unwanted, that is, sexual experiences that were forced on you or done against your will by an adult (someone at least five or more years older than you), while growing up. Indicate if you had any of the following experiences *before* the age of 16.

1. An invitation or request to do something sexual. Age(s)_____
2. Kissing and hugging in a sexual way. Age(s)_____
3. An adult showing his/her sex organs to you. Age(s)_____
4. You showing your sex organs to an adult. Age(s)_____
5. An adult fondling you in a sexual way. Age(s)_____

[1]Address correspondence to Michael R. Stevenson, P O Box 15700, Northern Arizona University, Flagstaff, AZ 86011; e-mail: Michael.Stevenson@nau.edu

References

Abuse

Exhibit

Childhood Sexual Abuse Scale

Instructions: These next questions are about activity before you were 12 years old.

1. Someone tried to touch me in a sexual way against my will.

2. Someone tried to make me touch them in a sexual way against my will.

3. I believe that I have been sexually abused by someone.

4. Someone threatened to tell lies about me or hurt me unless I did something sexual with them.

Early Sexual Experiences Checklist

ROWLAND S. MILLER 1 AND JAMES A. JOHNSON, Sam Houston State University

1 Address correspondence to Rowland Miller, Division of Psychology and Philosophy, Sam Houston State University, Huntsville, TX 77341-2447;

e-mail: psy_rsm@shsu.edu

Self-report biases and definitional problems have plagued studies of sexual abuse of children. Various investigators have forced respondents to label themselves as “sexu ally abused” (e.g., Kercher & McShane, 1984) or to make subtle distinctions among vague categories (e.g., “kissing or hugging in a sexual way”; Kilpatrick, 1986) in order to be counted as victims of deleterious, unwanted childhood sexual experiences. Miller, Johnson, and Johnson (1991) created the Early Sexual Experiences Checklist (ESEC)

to provide an efficient, accessible procedure for detect

ing such experiences that avoids these methodological and

conceptual problems. The ESEC merely asks respondents

to check any specific, overt sexual behaviors that occurred

when the respondents did not want them to. Coupled with

reports of (a) the respondent’s age during the events, (b)

the age of the person who initiated the events, or (c) any

coercion, the ESEC allows diverse operationalizations of

unwanted sexual experience that span the existing literature

Exhibit

Early Sexual Experiences Checklist

Your sex: _____ Male _____ Female

Early Sexual Experiences

When you were under the age of sixteen (16), did any of
these incidents ever happen to you when you did not want
them to?

Please check those that occurred:

_____ Another person showed his or her sex organs to you.

_____ You showed your sex organs to another person at his
or her request.

_____ Someone touched or fondled your sexual organs.

_____ You touched or fondled another person’s sex organs at
his or her request.

_____ Another person had sexual intercourse with you.

_____ Another person performed oral sex on you.

_____ You performed oral sex on another person.

_____ Someone told you to engage in sexual activity so that

he or she could watch.

_____ You engaged in anal sex with another person.

_____ Other (please specify):
_____

_____ None of these events ever occurred.

If any of these incidents ever happened to you, please answer the following questions by thinking about the one behavior that bothered you

the most.

In addition, please circle the behavior above that bothered you the most.

1. How old were you when it happened? _____

2. Approximately how old was the other person involved?
_____

3. Who was the other person involved?

____ relative ____ friend or acquaintance ____ stranger

4. If the other person was a relative, how were they related to you? (i.e., cousin, father, sister, etc.)
_____

5. How many times did this behavior occur?

____ just once ____ twice ____ 3 or 4 times ____ 5 times or more

6. Over how long a period did this behavior occur?

____ just once ____ a month or less ____ several months ____ a year or more

7. How much did the experience bother you at the time?

1 2 3
4 5 6
7

not at all
moderately
extremely

8. How much does the experience bother you now?

1 2 3
4 5 6
7

not at all
moderately
extremely

9. What kind of psychological pressure or physical force did the person use, if any? Please check all that apply:

_____ They tried to talk you into it.

_____ They scared you because they were bigger or stronger.

_____ They said they would hurt you.

_____ They bribed you.

_____ They pushed, hit, or physically restrained you.

_____ You were afraid they wouldn't like or love you.

_____ They physically harmed or injured you.

_____ They threatened you with a weapon. The What-If-Situations-Test (WIST; Nemerofsky, 1986) was developed to measure performance of preschool-age children in sexual abuse prevention programs. The WIST is constructed from the learning objectives of the Children's Primary Prevention Training Program (Nemerofsky, Sanford, Baer, Cage, & Wood, 1986) and is composed of situations that require the child to determine how he or she would respond. The test items measure the skills and concepts taught in the prevention program and address skills and concepts thought to be essential in reducing the risk of sexual victimization (Conte, Rosen, & Saperstein, 1986; Wurtele, 1987). The WIST can be used as a pretest measure, as well as a measure of performance in sexual abuse prevention programs. Description The WIST consists of 29 items addressing (a) the names and location of the child's "private parts," (b) appropriate requests to touch or to examine the child's genitals by physicians, (c) requests for touching of the child's genitals by others, (d) requests for the child to touch another individual's genitals, (e) the child's right to refuse to be touched, (f) appropriate requests to touch (hug/kiss) the child by

others, (g) requests to keep secrets, (h) requests to keep secrets about genital touching, (i) attempts to provide gifts/bribes/ presents/incentives to touch child's genitals or have the child touch the genitals of another person, (j) actions to be taken if the child was afraid and/or uncomfortable, and (k) the child's role in potential abuse situations. Eleven items require the child to make a determination about the appropriateness of an action or situation (e.g., If someone touches a child's private parts, should the child tell?). Seventeen items deal with actions that a child should take in abuse situations (e.g., What would you do if someone touched your private parts?). One item addresses the names and locations of the child's private parts. Response Mode and Timing The WIST is administered, on an individual basis, by the child's teacher. The child's responses are written down verbatim and scored by comparison to a key. The test requires approximately 15 minutes to complete. Scoring Scores can range from 0 to 64, with higher scores indicating greater understanding of child sexual abuse prevention skills and concepts. WIST items are differently keyed according to the nature of the item. The 11 WIST items requiring the child to make a determination about the appropriateness of an action or situation are scored 0 points for a wrong answer and 1 point for a correct response. The 17 items addressing actions a child could take in abuse situations receive 1 point for an assertive or motoric response, 2 points for disclosure, and 3 points for both an assertive and a disclosure response. The WIST item that requires the child to name and locate his or her private parts receives 0 points for a wrong answer, 1 point for a partial answer (e.g., child names only one private part), and 2 points for a complete correct answer (e.g., a girl's private parts are her vagina, buttocks, and breasts). Reliability In a sample of 1,044 3- to 6-year-old children (Nemerofsky, 1991), the Cronbach's alpha for the WIST was .83, indicating good reliability. Validity In a study using the WIST pretest mean score as the covariate, WIST posttest mean scores of children who had completed a sexual abuse prevention training program were compared to the control group of children who had not received the training. A significant difference was found between groups, with the experimental group of children scoring significantly higher on the WIST posttest following participation in the sexual abuse prevention training program than the control group of children who had not received the training (Nemerofsky, Carran, & Rosenberg, 1994).

_____ They drugged you or got you drunk.

_____ Other (please specify): _____

_____ None of these occurred. What-If-Situations-Test ALAN G. NEMEROFSKY, 1 Community College of Baltimore County D EBORAH T. CARRAN, Johns Hopkins University 1 Address correspondence to Alan G. Nemerofsky, CCBC Essex, 7201 Rossville Blvd., Baltimore, MD 21237; e-mail: ANemerofsky@ccbcmd.edu

Conte, J. R., Rosen, C., & Saperstein, L. (1986). An analysis of programs to prevent the sexual victimization of children. Journal of Primary Prevention, 6, 141–155.

Nemerofsky, A. G. (1986). The What-If-Situations-Test. Baltimore, MD:

Author.

Nemerofsky, A. G. (1991). Child sexual abuse prevention: Teacher and

child variables affecting the learning of skills and concepts in a sexual

abuse prevention program. Unpublished doctoral dissertation, The

Johns Hopkins University, Baltimore, MD. Nemerofsky, A. G., Carran, D. T., & Rosenberg, L. A. (1994). Age variation in performance among preschool age children in a sexual abuse prevention program. Journal of Child Sexual Abuse, 3, 85–102. Nemerofsky, A. G., Sanford, H. J., Baer, B., Cage, M., & Wood, D. (1986). The children's primary prevention training program. Baltimore, MD: Author. Wurtele, S. K. (1987). School-based sexual abuse prevention programs: A review. Child Abuse and Neglect, 11, 483–495.

Exhibit

What-If-Situations-Test

Child Code Number:

Circle: Pretest Posttest

1. Tell me the names of your private parts.

2. What would you do if someone touched you in a way you did not like?

3. What would you do if someone touched you in a way that you liked?

4. What would you do if someone asked you to keep a secret?

5. What would you do if someone tried to touch your private parts?

6. What would you do if someone touched you in a way that made you feel uncomfortable?

7. Is it OK for a mom or dad to give you a hug if you want one? (Circle) Yes No

8. Do you have to let anyone touch you on your private parts? (Circle) Yes No

9. What would you do if someone touched your private parts?

10. What would you do if someone said they would give you a present if you would keep a secret?

11. If someone makes a child touch their private parts:

a. Did the child do anything wrong? Yes No

b. Is it the child's fault? Yes No

c. Should the child tell? Yes No

d. Should the child ask for help? Yes No

12. What would you do if someone asked you to touch their private parts?

13. What would you do if someone asked you to keep a secret about touching private parts?

14. What would you do if someone said they would give you a present if you would touch their private parts?

15. What would you do if someone made you touch their private parts?

16. If someone touches a child's private parts:

a. Did the child do anything wrong? Yes No

b. Is it the child's fault? Yes No

c. Should the child tell? Yes No

d. Should the child ask for help? Yes No

17. Would it be OK for your doctor to look at your private parts if you were hurt there? Yes No

18. What would you do if you were scared or confused or felt uncomfortable?

19. What would you say if someone asked you to touch their private parts?

20. What should a child do if someone touched his/her private parts and promised not to do it again?

21. If someone touched your private parts:

a. What would you say?

b. What would you do?

c. Who would you tell? Empathy can be defined as one individual's reactions to the observed experiences of another (Davis, 1983). A fourstage model of empathy by Marshall, Hudson, Jones, and Fernandez (1995) includes emotion recognition, perspective taking, emotional response, and appropriate action. Several measures have been developed to assess general empathy, such as the Interpersonal Reactivity Index (IRI; Davis,1983), Hogan's Empathy Scale (Hogan, 1969), or the Emotional Empathy Scale (Mehrabian & Epstein, 1972). Sexual offenders typically display a lack of empathy for their victims (Marshall, 1997). Child sexual abuse offenders' empathy deficits are greatest for their own victims compared to nonsexual offenders (Marshall, Hamilton, & Fernandez, 2001). Contact sexual offenders score lower than child pornography offenders in victim empathy (Bates & Metcalf, 2007; Elliott, Beech, Mandeville-Norden, & Hayes, 2009). The Empathy for Children Scale (ECS) was developed to measure an individual's cognitive and emotional empathy for child victims. Three scenarios are used, assessing empathy with respect to an "accident victim," a "stranger child sexual abuse victim," and "(fantasized) own child sexual abuse victim." The ECS can be used as a research tool in examining respective empathy deficits of various subsamples. It can also serve as a clinical tool for therapists in treatment planning and treatment outcome assessment. Description The ECS is based on the Child Molester Empathy Measure (CMEM; Fernandez & Marshall,

2003; Fernandez, Marshall, Lightbody, & O'Sullivan, 1999), in that it uses the same three scenarios to assess empathy for child victims using two subscales (cognitive and emotional empathy) for each scenario. However, as the ECS was specifically developed for administration with pedophilic nonoffenders, the original "own child sexual abuse victim" scenario was modified to offer a fantasized own victim. Changes to the scenarios also improved the comparability of the scenarios. Furthermore, the ECS assesses data regarding age and gender of (fantasized) own victim and imagined general sexual abuse victim. With 75 items rated on 5point Likert-type scales, the ECS is less complex to rate for the respondents, as well as more economic to administer (the CMEM has 150 items and uses 11-point Likert-type scales). Higher scores indicate more empathy. Owing to its design, it may be used in both forensic and nonforensic settings. Therefore, its use is not limited to individuals with known victims, such as convicted sexual offenders. The instrument is available in English, French, and German (Feelgood & Schaefer, 2005). Response Mode and Timing For each item, respondents are to circle the number (0–4; 0 = Not at all; 4 = Very Much) that best describes how, in their opinion, the child might feel (cognitive empathy) and how they feel when imagining what the child experienced (emotional empathy). It typically takes 20 to 30 minutes to complete the instrument. Scoring The items for each subscale are added to form total scores. Items 4 and 7 are reverse scored for cognitive empathy, and Items 1, 8, and 9 are reverse scored for emotional empathy. It is possible to have an overall empathy score for each scenario by simply adding the total scores for cognitive and emotional empathy for the respective scenarios. Reliability One hundred and fifty men (83 reporting sexual contacts with children, 67 "potential" perpetrators) who volunteered for a treatment program for individuals with a sexual interest in minors, the Berlin Prevention Project Dunkelfeld (PPD), completed the ECS as part of an assessment battery (Beier, Ahlers et al., 2009; Beier, Neutze et al., 2009). Cognitive distortion and social desirability were controlled using the Bumby MOLEST Scale (BMS; Bumby, 1996) and the Balanced Inventory of Desirable Responding (BIDR20; Paulhus, 1991; German version: Musch, Brockhaus, Empathy for Children Scale GERARD A. SCHAEFER, 1 Institute of Sexology and Sexual Medicine, Charité— Universitätsmedizin Berlin, Freie und Humboldt-Universität zu Berlin, Germany S TEVEN FEELGOOD, Clinical Psychology and Psychotherapy, Technical University, Dresden, Germany 1 Address correspondence to Gerard A. Schaefer, Institute of Sexology and Sexual Medicine, University Clinic Charité Campus Mitte, Freie und

HumboldtUniversität zu Berlin, Luisenstraße 57, D-10117 Berlin-Mitte, Germany; e-mail: gerard.schaefer@charite.de

& Bröder, 2002). Significant correlations with the BMS cognitive distortion scale were found (-.42 to -.50) and only one small correlation with social desirability (-.19 for accident victim). Internal consistency (Cronbach's alpha = .96) supports the structure of the scale (Schaefer & Feelgood, 2006).

Validity

Comparing child sexual abuse offenders diagnosed with pedophilia, no differences were found between undetected and detected offenders concerning emotional empathy regarding their own victims (Schaefer, Neutze, Mundt, & Beier, 2008). Similar profiles to those found in samples of detected offenders (Marshall et al., 2001) were identified in a sample of PPD offenders (i.e., undetected child sexual abuse offenders). They displayed less empathy for their own victim than for other victims of child sexual abuse and the greatest empathy for a child car accident victim (Schaefer & Feelgood, 2006). Differences between these groups support discriminant validity. The lack of social desirability responding relative to the ECS supports diver gent validity.

Other Information

When using the instrument to assess empathy deficits within a population of known (e.g., convicted) offenders, the text

passages in italicized uppercase letters must be deleted.

Steven Feelgood is also affiliated with the Social Therapy

Unit, Brandenburg an der Havel Prison, Brandenburg,

Germany.

Copies of the instrument and information regarding revi

sions of any part of the instrument may be requested by

e-mail to the first author.

Bates, A., & Metcalf, C. (2007). A psychometric comparison of Internet and non-Internet sex offenders from a community treatment sample. Journal of Sexual Aggression, 13, 11–20.

Beier, K. M., Ahlers, C. J., Goecker, D., Neutze, J., Mundt, I. A., Hupp, E., et al. (2009). Can pedophiles be reached for primary prevention of child sexual abuse? First results of the Berlin Prevention Project Dunkelfeld (PPD). Journal of Forensic Psychiatry and Forensic Psychology, 20, 851–867. Beier, K. M., Neutze, J., Mundt, I. A., Ahlers, C. J., Goecker, D., Konrad, A., et al. (2009). Encouraging self-identified pedophiles and hebephiles to seek professional help: First results of the Berlin Prevention Project Dunkelfeld (PPD). Child Abuse and Neglect, 33, 545–549. Bumby, K. M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. Sexual Abuse: Journal of Research and Treatment, 8, 37–54. Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. Journal of Personality and Social Psychology, 44, 113–126. Elliott, I. A., Beech, A. R., Mandeville-Norden, R., & Hayes, E. (2009). Psychological profiles of Internet sexual offenders: Comparisons with contact sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 21, 76–92. Feelgood, S., & Schaefer, G. A. (2005). German version of the Empathy for Children Scale (ECS). Unpublished manuscript. Fernandez, Y. M., & Marshall, W. L. (2003). Victim empathy, social self-esteem and psychopathy in rapists. Sexual Abuse: A Journal of Research and Treatment, 15, 11–26. Fernandez, Y. M., Marshall, W. L., Lightbody, S., & O'Sullivan, C. (1999). The Child Molester Empathy Measure. Sexual Abuse: A Journal of Research and Treatment, 11, 17–31. Hogan, R. (1969).

Development of an empathy scale. Journal of Consulting and Clinical Psychology, 33, 307–316. Marshall, W. L. (1997). The relationship between self-esteem and deviant sexual arousal in non-familial child molesters. Behavior Modification, 21, 86–96. Marshall, W. L., Hamilton, K., & Fernandez, Y. (2001). Empathy deficits and cognitive distortions in child molesters. Sexual Abuse: A Journal of Research and Treatment, 13, 123–130. Marshall, W. L., Hudson , S. M., Jones, R., & Fernandez, Y. M. (1995). Empathy in sex offenders. Clinical Psychological Review, 15, 99–113. Mehrabian, A., & Epstein, N. (1972). A measure of emotional empathy. Journal of Personality, 40, 525–543. Musch, J., Brockhaus, R., & Bröder, A. (2002). Ein Inventar zur Erfassung von zwei Faktoren sozialer Erwünschtheit [An inventory for the assessment of two factors of social desirability]. Diagnostica, 48(3), 121–129. Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), Measures of personality and social psychological attitudes (pp. 17–41). San Diego, CA: Academic Press. Schaefer, G. A., & Feelgood, S. (2006, September). Validation of a new scale for measuring victim empathy in pedophiles: The Empathy for Children Scale (ECS). Paper presented at the 9th International Conference of the International Association for the Treatment of Sexual Offenders (IATSO), Hamburg, Germany. Schaefer, G. A., Neutze, J., Mundt, I. A., & Beier, K. M. (2008, October). Pedophiles and hebephiles in the community: Findings from the Berlin Prevention Project Dunkelfeld (PPD). Paper presented at the 27th Annual Meeting of the Association for the Treatment of Sexual Abusers, Atlanta, GA. Exhibit Empathy for Children Scale Instructions: In the following you will find three short stories. You will be asked to indicate at first how you believe the child in the story feels, and afterwards how you feel when thinking about the child. Story 1: Imagine a child that was badly injured in road traffic and had to spend some time in hospital. The child is now out of hospital and will live with a permanent disability. In your opinion, how may the child feel or have felt, what may it experience or have experienced while in hospital and afterwards? For each of the following descriptions, please circle the number that best indicates the child’s experience. The child . . . . Not at all Very Much 1. feels guilty. 0 1 2 3 4 2. feels sad. 0 1 2 3 4 3. feels angry. 0 1 2 3 4 4. is self-confident. 0 1 2 3 4 5. has nightmares. 0 1 2 3 4 6. has suicidal thoughts. 0 1 2 3 4 7. is successful in school. 0 1 2 3 4 8. has sleep disturbances. 0 1 2 3 4 9. feels lonely. 0 1 2 3 4 10. is withdrawn from others. 0 1 2 3 4 11. has psychological problems. 0 1 2 3 4 12. feels helpless. 0 1 2 3 4 13. is

suffering. 0 1 2 3 4 14. is tense. 0 1 2 3 4 15. feels ashamed. 0 1 2 3 4 Now please circle the number that best indicates how you feel when imagining what the child experienced. I feel . . . / I am . . . Not at all Very Much 1. cheerful. 0 1 2 3 4 2. furious. 0 1 2 3 4 3. disturbed. 0 1 2 3 4 4. distraught. 0 1 2 3 4 5. devastated. 0 1 2 3 4 6. helpless. 0 1 2 3 4 7. upset. 0 1 2 3 4 8. good. 0 1 2 3 4 9. stimulated. 0 1 2 3 4 10. shocked. 0 1 2 3 4 How old was the child you imagined? Ca. years Of what gender was the child you imagined? c female c male

Story 2:

Now imagine a child that had sex with an adult male. (THE RELATIONSHIP WITH THE CHILD AS WELL AS THE NATURE AND FREQUENCY OF SEXUAL

CONTACT MATCH YOUR OWN SEXUAL EXPERIENCE WITH CHILDREN. IF YOU HAVE NOT HAD ANY SEXUAL EXPERIENCE WITH CHILDREN, THEN IMAGINE THE

STORY MATCHED YOUR USUAL SEXUAL FANTASIES OF CHILDREN.) In your opinion, how may the child feel or have felt, what may it experience or

have experienced while this sexual contact was occurring and afterwards?

For each of the following descriptions, please circle the number that best indicates the child’s experience.

The child . . . Not at all Very Much

1. feels guilty. 0 1 2 3 4

2. feels sad. 0 1 2 3 4

3. feels angry. 0 1 2 3 4

4. is self-confident. 0 1 2 3 4

5. has nightmares. 0 1 2 3 4

6. has suicidal thoughts. 0 1 2 3 4

7. is successful in school. 0 1 2 3 4

8. has sleep disturbances. 0 1 2 3 4

9. feels lonely. 0 1 2 3 4

10. is withdrawn from others. 0 1 2 3 4

11. has psychological problems. 0 1 2 3 4

12. feels helpless. 0 1 2 3 4

13. is suffering. 0 1 2 3 4

14. is tense. 0 1 2 3 4

15. feels ashamed. 0 1 2 3 4

Now please circle the number that best indicates how you
feel when imagining what the child experienced.

I feel . . . / I am . . . Not at all Very Much

1. cheerful. 0 1 2 3 4

2. furious. 0 1 2 3 4

3. disturbed. 0 1 2 3 4

4. distraught. 0 1 2 3 4

5. devastated. 0 1 2 3 4

6. helpless. 0 1 2 3 4

7. upset. 0 1 2 3 4

8. good. 0 1 2 3 4

9. stimulated. 0 1 2 3 4

10. shocked. 0 1 2 3 4

How old was the child you imagined? Ca. years

Of what gender was the child you imagined? c female c male

Story 3:

Now think of a child with whom you have had sexual contact.
(IF YOU HAVE NOT HAD ANY SEXUAL CONTACT WITH CHILDREN,
PLEASE IMAGINE A

CHILD YOU HAD OR HAVE SEX WITH IN YOUR FANTASIES.) In your

opinion, how may the child feel or have felt, what may it experience or have

experienced while this sexual contact was occurring and afterwards?

For each of the following descriptions, please circle the number that best indicates the child's experience.

IF YOU HAVE NOT HAD ANY SEXUAL CONTACT WITH CHILDREN PLEASE TICK THE BOX TO THE RIGHT. ☐

The child . . . Not at all Very Much

1. feels guilty. 0 1 2 3 4

2. feels sad. 0 1 2 3 4

3. feels angry. 0 1 2 3 4

4. is self-confident. 0 1 2 3 4

5. has nightmares. 0 1 2 3 4

6. has suicidal thoughts. 0 1 2 3 4

7. is successful in school. 0 1 2 3 4

8. has sleep disturbances. 0 1 2 3 4

9. feels lonely. 0 1 2 3 4

10. is withdrawn from others. 0 1 2 3 4

11. has psychological problems. 0 1 2 3 4

12. feels helpless. 0 1 2 3 4

13. is suffering. 0 1 2 3 4

14. is tense. 0 1 2 3 4

15. feels ashamed. 0 1 2 3 4

Now please circle the number that best indicates how you feel when imagining what the child experienced.

IF YOU HAVE NOT HAD ANY SEXUAL CONTACT WITH CHILDREN PLEASE TICK THE BOX TO THE RIGHT. ☐

I feel . . . / I am . . . Not at all Very Much

1. cheerful. 0 1 2 3 4

2. furious. 0 1 2 3 4

3. disturbed. 0 1 2 3 4

4. distraught. 0 1 2 3 4

5. devastated. 0 1 2 3 4

6. helpless. 0 1 2 3 4

7. upset. 0 1 2 3 4

8. good. 0 1 2 3 4

9. stimulated. 0 1 2 3 4

10. shocked. 0 1 2 3 4

How old was the child you imagined? Ca. years

Of what gender was the child you imagined? c female c male

1 Address correspondence to Michael R. Stevenson, P O Box 15700, Northern Arizona University, Flagstaff, AZ 86011; e-mail:

Michael.Stevenson@nau.edu

The Unwanted Childhood Sexual Experience Questionnaire

can be used to document the age and extent of respon

dents' unwanted childhood sexual experiences with adults.

Instructions intentionally refer to unwanted childhood sex

ual experiences rather than abusive sexual experiences or

experiences of sexual victimization in an attempt to avoid

unintended bias in reporting. It defines an adult as someone

who is at least 5 years older than the respondent.

Description

Each of the 13 items refers to a different set of behaviors that

can be categorized as minimal contact (Items 1–3), moder

ate contact (Items 4–8), or maximal contact (Items 9–13).

Items were drawn from a larger questionnaire designed by

Finkelhor (1979) and have been used in other studies (e.g.,

Fromuth, 1986; Stevenson & Gajarsky, 1992).

Response Mode and Timing

Respondents simply indicate in the space provided the

age or ages at which any of the unwanted sexual behav

iors occurred. The scale can be completed in less than

5 minutes.

Scoring

The questionnaire allows for the reporting of the frequency

with which each of the behaviors occur in the sample, and

Unwanted Childhood Sexual Experiences

Questionnaire

MICHAEL R. STEVENSON, 1 Ball State University

Exhibit

Unwanted Childhood Sexual Experiences Questionnaire

It is now generally realized that most people have sexual experiences as children and while growing up. By “sexual” it is meant any

behavior or event that might seem “sexual” to you. Please try to remember the unwanted, that is, sexual experiences that were forced

on you or done against your will by an adult (someone at least five or more years older than you), while growing up. Indicate if you had

any of the following experiences before the age of 16.

1. An invitation or request to do something sexual.
Age(s)_____

2. Kissing and hugging in a sexual way. Age(s)_____

3. An adult showing his/her sex organs to you. Age(s)_____

4. You showing your sex organs to an adult. Age(s)_____

5. An adult fondling you in a sexual way. Age(s)_____

Activiity (see Behavior)

Exhibit

Sexual History and Adjustment Questionnaire

Retrospective Reports of Childhood Experiences with Nudity and Sleeping in the Parental Bed

Please use the following scale for questions 1-10: 1 2 3 4 5

almost never rarely sometimes often very often

1. When you were between the ages of 0-5, how often do you remember seeing your mother naked?

2. When you were between the ages of 6-11, how often do you remember seeing your mother naked?

3. When you were between the ages of 0-5, how often do you remember seeing your father naked?

4. When you were between the ages of 6-11, how often do you remember seeing your father naked?

5. When you were between the ages of 0-5, how often do you remember seeing your same-sex siblings or friends naked?

6. When you were between the ages of 6-11, how often do you remember seeing your same-sex siblings or friends naked?

7. When you were between the ages of 0-5, how often do you remember seeing your opposite-sex siblings or friends naked?

8. When you were between the ages of 6-11, how often do you remember seeing your opposite-sex siblings or friends naked?

9. When you were between the ages of 0-5, how often do you remember sleeping in the same bed as your parents?

10. When you were between the ages of 6-11, how often do you remember sleeping in the same bed as your parents?

Parental Attitudes Items

Please use the following scale for questions 11-14: 1 2 3 4 5

extreme moderate neither comfort moderate extreme

discomfort discomfort nor discomfort comfort comfort

11. In general, over the course of your childhood, please rate the degree of comfort you felt in talking about sexual matters with your mother:

12. In general, over the course of your childhood, please rate the degree of comfort you felt in talking about sexual matters with your father:

13. While you were growing up, please rate the degree of comfort you think your mother felt when talking about sexuality:

14. While you were growing up, please rate the degree of comfort you think your father felt when talking about sexuality:

15. How would you characterize your mother's attitude toward sexuality when you were growing up? 1 2 3 4 5

extremely moderately neither positive moderately extremely

negative negative nor negative positive positive 16. How would you characterize your father's attitude toward sexuality when you were growing up? 1 2 3 4 5 extremely moderately neither positive moderately extremely negative negative nor negative positive positive 17. Overall, how well do you feel that your upbringing prepared you to deal with issues of sexuality and sexual relationships? 1 2 3 4 5 not at all poorly adequately pretty well very well 18. How often do you remember issues of sexuality being discussed in your home when you were growing up? 1 2 3 4 5 almost never rarely sometimes often very often 19. In general, how often was there physical contact/affection displayed in your family? 1 2 3 4 5 almost never rarely sometimes often very often Sexual Adjustment Items Please use the following scale for questions 20-29: 1 2 3 4 5 strongly somewhat neither agree somewhat strongly disagree disagree nor disagree agree agree 20. I feel good about myself. 21. I experience guilt or anxiety when it comes to my sex life. 22. I am happy with my sex life. 23. I am heterosexual. 24. I have sex more often than

most people of my age and situation (e.g., married versus single). 25. I tend to engage in casual sexual relationships. 26. I have experienced sexual problems. 27. I would like my sex life to be more active than it is. 28. I am very consistent in making certain that birth control is a part of my sexual encounters. 29. I am knowledgeable about sex. 30. Regarding physical contact and affection in your family how often do you remember having feelings of discomfort about this contact? 1 2 3
4 5 almost never rarely sometimes often very
often

Lief, H. I., Fullard, W., & Devlin, S. J. (1990). A new measure of adolescent sexuality: SKAT-A. Journal of Sex Education and Therapy, 16, 79–91.

Lief, H. I., & Reed, D. M. (1972). Sex Knowledge and Attitude Test. Philadelphia: University of Pennsylvania, Center for the Study of Sex Education in Medicine.
MacCallum, R. (1986). Specification searches in covariance structure modeling. Psychological Bulletin, 100, 107–120.
Werts, C. E., Linn, R. L., & Jöreskog, K. J. (1974). Interclass reliability estimates: Testing structural assumptions. Educational and Psychological Measurement, 34, 25–33.

1 Address correspondence to Douglas Kirby, ETR Associates, P. O. Box 1830, Santa Cruz, CA 95061-1830; e-mail: dougk@etr.org

Mathtech Questionnaires: Sexuality Questionnaires

for Adolescents

DOUGLAS KIRBY, 1 ETR Associates

The questionnaires have two purposes: first, to measure the

most important knowledge areas, attitudes, values, skills,

and behaviors that either facilitate a positive and fulfilling

sexuality or reduce unintended pregnancy among adoles

cents; and second, to measure important possible outcomes

of sexuality education programs.

The Center for Disease Control funded Mathtech, a private

research firm, to develop methods of evaluating sexuality

education programs. Mathtech reviewed existing question

naires for adolescents and determined that it was necessary

to develop new questionnaires. With the help of about 20

professionals in the field of adolescent sexuality and preg

nancy, Mathtech identified more than 100 possible outcomes of sexuality education programs and then had 100 professionals rate (anonymously) each of those outcomes according to its importance in reducing unintended pregnancy and facilitating a positive and fulfilling sexuality. Mathtech then calculated the mean ratings of those outcomes and developed questionnaires to measure many of the most important outcomes. The questionnaires, which measure these important outcomes, include the Knowledge Test, the Attitude and Value Inventory, and the Behavior Inventory.

KNOWLEDGE TEST

Description

The Knowledge Test is a 34-item multiple-choice test. It includes questions in the following areas: adolescent physical development, adolescent relationships, adolescent sexual activity, adolescent pregnancy, adolescent marriage, the probability of pregnancy, birth control, and sexually transmitted disease. It has been used successfully with both junior and senior high school students.

To develop the questionnaires, we completed the following steps: (a) generated between 5 and 20 items in each of the content areas that the 100 professionals indicated as important; (b) pretested the questionnaire with small groups of adolescents and adults, and clarified many items; (c) administered the questionnaire to 729 adolescents, analyzed their answers, removed items that were too easy or too difficult, and also removed items not positively related to the overall test score; (d) removed questions

from content domains that had too many questions; and (e) made numerous refinements following subsequent administrations of the questionnaires and reviews by other professionals. Response Mode and Timing Respondents circle the single best answer to each question. Bright students commonly take about 15 to 20 minutes; slower students may take as long as 45 minutes to complete the questionnaire. Scoring The answers to the test are included at the end of the test (see the Exhibit). To obtain the percentage correct, count the number of correct answers and divide by 34. No special provisions are made for students who do not answer questions. Reliability The test was administered to 58 adolescents on one occasion, and then again 2 weeks later. The test-retest reliability coefficient was .89. Validity Older students obtained higher scores than younger students; and students with overall higher grade point TABLE 1 Reliability Coefficients for the Scales in the Attitude and Value Inventory Cronbach's alpha Scale .89 Clarity of long term goals .73 Clarity of personal sexual values .81 Understanding of emotional needs .78 Understanding of personal social behavior .80 Understanding of personal sexual response .66 Attitude toward gender roles .75 Attitude toward sexuality in life .72 Attitude toward the importance of birth control .94 Attitude toward premarital sex .58 Attitude toward the use of force and pressure in sexual activity .70 Recognition of the importance of the family .73 Self esteem .85 Satisfaction with personal sexuality .81 Satisfaction with social relationships TABLE 2 Reliability Coefficients for the Scales in the Behavior Inventory Test Retest r a n Alpha b n Scale .84 39 .58 541 Social decision making skills .65 36 .61 464 Sexual decision making skills .57 41 .75 529 Communication skills .68 32 .62 409 Assertiveness skills .88 17 .58 243 Birth control assertiveness skills .69 40 .81 517 Comfort engaging in social activities .66 36 .66 461 Comfort talking with friends, girl/ boyfriend, and parents about sex .40 33 .63 133 Comfort talking with friends, girl/ boyfriend, and parents about birth control .62 39 .73 156 Comfort talking with parents about sex and birth control .44 41 NA c NA Comfort expressing concern and caring .68 35 .68 455 Comfort being sexually assertive (saying no) .70 37 NA NA Comfort having current sex life, what ever it may be .38 14 .86 449 Comfort getting and using birth control a The test retest coeffi cient is the correlation coeffi cient based upon two administrations of the same questionnaire 2 weeks apart. b Alpha is Cronbach's alpha based upon all the intercorrelations within each scale. c NA means not applicable because alpha requires two or more items, and these scales had only one item. averages had higher scores

than students with lower grade point averages. Content validity was determined by experts who selected both the domains and the items for the domains. ATTITUDE AND VALUE INVENTORY Description The Attitude and Value Inventory includes 14 different scales, each consisting of five 5-point Likert-type items. The responses include strongly disagree, disagree, neutral, agree, strongly agree. The scales are identified in Table 1. To develop the questionnaires, we completed the following steps: (a) generated 5 to 10 items for each of the psychological outcomes rated important by the 100 experts; (b) had the items reviewed by small groups of both adults and adolescents who made suggestions for changes; (c) had two psychologists trained in questionnaire design and scale construction examine each item for unidimensionality and clarity; and (d) had more than 200 adolescents complete the questionnaire, removing those items that had a correlation coeffi cient greater than .30 with the Crowne-Marlowe (1964) Social Desirability Scale, that had the lowest scale loadings on each scale, and that had mean scores near the minimum or maximum possible score. Response Mode and Timing Respondents should circle the number indicating their agreement/disagreement with each item. Bright adolescents complete the questionnaire in about 10 minutes; slower students may take a half hour. Scoring Following the Attitude and Value Inventory are all the scales, with the items grouped by scale. In front of each item is a plus sign or minus sign indicating whether the item should be positively scored or reverse scored. The mean score for each scale should be determined by adding the responses and dividing by 5. Higher scores represent more favorable attitudes. Reliability Reliability was determined by administering the questionnaire to 990 students and calculating Cronbach's alpha. These are included in Table 1. BEHAVIOR INVENTORY Description Many behaviors have at least three important components or aspects to them: the skill with which the behavior is completed, the comfort experienced during that behavior, and the frequency of that behavior. The Behavior Inventory measures these three aspects of several kinds of behavior. The actual measures are identified in Tables 2 and 3. The questions measuring skills use 5-point scales with answers ranging from almost always to almost never; those measuring comfort use 4-point scales ranging from comfortable to very uncomfortable; those measuring sexual activity, use of birth control, and frequency of communication ask how many times during the previous month the respondent engaged in the specified activity.

TABLE 3

Test retest Reliability Coefficients for the Behavior Questions

in the Behavior Inventory

r a Question

1.00 Q43: Ever had sexual intercourse

.78 Q44: Had intercourse last month

.88 Q45: Frequency of intercourse last month

.97 Q46: Frequency of intercourse last month with no birth control

.89 Q47: Frequency of intercourse last month using diaphragm,

withdawal, rhythm, or foam (without condoms)

.97 Q48: Frequency of intercourse last month using pill, condoms,

or IUD

.80 Q49: Frequency of conversations with parents about sex last

month

.81 Q50: Frequency of conversations with friends about sex last

month

.83 Q51: Frequency of conversations with boy/girlfriend about sex

last month

.71 Q52: Frequency of conversations with parents about birth

control last month

.69 Q53: Frequency of conversations with friends about birth

control last month

.75 Q54: Frequency of conversations with boy/girlfriend about

birth control last month

Note: N = 41.

a The measure of reliability is the correlation coefficient between the two

administrations of the questionnaire given 2 weeks apart.

It is important to realize that the questions measuring

skill do not try to assess skill in the classroom but, instead,

measure the frequency with which respondents actually use

important skills in everyday life.

The panel of 100 experts rated most highly most of the

skills, areas of comfort, and behaviors for which we devel

oped measures. We tried many different ways of measuring

skills and after a variety of attempts and pretests with small

groups of adolescents, we settled on the current approach

in which we identified key behaviors in various skills and

simply asked what proportion of the time respondents

engage in those behaviors.

The scales measuring comfort and behaviors flowed

directly from the outcomes specified by the experts. We

conducted minitests with both adults and adolescents to

determine for how many months they could accurately

measure their communication and sexual behavior. Nearly

all adolescents could remember their behavior for the pre

vious month.

The entire inventory was reviewed by psychologists

who examined each item for clarity, unidimensionality, and

comprehensibility. More than 100 adolescents completed

the questionnaire; their responses indicated that most data

were reliable.

Because of the great sensitivity of these questions, the

researcher should (a) get appropriate approval to administer

the questionnaire, (b) emphasize to the students that com

pleting the questionnaire is voluntary, and (c) take every

reasonable measure to assure that the answers remain abso

Exhibit

Knowledge Test

We are trying to find out is this program is successful.
You can help us by completing this questionnaire.

To keep your answers confidential and private, do not put
your name anywhere on this questionnaire. Please use a
regular pen or pencil

so that all questionnaires will look about the same and no
one will know which is yours.

Because this study is important, your answers are also
important. Please answer each question carefully. Thank you
for your help.

Name of school or organization where course was
taken:_____

Teacher's name:

Your birth date: Month Day
_____

Your sex (Check one): Male Female
_____

Your grade level in school (Check one): 9_10_11_12_

Please circle the one best answer to each of the questions below.

1. By the time teenagers graduate from high schools in the United States:

a. only a few have had sex (sexual intercourse).

b. about half have had sex.

c. about 80% have had sex.

2. During their menstrual periods, girls:

a. are too weak to participate in sports or exercise.

b. have a normal, monthly release of blood from the uterus.

c. cannot possibly become pregnant.

d. should not shower or bathe.

e. all of the above.

3. It is harmful for a woman to have sex (sexual intercourse) when she:

a. is pregnant.

b. is menstruating.

c. has a cold.

d. has a sexual partner with syphilis.

e. none of the above.

4. Some contraceptives:

a. can be obtained only with a doctor’s prescription.

b. are available at family planning clinics.

c. can be bought over the counter at drug stores.

d. can be obtained by people under 18 without their parents’ permission.

e. all of the above.

5. If 10 couples have sexual intercourse regularly without using any kind of birth control, the number of couples who become pregnant by the end of 1 year is about:

a. one.

b. three.

c. six

d. nine.

e. none of the above.

6. When unmarried teenage girls learn they are pregnant, the largest group of them decide:

a. to have an abortion.

b. to put the child up for adoption.

c. to raise the child at home.

d. to marry and raise the child with the husband.

e. none of the above.

7. People having sexual intercourse can best prevent getting a sexually transmitted disease (VD or STD) by using:

a. condoms (rubbers).

b. contraceptive foam.

c. the pill.

d. withdrawal (pulling out).

8. When boys go through puberty:

a. they lose their “baby fat” and become slimmer.

b. their penises become larger.

c. they produce sperm.

d. their voices become lower.

e. all of the above.

9. Married teenagers:

a. have the same social lives as their unmarried friends.

b. avoid pressure from friends and family.

c. still fit in easily with their old friends.

d. usually support themselves without help from their parents.

e. none of the above.

10. If a couple has sexual intercourse and uses no birth control, the woman might get pregnant:

a. anytime during the month.

b. only 1 week before menstruation begins.

c. only during menstruation.

d. only 1 week after menstruation begins.

e. only 2 weeks after menstruation begins.

11. The method of birth control which is least effective is:

a. a condom with foam.

b. the diaphragm with spermicidal jelly.

c. withdrawal (pulling out).

d. the pill.

e. abstinence (not having intercourse).

12. It is possible for a woman to become pregnant:

a. the first time she has sex (sexual intercourse).

b. if she has sexual intercourse during her menstrual period.

c. if she has sexual intercourse standing up.

d. if sperm get near the opening of the vagina, even though the man's penis does not enter her body.

e. all of the above.

13. Physically:

a. girls usually mature earlier than boys.

b. most boys mature earlier than most girls.

c. all boys and girls are fully mature by age 16.

d. all boys and girls are fully mature by age 18.

14. It is impossible now to cure:

a. syphilis.

b. gonorrhea.

c. herpes virus # 2.

d. vaginitis.

e. all of the above.

15. When men and women are physically mature:

a. each female ovary releases two eggs each month.

b. each female ovary releases millions of eggs each month.

c. male testes produce one sperm for each ejaculation (climax).

d. male testes produce millions of sperm for each ejaculation (climax).

e. none of the above.

16. Teenagers who choose to have sexual intercourse may possibly:

a. have to deal with a pregnancy.

b. feel guilty.

c. become more close to their sexual partners.

d. become less close to their sexual partners.

e. all of the above.

17. As they enter puberty, teenagers become more interested in sexual activities because:

a. their sex hormones are changing.

b. the media (TV, movies, magazines, records) push sex for teenagers.

c. some of their friends have sex and expect them to have sex also. d. all of the above. 18. To use a condom the correct way, a person must: a. leave some space at the tip for the guy's fluid. b. use a new one every time sexual intercourse occurs. c. hold it on the penis while pulling out of the vagina. d. all of the above. 19. The proportion of American girls who become pregnant before turning 20 is: a. 1 out of 3. b. 1 out of 11. c. 1 out of 43. d. 1 out of 90. 20. In general, children born to young teenage parents: a. have few problems because their parents are emotionally mature. b. have a greater chance of being abused by their parents. c. have normal birth weight. d. have a greater chance of being healthy. e. none of the above. 21. Treatment for venereal disease is best if: a. both partners are treated at the same time. b. only the partner with the symptoms sees a doctor. c. the person takes the medicine only until the symptoms disappear. d. the partners continue having sex (sexual intercourse). e. all of the above. 22. Most teenagers: a. have crushes or infatuations that last a short time. b. feel shy or awkward when first dating. c. feel jealous sometimes. d. worry a lot about their looks. e. all of the above. 23. Most unmarried girls who have children while still in high school: a. depend upon their parents for support. b. finish high school and graduate with their class. c. never have to be on public welfare. d. have the same social lives as their peers. e. all of the above. 24. Syphilis: a. is one of the most dangerous of the venereal diseases. b. is known to cause blindness, insanity, and death if untreated. c. is first detected as a chancre sore on the genitals. d. all of the above. 25. For a boy, nocturnal emissions (wet dreams) means he: a. has a sexual illness. b. is fully mature physically. c. is experiencing a normal part of growing up. d. is different from most other boys. 26. If people have sexual intercourse, the advantage of using condoms is that they: a. help prevent getting or giving VD. b. can be bought in

drug stores by either sex. c. do not have dangerous side effects. d. do not require a prescription. e. all of the above. 27. If two people want to have a close relationship, it is important that they: a. trust each other and are honest and open with each other. b. date other people. c. always think of the other person first. d. always think of their own needs first. e. all of the above.

28. The physical changes of puberty:

a. happen in a week or two.

b. happen to different teenagers at different ages.

c. happen quickly for girls and slowly for boys.

d. happen quickly for boys and slowly for girls.

29. For most teenagers, their emotions (feelings):

a. are pretty stable.

b. seem to change frequently.

c. don’t concern them very much.

d. are easy to put into words.

e. are ruled by their thinking.

30. Teenagers who marry, compared to those who do not:

a. are equally likely to finish high school.

b. are equally likely to have children.

c. are equally likely to get divorced.

d. are equally likely to have successful work careers.

e. none of the above.

31. The rhythm method (natural family planning):

a. means couples cannot have intercourse during certain days of the woman’s menstrual cycle.

b. requires the woman to keep a record of when she has her period.

c. is effective less than 80% of the time.

d. is recommended by the Catholic church.

e. all of the above.

32. The pill:

a. can be used by any woman.

b. is a good birth control method for women who smoke.

c. usually makes menstrual cramping worse.

d. must be taken for 21 or 28 days in order to be effective.

e. all of the above.

33. Gonorrhea:

a. is 10 times more common than syphilis.

b. is a disease that can be passed from mothers to their children during birth.

c. makes many men and women sterile (unable to have babies).

d. is often difficult to detect in women.

e. all of the above.

34. People choosing a birth control method:

a. should think only about the cost of the method.

b. should choose whatever method their friends are using.

c. should learn about all the methods before choosing the one that’s best for them.

d. should get the method that’s easiest to get.

e. all of the above.

Answers to the Knowledge Test

Question	Answer	Question	Answer	Question	Answer
1	b	12	e	23	a

2 b 13 a 24 d

3 d 14 c 25 c

4 e 15 d 26 e

5 d 16 e 27 a

6 a 17 d 28 b

7 a 18 d 29 b

8 e 19 a 30 e

9 e 20 b 31 e

10 a 21 a 32 d

11 c 22 e 33 e

34 c Attitude and Value Inventory The questions below are not a test of how much you know. We are interested in what you believe about some important issues. Please rate each statement according to how much you agree or disagree with it. Everyone will have different answers. Your answer is correct if it describes you very well. Circle: 1 = if you Strongly Disagree with the statement. a 2 = if you Somewhat Disagree with the statement. 3 = if you feel Neutral about the statement. 4 = if you Somewhat Agree with the statement. 5 = if you Strongly Agree with the statement. 1. I am very happy with my friendships. 2. Unmarried people should not have sex (sexual intercourse). 3. Overall, I am satisfied with myself. 4. Two people having sex should use some form of birth control if they aren't ready for a child. 5. I'm confused about my personal sexual values and beliefs. 6. I often find myself acting in ways I don't understand. 7. I am not happy with my sex life. 8. Men should not hold jobs traditionally held by women. 9. People should never take "no" for an answer when they want to have sex. 10. I don't know what I want out of life. 11. Families do very little for their children. 12. Sexual relationships create more problems than they're worth. 13. I'm confused about what I should and should not do sexually. 14. I know what I want and need emotionally. 15. No one should pressure another person into sexual activity. 16. Birth control is not very important. 17. I know what I need to be happy. 18. I am not satisfied with my sexual behavior (sex life). 19. I usually understand the way I act. 20. People should not

have sex before marriage. 21. I do not know much about my own physical and emotional sexual responses. 22. It is all right for two people to have sex before marriage if they are in love. 23. I have a good idea of where I'm headed in the future. 24. Family relationships are not important. 25. I have trouble knowing what my beliefs and values are about my personal sexual behavior. 26. I feel I do not have much to be proud of. 27. I understand how I behave around others. 28. Women should behave differently from men most of the time. 29. People should have sex only if they are married. 30. I know what I want out of life. 31. I have a good understanding of my own personal feelings and reactions. 32. I don't have enough friends. 33. I'm happy with my sexual behavior now. 34. I don't understand why I behave with my friends as I do. 35. At times I think I'm no good at all. 36. I know how I react in different sexual situations. 34. I have a clear picture of what I'd like to be doing in the future. 38. My friendships are not as good as I would like them to be. 39. Sexually, I feel like a failure. 40. More people should be aware of the importance of birth control. 41. At work and at home, women should not have to behave differently from men, when they are equally capable. 42. Sexual relationships make life too difficult. 43. I wish my friendships were better. 44. I feel that I have many good personal qualities. 45. I am confused about my reactions in sexual situations.

46. It is all right to pressure someone into sexual activity.

47. People should not pressure others to have sex with them.

48. Most of the time my emotional feelings are clear to me.

49. I have my own set of rules to guide my sexual behavior (sex life).

50. Women and men should be able to have the same jobs, when they are equally capable.

51. I don't know what my long-range goals are.

52. When I'm in a sexual situation, I get confused about my feelings.

53. Families are very important.

54. It is all right to demand sex from a girlfriend or boyfriend.

55. A sexual relationship is one of the best things a person can have.

56. Most of the time I have a clear understanding of my feelings and emotions.

57. I am very satisfied with my sexual activities just the way they are.

58. Sexual relationships only bring trouble to people.

59. Birth control is not as important as some people say.

60. Family relationships cause more trouble than they're worth.

61. If two people have sex and aren't ready to have a child, it is very important they use birth control.

62. I'm confused about what I need emotionally.

63. It is all right for two people to have sex before marriage.

64. Sexual relationships provide an important and fulfilling part of life.

65. People should be expected to behave in certain ways just because they are male or female.

66. Most of the time I know why I behave the way I do.

67. I feel good having as many friends as I have.

68. I wish I had more respect for myself.

69. Family relationships can be very valuable.

70. I know for sure what is right and wrong sexually for me.

a The five response options are repeated following each item.

Scales in the Attitude and Value Inventory

Clarity of Long-Term Goals: -Q10, +Q23, +Q30, +Q37, +Q51.

Clarity of Personal Sexual Values: -Q5, -Q13, -Q25, +Q49, +70.

Understanding of Emotional Needs: +Q14, +Q17, +Q48, +Q56, -Q62.

Understanding of Personal Social Behavior: -Q6, +Q19, +Q27, -Q34, +Q66.

Understanding of Personal Sexual Responses: -Q21, +Q31, +Q36, -Q45, -Q52.

Attitude Toward Various Gender Role Behaviors: -Q8, -Q28, +Q41, +Q50, +Q65.

Attitude Toward Sexuality in Life: -Q12, -Q42, +Q55, -Q58, +64.

Attitude Toward the Importance of Birth Control: +Q4, -Q16, +Q40, -Q59, +Q61.

Attitude Toward Premarital Intercourse: +Q2, +Q20, -Q22, +Q29, -Q63.

Attitude Toward the Use of Pressure and Force in Sexual Activity: -Q9, +Q15, -Q46, +Q47, +Q54.

Recognition of the Importance of the Family: -Q11, -Q24, +Q53, -Q60, +Q69.

Self-Esteem: +Q3, -Q26, -Q35, +Q44, -Q68.

Satisfaction with Personal Sexuality: -Q7, -Q18, +Q33, -Q39, +Q57.

Satisfaction with Social Relationships: +Q1, -Q32, -Q38, -Q43, +Q67.

Note. + means that the item is positive; - means the item is negative and should be reverse scored. On some scales, people will have different views about

whether larger scores represent socially desirable or undesirable scores.

Behavior Inventory

Part 1

The questions below ask how often you have done some things. Some of the questions are personal and ask about your social life

and sex life. Some questions will not apply to you. Please do not conclude from the questions that you should have had all of the

experiences the questions ask about. Instead, just mark whatever answer describes you best.

Circle: 1 = if you do it almost never, which means about 5% of the time or less. 2 = if you do it sometimes, which means about 25% of the time. 3 = if you do if half the time, which means about 50% of the time. 4 = if you do it usually, which means about 75% of the time. 5 = if you do it almost always, which means about 95% of the time or more. DNA = if the question does not apply to you. 1. When things you've done turn out poorly, how often do you take responsibility for your behavior and its consequences? a 2. When things you've done turn out poorly, how often do you blame others? 3. When you are faced with a decision, how often do you take responsibility for making a decision about it? 4. When you have to make a decision, how often do you think hard about the consequences of each possible choice? 5. When you have to make a decision, how often do you get as much information as you can before making the decision? 6. When you have to make a decision, how often do you fi rst discuss it with others? 7. When you have to make a decision about your sexual behavior (for example, going out on a date, holding hands, kissing, petting, or having sex), how often do you take responsibility for the consequences? 8. When you have to make a decision about your sexual behavior, how often do you think hard about the consequences of each possible choice? 9. When you have to make a decision about your sexual behavior, how often do you first get as much information as you can? 10. When you have to make a decision about your sexual behavior, how often do you first discuss it with others? 11. When you have to make a decision about your sexual behavior, how often do you make it on the spot without worrying about the consequences? 12. When a friend wants to talk with you, how often are you able to clear your mind and really listen to what your friend has to say? 13. When a friend is talking with you, how often do you ask questions if you don't understand what your friend in saying? 14. When a friend is talking with you, how often do you nod your head and say "yes" or something else to show that you are interested? 15. When you want to talk with a friend, how often are you able to get your friend to really listen to you? 16. When you talk with a friend, how often do you ask for your friend's reaction to what you've said? 17. When you talk with a friend, how often do you let your feelings show? 18. When you are with a friend you care about, how

often do you let that friend know you care? 19. When you talk with a friend, how often do you include statements like “my feelings are . . .,” “the way I think is . . .,” or “it seems to me”? 20. When you are alone with a date or boy/girlfriend, how often can you tell him/her your feelings about what you want to do and do not want to do sexually? (If you are a boy, boy/girlfriend means girlfriend; if you are a girl, it means boyfriend.) 21. If a boy/girl puts pressure on you to be involved sexually and you don’t want to be involved, how often do you say “no”? (If you are a boy, boy/girl means girl; if you are a girl, it means boy.) 22. If a boy/girl puts pressure on you to be involved sexually and you don’t want to be involved, how often do you succeed in stopping it? 23. If you have sexual intercourse with your boy/girlfriend, how often can you talk with him/her about birth control? 24. If you have sexual intercourse and want to use birth control, how often do you insist on using birth control? Part 2 In this section, we want to know how uncomfortable you are doing different things. Being “uncomfortable” means that it is difficult for you and it makes you nervous and uptight. For each item, circle the number that describes you best, but if the item doesn’t apply to you, circle DNA. Circle: 1 = if you are comfortable. 2 = if you are a little uncomfortable. 3 = If you are somewhat uncomfortable. 4 = If you are very uncomfortable. DNA = if the question does not apply to you. 25. Getting together with a group of friends of the opposite sex. b 26. Going to a party. 27. Talking with teenagers of the opposite sex. 28. Going out on a date. 29. Talking with friends about sex. 30. Talking with a date or boy/girlfriend about sex. (If you are a boy, boy/girlfriend means girlfriend; if you are a girl, it means boyfriend.)

31. Talking with parents about sex.

32. Talking with friends about birth control.

33. Talking with a date or boy/girlfriend about birth control. (If you are a boy, boy/girlfriend means girlfriend; if you are a girl, it means boyfriend.)

34. Talking with parents about birth control.

35. Expressing concern and caring for others.

36. Telling a date or boy/girlfriend what you want to do and do not want to do sexually.

37. Saying “no” to a sexual come-on.

38. Having your current sex life, whatever it may be (it may be doing nothing, kissing, petting, or having intercourse).

If you are not having sexual intercourse, circle DNA in the four questions below.

39. Insisting on using some form of birth control, if you are having sex.

40. Buying contraceptives at a drug store, if you are having sex.

41. Going to a doctor or clinic for contraception, if you are having sex.

42. Using some form of birth control, if you are having sex.

Part 3

Circle the correct answer to the following two questions.

43. Have you ever had sex (sexual intercourse)? yes no

44. Have you had sex (sexual intercourse) during the last month? yes no

Part 4

The following questions ask how many times you did some things during the last month. Put a number in the right hand space to show

the number of times you engaged in that activity. If you did not do that during the last month, put a “0” in the space.

Think carefully about the times that you have had sex during the last month. Think also about the number of times you did not use birth

control and the number of times you used different types of birth control.

45. Last month, how many times did you have sex (sexual intercourse) ____ times in the last month

46. Last month, how many times did you have sex when you or your partner did not use

any form of birth control? ____ times in the last month

47. Last month, how many times did you have sex when you or your partner used a

diaphragm, withdrawal (pulling out before releasing fluid), rhythm (not having sex on

fertile days), or foam without condoms? ____ times in the last month

48. Last month, how many times did you have sex when you or your partner used the pill,

condoms (rubbers), or an IUD? ____ times in the last month

If you add your answer to questions #46, #47, and #48, the total number should equal your answer to #45. (If it does not, please cor

rect your answers.)

49. During the last month, how many times have you had a conversation or discussion

about sex with your parents? ____ times in the last month

50. During the last month, how many times have you had a conversation or discussion about

sex with your friends? ____ times in the last month

51. During the last month, how many times have you had a conversation or discussion about

sex with a date or boy/girlfriend? (If you are a boy, boy/girlfriend means girlfriend; if you

are a girl, it means boyfriend.) ____ times in the last month

52. During the last month, how many times have you had a conversation or discussion

about birth control with your parents? ____ times in the last month

53. During the last month, how many times have you had a conversation or discussion

about birth control with your friends? ____ times in the last month

54. During the last month, how many times have you had a conversation or discussion about

birth control with a date or boy/girlfriend? ____ times in the last month

Thank you for completing this questionnaire.

a The six response options are repeated following Items 1–24.

b The five response options are repeated following Items 25–42. Scales in the Behavior Inventory Social decision-making skills Comfort talking with friends, girl/boyfriend, and parents about birth control +Q1 –Q32 –Q2 –Q33 +Q3 –Q34 +Q4 +Q5 +Q6 Sexual decision-making skills Comfort talking with parents about sex and birth control +Q7 –Q31 –Q8 –Q34 +Q9 +Q10 –Q11 Communication skills Comfort expressing concern and caring +Q12 –Q35 +Q13 +Q14 +Q15 +Q16 +Q17 +Q18 +Q19 Assertiveness skills Comfort being sexually assertive (saying “No”) +Q20 –Q36 +Q21 –Q37 +Q22 Birth control assertiveness skills Comfort having current sex life, whatever it may be +Q23 –Q38 +Q24 Comfort engaging in social activities Comfort getting and using birth control –Q25 –Q39 –Q26 –Q40 –Q27 –Q41 –Q28 –Q42 Comfort talking with friends, girl/boyfriend, and parents about sex Q29 Q30 Q31 Note. + means the item is positive; – means the item is negative and should be reverse scored.

The Worry About Sexual Outcomes (WASO) Scale was

developed to assess adolescents’ worry regarding outcomes

of risky sexual behavior (i.e., STIs/HIV infection and unin

tended pregnancy; Sales et al., 2008).

Description

The WASO was developed as part of an NIMH-funded

intervention grant (Sales et al., 2008). Domains pertinent

to worry about the outcomes of risky sexual behavior were

selected based on a review of the empirical literature.

Three topics were frequently noted in the literature with regard to worry pertaining to the sexual outcomes of risky sexual behavior: (a) pregnancy, (b) STI, and (c) HIV. Focus groups of African American adolescent females were conducted to verify that these topics were relevant in their sexual relationships. Eighteen items were created to assess worry in these domains. Health educators assessed face validity of the items. The measure was pilot-tested on 15 African American adolescent females 14 to 18 years of age. Based on their suggestions, items were revised to enhance reading comprehension. Items that were highly correlated and thought to assess the same construct, as well as items that decreased the Cronbach's alpha below .90, were deleted, leaving a 10-item scale consisting of two subscales: STI/HIV Worry (8 items) and Pregnancy Worry (2 items). Data from a longitudinal evaluation study were used to validate the measure (Sales et al., 2008).

Though the WASO was designed for adolescent females and validated with an African American female sample, the items are likely more broadly applicable to individuals of other racial or ethnic backgrounds and other age groups, and to males.

Response Mode and Timing

A single stem is used for all items, "In the past 6 months,

how often did you worry that . . .” Each item requires a response based on a 4-point Likert-type scale: 1 (Never), 2 (Sometimes), 3 (Often), and 4 (Always). The scale typically takes less than 5 minutes to complete. Scoring All items are coded so that higher values indicate more frequent worrying about these health outcomes. Scores can be calculated in two ways: (a) items are summed to create a total scale score for the full 10 items, or (b) items are summed to create two subscale scores: STI/HIV Worry (8 items) and Pregnancy Worry (2 items). Scores on the total scale range from 10 to 40. Scores on the STI/HIV Worry subscale range from 8 to 32. Scores on the Pregnancy Worry subscale range from 2 to 8. The mean score for participants in our validation sample for the total scale was 16.81 (SD = 6.43). Participants in the validation sample had a mean score of 15.52 (SD = 5.96) for the STI/HIV Worry subscale and a mean score of 4.43 (SD = 2.03) for the Pregnancy Worry subscale (Sales et al., 2008). Reliability Stability of the measure was assessed by Pearson correlation. Because it has been suggested that the length of time between reliability assessments mirrors the length of time in intervention studies (Gliner, Morgan, & Harmon, 2001), measurement stability was assessed with 6 months between administrations. Baseline scores on the full WASO (all 10 items) were significantly correlated with scores at 6-month follow-up ($r = .38$, $p < .01$) and with scores at 12-month follow-up ($r = .27$, $p < .01$). Further, scores at 6-month follow-up were significantly correlated with scores at 12-month follow-up ($r = .44$, $p < .01$; Sales et al., 2008). Validity The WASO was correlated with other related constructs in the predicted directions (Sales et al., 2008). Specifically, frequency of worry about sexual outcomes was negatively associated with sexual communication self-efficacy (with new partner and steady partner), frequency of sexual communication with partner (Milhausen et al., 2007), attitudes about condom use (St. Lawrence et al., 1994), and

1 Address correspondence to Jessica McDermott Sales, Emory University, Rollins School of Public Health, Department of Behavioral Sciences and Health Education, 1520 Clifton Rd., NE, Room 266, Atlanta, GA 30322; e-mail: jmcderm@emory.edu

JESSICA MCDERMOTT SALES, 1 Emory University

ROBIN R. MILHAUSEN, University of Guelph

J OSH SPITALNICK, Emory University

The Adolescent Perceived Costs and Benefits Scale for Sexual Intercourse (Small, Silverberg, & Kerns, 1993) was developed to measure the costs and benefits that adolescents perceive for engaging in nonmarital sexual intercourse. Adolescent sexual activity is often viewed as problematic because of its potential risk to the adolescent's health and life prospects, as well as the possible negative consequences for the broader society. The present measure considers the adolescent as a decision maker and is based on the assumption that if we wish to understand why adolescents become sexually active, it is important to understand the positive and negative consequences adolescents associate with engaging in the behavior.

Description

The Adolescent Perceived Costs and Benefits Scale for Sexual Intercourse consists of two independent subscales of 10 items each. The Perceived Costs subscale assesses the perceived costs associated with engaging in sexual intercourse; the Perceived Benefits subscale assesses the perceived benefits of sexual activity. Each item is responded to using a 4-point Likert-type format. Responses range from 0

(strongly disagree) to 3 (strongly agree). The scale is based

on current research and theory on adolescent development,

which views the adolescent as a decision maker and recog

nizes the importance of understanding the meanings that

adolescents ascribe to behavior.

The scale was developed over a multiyear period and

involved extensive interviews with a diverse sample of ado

lescents. It underwent a number of refinements as a result of

pilot testing. A parallel measure for assessing adolescents'

perceptions of the costs and benefit of using alcohol is also

available (see Philipp, 1993; Small et al., 1993).

Response Mode and Timing

Respondents are asked to indicate the number correspond

ing to their degree of agreement or disagreement with each

of the items. This can be done by circling the appropri

ate response or filling it in on a machine-scorable answer

sheet. Each subscale takes approximately 3 to 5 minutes

to complete.

Scoring

For each subscale a total perceived costs or benefits score

is obtained by summing the 10 individual items. Scores can range from 0 to 30 with a higher score reflecting higher perceived costs or benefits. Individual items can also be examined to gain insight into the primary or modal reasons particular groups of adolescents perceive for engaging or not engaging in sexual intercourse. Reliability Internal reliability, as determined by Cronbach's alpha, was .86

for both the perceived costs and the perceived benefits subscales based on a sample of 2,444 male and female adolescents. Based on a sample of 124 male and female adolescents, the subscales had a test-retest reliability over a 2-week period of .70 and .65 for the cost and benefits scales respectively. Validity As expected, Small et al. (1993) found that adolescents who were not sexually active perceived significantly more costs for engaging in sexual intercourse than their sexually active peers. The correlation between sexual intercourse status and perceived costs was r = .32. Females perceived more costs (M = 17.30) for engaging in sexual intercourse than their male counterparts (M = 14.80). Small et al. (1993) reported that adolescent females perceived fewer significant benefits (M = 17.68) for engaging in sexual intercourse than their male peers (M = 18.22). The correlation between sexual activity status and the perceived benefits subscale was small but significant (r = .11). Overall, sexually active teens perceived more benefits than adolescents who were not sexually active. However, although the perceived benefits scores for the nonsexually active teens remained stable across grade levels, after the 9th grade there was a decrease in the perceived benefits scores of teens who were sexually active. Small et al. suggested two possible explanations for this finding. First, with experience sexually active teens may come to realize that many of their beliefs regarding the benefits of sexual intercourse do not hold true. Second, at younger ages, when sexual intercourse is generally less acceptable, teens must first believe there are many benefits for sexual intercourse before becoming sexually active. At older ages, when sexual activity is more acceptable, there is less of a need to be convinced of the value of the behavior before engaging in it.

Adolescent Perceived Costs and Benefi ts Scale

for Sexual Intercourse

STEPHEN A. SMALL, 1 University of Wisconsin-Madison

1 Address correspondence to Stephen Small, Department of Human Development and Family Studies, University of Wisconsin-Madison, 1430 Linden

Aggression

Exhibit

Attraction to Sexual Aggression Scale

Social Relationships Research

Instructions: On the following pages there are a variety of different questions. Please answer all the questions to the best of your ability. If

you are unsure of the answer to a question, please give your best guess. It is important that all of the questions be answered. There are

no right or wrong answers, and no trick questions. Please answer the question by placing a tick in the box you choose, like this: Y. Please

work quickly and be AS HONEST as possible. Your responses will be kept completely confidential. Thank you for your cooperation.

1. People frequently think about different activities even if they never do them. For each kind of activity listed, please indicate how often you have thought of trying it:

Never Sometimes Often

a. Necking (deep kissing) a

b. Petting

c. Oral sex

d. Heterosexual intercourse

e. Anal intercourse

f. Homosexual acts

g. Group sex

h. Bondage sex

i. Whipping, spanking sex

j. Robbing a bank

k. Raping a woman

l. Forcing a female to do something sexual she didn't want to

m. Being forced to do something sexual you didn't want to

n. Transvestism (wearing women's clothes)

o. Sex with children

p. Killing someone

q. Selling illegal drugs

2. Whether or not you have ever thought of it, do you find the idea of:

Very Somewhat Somewhat Very

unattractive unattractive attractive attractive

a. Necking (deep kissing) b

3. What percentage of males do you think would find the following activities sexually arousing?

a. Anal intercourse c

b. Group sex

c. Homosexual acts

d. Armed robbery

e. Bondage sex

f. Whipping, spanking sex

g. Rape

h. Robbing a bank

i. Forcing a female to do something sexual she really didn't want to

j. Killing someone

k. Transvestism

l. Sex with a child

m. Being forced to do something sexual they didn't want to

4. What percentage of females do you think would find the following activities sexually arousing?

a. Anal intercourse d

5. How sexually arousing do you think you would find the following activities if you engaged in them (even if you have never actually

engaged in them and never would)?

Not arousing Very

at all arousing

a. Oral sex e

b. Heterosexual intercourse

c. Anal intercourse

d. Homosexual acts

e. Group sex

f. Bondage sex

g. Whipping, spanking sex

h. Robbing a bank

i. Raping a female

j. Forcing a female to do something sexual she didn't want to do

k. Transvestism (wearing women's sex)

l. Being forced to do something sexual you didn't want to do

m. Sex with children

n. Killing someone

6. If you were sure that no one would ever find out and that you'd never be punished for it, how likely would you

be to do the following?

Very Very

unlikely likely

a. Oral sex f

b. Heterosexual intercourse

c. Anal intercourse

d. Homosexual acts

e. Group sex

f. Bondage sex

g. Whipping, spanking sex

h. Robbing a bank

i. Raping a female

j. Forcing a female to do something sexual she didn't want to

k. Transvestism (wearing women's clothes)

l. Sex with children

m. Killing someone

n. Selling illegal drugs

7. If your best male friend were assured that no one would find out and that he'd never be punished for it, how likely do you think he would be to do the following:

Very Very

unlikely likely

a. Oral sex g

8. Approximately what percentage of your male friends, would you estimate, have done the following:

a. Anal intercourse h

b. Group sex

c. Homosexual acts

d. Armed robbery

e. Bondage sex

f. Whipping, spanking sex

g. Rape

h. Robbing a bank

i. Forcing a female to do something sexual she didn’t want to

j. Killing someone

k. Transvestism

l. Sex with a child

m. Being forced to do something sexual they didn’t want to

n. Selling illegal drugs

9. How likely do you think it is that at some point in the future you might try to following activities?

Very Very

unlikely likely

a. Oral sex i

End of questionnaire

Thanks for your responses.

a These items are followed by boxes under each of the response options, providing a place for the respondent to 3 option chosen.

b The same items as shown for Question 1 are repeated, with boxes under each of the four response options.

c The response options are indicated by 11 boxes identified from 0% to 100%.

d The same items and response options as shown for #3 repeated.

e Seven boxes between the two anchors are provided for responses.

f Seven boxes between the two anchors are provided for responses.

g The same items and response options as shown for Question 6 are repeated.

h The response options are indicated by 11 boxes identified from 0% to 100%.

i The same items and response options as shown for Question 6 are repeated.

Aggressive Sexual Behavior Inventory

DONALD L. MOSHER, 1 University of Connecticut

The Aggressive Sexual Behavior Inventory (ASBI; Mosher & Anderson, 1986) was developed to measure sexual aggression by men against women that occurs in dating or other heterosocial-heterosexual situations. College men, but particularly college men with a macho personality constellation that includes callous sexual attitudes toward women, frequently use these tactics (Mosher & Anderson, 1986). In studies of sexual aggression, answers to a single question about the occurrence of date rape or to a hypothetical question asking about the likelihood of rape if one were not going to be caught suffer from problems of unreliability and false reporting. Although men might also under- or overreport on these 20 items, the summed score, when anonymous, is a better estimate of each man's history of

aggressive sexual behavior. The ASBI can be treated as an individual-differences measure of sexual aggression or as a dependent variable when studying predictive correlates of aggressive sexual behavior.

Description

The ASBI consists of 20 items (or a 10-item short form) arranged in a 7-point Likert-type format to rate frequency of occurrence from 1 (never) to 7 (extremely frequently). From the responses of a sample of 125 college men to 33 items, a varimax factor analysis with an orthogonal rotation extracted six factors that were named Sexual Force, Drugs and Alcohol, Verbal Manipulation, Angry Rejection, Anger Expression, and Threat.

Response Mode and Timing

Respondents can circle the number from 1 to 7 correspond ing to their frequency of using the tactic, but the more com mon scoring is to mark the answers on machine-scoreable answer sheets. The inventory requires approximately 5 minutes to complete.

Scoring

All 20 items are keyed in the same direction with a higher score indicating a greater frequency of aggressive sexual behavior. Scores can range from 20 to 140 or from 10 to 70 on the short form. For each specific factor, the percent age of 125 University of Connecticut college men who endorsed one or more items in the factor and the numbers

of the items loading most highly on specific factors follows: Sexual Force, 28% (3, 9, 11, 14, 17, 19); Drugs and Alcohol, 75% (2, 6, 15); Verbal Manipulation, 64% (1, 4, 7, 20); Angry Rejection, 43% (10, 13); Anger Expression, 46% (8, 16, 18); and Threat, 13% (5, 12). The 10-item short form includes Items 1, 4, 5, 6, 11, 12, 13, 15, 18, and 19. Reliability In a sample of 125 college men (Mosher & Anderson, 1986), the Cronbach alpha for the summed scores from the 20 items was .94. It is recommended that the summed score of the 20 items be regarded as a homogeneous measure of aggressive sexual behavior. The short form of 10 items had a Cronbach alpha of .87 in a sample of 55 male rock musicians (Zaitchik, 1986). Validity As expected, Mosher and Anderson (1986) found that the summed score of the ASBI was significantly correlated with Macho Personality, r = .33, Callous Sexual Attitudes, r = .53, Violence as Manly, r = .23, and Danger as Exciting, r = .26, as measured by the Hypermasculinity Inventory (Mosher & Sirkin, 1984). As expected, aggressive sexual behavior (Anderson, 1983) was significantly negatively correlated with Sex-Guilt, r = −.53, and Hostility-Guilt, r = −.49, as measured by the Mosher Forced-Choice Guilt Inventory (Mosher, 1966). When 125 college men imagined themselves in the role of rapist during guided imagery of a realistic-violent and nonerotic-rape, men scoring higher on aggressive sexual behavior, in comparison to men scoring lower, reported significantly more subjective sexual arousal, as hypothesized, but contrary to expectations they also experienced more affective anger, distress, fear, shame, and guilt (Mosher & Anderson, 1986). These results were interpreted as consistent with the revivification by the guided imagery of rape of the sexually aggressive men’s mood-congruent, state-memories (Bower, 1981) of their own previous acts of sexual aggression. In a sample of rock musicians, Zaitchik (1986) found that the ASBI was correlated .75 with macho personality, .72 with cocaine use, .70 with amphetamine use, .50 with marijuana use, and −.35 with life satisfaction.

1 Address correspondence to Donald L. Mosher, 648 Ternberry Forest Drive, The Villages, FL 32162; e-mail: dlmosher@aol.com

Anderson, R. D. (1983). Hyper-masculine attitudes, aggressive sexual behaviors, and the reactions of college men to a guided imagery presentation of realistic rape. Unpublished master’s thesis, University of Connecticut, Storrs.

Bower, G. H. (1981). Mood and mercy. American Psychologist, 36, 129- 148.

Mosher, D. L. (1966). The development and multitrait-multimethod matrix analysis of three measures of guilt. Journal of Consulting Psychology, 30, 25-29. Mosher, D. L., & Anderson, R. D. (1986). Macho personality, sexual aggression, and reactions to guided imagery of realistic rape. Journal of Research in Personality, 20(2), 77-94. Mosher, D. L., & Sirkin, M. (1984). Measuring a macho personality constellation. Journal of Research in Personality, 18, 150-163. Zaitchik, M. (1986). Macho personality and life satisfaction in rock musicians. Unpublished master's thesis, University of Connecticut, Storrs.

Exhibit

Aggressive Sexual Behavior Inventory

Instructions: The following 20 items sample behavior that sometimes occurs in dating or man-woman sociosexual interactions. The

items describe various techniques, which may or may not be successful, for gaining increased sexual access to women. Some of the

behaviors are acceptable to some men and others are not. Because you are an anonymous subject in a psychological study, you are

asked to be as truthful as you can be. Each item is to be rated on a 7-point scale of the frequency of past use of the tactic in which 1

means never and 7 means extremely frequent. If, for example, an item said, "I shave with an electric razor," you would mark the item

with a 1, if you never shave with an electric razor, with a 7, if you shaved extremely frequently with an electric razor, and with a

number between 2-6 to represent the relative frequency with which you shaved with an electric razor. Record your answers on

the separate answer sheet.

1. I have threatened to leave or to end a relationship if a woman wouldn’t have sex with me.

2. I have gotten a woman drunk in order to have sex with her.

3. I have waited my turn in line with some other guys who were sharing a “party girl.”

4. I have told a woman that I wanted to come into her apartment so I could get her where I wanted.

5. I have warned a woman that she could get hurt if she resisted me, so she should relax and enjoy it.

6. I have gotten a woman high on marijuana or pills so she would be less able to resist my advances.

7. I have told a woman I was petting with that she couldn’t stop and leave me with “blue balls.”

8. I have blown my top and sworn or broken something to show a woman that she shouldn’t get me angry.

9. I have brought a woman to my place after a date and forced her to have sex with me.

10. I have told a woman I was going out with that I could find someone else to give me sex if she wouldn’t.

11. I have calmed a woman down with a good slap or two when she got hysterical over my advances.

12. I have promised a woman that I wouldn’t harm her if she did everything that I told her to do.

13. I have called a woman an angry name and pushed her away when she would not surrender to my need for sex.

14. I have forced a woman to have sex with me and some of my pals.

15. I have turned a woman on to some expensive drugs so that she would feel obligated to do me a sexual favor.

16. I have roughed a woman up a little so that she would understand that I meant business.

17. I have pushed a woman down and made her undress or torn her clothes off if she wouldn’t cooperate.

18. I have gripped a woman tightly and given her an angry look when she was not giving me the sexual response I wanted.

19. I have gotten a little drunk and forced a woman that I'm with to have sex with me.

20. I have told a woman that her refusal to have sex with me was changing the way I felt about her.

Aging

Exhibit

Senior Adult Sexuality Scales

Biographical Information I (Part I)

Instructions: Please answer all questions by placing a check or a statement in the appropriate space provided.

1. Relationship Status: Married _____ Committed Partners _____ Remarried _____ Single _____ Divorced _____ Widowed _____ Separated _____ Other (specify) _____

2. If remarried or in a committed partnership: More than 10 years _____ Less than 10 years _____

3. How many children do your have? None _____ One _____ Two _____ Three _____ Four or More _____

4. Education: Completed Elementary School _____ Some High School _____ College Graduate _____ Some College _____ Other (specify) _____ Graduate School _____

5. Religious Affiliation: Catholic _____ Protestant _____ Jewish _____ Other (specify) _____

6. How religious do you consider yourself? Very Religious _____ Moderately Religious _____ Somewhat Religious _____ Not Religious _____

7. State of Retirement: Fully Retired _____ Partially Retired _____ Full-Time Employed _____

8. How would you rate your present state of health? Excellent _____ Good _____ Fair _____ Poor_____

9. Lifetime Occupation (i.e., homemaker, salesperson, executive, lawyer, etc.):

10. Current income from all sources: Under $15,000_____ Between $15-25,000 _____ Between $25-35,000 _____ Between $35-50,000 _____ Above $50,000 _____

11. Type of community in which you are living more than half of each year: Small Town _____ Small City _____ Large City _____ Retirement Community _____ Suburban Community _____

12. If you checked retirement type community in question 11, where was the original residence in which you spent the major portion of your working life? Small Town_____ Small City_____ Large City_____ Suburban Community_____ Other (specify)_____

13. What is your age? _____years

14. What is your sex? _____Female _____Male

Senior Adult Sexuality Scales (SASS) (Part II)

Attitudes—Scale I

1. I think there is too much sexual freedom today. a

2. Abortion is a greater evil than bringing an unwanted child into the world.

3. Sexual activity amongst older single senior citizens is not acceptable behavior.

4. Premarital sexual intercourse is morally wrong.

5. Women should not initiate sexual activity as often as men.

6. Stronger laws should be passed to curb homosexuality.

7. Frequent desire for oral-genital sex is an indicator of an excessive sex drive.

8. Sexual intercourse should only occur between married partners.

9. Masturbation is generally an unhealthy practice.

10. Sexual activity between young adults simply for enjoyment is unacceptable behavior.

11. Men who lose their spouses generally need sexual activity more frequently than women who lose their spouses.

12. Women should not experience sexual intercourse with their mate prior to marriage.

13. I think people are too sexually active today.

14. Laws should be passed to ban pornography.

15. Too much information about sex and contraception is available to young people today.

16. Modern attitudes and morals about sex are responsible for the breakdown in the American family.

Senior Adult Sexuality Scales (SASS) (Part III)

Interest—Scale II

Part A

1. Having sex with someone I have recently met b

2. Stimulating my own genitals until climax (ejaculation, orgasm)

3. Having sex with someone other than my spouse or regular mate

4. Having sex with more than one partner at a time (group sex)

5. Having sex with partners considerably younger than myself

6. Watching sex movies

7. Reading sex books or magazines

8. Receiving oral sex to climax (ejaculation, orgasm)

9. Receiving oral sex until partner reaches climax

10. Extramarital/extra committed partner sex activity

Part B

1. Kissing, cuddling, touching, petting

2. Having my breasts stroked or kissed

3. Body massage as sex play

4. Having sex in the shower

5. Extended foreplay that leads to intercourse

6. Sex only with someone of the opposite sex

7. Talking about sex with my partner

Senior Adult Sexuality Scales (SASS) (Part IV)

Activities–Scale III

1. How often do you engage in sexual intercourse?

___times per day ___times per week ___times per month

___times per year ___never c

2. How often do you engage in touching, cuddling, petting as foreplay to sexual intercourse?

3. How often do you engage in oral sex as foreplay to sexual intercourse?

4. How often do you reach orgasm (climax)?

5. How often do you use a vibrator or other objects for sexual stimulation with a partner?

6. How often do you initiate (start) sexual activity with your partner?

Senior Adult Sexuality Scales (SASS) (Part V)

Biographical Information II

1. How would you rate your current participation in athletic activities? d

2. How would you rate your participation in athletic activities when you were 35-45 years old?

3. How would you rate your current participation in social functions?

4. How would you rate your participation in social functions when you were 35-45 years old?

5. How would you rate your current participation in sexual activities?

6. How would you rate your participation in sexual activities when you were 35-45 years old?

7. How would you rate your current interest in sexual activities, if it were available whenever you wanted it? e

8. How would you rate your interest in sexual activity when you were 35–45 years old?

9. How would you rate your current sexual attitudes? f

10. How would you rate your sexual attitudes when you were 35–45 years old?

11. (Circle the appropriate statement)

Do you consider yourself a:

Heterosexual person (preference for sexual partner of opposite sex)

Homosexual person (preference for sexual partner of same sex)

Bisexual person (can prefer sexual partner of either sex)

a Each item in this section is followed by 7-point Strongly Agree-Strongly Disagree scales.

b Each item in this section is followed by 7-point Very Interested-Not Interested scales.

c The remaining items in this section are followed by the same response options.

d Items 1–6 are followed by 7-point Inactive-Very Active scales.

e Items 7 and 8 are followed by 7-point Not Interested-Very Interested scales.

f Items 9 and 10 are followed by 7-point Very Conservative-Very Liberal scales.

The Aging Sexual Knowledge and Attitudes Scale

(ASKAS) is designed to measure two realms of sexuality:

(a) knowledge about changes (and nonchanges) in sexual

response to advanced age in males and females and (b) gen

eral attitudes about sexual activity in the aged. The items are

largely specific to the elderly rather than a general sexual

knowledge-attitudes scale. The ASKAS was developed for use in assessing the impact of group or individual interventions on behalf of sexual functioning in the aged utilizing, for example, a pretest-posttest procedure. Further, the measure may form the basis for group and individual discussion about sexual attitudes and/or sexual knowledge. The scale is also appropriate for use in educational programs for those working with the aged. The actual numerical scores may be conveniently used for research purposes, but the individual items are also useful to assess the extent of an individual's knowledge upon which to base clinical interventions, as well as identifying attitudinal obstacles to sexual intimacy in old age.

Description, Response Mode, and Timing

The ASKAS consists of 61 items, 35 true/false/don't know in format and 26 items responded to on a 7-point Likert-type scale as to degree of agreement or disagreement with the particular item. The 35 true/false questions assess knowledge about sexual changes and nonchanges which are or are not age related. The 26 agree/disagree items assess attitudes toward sexual behavior in the aged. The items are counterbalanced. The instrument takes 20–40 minutes to complete.

Scoring

The ASKAS may be given in an interview of paper-and

pencil format and may be group administered or individu

ally administered. The nature of the scoring and items are

readily adaptable to computer scoring systems. Scoring is such that a low knowledge score indicates high

knowledge and a low attitude score indicates a more per

missive attitude. The rationale for the low knowledge score

reflecting high knowledge is that don’t know was given a

value of 3, indicating low knowledge. In the Knowledge

section, Questions 1 through 35, the following scoring

applies: true = 1, false = 2, and don’t know = 3. Items 1, 10,

14, 17, 20, 30, and 31 are reversed scored. In the Exhibit,

the correct answers are in parentheses for Items 1 through

35. The attitude questions, 36 through 61, are each scored

according to the value selected by the respondent with the exception of Items 44, 47, 48, 50–56, and 59 in which the scoring is reversed. Reliability The reliability of the ASKAS has been examined in several different studies, and in varying ways, summarized in Table 1. As can be seen, reliabilities are very positive and at acceptable levels. Validity Presented in Table 2 are the means and standard deviations of ASKAS scores from several studies. These means are not meant to be viewed as normative, but rather illustrative of group variation in ASKAS performance. The validity of the ASKAS has been examined in a sexual education program for older persons, by individuals working with older persons, and by adult family members of aged persons in which each group received the psychological-educational intervention separately (White & Catania, 1981). Each experimental group had a comparable

Aging Sexual Knowledge and Attitudes Scale

CHARLES B. WHITE, 1 Trinity University TABLE 1 Aging Sexual Knowledge and Attitudes Scale (ASKAS) Reliabilities Type of Reliability Sample Type of reliability coefficient size sample Knowledge Split-half a .91 163 Nursing home

staff Split-half a .90 279 Nursing home residents Alpha .93 163 Nursing home staff Alpha .91 279 Nursing home residents Alpha .92 30 Community older adults Alpha .90 30 Nursing home staff Alpha .90 30 Families of older adults Test-retest .97 15 Community older adults Test-retest .90 30 Staff of nursing home and families of the older adults Attitudes Split-half a .86 163 Nursing home staff Split-half a .83 279 Nursing home residents Alpha .85 163 Nursing home staff Alpha .76 279 Nursing home residents Alpha .87 30 Community older adults Alpha .87 30 Nursing home staff Alpha .86 30 Families of older adults Test-retest .96 15 Community older adults Test-retest .72 30 Staff of nursing home and families of the aged a These correlations have been corrected for test length. 1 Address correspondence to Charles B. White, Trinity University, 1 Stadium Drive, San Antonio, TX 78212; e-mail: cwhite@Trinity.Edu

nonintervention control group. In all cases, the educational

intervention resulted in significant increases in knowledge

and significant changes in the direction of a more permis

sive attitude, both relative to their own pretest scores and

relative to the appropriate control group, whereas the con

trol group posttest scores were not significantly changed

relative to their pretest scores. There was a 4–6 week period

between pre- and posttests.

Hammond (1979) utilized the ASKAS in a sexual educa

tion program for professionals working with the aged. She

TABLE 2

Aging Sexual Knowledge and Attitudes Scale (ASKAS)

Score Means and Standard Deviations Score by Group

Group n Mean SD

Nursing home residents a 273

Attitudes 84.56 23.32

Knowledge 65.62 15.09

Community older adults b 30

Attitudes 86.40 17.28

Knowledge 73.73 12.52

Families of older adults b 30

Attitudes 75.00 22.66

Knowledge 78.00 13.61

Persons who work with older adults b 30

Attitudes 76.00 17.60

Knowledge 62.46 12.50

Nursing home staff b 163

Attitudes 61.08 25.79

Knowledge 64.19 17.25

Note. The possible range of ASKAS scores are as follows:
Knowledge = 35–105;

Attitudes = 26–182. All scores reported here are the
pretest scores in cases where

both pretests and posttests were administered.

a White, 1981.

b White and Catania, 1981.

Exhibit

Aging Sexual Knowledge and Attitudes Scale

Knowledge Questions (Correct answer shown in parentheses.)

*1. Sexual activity in aged persons is often dangerous to
their health. (F)

True False Don’t know a

2. Males over the age of 65 typically take longer to attain an erection of their penis than do younger males. (T)

3. Males over the age of 65 usually experience a reduction in intensity of orgasm relative to younger males. (T)

4. The firmness of erection in aged males is often less than that of younger persons. (T)

5. The older female (65+ years of age) has reduced vaginal lubrication secretion relative to younger females. (T)

6. The aged female takes longer to achieve adequate vaginal lubrication relative to younger females. (T)

7. The older female may experience painful intercourse due to reduced elasticity of the vagina and reduced vaginal lubrication. (T)

8. Sexuality is typically a life-long need. (T)

9. Sexual behavior in older people (65+) increases the risk of heart attack. (F)

*10. Most males over the age of 65 are unable to engage in sexual intercourse. (F)

11. The relatively most sexually active younger people tend to become the relatively most sexually active older people. (T)

12. There is evidence that sexual activity in older persons has beneficial physical effects on the participants. (T)

13. Sexual activity may be psychologically benefi cial to older person participants. (T)

*14. Most older females are sexually unresponsive. (F)

15. The sex urge typically increases with age in males over 65. (F)

16. Prescription drugs may alter a person’s sex drive. (T)

*17. Females, after menopause, have a physiologically induced need for sexual activity. (F)

18. Basically, changes with advanced age (65+) in sexuality involve a slowing of response time rather than a reduction of interest in sex. (T)

19. Older males typically experience a reduced need to ejaculate and hence may maintain an erection of the penis for a longer time than younger males. (T)

*20. Older males and females cannot act as sex partners as both need younger partners for stimulation. (F)

21. The most common determinant of the frequency of sexual activity in older couples is the interest or lack of interest of the husband in a sexual relationship with his wife. (T)

22. Barbiturates, tranquilizers, and alcohol may lower the sexual arousal levels of aged persons and interfere with sexual responsiveness. (T)

23. Sexual disinterest in aged persons may be a reflection of a psychological state of depression. (T)

24. There is a decrease in frequency of sexual activity with older age in males. (T)

25. There is a greater decrease in male sexuality with age than there is in female sexuality. (T)

26. Heavy consumption of cigarettes may diminish sexual desire. (T)

27. An important factor in the maintenance of sexual responsiveness in the aging male is the consistency of sexual activity throughout his life. (T)

28. Fear of the inability to perform sexually may bring about an inability to perform sexually in older males. (T)

29. The ending of sexual activity in old age is most likely and primarily due to social and psychological causes rather than biological and physical causes. (T)

*30. Excessive masturbation may bring about an early onset of mental confusion and dementia in the aged. (F)

*31. There is an inevitable loss of sexual satisfaction in post-menopausal women. (F)

32. Secondary impotence (or non-physiologically caused) increases in males over the age of 60 relative to young males. (T)

33. Impotence in aged males may literally be effectively treated and cured in many instances. (T)

34. In the absence of severe physical disability, males and females may maintain sexual interest and activity well into their 80s and 90s. (T)

35. Masturbation in older males and females has benefi cial effects on the maintenance of sexual responsiveness. (T)

Attitude Questions (7-point Likert-type scale, where disagree = 1, agree = 7)

36. Aged people have little interest in sexuality. (Aged = 65+ years of age.)

37. An aged person who shows sexual interest brings disgrace to himself/herself.

38. Institutions, such as nursing homes, ought not to encourage or support sexual activity of any sort in its residents.

39. Male and female residents of nursing homes ought to live on separate floors or separate wings of the nursing home.

40. Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple.

41. As one becomes older (say past 65) interest in sexuality inevitably disappears.

For Items 42, 43, and 44:

If a relative of mine, living in a nursing home, was to have a sexual relationship with another resident I would:

42. Complain to the management.

43. Move my relative from this institution.

+44. Stay out of it as it is not my concern.

45. If I knew that a particular nursing home permitted and supported sexual activity in residents who desired such, I would not place a relative in that nursing home.

46. It is immoral for older persons to engage in

recreational sex.

+47. I would like to know more about the changes in sexual functioning in older years.

+48. I feel I know all I need to know about sexuality in the aged.

49. I would complain to the management if I knew of sexual activity between any residents of a nursing home.

+50. I would support sex education courses for aged residents of nursing homes.

+51. I would support sex education courses for the staff of nursing homes.

+52. Masturbation is an acceptable sexual activity for older males.

+53. Masturbation is an acceptable sexual activity for older females.

+54. Institutions, such as the nursing home, ought to provide large enough beds for couples who desire such to sleep together.

+55. Staff of nursing homes ought to be trained or educated with regard to sexuality in the aged and/or disabled.

56. Residents of nursing homes ought not to engage in sexual activity of any sort.

57. Institutions, such as nursing homes, should provide opportunities for the social interaction of men and women.

AIDS (see HIV/AIDS)

Crowne, D. P., & Marlowe, D. (1964). The approval motive: Studies in evaluative dependence. New York: Wiley.

Janda, L. H., & O'Grady, K. E. (1980). Development of a sex anxiety inventory. Journal of Consulting and Clinical Psychology, 48, 169–175. Mosher, D. L. (1965). Interaction of fear and guilt in inhibiting unacceptable behavior. Journal of Consulting Psychology, 29, 161–167. Vanwesenbeeck, I. (2001). Psychosexual correlates of viewing sexually explicit sex on television among women in the Netherlands. The Journal of Sex Research, 38, 361–368.

Exhibit

Sex Anxiety Inventory

1. Extramarital sex . . .

a. is OK if everyone agrees.

b. can break up families.

2. Sex . . .

a. can cause as much anxiety as pleasure.

b. on the whole is good and enjoyable.

3. Masturbation . . .

a. causes me to worry.

b. can be a useful substitute.

4. After having sexual thoughts . . .

a. I feel aroused.

b. I feel jittery.

5. When I engage in petting . . .

a. I feel scared at first.

b. I thoroughly enjoy it.

6. Initiating sexual relationships . . .

a. is a very stressful experience.

b. causes me no problem at all.

7. Oral sex . . .

a. would arouse me.

b. would terrify me.

8. I feel nervous . . .

a. about initiating sexual relations.

b. about nothing when it comes to members of the opposite sex.

9. When I meet someone I'm attracted to . . .

a. I get to know him or her.

b. I feel nervous.

10. When I was younger . . .

a. I was looking forward to having sex.

b. I felt nervous about the prospect of having sex.

11. When others flirt with me . . .

a. I don't know what to do.

b. I flirt back.

12. Group sex . . .

a. would scare me to death.

b. might be interesting.

13. If in the future I committed adultery . . .

a. I would probably get caught.

b. I wouldn't feel bad about it.

14. I would . . .

a. feel too nervous to tell a dirty joke in mixed company.

b. tell a dirty joke if it were funny.

15. Dirty jokes . . .

a. make me feel uncomfortable.

b. often make me laugh.

16. When I awake from sexual dreams . . .

a. I feel pleasant and relaxed.

b. I feel tense.

17. When I have sexual desires . . .

a. I worry about what I should do.

b. I do something to satisfy them.

18. If in the future I committed adultery . . .

a. it would be nobody's business but my own.

b. I would worry about my spouse finding out.

19. Buying a pornographic book . . .

a. wouldn't bother me.

b. would make me nervous.

20. Casual sex . . .

a. is better than no sex at all.

b. can hurt many people.

21. Extramarital sex . . .

a. is sometimes necessary.

b. can damage one's career.

22. Sexual advances . . .

a. leave me feeling tense.

b. are welcomed.

23. When I have sexual relations . . .

a. I feel satisfied.

b. I worry about being discovered.

24. When talking about sex in mixed company . . .

a. I feel nervous.

b. I sometimes get excited.

25. If I were to flirt with someone . . .

a. I would worry about his or her reaction.

b. I would enjoy it.

Arousal/Arousability

Coleman, E., Hoon, P. W., & Hoon, E. F. (1983). Arousability and sexual satisfaction in lesbian and heterosexual women. The Journal of Sex Research, 19, 58-73.

Flax, C. C. (1980). Comparison between married women with ileostomies and married women without ileostomies on sexual anxiety, control, arousability and fantasy. Unpublished doctoral dissertation, New York University, New York.

Hoon, E. F., & Hoon, P. W. (1977, September). Sexual differences between males and females on a self-report measure. Paper presented at the Fifth Annual Canadian Sex Research Forum, Banff, Alberta. Hoon, E. F., & Hoon, P. W. (1978). Styles of sexual expression in women: Clinical implications of multivariate analyses. Archives of Sexual Behavior, 7, 106-116. Hoon, E. F., Hoon, P. W., & Wincze, J. P. (1976). The SAI: An inventory for the measurement of female sexual arousability. Archives of Sexual Behavior, 5, 291-300. Hoon, P. W., & Hoon, E. F. (1982). Effects of experience in cohabitation on erotic arousability. Psychological Reports, 50, 255-258. Murphy, W., Coleman, E., Hoon, E. F., & Scott, C. (1980). Sexual dysfunction and treatment in alcoholic women. Sexuality and Disability, 3, 240-255.

Exhibit

Sexual Arousability Inventory

Instructions: The experiences in this inventory may or may not be sexually arousing to you. There are no right or wrong answers. Read

each item carefully, and then circle the number which indicates how sexually aroused you feel when you have the described experience,

or how sexually aroused you think you would feel if you actually experienced it. Be sure to answer every item. If you aren’t certain about

an item, circle the number than seems about right. Rate feelings of arousal according to the scale below. -1 adversely affects arousal; unthinkable, repulsive, distracting 0 doesn’t affect sexual arousal 1 possibly causes sexual arousal 2 sometimes causes sexual arousal;

slightly arousing 3 usually causes sexual arousal; moderately arousing 4 almost always sexually arousing; very arousing 5 always causes sexual arousal; extremely arousing

* 1. When a loved one stimulates your genitals with mouth and tongue a

* 2. When a loved one fondles your breasts with his/her hands

3. When you see a loved one nude

4. When a loved one caresses you with his/her eyes

* 5. When a loved one stimulates your genitals with his/her finger

* 6. When you are touched or kissed on the inner thighs by a loved one

7. When you caress a loved one’s genitals with your fingers

8. When you read a pornographic or “dirty” story

* 9. When a loved one undresses you

*10. When you dance with a loved one

*11. When you have intercourse with a loved one

*12. When a loved one touches or kisses your nipples

13. When you caress a loved one (other than genitals)

*14. When you see pornographic pictures or slides

*15. When you lie in bed with a loved one

*16. When a loved one kisses you passionately

17. When you hear sounds of pleasure during sex

*18. When a loved one kisses you with an exploring tongue

*19. When you read suggestive or pornographic poetry

20. When you see a strip show

21. When you stimulate your partner’s genitals with your

mouth and tongue

22. When a loved one caresses you (other than genitals)

23. When you see a pornographic movie (stag film)

24. When you undress a loved one

25. When a loved one fondles your breasts with mouth and tongue

*26. When you make love in a new or unusual place

27. When you masturbate

28. When your partner has an orgasm

Note. Asterisks indicate those items comprising shortened form A. Form B consists of items without asterisks.

a The seven response options are repeated following each item.

Sexual Anxiety Inventory

Now rate each of the items according to how anxious you feel when you have the described experience. The meaning of anxiety is

extreme uneasiness, distress. Rate feelings of anxiety according to the scale below: -1 relaxing, calming 0 no anxiety 1 possibly causes some anxiety 2 sometimes causes anxiety; slightly anxiety producing 3 usually causes anxiety; moderately anxiety producing 4 almost always causes anxiety; very anxiety producing 5 always causes anxiety; extremely anxiety producing

1. When a loved one stimulates your genitals with mouth and tongue a

2. When a loved one fondles your breasts with his/her hands

3. When you see a loved one nude

4. When a loved one caresses you with his/her eyes

5. When a loved one stimulates your genitals with his/her finger

6. When you are touched or kissed on the inner thighs by a

loved one

7. When you caress a loved one’s genitals with your fingers

8. When you read a pornographic or “dirty” story

9. When a loved one undresses you

10. When you dance with a loved one

11. When you have intercourse with a loved one

12. When a loved one touches or kisses your nipples

13. When you caress a loved one (other than genitals)

14. When you see pornographic pictures or slides

15. When you lie in bed with a loved one

16. When a loved one kisses you passionately

17. When you hear sounds of pleasure during sex

18. When a loved one kisses you with an exploring tongue

19. When you read suggestive or pornographic poetry

20. When you see a strip show

21. When you stimulate your partner’s genitals with your mouth and tongue

22. When a loved one caresses you (other than genitals)

23. When you see a pornographic movie (stag film)

24. When you undress a loved one

25. When a loved one fondles your breasts with mouth and tongue

26. When you make love in a new or unusual place

27. When you masturbate

28. When your partner has an orgasm

a The seven response options are repeated following each item.

Three self-report measures of subjective sexual arousal were developed to serve as standard measures. Construction of the measures was designed to permit comparison of male and female subjective sexual arousal. To secure more uni form measurement across laboratories, item selection and analysis were guided by past research and theory, and care ful attention was paid to the psychometric properties of the measures. From the perspective of involvement theory (Mosher, 1980), subjective sexual arousal is defined as a specific affect-cognition blend, in consciousness, of physio logical sexual arousal with its accompanying sexual affects. The multiple indicators of self-reported sexual arousal were derived from past research that had variously used Likert type rating scales (Jakobovits, 1965; Mosher & Abramson, 1977; Schmidt & Sigusch, 1970), adjective checklists (Mosher & Abramson, 1977; Mosher & Greenberg, 1969), and a checklist of genital sensations (Mosher & Abramson, 1977; Schmidt & Sigusch, 1970). Mosher, Barton-Henry, and Green (1988) developed the three measures of subjec tive sexual arousal presented here.

Descriptions and Scoring

Ratings of Sexual Arousal consists of the five items, selected from a pool of 11 items, yielding the highest alpha coeffi cients across self-reports to four types of erotic fantasies.

The five items selected were sexual arousal, genital sensations, sexual warmth, nongenital physical sensations, and sexual absorption. Each item is further defined: for example, “Sexual Warmth—a subjective estimate of the amount of sexual warmth experienced in the genitals, breasts, and body as a function of increasing vasocongestion (i.e., engorgement with blood).” If a sixth item is desired, the next best item is “Sexual Tension—subjective estimate of the sexual tension that presses toward release.” A 7-point Likert-type format is used to rate the items with anchors of, for example, 1, no sexual arousal at all to 7, extremely sexually aroused. This measure is appropriate for educated populations of men and women. The definitions of the concepts include technical vocabulary. Respondents respond to these instructions: “For each item, place a circle around the number that best describes how you felt during the experience.” Average completion time is 2 minutes. Scores are summed and a mean item score can be calculated. Higher scores indicate more subjective sexual arousal. Affective Sexual Arousal consists of five adjective prompts selected from a pool of 10 items embedded in a 70-item adjective checklist patterned after the Differential Emotions Scale (Izard, Doughty, Bloxom, & Kotsch, 1974; Mosher & White, 1981). The adjective prompts that were included, following the item analysis across the four erotic fantasies, were sexually aroused, sensuous, turned-on, sexually hot, and sexually excited. If a sixth item is needed, it should be “sexy.” Each adjective prompt was rated on a 5-point Likert-type scale as follows: 1,

very slightly or not at all; 2, slightly; 3, moderately; 4, considerably; or 5, very strongly. This measure of subjective sexual arousal contains standard and slang vocabulary understandable by both men and women, but it probably should be embedded within an affect adjective checklist. Respondents respond by circling the number which best describes “how they felt during the experience.” Completion time can be estimated at 10 items per minute if embedded in a larger affect checklist. Scores are summed across the five items, and a mean item score can be computed. Higher scores indicate more subjective sexual arousal. Genital Sensations is an 11-item checklist modified from earlier versions of self-reports of genital sensations (Mosher & Abramson, 1977; Schmidt & Sigusch, 1970) by placing the items in an ordinal order and by writing brief descriptions of the genital sensations and bodily responses. The 11 items are as follows: no genital sensations, onset of genital sensations, mild genital sensations, moderate genital sensations, prolonged moderate genital sensations, intense genital sensations, prolonged intense genital sensations, mild orgasm, moderate orgasm, intense orgasm, and multiple orgasm. An example of the definitions given is “(4) Moderate genital sensations—vasocongestion sufficient to erect penis fully or to lubricate vagina fully.” The vocabulary is appropriate for educated populations, but the arrangement into an ordered scale educates and helps a less educated group to respond. Respondents check the peak or highest level of genital sensations felt during the experience, and, thus, achieve a score of 1 to 11. The measure requires 2 to 3 minutes to complete. Reliability Cronbach alpha coefficients for the two 5-item measures— Ratings of Sexual Arousal and Affective Sexual Arousal—in a sample of 120 male and 121 female college students, as measured across four fantasy conditions, ranged from .92 to .97 and were robust across erotic conditions (Mosher et al., 1988). Median Cronbach alpha coefficients for Ratings of Sexual Arousal were .97 and for Affective Sexual Arousal were .96.

Multiple Indicators of Subjective Sexual Arousal

DONALD L. MOSHER, 1 University of Connecticut

1 Address correspondence to Donald L. Mosher, 648 Ternberry Forest Drive, The Villages, FL 32162; e-mail: dlmosher@aol.com

Validity

Evidence of convergent validity between the measures

when cast into an intercorrelation matrix was strong, with a median validity coefficient—same scale across erotic conditions—of .52. Intercorrelations of the three measures of subjective sexual arousal within an erotic condition revealed median intercorrelations of approximately .81 for Ratings of Sexual Arousal with Affective Sexual Arousal, .74 for Ratings of Sexual Arousal with Sensations, and .69 of Affective Sexual Arousal with Genital Sensations (Mosher et al., 1988). Further evidence of construct validity is available in the body of literature cited above which used similar measures.

Izard, C. E., Dougherty, F. E., Bloxom, B. M., & Kotsch, W. E. (1974).

The Differential Emotions Scale: A method of measuring the subjective experience of discrete emotions. Unpublished manuscript, Department of Psychology, Vanderbilt University. Jakobovits, L. (1965). Evaluational reactions to erotic literature. Psychological Reports, 16, 985-994. Mosher, D. L. (1980). Three dimensions of depth of involvement in human sexual response. The Journal of Sex Research, 16, 1-42. Mosher, D. L. (1984). Sexual desire in involvement theory: Sexual motivators. Unpublished manuscript. Mosher, D. L., & Abramson, P. R. (1977). Subjective sexual arousal to films of masturbation. Journal of Consulting and Clinical Psychology, 35, 796-807. Mosher, D. L., Barton-Henry, M., & Green, S. E. (1988). Subjective sexual arousal and involvement theory: Development of multiple indicators. The Journal of Sex Research, 25, 412-425. Mosher, D. L., & Greenberg, I. (1969). Females' affective responses to reading erotic literature. Journal of Consulting and Clinical Psychology, 33, 472-477. Mosher, D. L., & White, B. B. (1981). On differentiating shame from shyness. Motivation and Emotions, 5, 61-74. Schmidt, G., & Sigusch, V. (1970). Sex differences in responses to psychosexual stimulation by films and slides. The Journal of Sex Research, 6, 268-283.

Exhibit

Multiple Indicators of Subjective Sexual Arousal

Ratings of Sexual Arousal

Instructions: For each item, place a circle around one number that best described how you felt during the experience.

1. Sexual Arousal—a subjective estimate of your overall level of sexual arousal.

1 2 3 4 5 6 7

No sexual Extremely

arousal at all sexually aroused

2. Genital Sensations—a subjective estimate of the amount and quality of sensation experienced in your genitals.

1 2 3 4 5 6 7

No Extreme

sensation at all genital sensation

3. Sexual Warmth—a subjective estimate of the amount of sexual warmth experienced in the genitals, breasts and body as a function of increasing vasocongestion, i.e., engorgement with blood.

1 2 3 4 5 6 7

No sexual Extreme

warmth at all sexual warmth

4. Non-Genital Physical Sensations—a subjective estimate of the physical sensations such as tickling, fl oating, or fullness that accompany your experience of sexual arousal.

1 2 3 4 5 6 7

No Extreme

sensation at all non-genital

physical sensation

5. Sexual Absorption—a subjective estimate of your level of absorption in the sensory components of the experience.

1 2 3 4 5 6 7

No Extreme

absorption at all absorption

Ratings of Affective Sexual Arousal

Instructions: a This scale consists of a number of words that describe different emotions or feelings. Please indicate the extent to which

each word describes the way you felt during the preceding experiences. Record your answers by indicating the appropriate number on

the five-point scale on the attached answer sheet. Presented below is the scale for indicating the degree to which each word describes

the way you feel. 1 2 3 4 5 Very slightly Slightly Moderately Considerably Very strongly

In deciding on your answer to a given item or word, consider the feeling connoted or defined by that word. Then, if during the experi

ence you felt that way very slightly or not at all, you would darken the blank under the number 1 on the scale; if you felt that way to a mod

erate degree, you would darken the blank under 3; if you felt that way very strongly, you would darken the circle under 5, and so forth.

Remember, you are requested to make your responses on the basis of the way you felt during the experience. Work at a good pace. It

is not necessary to ponder; the first answer you decide on for a given word is probably the most valid. It should not take more than a

few minutes to complete the scale.

Items:

1. Sexually aroused

2. Sensuous

3. Turned-on

4. Sexually hot

5. Sexually excited Ratings of Genital Sensations

Instructions: Genital sensations refer to sensory sensations in the genital region that accompany any source of somatogenic or psycho

genic sexual stimulation and that are a function of increasing vasocongestion in the genital area. Males experience these sensations as

accompaniments of penile erections and females experience these sensations as a function of the engorgement of the labia and the

orgasmic platform in the vagina with accompanying vaginal lubrication. Below, indicate the peak level of genital sensation that you felt

during the experience. The items are:

_____ 1. No genital sensations.

_____ 2. Onset of genital sensations—onset of swelling of penis or vulva or nipple erection.

_____ 3. Mild genital sensations—vascongestion sufficient to begin penile erection or to begin vaginal lubrication.

_____ 4. Moderate genital sensations—vasocongestion sufficient to erect penis fully or to lubricate vagina fully.

_____ 5. Prolonged moderate genital sensations—maintain erection for several minutes or considerable vaginal lubrication for several minutes.

_____ 6. Intense genital sensations—hard or pulsing erection and elevation of testicles in the scrotum; or receptive, engorged vagina or sex flush, or breast swelling or retraction of clitoris or ballooning of vagina.

_____ 7. Prolonged intense genital sensations—near orgasmic levels of genital sensations; swelling of head of penis or high levels of muscular tension or heavy breathing or high heart rate; lasting several minutes and will produce orgasm if continued.

_____ 8. Mild orgasm—mild orgasmic release, slow reduction of vasocongestion, 3–5 contractions.

_____ 9. Moderate orgasm—moderate orgasmic release, average time to resolution of vascongestion, 5–8 contractions.

_____ 10. Intense orgasm—intense orgasmic release with rapid resolution of vasocongestion, 8–12 contractions.

_____ 11. Multiple orgasm—repeated orgasmic release in a single sexual episode.

a These instructions assume the five sexual prompts are embedded within a longer affect adjective checklist.

Assault (see Aggression, Rape)

Alberti, R. E., & Emmons, M. L. (1986). Your perfect right: A guide to assertive living. San Luis Obispo, CA: Impact Publishers. Batista, N. (1995). The design and evaluation of a counseling intervention program in sexual assertiveness in adolescents. Unpublished doctoral dissertation. University of Puerto Rico, Rio Piedras. Kelly, J. A., St. Lawrence, J. S., Hood, H. V., & Brasfield, T. L. (1989). Behavioral intervention to reduce AIDS risk activities. Journal of Counseling and Clinical Psychology, 57, 60–67. Rotheram-Borus, M. J., & Koopman, C. (1989, January). Research on AIDS prevention among runaways: The state of the art and recommendations for the future. Paper presented at the National Institute of Child Health and Human Development Technical Review and Research Planning Meeting on Adolescents and HIV Infection. Bethesda, MD. Yesmont, G. (1992a, April). The development of the Intimate Relationships Questionnaire. Paper presented at the 63rd Annual Meeting of the Eastern Psychological Association. Boston, MA. Yesmont, G. (1992b). The relationship of assertiveness to college students' safer sex behaviors. Adolescence, 27, 253–272.

Exhibit

Intimate Relationships Questionnaire

Each item below describes a situation and three responses that are thoughts or behaviors. These intimate situations involve a dating

couple. Try to imagine a situation in your life that is as close to the one described as possible.

After reading each item, circle a number to the right of each response, indicating how similar it might be to the thought you might have

or the behavior you might show, in the actual situation.

Please rate every response to each situation. Use the following scale for your ratings:

1 2 3 4 5

Not at all Slightly Somewhat Mostly Just

like me like me like me like me like me

1. During the past few weeks your boyfriend (girlfriend) seems less enthusiastic and caring about your relationship.

(AG) a a. You'll decide to confront him (her) on your next date and let out your angry feelings. 1 2 3 4 5

(NON) b. You'll wait for him (her) to call you and you'll complain to your friends. 1 2 3 4 5

(AS) c. You'll decide to speak to him (her) frankly and suggest you try to work things out. 1 2 3 4 5

2. When your date says he (she) won't have sex with you if you insist on using a condom, you say. . .

(AS) a. O.K. Then how about trying some other things besides intercourse? 1 2 3 4 5

(AG) b. Your attitude doesn't make any sense! That's it for us. Let's go home. 1 2 3 4 5

(NON) c. O.K. You're more important to me, we don't need to use it. 1 2 3 4 5

3. You're at a party with your boyfriend (girlfriend) and notice that he (she) is very attentive to someone of the opposite sex that you've never seen before. You think. . .

(NON) a. I'll make the best of it—after all, he's (she's) going home with me tonight. 1 2 3 4 5

(AS) b. I really would like more of his (her) attention tonight and I'm going to tell him (her). 1 2 3 4 5

(AG) c. How could he (she) ignore me like this—I'll find someone on my own I can talk to and make him (her) jealous. 1 2 3 4 5

4. You want to tell your date that you'd like to use a condom when making love tonight and you think. . .

(AS) a. If I can't convince him (her) to use a condom tonight, we can find other safe ways of enjoying ourselves for now. 1 2 3 4 5

(NON) b. Using a condom is a good idea but I don't think I have the nerve to ask him (her) to use one. 1 2 3 4 5

(AG) c. He (she) should do what I ask without any

hesitation if he (she) loves me. 1 2 3 4 5

5. Your boyfriend (girlfriend) gets silent instead of saying what's on his (her) mind. You think. . .

(AG) a. Here it comes. The big silent treatment. I'm going to get mad and force him (her) to talk to me. 1 2 3 4 5 (NON) b. If I make a joke and distract him (her), maybe he'll (she'll) forget what's bothering him (her). 1 2 3 4 5 (AS) c. I'll tell him (her) it bothers me when he (she) gets silent because it leaves me confused about what he's (she's) thinking. 1 2 3 4 5 6. When you're asked by your date if you have any disease that you could give him (her) if you make love that night, you think. . . (AG) a. Who does he (she) think I am—some degenerate who runs around infecting people? 1 2 3 4 5 (AS) b. I'm glad he (she) asked because it gives me a chance to ask the same question. 1 2 3 4 5 (NON) c. I'd better answer or he (she) may get annoyed with me. 1 2 3 4 5 7. When your date asks you if you agree to using a condom when you both make love tonight, you think. . . (AG) a. This is a turn-off. I don't want anybody telling me what we should do when we make love. 1 2 3 4 5 (NON) b. I'd better do what he (she) says or he'll (she'll) be frustrated tonight. 1 2 3 4 5 (AS) c. I'm glad he (she) brought this up, now we're both protected. 1 2 3 4 5 8. Your boyfriend (girlfriend) has criticized your appearance in front of your friends. You say. . . (AS) a. It hurt my feelings when you criticized me. If you have something to say, please bring it up before we go out. 1 2 3 4 5 (AG) b. How could you do such a rotten thing to me? If you do that again—we're through! 1 2 3 4 5 (NON) c. I guess I don't look so great tonight since you criticized me in front of my friends. 1 2 3 4 5 9. When you suggest to your date that a condom be used for mutual protection when you make love tonight, your date teases you about being such a worrier. . . (NON) a. You then become silent for a while, until he (she) comes around to agreeing with you. 1 2 3 4 5 (AS) b. You then tell your date you'd love to make love with him (her), but you always use condoms. 1 2 3 4 5 (AG) c. You then tell your date he's (she's) being really immature. 1 2 3 4 5 10. You want to ask if your date's been tested for AIDS and you say. . . (NON) a. I was wondering about. . . well this is embarrassing to talk about. . . but. . . have you ever been tested for AIDS? You don't have to answer that if you don't want to. 1 2 3 4 5 (AG) b. I want you to tell me right now if you've been tested for AIDS. 1 2 3 4 5 (AS) c. I really like you a lot, but with all this talk about AIDS, I'd like to be a little careful. I've been tested for AIDS, have you? 1 2

3 4 5 11. If your date refuses to use a condom you think. . . (AS) a. I can find out what he (she) has against them and we can talk about it. 1 2 3 4 5 (NON) b. I'm afraid he (she) won't want to see me again if I insist. 1 2 3 4 5 (AG) c. If he (she) won't do what I say—that's it for us. 1 2 3 4 5 12. When neither you nor your date has any condoms one evening, you say. . . (NON) a. Oh. . . that's O.K. I suppose we can do it just once without one. 1 2 3 4 5 (AG) b. That's irresponsible. If you like me you'd always have them when we're together. 1 2 3 4 5 (AS) c. I don't have any either, but we can satisfy each other without intercourse tonight. 1 2 3 4 5 13. You tell your date that you'd like to wait until know each other a little you better before having sex. When he (she) gets annoyed you would. . . (AG) a. Tell your date that you couldn't go out with someone who argues with you about this. 1 2 3 4 5 (AS) b. Re-state your feeling that you'd like to wait. 1 2 3 4 5 (NON) c. Change your mind and have sex with him (her) sooner than you'd planned. 1 2 3 4 5 14. When you suggest to your date that you a condom be used when you make love tonight, he (she) says, "You don't trust me. I told you I've never been exposed to AIDS or herpes, or any other disease." (AS) a. You say, "I'm sorry, but we have no way of knowing that. I'd feel so much better if we used condoms." 1 2 3 4 5 (AG) b. You say, "It's not a question of trust. You don't understand what I'm saying." 1 2 3 4 5 (NON) c. You say, "I'm sorry. I do trust you. Let's drop the whole subject. I don't want to argue." 1 2 3 4 5 a Response classification: AG = Aggressive; AS = Assertive; NON = Nonassertive

Attitudes (also see Behavior, Beliefs and Cognitions, Emotions, Ideology, Knowledge, and Permissiveness; also see specific attitude topics)

Alexander, M. G., & Fisher, T. D. (2003). Truth and consequences: Using the bogus pipeline to examine sex differences in self-reported sexuality. The Journal of Sex Research, 40, 27–35.

Calderwood, D. (1971). About your sexuality. Boston: Beacon.

Chia, S. C. (2006). How peers mediate media influence on adolescents' sexual attitudes and sexual behavior. Journal of Communication, 56, 585–606.

Fisher, T. D. (1986). An exploratory study of parent-child communication about sex and the sexual attitudes of early, middle, and late adolescents. The Journal of Genetic Psychology, 147, 543–557. Fisher, T. D. (2007). Sex of experimenter and social norm effects on reports of sexual behavior in young men and women. Archives of Sexual Behavior, 36, 89–100. Fisher, T. D. (2009). The impact of socially conveyed norms on the reporting of sexual behavior and attitudes by men and women. Journal of Experimental Social Psychology, 45, 567–572. Fisher, T. D., & Hall, R. G. (1988). A scale for the comparison of the sexual attitudes of adolescents and their parents. The Journal of Sex Research, 24, 90–100. Lief, H. I., & Reed, D. M. (1972). Sex Knowledge and Attitude Test. Philadelphia: Center for the Study of Sex Education in Medicine, University of Pennsylvania.

Exhibit

Attitudes Toward Sexuality Scale

For each of the following statements, please circle the response which best reflects your reaction to that statement. 1 2 3 4
5

Strongly Somewhat Neutral Somewhat Strongly

Disagree Disagree Agree Agree

1. Nudist camps should be made completely illegal. 1
2 3 4 5

2. Abortion should be made available whenever a woman feels

it would be the best decision. a

3. Information and advice about contraception (birth control) should be given to any individual who intends to have intercourse.

4. Parents should be informed if their children under the age of eighteen have visited a clinic to obtain a contraceptive device.

5. Our government should try harder to prevent the distribution of pornography.

6. Prostitution should be legalized.

7. Petting (a stimulating caress of any or all parts of the body) is immoral behavior unless the couple is married.

8. Premarital sexual intercourse for young people is unacceptable to me.

9. Sexual intercourse for unmarried young people is acceptable without affection existing if both partners agree.

10. Homosexual behavior is an acceptable variation in sexual orientation [original term: preference].

11. A person who catches a sexually transmitted [original term: venereal] disease is probably getting exactly what he/she deserves.

12. A person's sexual behavior is his/her own business, and nobody should make value judgments about it.

13. Sexual intercourse should only occur between two people who are married to each other.

a The 5-point scale is repeated after each item.

The original Trueblood Sexual Attitudes Questionnaire

(TSAQ) (Trueblood, Hannon, & Hall, 1998) was devel

oped to reliably measure attitude change regarding the

most common topics relating to sexual behavior covered in

human sexuality courses. The authors were also interested

in comparing attitudes by gender, ethnicity, sexual experience, etc. Based on Story's (1979) approach, the TSAQ was divided into sexual attitudes acceptable for oneself versus acceptable for others. TSAQ items were developed based on an analysis of the content of college sexuality course textbooks, with a final scale containing 90 items divided into five subscales: Autoeroticism, Heterosexuality, Homosexuality, Sexual Variations, and Commercial Sex. Topics less directly related to sexual behavior per se (e.g., abortion, marital relationships) were not included. Internal consistency (reliability) was assessed using coefficient alpha, which was .93 for the Self scale and .96 for the Other scale. Subscale coefficients (e.g., Autoeroticism Self) ranged from .67 to .97, with the lowest coefficients for Heterosexuality and Commercial Sex. The revision (Hannon, Hall, Gonzalez, & Cacciapaglia, 1999) was designed to shorten the scale, replace poor items, and to assess test/retest reliability.

Description

The current questionnaire contains 80 items reflecting Self (40 items) versus Other (40 items) across the five subscales.

Each item is rated on a 9-point Likert-type scale, ranging from 1, I completely disagree to 9, I completely agree. Some questions are reverse scored. For total and subscale scores,

higher numbers indicate a more liberal attitude. Questions from the five subscales are randomly ordered within the Self scale. The same 40 questions were reworded to reflect attitudes toward others and then randomly ordered within the Other scale. The following list shows sample items. The division of the items into Self versus Other, with five major areas of content coverage in each, allows for more refined measurement of attitudes following a sexuality course. Changes in attitudes toward Self versus Others can be compared. One can note differential change in the five content areas, as they may vary in amenability to change. The questionnaire can also be used to study subgroups of particular interest (e.g., ethnic, age, Greek (fraternity/ sorority) versus non-Greek. Information from responses to the questionnaire may be used to guide the development of future courses, depending on course goals. Although the scale has been used primarily with college students, there is no reason it cannot be used on other populations. It has been used by Duyan and Duyan (2005), by Petroski, Spears, Dempsey, and Kapalka (2007), and is listed in the GASP Measures Database, an American Psychological Association division site. Response Mode and Timing This questionnaire can be implemented as a paper instrument or by using online survey software. It typically takes 15–20 minutes to complete. Scoring The mean rating for the 8 questions in each subscale is normally reported, as well as the overall mean rating for Self and Other. The attached questionnaire has the subscale indicated for each question, as well as an R for reverse scoring. Reliability and Validity The questionnaire was tested in 1999 on 143 female and 51 male college students (median age = 20) in Northern California. Coefficient alpha was .97 for the entire measure, .93 for the Self scale, and .96 for the Other scale. Testretest reliability after 3 weeks was .94

(p < .01). Caucasians were significantly more liberal on both the Self and Other scales than Asians and Hispanics, who did not differ from each other, F (2, 157) = 10.86, p < .001. Gender differences were not significant. Mean scores for the Self and Other scales for the single test and retesting are shown in Table 1. Test-retest reliability is excellent. Self versus Other comparisons were significantly different on both testings (p < .001). As expected, the participants were more liberal about others' behavior than their own. Coefficient alpha for each subscale is shown in Table 2, along with the mean rating for each of the 10 subscales. Ratings were acceptable for all subscales except

Trueblood Sexual Attitudes Questionnaire

ROSEANN HANNON, DAVID HALL, 1 VIANEY GONZALEZ, AND HOLLY CACCIAPAGLIA,

University of the Pacifi c, Stockton

1 Please address correspondence to David S. Hall, 2111 Lido Circle, Stockton, CA 95207; e-mail: airsafe1@comcast.net
TABLE 1 Mean and Standard Deviation for the Basic Scales
Self Other Single test (N = 194) 3.47 (1.33) 5.21 (1.92)
Retest (N = 104) 3.55 (1.48) 5.24 (2.04)

Heterosexuality. The mean ratings for Self were signifi

cantly more conservative than for Other in each of the five

areas. The largest mean difference between Self and Other

occurred for Homosexuality. The revised questionnaire had acceptable internal con

sistency for the total score, the Self and Other scores, and

8 of the 10 subscale scores. The Heterosexuality subscale

TABLE 2

Mean (SD) and Reliability (Coefficient Alpha) for the Five

Subscales

Self Other F p <

Autoeroticism 4.33 (2.13) .88 6.13 (2.29) .91 260.06 .001

Heterosexuality 4.79 (1.52) .68 4.98 (1.37) .56 5.96 .015

Homosexuality 1.91 (1.57) .91 4.93 (3.15) .98 217.26 .001

Variations 2.90 (1.52) .78 7.96 (2.22) .88 306.05 .001

Commercial Sex 3.43 (1.48) .76 5.07 (1.86) .81 328.06 .001

Exhibit

Trueblood Sexual Attitudes Questionnaire

Subscales

1 Masturbation/Erotic

2 Heterosexual

3 Homosexual

4 Variations

5 Commercial

Please answer the following questions about your attitudes toward your personal sexual behavior by writing the number between 1 and

9 that best represents how you feel in response to each question.

I Completely I Completely

Disagree Agree

_1__ 1. I find that masturbating is an acceptable sexual outlet when I am not currently involved with a partner.

_2__ 2. I would engage in sexual intercourse with my fiancée before marriage.

_3__ 3. I would engage in oral genital sexual stimulation with a partner of the same sex.

_5__ 4. I would watch pornography with my partner to learn new sexual techniques.

_4__ 5. I could be involved in more than one sexual relationship at a time.

_4__ 6. I would find it acceptable to dress in the clothing of the opposite gender if I found it sexually arousing.

_3__ 7. It is acceptable for me to engage in bisexuality.

_1__ 8. Videotaping myself and my partner during sexual activity is acceptable to me if it is arousing.

_5__ 9. I do not believe there should be censorship of sexual materials because I want the freedom to enjoy sexual materials.

_3__ 10. It is acceptable for me to be attracted to members of the same sex as well as members of the opposite sex.

_4__ 11. I would find it acceptable to inflict pain on a consenting individual if I found it sexually arousing.

_4__ 12. I find it acceptable to watch other people engage in sexual activity.

_1__ 13. I personally believe it is acceptable for me to think or daydream about sexual activity.

_5__ 14. I believe I would engage in sex more often if I watched pornography.

_2R__ 15. I would use my sexual activity only for reproduction, not for pleasure.

_1__ 16. When I am engaged in sexual activity with my partner, it is acceptable to fantasize about someone else.

_5__ 17. I would sell my sexual services for money.

_4__ 18. I would enjoy being dominated in a sexual relationship.

_2__ 19. I would use sexual activity for my own personal sexual pleasure.

_4__ 20. I would enjoy being the dominator in a sexual relationship.

_1__ 21. Even if I were married, I would engage in masturbation as an acceptable means of sexual outlet.

_3__ 22. It would be acceptable to me if a member of my own sex made an advance toward me.

_5__ 23. I would watch pornography to enhance my sexual relationships.

_5__ 24. I would appear in sexually explicit entertainment for money.

_3__ 25. I would engage in sexual intercourse with a partner of the same sex.

_1__ 26. I would use erotica (magazines, videos, books) as a means to stimulate sexual arousal for myself.

_2R__ 27. I would engage in sexual intercourse only with my spouse.

_4__ 28. I would find it acceptable to receive a sexually obscene phone call if I found it sexually arousing.

_3__ 29. I would engage in mutual touching with a partner of the same sex.

_3__ 30. It is acceptable for me to engage in homosexuality.

_4__ 31. I would engage in group sex (3 or more people consenting).

_2__ 32. I would engage in sexual intercourse with a person of the opposite sex the first time we met.

_1__ 33. If I were single, I would engage in masturbation as a means of sexual outlet.

_2R__ 34. I would engage in sexual intercourse only if I loved my partner.

_5__ 35. It is acceptable for me to engage in prostitution.

_3__ 36. I consider it acceptable for me to be attracted to members of the same sex.

_2__ 37. I would engage in oral genital sexual stimulation with a partner of the opposite sex.

_5R__ 38. I would not watch pornography because it is harmful.

_2__ 39. I would engage in anal sexual stimulation with a partner of the opposite sex.

_1__ 40. When I am in a sexual relationship, I think it is still acceptable to fantasize about someone else.

The following questions refer to your beliefs about others.

_4__ 41. It is acceptable if other people are involved in more than one sexual relationship at a time.

_1__ 42. While other people are engaged in sexual activity with their partner, it is acceptable for them to fantasize about

someone else.

_1__ 43. It is acceptable if other people use erotica (magazines, videos, books) as a means to stimulate sexual arousal for

themselves.

_3__ 44. It is acceptable for another person to engage in oral genital sexual stimulation with a partner of the same sex.

_4__ 45. It is acceptable for other people to receive sexually obscene phone calls if they find this sexually arousing.

_1__ 46. It is acceptable for other people to think or daydream about sexual activity.

_5__ 47. It is acceptable for other people to engage in prostitution.

_5__ 48. It is acceptable if other people appear in sexually explicit entertainment for money.

_1__ 49. It is acceptable for other people to engage in masturbation as a means of sexual outlet if they are single.

_5__ 50. It is acceptable for other people to watch pornography to enhance their sexual relationships.

_5R__ 51. Other people should not watch pornography because it is harmful.

_1__ 52. It is acceptable for other people to videotape themselves and their partner during sexual activity if it is arousing to

them.

_4__ 53. It is acceptable for other people to engage in group sex (3 or more people consenting).

_3__ 54. It is acceptable for another person to be attracted to members of the same sex as well as the opposite sex.

_3__ 55. It is acceptable if other people find it acceptable when someone of their same sex makes an advance toward them.

_4__ 56. It is acceptable for another person to enjoy being dominated in a sexual relationship.

_2__ 57. It is acceptable for another person to engage in anal sexual stimulation with a partner of the opposite sex.

_5__ 58. It is acceptable if other people watch pornography with their partner to learn new sexual techniques.

_2__ 59. It is acceptable for other people to engage in sexual intercourse with a person of the opposite sex the first time they

meet.

_5__ 60. I believe other people would engage in sex more often if they watched pornography.

_3__ 61. It is acceptable for another person to engage in sexual intercourse with a partner of the same sex.

_3__ 62. It is acceptable for other people to engage in homosexual activity.

_1__ 63. Even if they are married, it is acceptable for other people to engage in masturbation as a means of sexual outlet.

_4__ 64. It is acceptable for other people to dress in the clothing of the opposite gender if they find it sexually arousing.

_3__ 65. It is acceptable if other people are attracted to members of the same sex.

_2__ 66. It is acceptable if other people use sexual

activity for their personal sexual pleasure.

_2__ 67. It is acceptable if other people engage in sexual intercourse with their fiancée before marriage.

_1__ 68. When they are in a sexual relationship, it is still acceptable for other people to fantasize about someone else.

_2__ 69. It is acceptable for another person to engage in oral genital sexual stimulation with a partner of the opposite sex.

_2R__ 70. It is acceptable if other people engage in sexual intercourse only with a partner they love.

_1__ 71. It is acceptable for other people to use masturbation as a sexual outlet when they are not currently involved with a

partner.

_2R__ 72. It is acceptable for other people to use sexual activity only for reproduction, not pleasure.

_4__ 73. It is acceptable for other people to inflict pain on another consenting individual if they find it sexually arousing.

_3__ 74. It is acceptable for another person to engage in mutual touching with a partner of the same sex.

_3__ 75. It is acceptable for other people to engage in bisexuality.

_4__ 76. It is acceptable for another person to enjoy being the dominator in a sexual relationship.

_2R__ 77. It is acceptable if other people only engage in sexual intercourse with their own spouse.

_4__ 78. It is acceptable if another person watches others engage in sexual activity.

_5__ 79. It is acceptable for other people to believe there should not be censorship of sexual materials because they want the

freedom to enjoy sexual materials.

_5__ 80. It is acceptable for other people to sell their sexual services for money.

Note. Numbers in the answer space indicate the subscale the question is associated with, and the R is reversed scored. Contact David Hall at airsafe1@

comcast.net for a printable copy without scoring information. There is no copyright on this questionnaire.

Sexual Attitudes Scale and Brief Sexual Attitudes Scale

SUSAN S. HENDRICK 1 AND CLYDE HENDRICK, Texas Tech University

1 Address correspondence to Susan S. Hendrick, Department of Psychology, Texas Tech University, Lubbock, TX 79409-2051; e-mail: s.hendrick@

ttu.edu

SEXUAL ATTITUDES SCALE

The Sexual Attitudes Scale (SAS; Hendrick & Hendrick,

1987) was developed to broaden the assessment of sexual

attitudes from a heavy reliance on sexual permissiveness

to a more comprehensive and multidimensional approach.

Although we viewed sexual attitudes as more than just per

missiveness, we realized that permissiveness is extremely

important and included it as a major aspect of our mea

surement of sexual attitudes. The SAS was also designed

to assess attitudes generically, including maritally, premar

itally, and for nonmarital couples. Finally, the scale was

intended to be psychometrically sound and to complement

rather than duplicate existing measures.

Description

Initial work on the SAS (Hendrick, Hendrick, Slapion-Foote,

& Foote, 1985) involved item generation and reduction via principal components analysis (PCA) to a 58-item scale measuring Sexual Permissiveness, Sexual Responsibility, Sexual Communion, Sexual Instrumentality, and Sexual Conventionality. After additional sampling of nearly 1,400 university students from both Florida and Texas and extensive analyses employing PCA with Varimax rota tion, 43 items across four factors were retained in a final scale (Hendrick & Hendrick, 1987). Given the nature of PCA, the factors were orthogonal, and the subscales were only modestly related. The subscales and number of items are as follows (the full scale is reproduced in the Exhibit). Permissiveness (21 items) measures a casual, open attitude toward sex. Sexual Practices (7 items) measures responsible (e.g., birth control) and tolerant (e.g., masturbation) sexual attitudes. Communion (9 items) presents sex as an ideal or "peak experience." Finally, Sexual Instrumentality (6 items) reflects sex as a natural, biological, self-oriented aspect of life. The items are all written as statements and are in a Likert format with which the respondent rates his/her degree of agreement. As noted, the scale is appropriate for partnered couples of all types whose relationships have a sexual component. Response Mode and Timing Instructions for the SAS are included in the Exhibit. The items are rated on a 5-point basis in a Likert format, with 1 = strongly agree, 2 = moderately agree, 3 = neither agree nor disagree, 4 = moderately disagree, and 5 = strongly disagree. Scoring The lower the score, the greater the endorsement of a subscale, although direction of scoring can be reversed. Two items on the Permissiveness subscale are reverse-scored. The SAS can be completed typically in 10 minutes or less. Scores for a given subscale are represented by subscale mean scores (i.e., total the item scores and divide by the number of items). We have not found it useful to obtain a

total score on the SAS, given that the subscales are rela

tively independent, representing different orientations

toward sex (see following section).

Reliability

Reliability indices for the SAS are taken from Hendrick

and Hendrick (1987); however, the scale has been used

fairly widely for over 20 years and has been translated

from English into a variety of languages. Reliability herein

refers to internal consistency (Cronbach's alpha), test

retest reliability, and intersubscale (i.e., intra SAS) correla

tions. Values were quite similar across two studies, with

standardized alphas ranging from .71 for Sexual Practices

to .94 for Permissiveness (Study I). Test-retest correlations

(Study I only) ranged from .66 for Instrumentality to .88

for Permissiveness. Finally, intrascale correlations ranged

from r = .00 between Permissiveness and Sexual Practices

to r = .44 between Permissiveness and Instrumentality

(Study II).

Validity

Initial criterion validity was demonstrated (Hendrick &

Hendrick, 1987) by appropriate correlations between the

SAS and measures such as the Reiss Male and Female

Sexual Permissiveness Scales (Reiss, 1967) and the Revised

Mosher Guilt Inventory (Green & Mosher, 1985). In other

research (Hendrick & Hendrick, 1995), men reported themselves to be more permissive and instrumental in their sexual attitudes than women reported themselves to be. Relating these sexual attitudes to love attitudes for both women and men separately (see Hendrick & Hendrick, 1986, for a description of the Love Attitudes Scale), Permissiveness was positively related to game-playing love and negatively related to friendship love, practical love, and altruistic love. Sexual Practices was related inconsistently to love attitudes. Communion was positively related to passionate love, possessive love, and altruistic love. Instrumentality was positively related to game-playing love and negatively related to altruistic love.

The SAS has been used in variety of studies: along with personality measures in a study of women with eating problems (Evans & Wertheim, 1998); to explore relationship infidelity and distress (Cann, Mangum, & Wells, 2001); using the internet for casual dating (Peter & Valkenburg, 2007); predicting sexual experiences and attitudes from religious variables (Murray, Ciarrocchi, & Murray-Swank, 2007); comparing men who commit different types of sexual assault (Abbey, Parkhill, Clinton-Sherrod, & Zawacki, 2007); using sexual terms and personality terms to predict sex and relationships (Shafer, 2001); and examining religious and sexual attitudes of Irish youth (Grey &

Swain, 1996). The SAS was also used in a study of French adults (Le Gall, Mullet, & Riviere Shafighi, 2002), wherein the scale performed well but was found to have a scale structure differing slightly from the original four-factor structure. Thus, the SAS is a solid and widely used scale, but some questions were raised about its factor structure. The Le Gall et al. findings and changes in language use and cohort influences over 2 decades prompted us to conduct a series of studies that resulted in the revision of the Sexual Attitudes Scale to the Brief Sexual Attitudes Scale, described below. Other Information The Sexual Attitudes Scale and the Brief Sexual Attitudes Scale are shown in the Exhibit, along with scoring instructions. The scales are in the public domain and free for research and clinical use. In the Exhibit, all 43 items in the SAS are shown; however, only the items in the BSAS are numbered. BRIEF SEXUAL ATTITUDES SCALE Description The Brief Sexual Attitudes Scale (BSAS; Hendrick, Hendrick, & Reich, 2006) was developed because our recent research and that of others (e.g., Le Gall et al., 2002) indicated that the factor structure had shifted slightly. In addition, attitudes and language usage change rapidly in our technology-oriented society. Finally, all indices being equal, the briefer the measure, the greater its practicality for both research and clinical use. Based on data from three studies (two existing data sets and one prospective study), and analyses that included principal components analyses, confirmatory factor analyses (CFA), alphas, subscale intercorrelations, test-retest correlations, correlations with relevant measures, and assessment of gender differences, the 43-item SAS was refined into the 23-item BSAS. The final four scales include Permissiveness (10 items), Birth Control (3 items), Communion (5 items), and Instrumentality (5 items). Response Mode, Timing, and Scoring The response format for the BSAS is similar to that for the SAS, and completion time ranges from 5–10 minutes. Scoring is handled similarly to the SAS, using mean scores for the subscales and no overall scale score. Reliability and Validity In Studies 1 and 2, using existing data sets (Hendrick et al., 2006), the BSAS and SAS performed similarly, though CFA fit indices were significantly better for the BSAS. Gender differences and correlations with other measures (e.g., love attitudes, relationship satisfaction) were very similar. In

Study 3, the prospective study (Hendrick et al. 2006), the

analytic strategy was similar to that for the previous two

studies. CFA indices for the BSAS showed a Goodness of Fit Index (GFI) of .98, AGFI of .95, RMSEA of .05, CFI of .99, and χ 2 (21, 518) = 52.3 (Hendrick et al., 2006). The alphas were .95 for Permissiveness, .88 for Birth Control, .73 for Communion, and .77 for Instrumentality. Inter-sub scale correlations were .20 or less except for one that was .40 (Permissiveness with Instrumentality). Test-retest cor relations were .92 for Permissiveness, .57 for Birth Control, .86 for Communion, and .75 for Instrumentality. The BSAS subscales correlated as expected for the most part with love attitudes and with other relationship-oriented measures. Finally, gender differences were consistent with Studies I and II. Women "were less endorsing of Permissiveness and Instrumentality than were men, and the genders did not differ on Birth Control or Communion" (Hendrick et al., p. 84, 2006). The BSAS has been used in other published research (Hendrick & Hendrick, 2006), and the article has been cited by Rathus and colleagues (Rathus, Nevid, & Fichner-Rathus, 2008).

Other Information

As noted above, the Brief Sexual Attitudes Scale is readily available.

Abbey, A., Parkhill, M. R., Clinton-Sherrod, A. M., & Zawacki, T. (2007). A comparison of men who committed different types of sexual assault in a community sample. Journal of Interpersonal Violence, 22, 1567– 1580.

Cann, A., Mangum, J. L., & Wells, M. (2001). Distress in response to relationship infidelity: The roles of gender and attitudes about relationships. The Journal of Sex Research, 38, 185–190. Evans, L., & Wertheim, E. H. (1998). Intimacy patterns and relationship satisfaction of women with eating problems and the mediating effects of depression, trait anxiety, and social anxiety. Journal of Psychosomatic Research, 44, 355–365. Green, S. E., & Mosher, D. L. (1985). A causal model of sexual arousal to erotic fantasies. The Journal of Sex Research, 21, 1–23. Grey, I. M., & Swain, R. B. (1996). Sexual and religious attitudes of Irish students. The Irish Journal of Psychology, 17, 213–227. Hendrick, C., & Hendrick, S. S. (1986). A theory and method of love. Journal of Personality and Social Psychology, 50, 392–402. Hendrick, C., Hendrick, S. S., & Reich, D. A. (2006). The Brief Sexual Attitudes Scale. The Journal of Sex Research, 43, 76–86. Hendrick, S. S., & Hendrick, C. (1987). Multidimensionality of sexual attitudes. The Journal of Sex Research, 23, 502–526. Hendrick, S. S., & Hendrick, C. (1995). Gender differences and similarities in sex and love. Personal Relationships, 2, 55–65. Hendrick, S. S., & Hendrick, C. (2006). Measuring respect in close relationships. Journal of Social and Personal Relationships, 23, 881– 899. Hendrick, S. S., Hendrick, C., Slapion-Foote, M. J., & Foote, F. H. (1985). Gender differences in sexual attitudes. Journal of Personality and Social Psychology, 48, 1630–1642. Le Gall, A, Mullet, E., & Shafighi, S. R. (2002). Age, religious beliefs, and sexual attitudes. The Journal of Sex Research, 39, 207–216. Murray, K. M., Ciarrocchi, J. W., & Murray-Swank, N. A. (2007). Spirituality, religiosity, shame and guilt as predictors of sexual attitudes and experiences. Journal of Psychology and Theology, 35, 222–234. Peter, J., & Valkenburg, P. M. (2007). Who looks for casual dates on the internet? A test of the compensation and the recreation hypotheses. New Media & Society, 9, 455–474. Rathus, S. A., Nevid, J. S., & Fichner-Rathus, L. (2007). Human sexuality in a world of diversity (7 th ed.). Boston, MA: Allyn & Bacon. Reiss, I. L. (1967). The social context of premarital sexual permissiveness. New York: Holt, Rinehart & Winston. Shafer, A. B. (2001). The Big Five and sexuality trait terms as predictors of relationships and sex. Journal of Research in Personality, 35, 313–338.

Exhibit

Sexual Attitudes Scale and Brief Sexual Attitudes Scale

Listed below are several statements that reflect different attitudes about sex. For each statement fill in the response on the answer

sheet that indicates how much you agree or disagree with that statement. Some of the items refer to a specific sexual relationship, while

others refer to general attitudes and beliefs about sex. Whenever possible, answer the questions with your current partner in mind.

If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never had a sexual

relationship, answer in terms of what you think your responses would most likely be. For each statement:

A = Strongly Agree with the Statement

B = Moderately Agree with the Statement

C = Neutral—Neither Agree nor Disagree

D = Moderately Disagree with the Statement

E = Strongly Disagree with the Statement

1. I do not need to be committed to a person to have sex with him/her.

2. Casual sex is acceptable.

3. I would like to have sex with many partners.

4. One-night stands are sometimes very enjoyable.

5. It is okay to have ongoing sexual relationships with more than one person at a time.

P It is okay to manipulate someone into having sex as long as no future promises are made.

6. Sex as a simple exchange of favors is okay if both people agree to it.

7. The best sex is with no strings attached.

8. Life would have fewer problems if people could have sex

more freely.

9. It is possible to enjoy sex with a person and not like that person very much.

P Sex is more fun with someone you don't love.

P It is all right to pressure someone into having sex.

P Extensive premarital sexual experience is fine.

P Premarital affairs are all right as long as one's partner doesn't know about them.

P Sex for its own sake is perfectly all right.

P I would feel comfortable having intercourse with my partner in the presence of other people.

P Prostitution is acceptable.

10. It is okay for sex to be just good physical release.

P Sex without love is meaningless.

P People should at least be friends before they have sex together.

P In order for sex to be good, it must also be meaningful.

11. Birth control is part of responsible sexuality.

12. A woman should share responsibility for birth control.

13. A man should share responsibility for birth control.

SP Sex education is important for young people.

SP Using "sex toys" during lovemaking is acceptable.

SP Masturbation is all right.

SP Masturbating one's partner during intercourse can increase the pleasure of sex.

C Sex gets better as a relationship progresses.

14. Sex is the closest form of communication between two people.

15. A sexual encounter between two people deeply in love is the ultimate human interaction.

C Orgasm is the greatest experience in the world.

16. At its best, sex seems to be the merging of two souls.

17. Sex is a very important part of life.

18. Sex is usually an intensive, almost overwhelming experience.

C During sexual intercourse, intense awareness of the partner is the best frame of mind.

C Sex is fundamentally good.

19. Sex is best when you let yourself go and focus on your own pleasure.

20. Sex is primarily the taking of pleasure from another person.

21. The main purpose of sex is to enjoy oneself.

22. Sex is primarily physical.

23. Sex is primarily a bodily function, like eating.

I Sex is mostly a game between males and females.

Note. Items included in the original SAS have a letter denoting their subscale and are not numbered. The BSAS includes the instructions shown at the

top, which are the same as for the SAS. The items are administered in the order shown. For purposes of analyses, we have A = 1 and E = 5. (The scor

ing may be reversed, so that A = strongly disagree, etc.) P = Permissiveness; SP = Sexual Practices; C = Communion; I = Instrumentality. Items 1–10 =

Permissiveness; 11–13 = Birth Control; 14–18 = Communion; 19–23 = Instrumentality.

The Sexual Attitude Scale (SAS) is a short-form scale

designed to measure liberal versus conservative attitudes

toward human sexual expression.

Description

The SAS contains 25 category partition (Likert type) items, two of which are worded negatively to partially offset the potential for response set bias. Each item is scored on a relative frequency scale as shown in the scoring key of the instrument. Obtained scores range from 0 to 100, where higher scores indicate greater degrees of conservatism and lower scores indicate more liberal attitudes. The SAS has a cutting score of 50, such that scores above that value indi cate the presence of an increasingly conservative attitude toward human sexual expression, whereas scores below that value indicate the presence of an increasingly liberal orientation. A score of 0 represents the most liberal posi tion and a score of 100 represents the most conservative position. The SAS can be used with all English speaking populations aged 12 or older. Readability statistics are as follows: Flesch Reading Ease: 63; Gunning's Fog Index: 10; and Flesch-Kincaid Grade Level: 7.

Response Mode and Timing

The SAS is a self-report scale that is normally completed in 5–7 minutes.

Scoring

Items 21 and 22 must first be reverse-scored by subtract ing the item response from K + 1, where K is the number

of response categories in the scoring key. After making

all appropriate item reversals, compute the total score

as S = (ΣSX i − N)(100) / [(K−1)N], where X is an item

response, 1 st small i is italic K is the number of
response

categories, and N is the number of properly completed

items. Total scores remain valid in the face of missing

values (omitted items) provided the respondent com

pletes at least 80% of the items. The effect of the scoring

Sexual Attitude Scale

WALTER W. HUDSON, 1, 2 WALMYR Publishing Co.

G ERALD J. MURPHY, New Orleans, Louisiana

1 Walter W. Hudson, 1934–1999.

2 Address correspondence to WALMYR Publishing Co., P.O. Box
12217, Tallahassee, FL 32317-2217; e-mail:
walmyr@walmyr.com S A M P L E

Exhibit

Sexual Attitude Scale (SAS)

Name:_____
Today’s Date:_____

This questionnaire is designed to measure the way you feel
about sexual behaviour. It is not a test, so there are no
right or wrong

answers. Answer each item as carefully and as accurately as
you can by placing a number beside each one as follows.

1 = Strongly disagree

2 = Disagree

3 = Neither agree nor disagree

4 = Agree

5 = Strongly agree

1._____ I think there is too much sexual freedom given to adults these days.

2._____ I think that increased sexual freedom undermines the American family.

3._____ I think that young people have been given too much information about sex.

4._____ Sex education should be restricted to the home.

5._____ Older people do not need to have sex.

6._____ Sex education should be given only when people are ready for marriage.

7._____ Pre-marital sex may be a sign of a decaying social order.

8._____ Extra-marital sex is never excusable.

9._____ I think there is too much sexual freedom given to teenagers these days.

10._____ I think there is not enough sexual restraint among young people.

11._____ I think people indulge in sex too much.

12._____ I think the only proper way to have sex is through intercourse.

13._____ I think sex should be reserved for marriage.

14._____ Sex should be only for the young.

15._____ Too much social approval has been given to homosexuals.

16._____ Sex should be devoted to the business of procreation.

17._____ People should not masturbate.

18._____ Heavy sexual petting should be discouraged.

19._____ People should not discuss their sexual affairs or business with others.

20._____ Severely handicapped (physically and mentally) people should not have sex.

21._____ There should be no laws prohibiting sexual acts between consenting adults.

22._____ What two consenting adults do together sexually is their own business.

23._____ There is too much sex on television.

24._____ Movies today are too sexually explicit.

25._____ Pornography should be totally banned from our bookstores.

Copyright © 1990, Walter W. Hudson & Gerald J. Murphy
Illegal to Photocopy or Otherwise
Reproduce

Note. Item 21and 22 are reverse scored.

In an attempt to develop a scale providing a focus for sexual

ity issues of the 1990s, we undertook the construction of this

attitude scale, with a particular focus on sexual coercion.

Description

The 1980s and 1990s had seen a focus on attitudes toward

sexual coercion, both in terms of their implications for

female and male psychological development and their rela

tionship to unintended pregnancy and Sexually transmitted

diseases (STDs). As such, a broad array of items focusing

on attitudes toward sexual relationships, in addition to more

specific issues, such as abortion, masturbation, homosexu

ality, contraception, sexuality in childhood and the aged, and sexuality education, were seen as important for inclusion in the inventory. The initial Attitudes Toward Sexuality Inventory (Patton & Mannison, 1993) was a 72-item questionnaire representing 10 attitudinal categories designed to evaluate a university course in human sexuality. There were 5 to 11 items in each category. The categories were selected to represent the main content areas of the course and included (a) contraception, (b) masturbation, (c) sexuality across the lifespan, (d) gender roles, (e) gay and lesbian relationships, (f) abortion, (g) STDs, (h) child sexual abuse, (i) rape, and (j) sexuality education. Items in the initial inventory were derived from a number of different sources. These questionnaires included a number of the Burt (1980) scales, such as Sexual Conservatism, Rape Myth Acceptance, Interpersonal Violence, and Sex Role Stereotyping. Other measures used included those focusing on attitudes toward homosexuality (Herek, 1988), AIDS (Greiger & Ponterotto, 1988), rape (Deitz, Blackwell, Daley, & Bentley, 1982; Dull & Giacopassi, 1987; Feild, 1978), dating relationships (Giarusso, Johnson, Goodchild, & Zellman, 1979), and women (Spence, Helmreich, & Stapp, 1973). As a result of preliminary research (Patton & Mannison, 1993, 1994), evaluations from independent experts in uni

versity sexuality education, and a review of item content and wording by a group of secondary school sexuality educators, changes were made. Several items were deleted, the focus of a number of items was changed, and other items were reworded to reflect subtle language shifts in the young adult population (Hall, Howard, & Boezio, 1986). Also, new items were added to capture various topical questions. In all, 35 items reflecting diverse issues in sexuality, including masturbation, sexuality in children and the aged, sexual coercion and assault in childhood and adulthood, homosexuality, abortion, and contraception were included in the revised inventory. Five items focusing on attitudes toward women (adapted from Spence et al., 1973) were also included, making a total of 40 items in the Revised Attitudes Toward Sexuality Inventory. Three reliable and clear factors were found in a factor analysis, and two other factors were less clear (Patton & Mannison, 1995). The three factors were Attitudes Toward Sexual Coercion and Assault (Items 2, 5, 6, 13, 17, 18, 25, 27, 29, 33, 37, 38), Attitudes Toward Sexuality Issues (Items 4, 7, 8, 15, 19, 20, 23, 35), and Attitudes Toward Gender Roles (Items 9, 28, 31, 32, 35). Response Mode and Timing The response format is a 6-point scale to which respondents reply from Strongly Agree through Strongly Disagree. The 6-point format was chosen in order to avoid a midpoint and invite a choice for one side or the other. The inventory typically requires 5–10 minutes to complete. Scoring Items were worded to counter any tendency to simply agree (or disagree) with all of them. This resulted in the reverse scoring of the following items: 4, 7, 13, 15, 19, 20, 23. On the Attitudes Toward Sexual Coercion and Assault factor, higher scores reflect greater acceptance of rape myths and sexual coercion. Higher scores on the Attitudes Toward Sexuality factor reflect less traditional attitudes toward sexuality. Higher scores on the Attitudes Toward Gender Roles factor reflect more traditional attitudes toward gender roles. Reliability The Cronbach alpha for the overall revised inventory was .85, and for the three clear factors, the alphas were .85, .79, and .68, respectively (Patton & Mannison, 1995). Validity The

initial version of the Attitudes Toward Sexuality Inventory has been used to evaluate attitude change following a university course. Pre- and posttest data were received from 115 students (Patton & Mannison, 1993). Patton and Mannison (1994) also used the initial version of the inventory in a study designed to measure attitude and behaviour

1 Address correspondence to Wendy Patton, School of Learning and Development, Queensland University of Technology, Kelvin Grove Campus 4059,

Brisbane, Australia; e-mail: w.patton@qut.edu.au

Revised Attitudes Toward Sexuality Inventory

WENDY PATTON 1 AND MARY MANNISON, Queensland University of Technology

change (measured by responses to problem situations)

following a university human sexuality course. Patton

and Mannison (1995) found significant differences. For

Factor 1, there was a significant difference between men

and women on all 12 items, with 10 of these at the $p < .001$

level. In every instance, men reported less disagreement

with the item, indicating that women have a more negative

response to sexual coercion. A similar pattern emerged with

regard to the attitudes toward rape myths, as well as those

items which reflected sexual coercion between people who

knew each other. It must be noted that the difference was

one of degree; all means were between 1.00 and 3.00 (i.e.,

between Strongly Disagree and Mildly Disagree).

On Factor 2 there were fewer items (four of eight) with

a significant gender difference. The significant items

showed women more accepting of the expression of sexu

ality in children and in the elderly, and more rejecting of the notion that male and female homosexuality is a threat to society. Again, the difference was one of degree on most items.

In Factor 3, all five items showed significant differences between women and men. These differences reflected greater acceptance of traditional gender role attitudes by men—that women being whistled at in public is a compliment, intoxication in women is worse than in men, and homosexuality is a threat to societal institutions.

Analyses of variance were also performed on the summed factor scores for the reliable factors, Factors 1, 2, and 3. As expected, the consistent gender differences found on individual items generally remained for the total factor score, with Factors 1 and 3 showing significant gender differences. Overall means for Factor 2, the general attitudes toward sexuality factor, showed no significant difference between women and men. Although the items reflected specific area differences, the summed score results reflected a representative look at gender differences, illustrating differences on

Exhibit

Revised Attitudes Toward Sexuality Inventory

Your Attitudes

This page and the next asks you about your attitudes toward

a number of sexual issues. Please offer your frank opinion by ticking

one of the following options:

SA Strongly Agree

A Agree

MA Mildly Agree

MD Mildly Disagree

D Disagree

SD Strongly Disagree

SA A MA MD D SD

1. Some girls will only respond sexually if a little force is used.

2. Women falsely report rape in order to call attention to themselves.

3. Engaging in sex, e.g., for athletes, does not affect their energy and

concentration.

4. A woman’s decision to have an abortion is a good enough reason to

have one.

5. A girl will often pretend she doesn’t want intercourse because she

doesn’t want to seem loose, but she’s really hoping the guy will force her.

6. In the majority of rapes, the woman already has a bad reputation.

7. Children should be encouraged to accept the practice of masturbation.

8. Easily accessible abortion will probably cause people to become

unconcerned and careless.

9. There’s nothing wrong with a little sweet talk to get what you want.

10. A woman cannot be forced to have intercourse against her will.

11. The primary goal of sexual intercourse should be to have children.

12. Sexual inaccessibility of a man’s partner is a common cause of child

sexual abuse in the home.

13. It’s not okay for a guy to pressure for more sex even if he thinks the girl

has led him on.

14. Normal males can commit rape.

15. Children should be ignored if found playing “doctors and nurses” or

other games of sexual exploration.

16. It doesn’t hurt children to have a little bit of sex play with their older relatives.

17. If the couple have dated a long time, it’s only natural for the guy to

pressure her for sex.

18. Women who are raped are usually a little to blame for the crime.

19. The elderly in nursing homes should have as much sexual access to

each other as they want.

20. Contraceptives should be readily available to teenagers.

21. Even if the guy gets sexually excited, it’s not okay for him to use force.

22. Rape is usually planned and premeditated.

23. Masturbation is a normal sexual activity throughout life.

24. Women should receive preferential treatment right now to make up

for past discrimination.

25. If a guy spends a lot of money on a girl, he’s got a right to expect a few

sexual favours.

26. Forcing a woman to have sex when she doesn’t want to is rape.

27. A woman who initiates a sexual encounter will probably have sex with

anybody.

28. Being whistled at in public is like getting a compliment.

29. You can’t blame a guy for not listening when the girl changes her mind

at the last minute.

30. No woman harbours a secret desire to be raped.

31. Sexuality education probably leads to experimentation and increased

sexual activity.

32. Intoxication among women is worse than among men.

33. A girl should give in to a guy’s advances so as not to hurt his feelings.

34. Rape has nothing to do with an uncontrollable desire for sex.

35. Male and female homosexuality is a threat to many of society’s institutions.

36. If there are rules about corporal punishment in schools, they should

apply equally to boys and girls.

37. If a girl engages in necking or petting and she lets things get out of hand,

it is her own fault if her partner forces sex on her.

38. A woman who claims she was raped by a man she knows can be

described as a “woman who changed her mind afterward.”

39. Most adults who contract AIDS get pretty much what they deserve.

40. No clubs should be allowed to refuse membership, terms, or conditions

of membership on the basis of gender.

The Attitudes Toward Unconventional Sex Scale (ATUSS)

was developed to assess a general disposition to engage in

unconventional sexual practices. In contrast to the two existing

measures of conventional sex (Hendrick & Hendrick, 1987;

Purnine, Carey, & Jorgensen, 1996), which confound general

tendencies toward unconventional sex with specific uncon

ventional behaviors, the ATUSS contains only global items

sex. Accordingly, the ATUSS can be used to determine the

extent to which a general tendency toward unconventional sex

predicts specific behaviors that may or may not be unconven

tional, without concern that item overlap may lead to spurious

associations (see Fincham & Bradbury, 1987).

Description

The 5-item ATUSS assesses the extent to which individuals

perceive that they enjoy sexual behaviors that deviate from traditional, conventional sexual practices. Items are rated on a 7-point Likert-type scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree).

Response Mode and Timing

The ATUSS can be administered in either paper-pencil or computerized response formats. Respondents should be instructed to choose the Likert rating that best describes their current attitudes or beliefs and assured that there are no “right or wrong” sexual attitudes. The ATUSS takes less than 2 minutes to complete.

Scoring

Items are coded such that higher scores indicate more computed by summing all scores (possible range = 5–35, see Exhibit).

Reliability

The ATUSS demonstrated high internal consistency in both a sample of 204 undergraduate college students (α = .80 for males; α = .76 for females) and a sample of 36 recently married couples (α = .86 for husbands; α = .70 for wives).

Validity

The ATUSS also demonstrated predictive validity in both

Attitudes Toward Unconventional Sex Scale

CAROLYN A. WENNER, 1 V. MICHELLE RUSSELL, AND JAMES K. MCNULTY,

University of Tennessee, Knoxville

1 Address correspondence to Carolyn Wenner, Department of Psychology, University of Tennessee, Knoxville, TN 37996; e-mail: cwenner@utk.edu

Attraction

Exhibit

Assessing Multiple Facets of Attraction to Women and Men

The first few questions below ask about how OFTEN you are attracted to women versus men. It does not matter if the attractions

are strong or weak; we are just trying to get a sense of how often they occur. The first question focuses on physical attractions and

the second question focuses on emotional attractions. By “physical,” we mean the type of attraction that you would associate with a

desire for sexual activity. By “emotional,” we mean the type of attraction that is usually associated with romantic love, including strong

desires for emotional closeness and intimacy. Physical and emotional attractions often occur together, but not always. This is why we

are asking about them separately.

1. Please provide a number between 0 and 100 to represent the percentage of your day-to-day PHYSICAL attractions which have been directed toward women versus men over the past 6 months. For example, 0% would mean that you have NEVER experienced attractions for women during the past 6 months, 100% would mean that you have ONLY experienced attractions for women during the past 6 months, and 50% would mean that you have been physically attracted to women about as often as you have been physically attracted to men during the past 6 months. You can provide any number between 0 and 100 (for example 20%, 83%, 99%).

Percentage of physical attractions directed toward women: _____

2. Now provide a number from 0% to 100% for the percentage of your EMOTIONAL attractions which are directed to women versus men. Percentage of emotional attractions directed toward women: _____

3. In general, what percentage of your sexual fantasies have been about women versus men over the past 6 months?

Percentage of sexual fantasies about women: _____

4. How often have you experienced a physical attraction for a woman during the past 6 months? _____ Almost never _____ Less than once a month _____ Once or twice a month _____ About once a week _____ More than once a week _____ About every day 5. About how many different women have you been physically attracted to in the past 6 months? _____ 6. If you answered “1” on the last question, is this someone that you are currently sexually or romantically involved with? ____ yes ____ no 7. How often have you experienced an emotional attraction for a woman during the past 6 months? _____ Almost never _____ Less than once a month _____ Once or twice a month _____ About once a week _____ More than once a week _____ About every day 8. About how many different women have you been emotionally attracted to in the past 6 months? _____ 9. If you answered “1” on the last question, is this someone that you are currently sexually or romantically involved with? ____ yes ____ no 10. How often have you had sexual fantasies about a woman, or women in general, in the past MONTH? _____ Almost never _____ Less than once a month _____ Once or twice a month _____ About once a week _____ More than once a week _____ About every day 11. The next question concerns the intensity of your physical attractions for women. This is on a 1 to 5 scale, so that 1 is “no attraction,” 3 is a moderate attraction (right in the middle of the scale), and 5 is the most intense attraction you can experience. Thinking about ALL of the attractions to women you have experienced in the past 6 months, how would you rate the AVERAGE intensity of those attractions? _____ 12. How would you rate the intensity of the STRONGEST attraction to a woman that you’ve experienced in the past 6 months? _____ 13. When you have sexual thoughts about a woman, or women in general, how strong is your desire to engage in sexual activity? Use the same 1 to 5 scale, so 1 is basically “no desire for sexual activity,” 3 is in the middle, and 5 is maximum desire for sexual activity. _____ The next set of questions focus on men. 14. How often have you experienced a physical attraction for a man during the past 6 months? _____ Almost never _____ Less than once a month _____ Once or twice a month _____ About once a week _____ More than once a week _____ About every day 15. About how many different men have you been physically attracted to in the past 6 months? _____ 16. If you answered “1” on the last question, is this someone that you are currently sexually or romantically involved with? ____yes

____no 17. How often have you experienced an emotional attraction for a man during the past 6 months? ______ Almost never ______ Less than once a month ______ Once or twice a month

Awareness

1. I am very aware of my sexual feelings.

2. I wonder whether others think I’m sexy.

3. I’m assertive about the sexual aspects of my life.

4. I’m very aware of my sexual motivations.

5. I’m concerned about the sexual appearance of my body.

6. I’m not very direct about voicing my sexual desires. (R)

7. I’m always trying to understand my sexual feelings.

8. I know immediately when others consider me sexy.

9. I am somewhat passive about expressing my sexual desires. (R)

10. I’m very alert to changes in my sexual desires.

11. I am quick to sense whether others think I’m sexy.

12. I do not hesitate to ask for what I want in a sexual relationship.

13. I am very aware of my sexual tendencies.

14. I usually worry about making a good sexual impression on others.

15. I’m the type of person who insists on having my sexual needs met.

16. I think about my sexual motivations more than most people do.

17. I’m concerned about what other people think of my sex appeal.

18. When it comes to sex, I usually ask for what I want.

19. I reflect about my sexual desires a lot.

20. I never seem to know when I’m turning others on.

21. If I were sexually interested in someone, I’d let that person know.

22. I’m very aware of the way my mind works when I’m sexually aroused.

23. I rarely think about my sex appeal. (R)

24. If I were to have sex with someone, I’d tell my partner what I like.

25. I know what turns me on sexually.

26. I don’t care what others think of my sexuality.

27. I don’t let others tell me how to run my sex life.

28. I rarely think about the sexual aspects of my life.

29. I know when others think I’m sexy.

30. If I were to have sex with someone, I’d let my partner take the initiative. (R)

31. I don’t think about my sexuality very much. (R)

32. Other people’s opinions of my sexuality don’t matter very much to me. (R)

33. I would ask about sexually-transmitted diseases before having sex with someone.

34. I don’t consider myself a very sexual person.

35. When I’m with others, I want to look sexy.

36. If I wanted to practice “safe sex” with someone, I would insist on doing so.

Behavior

Exhibit

Sexual Activity Questionnaire (Married/Cohabiting Version) a

Instructions: We are interested in learning more about how couples initiate sexual activities, and how their partners respond to these

initiations. By initiation of sexual activities, we mean any word and/or action that one person uses to indicate his or her interest in

engaging in sexual activities, at a point in time when the couple is not engaging in any sexual activities. Notice that we are interested in

initiations, whether or not any sexual activity results from the initiation. For example, one person may initiate sexual interactions by

complimenting his or her partner on his or her looks or using a code phrase that the partner knows indicates sexual interest. Other

examples of initiations would be if one person moved closer to their partner or if one person loosened or removed some of his or her

own or the partner's clothing. We are interested in the initiation of all levels of sexual activity from kissing (if you consider it a sexual

activity and not an expression of affection) to intercourse.

Please complete the attached questionnaire on a daily basis for one week. It is divided into 3 parts.

Part I. Part I of the questionnaire asks you to indicate, for each day of that particular week, whether either you or your partner initiated

sexual activity. You are also asked to indicate for each "initiation" who initiated the sexual activity, and whether the noninitiator's first

response was interest or disinterest in sex. By first response we mean the first thing he or she said or did in response to the initiation. In

some cases, the noninitiator’s first response might not be the same as their response a few seconds or minutes later. If sexual activity

was not initiated by either partner on that day, please indicate whether you considered initiating and your reasons for not doing so.

Further instructions for filling out this part of the questionnaire are on the questionnaire itself.

Part II. Fill in Part II of the questionnaire (the blue sheets) for the first occasion (if any) in that week on which sex was initiated, and the

noninitiator’s first response was that he or she was not interested. If no such initiation occurred in your relationship that week, leave

this part of the questionnaire blank.

Part III. Fill in Part III of the questionnaire (the yellow sheets) for the first occasion (if any) in that week on which sex was initiated, and the noninitiator’s first response was that he or she was interested in sex—that is, when both partners were interested from the outset. If no such initiation occurred that week, leave this part of the questionnaire blank. Since it is easy to forget the specifics of any particular communication or interaction, it is important that you complete Parts II and III of the questionnaire as soon as possible after the initiation occurs. Try to be as accurate as possible in completing the questionnaire.

Definitions: Sexual Activity: Any activity of a sexual (as opposed to purely affectionate) nature. Thus, this can include anything from kissing and touching to sexual intercourse. “SEX” is not necessarily intercourse. Initiation: Any communication (verbal or nonverbal) of a “desire” to participate in sexual activity. Sexual activity may or may not follow. Sexual Initiation Questionnaire Part I. For each day of the week, please indicate the following (see Instruction Sheet for definitions): (a) Whether sexual activity was initiated. (b) If sexual activity was initiated, indicate whether it was initiated by you or by your partner (male or female). Then indicate what the first response was of the noninitiator. That is, if sex was initiated by you, indicate what your partner’s first response was; if sex was initiated by your partner,

indicate what your first response was.

(c) If neither you nor your partner initiated sex on that day, indicate if you considered initiating sex but did not do so. If you did change your mind, indicate the reasons for doing so.

If sex initiated If sex not initiated

Date and Was sex By Noninitiator's Did you consider If yes, why

day of week initiated? whom? first response initiating? didn't you initiate?

_____ ___ yes ___ woman ___ interested ___ yes _____

___ no ___ man ___ uninterested ___ no _____

_____ ___ yes ___ woman ___ interested ___ yes _____

___ no ___ man ___ uninterested ___ no _____

_____ ___ yes ___ woman ___ interested ___ yes _____

___ no ___ man ___ uninterested ___ no _____

_____ ___ yes ___ woman ___ interested ___ yes _____

___ no ___ man ___ uninterested ___ no _____

_____ ___ yes ___ woman ___ interested ___ yes _____

___ no ___ man ___ uninterested ___ no _____

_____ ___ yes ___ woman ___ interested ___ yes _____

___ no ___ man ___ uninterested ___ no _____

The first of these days on which either you or your partner initiated sex and found that the noninitiator was initially not interested was _____ (write in day of the week). Please fill in Part II of the questionnaire on the blue paper for this occasion.

The first of these days on which either you or your partner initiated sex and found that the noninitiator was initially interested _____

___ (write in day of the week). Please fill in Part III of the questionnaire on the yellow paper for this occasion.

Part II. Complete Questions 1–14 (blue paper) if either you or your partner initiated sexual activity and the first response of the non

initiator was that he or she was not interested.

1. At the time of the initiation, where were you and your partner (e.g., in the kitchen of our home)?_____
_____

2. Briefly describe the main thing(s) you and your partner were doing prior to the initiation (e.g. reading, talking)._____
_____

3. The noninitiator indicated a desire for sexual activity by

saying:

doing:

4. The noninitiator responded to the initiator's initial advances by:

saying:

doing:

5. The initiator then responded to this reaction by:

saying:

doing:

6. How long did the disagreement continue? _____

minutes

7. How was the disagreement resolved?
_____

8. (a) How satisfied are you with how sexual activity was initiated?

_____ very satisfied

_____ satisfied

_____ neutral

_____ dissatisfied

_____ very satisfied

(b) Why?

9. (a) Overall, how satisfied are you with how the disagreement was resolved?

_____ very satisfied

_____ satisfied

_____ neutral

_____ dissatisfied

_____ very dissatisfied

b) Why?
_____

10. What behaviors did the initiator use to demonstrate a desire for sexual activities? (Check all that apply.)

_____ asked directly _____ removed or loosened clothing

_____ used some code words _____ played with man’s hair

with which the man was _____ lay down

familiar _____ changed tone of voice

_____ used pet names _____ made indirect talk of sex

_____ used more eye contact _____ set mood atmosphere

_____ touched her date (music, lighting, etc.)

_____ massaged or stroked _____ played games or light

_____ snuggled or cuddled “rough-housing”

_____ kissed date _____ made compliments

_____ shared a drink _____ used some force

_____ moved closer _____ allowed hand to wander

_____ talked about the _____ looked at sexual material

relationship

_____ used “suggestive” body

movements or postures

_____ others:

11. If you did engage in sexual activities at that time,

(a) Why did the person who was initially not interested
decide to have sex? _____

_____

(b) Which behaviors did you and your partner engage in at
that time (check all that apply)?

_____ hugging, cuddling

_____ kissing

_____ necking

_____ fondling or kissing breast

_____ fondling woman’s genitals

_____ fondling man’s genitals

_____ oral-genital stimulation

_____ coitus

_____ other (please specify)

_____

(c) About how long did you and your partner spend in sexual activity at that time? _____ minutes

(d) How enjoyable was this occasion of love-making for you?

_____ extremely unpleasant

_____ moderately unpleasant

_____ slightly unpleasant

_____ slightly pleasant

_____ moderately pleasant

_____ extremely pleasant

(e) How enjoyable do you think this occasion of love-making was for your partner?

_____ extremely unpleasant

_____ moderately unpleasant

_____ slightly unpleasant

_____ slightly pleasant

_____ moderately pleasant

_____ extremely pleasant

12. If you did not engage in sexual activity at that time,

(a) was sex initiated again later that day?

___ yes ___ no

(b) If yes, by whom? ___ the man ____ the woman ____ mutual consent

13. If there is any additional information that would help us to understand the situation that you described above, please provide it. _____

14. How confident are you that your responses are accurate?

_____ very unsure

_____ moderately unsure

_____ slightly unsure

_____ slightly sure

_____ moderately sure

_____ very sure

Part III. Complete Questions 15–25 (yellow paper) if either you or your partner initiated sexual activity and the first response of the noninitiator was that he or she was interested.

15. At the time of the initiation, where were you and your partner (e.g., in the kitchen of our home)?
_____
_____

16. Briefly describe the main thing(s) you and your partner were doing prior to the initiation (e.g. reading, talking)._____
_____

17. The initiator indicated a desire for sexual activity by:

saying:

doing:

18. The noninitiator responded to the initiator's initial advances by:

saying:

doing:

19. (a) How satisfied are you with how sexual activity was initiated?

_____ very satisfied

_____ satisfied

_____ neutral

_____ dissatisfied

_____ very dissatisfied

(b) Why?

20. What behaviors did the initiator use to demonstrate a desire for sexual activities? (Check all that apply.)

_____ asked directly _____ removed or loosened clothing

_____ used some code words _____ played with man's hair

with which the man was _____ lay down

familiar _____ changed tone of voice

_____ used pet names _____ made indirect talk of sex

_____ used more eye contact _____ set mood atmosphere

_____ touched her date (music, lighting, etc.)

_____ massaged or stroked _____ played games or light

_____ snuggled or cuddled "rough-housing"

_____ kissed date _____ made compliments

_____ shared a drink _____ used some force

_____ moved closer _____ allowed hand to wander

_____ talked about the _____ looked at sexual material

relationship

_____ used "suggestive" body

movements or postures

_____ others:

21 Did you and your partner engage in sexual activity at that time?

___ yes ___ no

22. If you did have sex at that time,

(a) which sexual behaviors did you and your partner engage in (check all that apply)?

_____ hugging, cuddling

_____ kissing

_____ necking

_____ fondling or kissing breast

_____ fondling woman’s genitals

_____ fondling man’s genitals

_____ oral-genital stimulation

_____ coitus

_____ others (please specify)
_____

(b) About how long did you and your partner spend in sexual activity at that time?

_____ minutes

(c) How enjoyable was this occasion of love-making for you?

_____ extremely unpleasant

_____ moderately unpleasant

_____ slightly unpleasant

_____ slightly pleasant

_____ moderately pleasant

_____ extremely pleasant

(d) How enjoyable do you think this occasion of love-making was for your partner?

_____ extremely unpleasant

_____ moderately unpleasant

_____ slightly unpleasant

_____ slightly pleasant

_____ moderately pleasant

_____ extremely pleasant

23. If you did not engage in sexual activity at that time,

(a) was sex initiated again later that day?

___ yes ___ no

(b) If yes, by whom? ___ the man ____ the woman ____ mutual consent

24. If there is any additional information that would help us to understand the situation that you described above, please provide it.
_____ 25. How confident are you that your responses are accurate? _____ very unsure _____ moderately unsure _____ slightly unsure _____ slightly sure _____ moderately sure _____ very sure a This version of the questionnaire is designed to be completed by cohabiting partners. The questionnaire can be modifi ed for use by dating couples. Cowart-Pollack Scale of Sexual Experience DEBRA COWART-STECKLER, 1 University of Mary Washington R OBERT H. POLLACK, University of Georgia The Cowart-Pollack Scale of Sexual Experience consists of two checklists of heterosexual activities: one for men and another for women. It was developed to assess the sexual experience of an individual or group of individuals in research, therapy, or the classroom. Description The checklists comprise a wide range of sexual activities for men and women, including oral contacts, masturbation, various intercourse positions, anal intercourse, and bondage. The female scale consists of 30 sexual activities. They range from “your nude breast felt by male” to “anal intercourse.” The male scale consists of 31 sexual activities, ranging from “feeling female’s nude breast” to “bondage.” Initially, the sexual experience scales consisted of 47 items drawn from previous studies (Bentler, 1968a, 1968b; Zuckerman, 1973). These 47-item scales were distributed to 153 men and 226 women during a group-testing session. After completion, the items were ordered from most to least frequent according to the percentages of subjects who reported that they had engaged in such behavior. In accordance with the Cornell technique of Guttman scaling with two response categories, the top and bottom 10% of the items were discarded. This procedure yielded the present scales. Investigations of the range of heterosexual experiences have shown a predictable sequence of

experiences for men and women (Cowart & Pollack, 1979; Cowart-Steckler, 1984). These experiences can be described using the Cornell technique of Guttman scaling in which the behaviors are ordered from most frequent to least frequent (Guttman, 1947). Guttman scaling assumes that an individual who experiences a less frequent behavior previously has experienced the more common behavior (Edwards, 1957). Applying the Guttman scaling technique to sexual experiences suggests that heterosexual relationships progress through similar sequences of experiences. An individual who responds to this scale, then, can be compared to the normative sample and the level of sexual experience can be ascertained. The Cowart–Pollack scale has been standardized using a college-aged sample (aged 18 to 21) and, therefore, is appropriate for people in that age group. Distributing the questionnaire to people of different ages may yield a different ordering in the sequence of behaviors. Response Mode and Timing When the scale is used in research, therapy, or to assess one's level of sexual experience, the items are ordered randomly. Respondents indicate that they have or have not experienced each behavior by circling yes or no in answer to the question "Have you experienced the following?" The scale usually requires an average of 10 minutes for completion. Scoring No scoring per se is required. A comparison between the ordering of the respondent's experiences and the norms established by the Cowart–Pollack scale will give an accurate indication of the respondent's level of sexual experience. Reliability and Validity The Cowart–Pollack scale has been distributed twice to large groups of college-aged individuals. In 1979 (Cowart & Pollack, 1979), the 31-item scale for men and the 30item scale for women were administered in a group-testing situation to 199 men and 213 women. The coefficient of 1 Address correspondence to Debra Cowart-Steckler, Department of Psychology, University of Mary Washington, Fredericksburg, VA 22401; e-mail: dsteckle@umw.edu

reproducibility for the male and female scales was .85 and

.88, respectively. A coefficient of at least .85 indicates reli

ability in the ordering of behaviors (Edwards, 1957).

In 1983 the Cowart–Pollack scale was distributed to 197

men and 212 women (Cowart-Steckler, 1984). These sub

jects were demographically similar to the subjects in 1979.

The coefficient of reproducibility was .88 for the male scale

and .87 for the female scale.

The major difference in the results of the 1979 and 1983

distribution was not in the ordering of sexual experiences

but in the numbers of men and women engaging in most

types of sexual experiences. There were significantly more

men and women from the 1983 sample engaging in sexual

activities. This finding suggests that, at least for individuals

aged 18 to 21, there has been an increase in sexual activity

Exhibit

Cowart-Pollack Scale of Sexual Experience

Men (N = 197) Women (N = 212)

Activity % Yes a Activity % Yes

Feeling female’s nude breast 98 Your nude breast felt by male 91

Male mouth contact with female’s nude breast 94 Male mouth contact with your breast 91

Exposure to erotic materials sold openly in Penetration of vagina by male’s finger 83

newsstands 93 Male lying prone on female without penetration 83

Male fi nger penetration of vagina 92 Partner’s observation of your nude body 80

Your observation of nude partner 91 Clitoral manipulation by male 79

Partner’s observation of your nude body 91 Your observation of nude partner 78

Clitoral manipulation by male 90 Male manipulation of vulva 77

Manipulation of penis by female 90 Manipulation of penis by female 76

Male lying prone on female without penetration 87 Sexual intercourse, male superior 67

Female mouth contact with penis 86 Female mouth contact with penis 67

Male manipulation of vulva 84 Male mouth contact with vulva 66

Sexual intercourse, male superior 83 Male tongue manipulation of clitoris 66

Masturbation 81 Male tongue penetration of vagina 66

Clitoral manipulation to orgasm by male 78 Sexual intercourse, face to face, side 60

Male mouth contact with vulva 77 Showering or bathing with partner 58

Sexual intercourse, partially clothed 77 Exposure to erotic materials sold openly in

Male tongue penetration of vagina 76 newsstand 58

Male tongue manipulation of clitoris 75 Sexual intercourse, partially clothed 56

Mutual oral stimulation of genitals to orgasm 74 Clitoral manipulation to orgasm by male 55

Sexual intercourse, face to face, side 73 Sexual intercourse, female superior 55

Exposure to hardcore erotic materials 72 Masturbation 54

Sexual intercourse, female superior 71 Sexual intercourse, vagina entered from rear 46

Showering or bathing with partner 68 Mutual oral stimulation of genitals to orgasm 45

Male tongue manipulation of female genitals to orgasm 66

Male tongue manipulation of your genitals to orgasm 45

Sexual intercourse, vagina entered from rear 63 Hand contact with partner’s anal area 40

Hand contact with partner’s anal area 61 Sexual intercourse, sitting position 37

Sexual intercourse, standing 48 Sexual intercourse, standing 28

Sexual intercourse, sitting 48 Exposure to hardcore erotic materials 24

Finger penetration of partner’s anus 39 Finger penetration of partner’s anus 19

Use of mild pain 16 Anal intercourse 13

a From Cowart-Steckler (1984). The experience scales are designed to measure cumulative heterosexual experience and homosexual experience

in terms of the variety of sexual activities of each type and

the frequency. Separate 1-item scales assess the number of

heterosexual partners and the number of homosexual part

ners. An orgasmic experience scale measures the variety

of sexual activities leading to orgasm and their cumulative

frequency. A 1-item masturbation scale measures cumulative masturbatory experience. Attitude scales are designed to measure (a) parental attitudes toward manifestations of sexual curiosity and behavior in children, (b) attitudes toward heterosexual activities as a function of the social relationship to the

other person, (c) attitudes toward heterosexual activi

ties as a function of the emotional relationship to the other person, and (d) attitudes toward homosexuality in general. EXPERIENCE SCALES Description and Scoring of Subscales 1. The Heterosexual Experience scale is an extension of prior Guttman-type scales. It consists of 14 items ranging from kissing to manual petting, oral stimulation of the breast, genital manipulation,

oral-genital contact, and coitus in various positions. For each of the 14 items, the subject rates his or her experience on a 5-point scale from 1 (never) to 5 (10 times or more). The score is the sum of the weighted item responses. Reliability. Coefficients of reproducibility were .97 for males and females on a 12-item earlier version of the scale (Zuckerman, 1973) and .93 and .94 on the current 14-item version (Zuckerman, Tushup, & Finner, 1976). Coefficients of scalability in the latter study were .77 and .81 in males and females, respectively. Retest reliabilities after a 15-week interval were .80, .92, .94, and .95 in four groups (Zuckerman et al., 1976). Validity. Subjects electing to take a course in human sexuality scored significantly higher than subjects in a personality course (Zuckerman et al., 1976). There were no initial sex differences. The males, but not the females, taking the sexuality course showed a greater increase than the control group. Heterosexual experience was positively correlated with all Sensation Seeking subscales in both males and females. Heterosexual college males scored higher than male members of a gay university group (Zuckerman & Myers, 1983). The scale correlated positively with levels of plasma testosterone and estradiol in college males (Daitzman & Zuckerman, 1980). 2. The Homosexual Experience scale consists of four items describing experiences of genital manipulation (active and passive) and oral-genital stimulation (active and passive) with members of one’s own sex. The subject responds on a 5-point scale for each item that ranges from 1 (never) to 5 (10 times or more). The score is the sum of the weighted item responses. Reliability. Coefficients of reproducibility were .98 and 1.00 and coefficients of scalability were .76 and 1.00 for males and females, respectively (Zuckerman et al., 1976). Retest reliabilities after a 15-week interval were .84 and .49 for two groups of males (the lower one after taking a sexuality course), and .67 and .80 for two groups of females. Validity. Males scored higher than females. Males, but not females, taking a course in human sexuality showed more increase than a control group (Zuckerman et al., 1976). Males in two gay groups scored higher than males in two heterosexual groups with practically no overlap in the two distributions (Zuckerman & Myers, 1983). The scales correlated positively with plasma estradiol levels in males, but not with testosterone (Daitzman & Zuckerman, 1980). 3. The Number of Heterosexual Partners scale consists of one item:. “With how many different persons of the opposite sex have you had sexual relationships in your lifetime?”. The subject responds on a 5-point scale ranging from 1 (none) to 5 (four or more). The score is the weight

(1 to 5) of the response choice. Reliability. Retest reliabilities after a 15-week interval were .91 and .76 for two groups of males and .85 and .94 for two groups of females (Zuckerman et al., 1976). Validity. Subjects taking a course in human sexuality scored higher than those taking a course in personality, and males scored higher than females (Zuckerman et al., 1976). The scale was unaffected by the course in human sexuality. It correlated positively with the Sensation Seeking subscales in both sexes. A heterosexual college male group scored higher than two gay male groups and a college church group (Zuckerman & Myers, 1983). The scale correlated positively with both plasma testosterone

Human Sexuality Questionnaire

MARVIN ZUCKERMAN, 1 University of Delaware

1 Address correspondence to Marvin Zuckerman, Department of Psychology, 220 Wolf Hall, University of Delaware, Newark, DE 19711; e-mail:

zuckerma@udel.edu

and estradiol in college males (Daitzman & Zuckerman,

1980).

4. The Number of Homosexual Partners scale consists of

one item: “With how many different persons of your own

sex have you had sexual relations in your lifetime?”. The

subject responds on a 5-point scale from 1 (none) to 5 (four

or more).

Reliability. Retest reliabilities were very low on this

scale after a 15-week interval: .56 and .37 for males and .26

and .27 for females (Zuckerman et al., 1976). Instability

may be due to changing interpretations of the term sexual

relations in a homosexual context or more willingness to

admit such relations on one occasion relative to another.

Another reason is the highly restricted range; most persons respond none, so the stability depends on the responses on the few individuals who respond one or more.

Validity. A group taking a sexuality course scored higher than a group taking a personality course. There were no sex differences (Zuckerman et al., 1976). Males taking the sexuality course increased on the scale relative to control males. Two groups of gay males scored higher than two groups of heterosexual males (Zuckerman & Myers, 1983). The scale did not correlate with either tes tosterone or estradiol in males (Daitzman & Zuckerman, 1980).

5. The Orgasmic Experience scale consists of eight items describing various ways in which orgasm can be achieved: masturbation, petting, genital manipulation, heterosexual and homosexual intercourse, oral stimulation from another, dreams, and fantasy alone. The scale is similar to Kinsey's (Kinsey, Pomeroy, & Martin, 1948) "total outlet" measure which also includes all types of sexual activity. Subjects rate how many times they have reached orgasm by each of the specified methods on the scale ranging from 1 (never) to 5 (10 times or more). The score is the sum of weighted item responses.

Reliability. Retest reliabilities after a 15-week inter val are .75 and .80 for males and .84 and .80 for females

(Zuckerman et al., 1976).

Validity. Males scored significantly higher than females, but there was no difference between those taking sexuality and personality courses (Zuckerman et al., 1976). All Sensation Seeking subscales correlated with the scale in males, but only the Experience Seeking subscale correlated with Orgasmic Experience in females. Both gay groups (college and church-affiliated) and the heterosexual college male group scored higher than the church-affiliated college male group on this scale (Zuckerman & Myers, 1983). Orgasmic experience correlated with plasma testosterone but not with estradiol in college males (Daitzman & Zuckerman, 1980).

6. The Masturbation scale is a one-item scale referring

3. Children are normally curious about sex.

4. Young children should be prevented from contact with pornographic pictures.

5. There is usually something wrong with a child who asks a lot of questions about sex.

6. Sex play is a normal thing in children.

7. Sex is one of the greatest problems to be contended with in children.

8. Pornography is not harmful to young children and there is no need to be concerned about their coming into contact with it.

9. There is nothing wrong with bathing boys and girls in the same bathtub.

10. Sex is no great problem for child if the parent does

not make it one.

11. It is very important that young boys and girls not be allowed to see each other completely undressed.

12. Children who take part in sex play become sex criminals when they grow up.

Scoring: Items 2, 3, 6, 8, 9, and 10 are weighted: A = 1; B = 2; C = 3; D = 4

Items 1, 4, 5, 7, 11, and 12 are reverse weighted: A = 4; B = 3; C = 2; D = 1

Score is sum of weighted responses: range = 12–48.

Attitudes Toward Heterosexual Activities: I. Social Relationship

Instructions: Answer these based on what you feel is right for most persons of your own sex and age.

Response options for all items are:

A) Never

B) All right with someone you are married to

C) All right with someone you are engaged to, or intend to marry

D) All right with someone you have been going with for some time

E) All right with anyone, no matter how long you have known them

1. Kissing without tongue contact. 9. Sexual intercourse in face to face position with

2. Kissing with tongue contact. the male on top.

3. Male feeling covered female breasts. 10. Female mouth contact with male’s penis.

4. Male feeling nude female breasts. 11. Male mouth contact with female genitalia.

5. Male lying prone on the female, petting without 12. Sexual intercourse, face to face with female on top.

penetration of her vagina. 13. Sexual intercourse, face to face, in side position.

6. Male mouth contact with female breast. 14. Sexual intercourse, entering from the rear.

7. Female manipulation of male penis.

8. Male manipulation of female genitalia (vaginal

and clitoral area).

Scoring: Response options are weighted as follows for all items:

A = 1; B = 2; C = 3; D = 4; E = 5

Score is sum of weighted response: range = 14–70.

Attitudes Toward Heterosexual Activities: II. Emotional Relationship

Instructions: Answer these based on what you feel is right for most persons of your own sex and age.

Response options for all items are:

A) Never all right regardless of how much you love the person

B) All right if you are deeply in love with the person

C) All right if you feel strong affection for the person

D) All right if you really like the person

E) All right regardless of how you generally feel about the person

1. Kissing without tongue contact.

2. Kissing with tongue contact.

3. Male feeling covered female breasts.

4. Male feeling nude female breasts.

5. Male lying prone on the female, petting without penetration of her vagina.

6. Male mouth contact with female breast.

7. Female manipulation of male penis.

8. Male manipulation of female genitalia (vaginal and clitoral area).

9. Sexual intercourse in face to face position with the male on top.

10. Female mouth contact with male's penis.

11. Male mouth contact with female genitalia.

12. Sexual intercourse, face to face, with female on top.

13. Sexual intercourse, face to face, in side position.

14. Sexual intercourse, entering vagina from the rear.

Scoring: Response options are weighted as follows for all items:

A = 1; B = 2; C = 3; D = 4; E = 5

Score is sum of weighted responses: range = 14–70.

Attitudes Toward Homosexuality

1. Do you think homosexuals (male or female) should have the right to legally marry?

A) Definitely not

B) No, I don't think so

C) Yes, maybe

D) Yes, definitely

2. Do you think homosexual couples (male or female) should have the right to adopt children?

A) Definitely not

B) No, I don't think so

C) Yes, maybe

D) Yes, definitely

3. Nearly all homosexuals are psychiatrically disturbed:

A) Strongly agree

B) Mildly agree

C) Mildly disagree

D) Strongly disagree

4. Except for differences in sexual preference, homosexuals are as normal as heterosexuals:

A) Strongly agree

B) Mildly agree

C) Mildly disagree

D) Strongly disagree

Scoring: Items 1, 2, and 4 are weighted: A = 1; B = 2; C = 3; D = 4

Item 3 is reverse weighted: A = 4; B = 3; C = 2; D = 1

Score is sum of weighted responses: range = 4–16.

Heterosexual Experience

Instructions: Heterosexual experience (with persons of the opposite sex). If you are male, substitute yourself for “male” in the item; if you

are female, substitute yourself for “female” in the item (e.g., for a female, Item 4 is “having your nude breast felt by a male.”)

Response options for all items are:

A) Never

B) Once or Twice

C) Several times

D) More than several times, less than ten times

E) Ten times or more

How many times have you done the following?

1. Kissing without tongue contact.

2. Kissing with tongue contact.

3. Male feeling covered female breasts.

4. Male feeling nude female breasts.

5. Male lying prone on the female, petting without penetration of her vagina.

6. Male mouth contact with female breast.

7. Female manipulation of male's penis.

8. Male manipulation of female genitalia (vaginal and clitoral areas).

9. Sexual intercourse in face to face position with the male on top.

10. Female mouth contact with male's penis.

11. Male mouth contact with female genitalia.

12. Sexual intercourse, face to face, with female on top.

13. Sexual intercourse, face to face, in side position.

14. Sexual intercourse, entering vagina from the rear.

Scoring: Response options are weighted as follows:

For all items A = 1; B = 2; C = 3; D = 4; E = 5

Score is sum of weighted responses: range = 14–70.

Homosexual Experience

Instructions: Homosexual experience (with a person of your own sex).

Response options for all items are:

A) Never

B) Once or twice

C) Several times

D) More than several, less than ten times

E) Ten times or more

How many times have you done the following?

1. Manipulating the genitals of a person of your own sex.

2. Having your genitals manipulated by a person of your own sex.

3. Performing mouth-genital contact on a person of your own sex.

4. Having mouth-genital contact performed on you by a person of your own sex.

Scoring: Response options are weighted as follows:

A = 1; B = 2; C = 3; D = 4; E = 5

Score is sum of weighted responses: range = 4–20.

One-Item Scales

Masturbation Experience

How many times have you engaged in manipulation of your own genitals:

A) Never

B) Once or twice

C) Several times

D) More than several, less than ten times

E) Ten times or more

Score is weighted response: A = 1; B = 2; C = 3; D = 4; E = 5: range = 1–5

Number of Heterosexual Partners a

With how many different persons of the opposite sex have

you had sexual intercourse in your lifetime?

A) None

B) One

C) Two

D) Three

E) Four or more

Score is weighted response: A = 1; B = 2; C = 3; D = 4; E = 5: range = 1-5

Number of Homosexual Partners

With how many different persons of your own sex have you had sexual relations in your lifetime?

A) None

B) One

C) Two

D) Three

E) Four or more

Score is weighted response: A = 1; B = 2; C = 3; D = 4; E = 5: range = 1-5

Orgasmic Experience b

Instructions: Orgasmic Experience (orgasm = sudden spasmodic discharge of sexual tension usually accompanied by ejaculation in the

male).

Response options for all items are:

A) Never

B) Once or twice

C) Several times

D) More than several, less than ten times

E) Ten times or more

How many times have you experienced orgasm through:

1. Masturbation

2. Petting, or body contact without manipulation of genitals

3. Manipulation of your genitals by someone else

4. Heterosexual intercourse

5. Homosexual relations

6. Oral stimulation by another

7. Dreams (nocturnal emissions)

8. Fantasy alone

Scoring: Response options are weighted as follows for all items:

A = 1; B = 2; C = 3; D = 4; E = 5

Score is sum of weighted responses: range = 8-40

a Note that the Number of Partners scales may be used as a consistency check on the heterosexual sexual intercourse item and any of the homosexual

experience items in regard to the report or denial of this type of experience.

b Note that the Orgasmic Experience scale may be used for a consistency check on heterosexual and homosexual activities and partners scales.

Beliefs and Cognitions (also see Attitudes, and Fantasy)

Sexual Beliefs

1. A real man has sexual intercourse very often 1 2 3 4 5

2. Orgasm is possible only by vaginal intercourse 1 2 3 4 5

3. Penile erection is essential for a woman’s sexual satisfaction 1 2 3 4 5

4. Homosexuality is a sickness 1 2 3 4 5

5. A woman has no other choice but to be sexually subjugated by a man’s power 1 2 3 4 5

6. A real man must wait the necessary amount of time to sexually satisfy a woman during intercourse 1 2 3 4 5

7. A woman may have doubts about a man’s virility when he fails to get an erection during sexual activity 1 2 3 4 5

8. Repeated engagement in oral or anal sex can cause serious health problems 1 2 3 4 5

9. A shorter duration of intercourse is a sign of a man’s power 1 2 3 4 5

10. Sex is an abuse of a male’s power 1 2 3 4 5

11. The consequences of a sexual failure are catastrophic 1 2 3 4 5

12. Women only pay attention to attractive younger men 1 2 3 4 5

13. It is not appropriate to have sexual fantasies during sexual intercourse 1 2 3 4 5

14. There are certain universal rules about what is normal during sexual activity 1 2 3 4 5

15. In bed the woman is the boss 1 2 3 4 5

16. Men who are not capable of penetrating women can’t satisfy them sexually 1 2 3 4 5

17. In sex, getting to the climax is most important 1 2 3 4 5

18. In sex, anything but vaginal intercourse is unacceptable 1 2 3 4 5

19. A woman’s body is her best weapon 1 2 3 4 5

20. A woman may stop loving a man if he is not capable of satisfying her sexually 1 2 3 4 5

21. Vaginal intercourse is the only legitimate type of sex 1 2 3 4 5

22. The quality of the erection is what most satisfies women 1 2 3 4 5

23. A successful career implies the control of sexual urges 1 2 3 4 5

24. Foreplay is a waste of time 1 2 3 4 5

25. Sex is meant only for procreation 1 2 3 4 5

26. In sex, the quicker/faster the better 1 2 3 4 5

27. People who don’t control their sexual urges are more easily controlled by others 1 2 3 4 5

28. A real man is always ready for sex and must be capable of satisfying any woman 1 2 3 4 5

29. If a man lets himself go sexually he is under a woman’s control 1 2 3 4 5

30. Anal sex is a perverted activity 1 2 3 4 5

31. A man must be capable of maintaining an erection until the end of any sexual activity 1 2 3 4 5

32. There is only one acceptable way of having sex (missionary position) 1 2 3 4 5

33. Sexual intercourse before marriage is a sin 1 2 3 4 5

34. Sex is a violation of a woman’s body 1 2 3 4 5

35. A man who doesn’t sexually satisfy a woman is a failure 1 2 3 4 5

36. Whenever the situation arises, a real man must be capable of penetration 1 2 3 4 5

37. Sex can be good even without orgasm 1 2 3 4 5

38. A real man doesn’t need much stimulation to reach orgasm 1 2 3 4 5

39. A woman at her sexual peak can get whatever she wants from a man 1 2 3 4 5

40. The greater the sexual intimacy, the greater the potential for getting hurt 1 2 3 4 5 C o m p l e t e l y D i s a g r e e D i s a g r e e D o n ’ t D i s a g r e e o r A g r e e A g r e e C o m p l e t e l y A g r e e Female Version The list presented below contains statements related to sexuality. Please read each statement carefully and circle the number in the right-hand column which corresponds to the extent to which you agree or disagree with each statement (circle only one option per statement), from 1 (completely disagree) to 5 (completely agree). There are no wrong or right answers, but it is very important that you be honest and that you answer all items. Sexual Beliefs 1. Love and affection from a partner are necessary for good sex 1 2 3 4 5 2. Masturbation is wrong and sinful 1 2 3 4 5 3. The most important component of sex is mutual affection 1 2 3 4 5 4. The best gift a woman could bring to marriage is her virginity 1 2 3 4 5 5. After menopause women lose their sexual desire 1 2 3 4 5 6. Women who have sexual fantasies are perverted 1 2 3 4 5 7. Masturbation is not a proper activity for respectable women 1 2 3 4 5 8. After menopause women can’t reach orgasm 1 2 3 4 5 9. There are a variety of ways of getting pleasure and reaching orgasm 1 2 3 4 5 10. Women who are not physically attractive can’t be sexually satisfied 1 2 3 4 5 11. In the bedroom the man is the boss 1 2 3 4 5 12. A good mother can’t be sexually active 1 2 3 4 5 13. Reaching climax/orgasm is acceptable for men but not for women 1 2 3 4 5 14. Sexual activity must be initiated by the man 1 2 3 4 5 15. Sex is dirty and sinful 1 2 3 4 5 16. Simultaneous orgasm for two partners is essential for a satisfying sexual encounter 1 2 3 4 5 17. Orgasm is possible only by vaginal intercourse 1 2 3 4 5 18. The goal of sex is for men to be satisfied 1 2 3 4 5 19. A successful professional career implies control of sexual behavior 1 2 3 4 5 20. As women age the pleasure they get from sex decreases 1 2 3 4 5 21. Men only pay attention to young, attractive women 1 2 3 4 5 22. Sex is a beautiful and pure activity 1 2 3 4 5 23. Sex without love is like food without flavor 1 2 3 4 5 24. As long as both partners consent, anything goes 1 2 3 4 5 25. Any woman who initiates sexual activity is immoral 1 2 3 4 5 26. Sex is

meant only for procreation 1 2 3 4 5 27. Sexual intercourse during menstruation can cause health problems 1 2 3 4 5 28. Oral sex is one of the biggest perversions 1 2 3 4 5 29. If women let themselves go sexually they are totally under men's control 1 2 3 4 5 30. Being nice and smiling at men can be dangerous 1 2 3 4 5 31. The most wonderful emotions that a woman can experience are maternal feelings 1 2 3 4 5 32. Anal sex is a perverted activity 1 2 3 4 5 33. In the bedroom the woman is the boss 1 2 3 4 5 34. Sex should happen only if a man initiates 1 2 3 4 5 35. There is just one acceptable way of having sex (missionary position) 1 2 3 4 5 36. Experiencing pleasure during sexual intercourse is not acceptable in a virtuous woman 1 2 3 4 5 37. A good mother must control her sexual urges 1 2 3 4 5 38. An ugly woman is not capable of sexually satisfying her partner 1 2 3 4 5 39. A woman who only derives sexual pleasure through clitoral stimulation is sick or perverted 1 2 3 4 5 40. Pure girls don't engage in sexual activity 1 2 3 4 5 C o m p l e t e l y D i s a g r e e D i s a g r e e D o n ' t D i s a g r e e o r A g r e e A g r e e C o m p l e t e l y A g r e e

The Sexual Modes Questionnaire (SMQ; Nobre &

Pinto-Gouveia, 2003) is a measure designed to assess

the interaction among cognitions, emotions, and sexual

responses.

Description

The SMQ is a self-report measure, with a male and a female

version that can be used in both clinical and nonclinical

samples. It is composed of three interdependent subscales:

the Automatic Thought (AT) subscale, the Emotional

Response (ER) subscale, and the Sexual Response (SR)

subscale.

Automatic Thought Subscale

The AT subscale is composed of 30 items (male) or 33

items (female) developed to evaluate automatic thoughts

and images experienced by the participants during sexual activity. Thoughts included in the scale were selected based on their theoretical and clinical relevance. For the male version we generated items pertaining to sexual perfor mance thoughts (especially the erectile response), thoughts of potential failure, sexually negative or conservative thoughts toward sexuality, and thoughts about the negative impact of age on sexual functioning. We generated items for the female version to assess failure and disengagement thoughts, low body-image thoughts, sexual abuse thoughts, thoughts about a partner's lack of affection, and sexual passivity and control thoughts (Nobre & Pinto-Gouveia, 2003).

Emotional Response Subscale

The ER subscale is composed of 30 items (male) or 33 items (female) that assess emotions that the respondents experience during sexual activity. Respondents are given a list of 10 emotions (worry, sadness, disillusion, fear, guilt, shame, anger, hurt, pleasure, satisfaction) to select from in evaluating their responses to the AT items.

Sexual Response Subscale

The SR subscale is composed of 30 items (male) or 33 items (female) that assess subjective sexual responses pertaining to the items of the AT subscale. Response Mode and Timing Using Likert-type scales, the participants may respond to

the SMQ using paper and pencil or computer. Respondents begin with the AT subscale by rating how frequently they experience each of the automatic thoughts during sexual activity (from 1 = Never to 5 = Always). Respondents then check from the list of 10 emotions (worry, sadness, disillusion, fear, guilt, shame, anger, hurt, pleasure, satisfaction) those that they usually experience whenever they engage in each automatic thought. Finally respondents rate the intensity of their subjective sexual arousal (from 1 = Very Low to 5 = Very High) when related to their previous thoughts and emotions. Scoring Both versions (male and female) of the AT subscale were submitted to factor analysis (Nobre & Pinto-Gouveia, 2003). We conducted a principal component analysis with varimax rotation of the female version, identifying six factors accounting for 53.1% of the total variance: (a) Sexual Abuse Thoughts, (b) Failure and Disengagement Thoughts, (c) Partner's Lack of Affection, (d) Sexual Passivity and Control, (e) Lack of Erotic Thoughts, and (f) Low Self Body-Image Thoughts (see Table 1).

Sexual Modes Questionnaire

PEDRO J. NOBRE, 1 Universidade de Trás-os-Montes e Alto Douro, Portugal

J OSÉ PINTO-GOUVEIA, Universidade de Coimbra, Portugal

1 Address correspondence to Pedro Nobre, Universidade de Trás-os-Montes e Alto Douro, Apartado 1013, 5001–801 Vila Real, Portugal; e-mail:

pnobre5@gmail.com TABLE 1 Items, Minimums, and Maximums of Female AT Factors and Totals Factors Item Number Minimum Maximum Sexual Abuse Thoughts 1, 2, 3, 4, 6, 15, 32, 33 8 40 Failure/ Disengagement Thoughts 19, 22, 26, 30 4 20 Partner's Lack of Affection 7, 12, 24, 27, 28 5 25 Sexual Passivity and Control 10, 14, 17, 21, 23, 29 6 30 Lack of Erotic Thoughts 5, 8, 11, 25, 31 5 25 Low Self Body Image Thoughts 9, 16, 20 3 15 Total 31 155 Note. Items 5, 8, 11, 25, and 31 are scored in reverse order. In the male version, we conducted a principal component analysis that identified five factors accounting for 54.7% of the total variance: (a) Failure Anticipation Thoughts, (b) Erection Concern Thoughts, (c) Age and Body FunctionRelated Thoughts, (d) Negative Thoughts Toward Sex, and (e) Lack of Erotic Thoughts (see Table 2). An index of negative automatic thoughts may be calculated by summing all automatic thought items (thoughts related to erotic cues were scored in reverse order). An index for each emotional

response may be calculated based on the following formula: total number of each emotion endorsed / total number of emotions endorsed. The emotional response index ranges from 0.0 to 1.0. An index of sexual response may be calculated based on the following formula: sum of the sexual response for each item / total number of sexual response items endorsed. The sexual response index ranges from 1 to 5. Reliability Internal consistency of both male and female AT subscales was assessed using Cronbach's α for the total scales and for each factor separately. Results were high for male and female total scales (α = .88 and .87, respectively), showing the general consistency of the measures (Nobre & Pinto-Gouveia, 2003). The internal consistency of the specific dimensions within each factor indicated Cronbach's α statistics ranging from .71 to .80 for the female version and from .69 to .83 for the male version (Nobre & PintoGouveia, 2003). We assessed test-retest reliability of both male and female AT subscales by computing Pearson product-moment correlation between two consecutive administrations with a 4-week interval. Results from the female version show the stability of the measure across time, with a high correlation for the total scale ($r = .95$, $p < .01$) and correlations from the specific dimensions ranging from $r = .52$, $p < .05$ to r

$= .90$, $p < .01$. Results from the male version show a more

moderate Pearson product-moment correlation between

Nobre, P. J., & Pinto-Gouveia, J. (2006). Emotions during sexual activity: Differences between sexually functional and dysfunctional men and women. Archives of Sexual Behavior, 35, 8–15.

Nobre, P. J., & Pinto-Gouveia, J. (2008). Differences in automatic thoughts presented during sexual activity between sexually functional and dysfunctional males and females. Journal of Cognitive Therapy and Research, 32, 37–49.

Rosen, R. C., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., et al. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. Journal of Sex & Marital Therapy, 26, 191–208. Rosen, R. C., Riley, A., Wagner, G., Osterloh, I. H., Kirkpatrick, J., & Mishra, A. (1997). The International Index of Erectile Function (IIEF): A multidimensional scale for assessment of erectile dysfunction. Urology, 49, 822–830.

Exhibit

Sexual Modes Questionnaire

Male Version

The items presented below are a list of thoughts one can have during sexual activity. In the first column, please indicate the frequency

with which you experience these thoughts by circling a number (1—Never to 5—Always). Next, indicate the types of emotions you

typically experience when having these thoughts by marking an X in the columns for the appropriate emotions. Finally, in the last col

umn, for each thought experienced indicate the intensity of your typical sexual response (arousal) while you are having that thought

by circling a number (1—Very Low to 5—Very High).

NOTE: For thoughts that you indicate as never experiencing, you do not need to fill out the emotion or sexual response column.

Example: Imagine that the thought “Making love is wonderful” comes to your mind very often whenever you are engaged in a sexual

activity, that this idea is accompanied by pleasurable emotions, and that your sexual arousal becomes very high. In this case your answer

should be:

Thoughts Emotions Sexual

Response

Type of Thoughts Frequency Types of Emotions Intensity

Example: Making love is wonderful 1 2 3 X 4 5 X 1 2 3 4 5X

Thoughts Emotions Sexual

Response

Type of Thoughts Frequency Types of Emotions Intensity

1. These movements and positions are fabulous 1 2 3 4 5
1 2 3 4 5

2. This time I cannot disappoint my partner 1 2 3 4 5
1 2 3 4 5

3. She will replace me with another guy 1 2 3 4 5
1 2 3 4 5

4. I’m condemned to failure 1 2 3 4 5 1 2 3 4 5

5. I must be able to have intercourse 1 2 3 4 5
1 2 3 4 5

6. This is not going anywhere 1 2 3 4 5 1 2 3 4 5

7. I’m not satisfying her 1 2 3 4 5 1 2 3 4 5

8. I must achieve an erection 1 2 3 4 5 1 2 3 4 5

9. I’m not penetrating my partner 1 2 3 4 5 1 2
3 4 5

10. My penis is not responding 1 2 3 4 5 1 2 3 4
5

11. Why isn’t this working? 1 2 3 4 5 1 2 3 4 5

12. I wish this could last longer 1 2 3 4 5 1 2
3 4 5

13. What is she thinking about me? 1 2 3 4 5 1 2
3 4 5

14. These movements and positions are fabulous 1 2 3 4 5
1 2 3 4 5 N e v e r S e l d o m S o m e t i m e s O f t e n
A l w a y s W o r r y S a d n e s s D i s i l l u s i o n e
d F e a r G u i l t S h a m e A n g e r H u r t P l e a s u
r e S a t i s f a c t i o n V e r y L o w L o w M o d e r a
t e H i g h V e r y H i g h N e v e r S e l d o m S o m e t
i m e s O f t e n A l w a y s W o r r y S a d n e s s D i s
i l l u s i o n e d F e a r G u i l t S h a m e A n g e r H
u r t P l e a s u r e S a t i s f a c t i o n V e r y L o w
L o w M o d e r a t e H i g h V e r y H i g h 15. What if
others knew I’m not capable . . . ? 1 2 3 4 5 1
2 3 4 5 16. If I fail again I am a lost cause 1 2 3 4 5

1 2 3 4 5 17. I’m the happiest man on earth 1 2 3 4 5
1 2 3 4 5 18. This is turning me on 1 2 3 4 5 1
2 3 4 5 19. If I don’t climax now, I won’t be able to
later 1 2 3 4 5 1 2 3 4 5 20. She is not being
as affectionate as she used to 1 2 3 4 5 1 2 3
4 5 21. She doesn’t find my body attractive anymore 1 2 3
4 5 1 2 3 4 5 22. I’m getting old 1 2 3 4 5
1 2 3 4 5 23. This is disgusting 1 2 3 4 5 1 2
3 4 5 24. This way of having sex is immoral 1 2 3 4 5
1 2 3 4 5 25. Telling her what I want sexually would be
unnatural 1 2 3 4 5 1 2 3 4 5 26. She is really
turned on 1 2 3 4 5 1 2 3 4 5 27. I must show
my virility 1 2 3 4 5 1 2 3 4 5 28. It will
never be the same again 1 2 3 4 5 1 2 3 4 5 29.
If I can’t get an erection, I will be embarrassed 1 2 3
4 5 1 2 3 4 5 30. I have other more important
matters to deal with 1 2 3 4 5 1 2 3 4 5
Female Version The items presented below are a list of
thoughts one can have during sexual activity. In the first
column, please indicate the frequency with which you
experience these thoughts by circling a number (1—Never to
5—Always). Next, indicate the types of emotions you
typically experience when having these thoughts by marking
an X in the columns for the appropriate emotions. Finally,
in the last column, for each thought experienced indicate
the intensity of your typical sexual response (arousal)
while you are having that thought by circling a number
(1—Very Low to 5—Very High). NOTE: For thoughts that you
indicate as never experiencing, you do not need to fill out
the emotion or sexual response column. Example: Imagine
that the thought “Making love is wonderful” comes to your
mind often whenever you are engaged in a sexual activity,
that this idea is accompanied by pleasurable emotions, and
that your sexual arousal becomes very high. In this case
your answer should be: Thoughts Emotions Sexual
response Type of Thoughts Frequency Types of Emotions
Intensity Making love is wonderful 1 2 3 X 4 5 X
1 2 3 4 5X Thoughts Emotions Sexual response Type of
Thoughts Frequency Types of Emotions Intensity 1. He is
abusing me 1 2 3 4 5 1 2 3 4 5 2. How can I get
out of this situation? 1 2 3 4 5 1 2 3 4 5 3.
He only wants to satisfy himself 1 2 3 4 5 1 2 3
4 5 4. Sex is all he thinks about 1 2 3 4 5 1 2
3 4 5 5. The way he is talking turns me on 1 2 3 4 5
1 2 3 4 5 6. He is violating me 1 2 3 4 5 1 2 3
4 5 N e v e r S e l d o m S o m e t i m e s O f t e n A l w
a y s W o r r y S a d n e s s D i s i l l u s i o n e d F e
a r G u i l t S h a m e A n g e r H u r t P l e a s u r e S
a t i s f a c t i o n V e r y L o w L o w M o d e r a t e H
i g h V e r y H i g h N e v e r S e l d o m S o m e t i m e

s O f t e n A l w a y s W o r r y S a d n e s s D i s i l l
u s i o n e d F e a r G u i l t S h a m e A n g e r H u r t
P l e a s u r e S a t i s f a c t i o n V e r y L o w L o w
M o d e r a t e H i g h V e r y H i g h

7. This way of having sex is immoral 1 2 3 4 5 1
2 3 4 5

8. These movements and positions are fabulous 1 2 3 4 5
1 2 3 4 5

9. I'm getting fat/ugly 1 2 3 4 5 1 2 3 4 5

10. If I let myself go he is going to think I'm

promiscuous 1 2 3 4 5 1 2 3 4 5

11. Making love is wonderful 1 2 3 4 5 1 2 3 4 5

12. He is not being as affectionate as he used to be 1 2 3
4 5 1 2 3 4 5

13. I'm not satisfying my partner 1 2 3 4 5 1 2
3 4 5

14. I must not show that I'm interested 1 2 3 4 5
1 2 3 4 5

15. This is disgusting 1 2 3 4 5 1 2 3 4 5

16. I'm not as physically attractive as I used to be 1 2 3
4 5 1 2 3 4 5

17. I should not take the lead in sexual activity 1 2 3 4 5
1 2 3 4 5

18. He only cares about me when he wants sex 1 2 3 4 5
1 2 3 4 5

19. I'm not getting turned on 1 2 3 4 5 1 2 3 4 5

20. I'm not feeling physically attractive 1 2 3 4 5
1 2 3 4 5

21. These activities shouldn't be planned ahead

of time 1 2 3 4 5 1 2 3 4 5

22. I can't feel anything 1 2 3 4 5 1 2 3 4 5

23. I don’t want to get hurt emotionally 1 2 3 4 5
1 2 3 4 5

24. Why doesn’t he kiss me? 1 2 3 4 5 1 2 3 4 5

25. My body turns him on 1 2 3 4 5 1 2 3 4 5

26. When will this be over? 1 2 3 4 5 1 2 3 4 5

27. If only he’d whisper something romantic in

my ear 1 2 3 4 5 1 2 3 4 5

28. He only loves me if I’m good in bed 1 2 3 4 5
1 2 3 4 5

29. I should wait for him to make the first move 1 2 3 4 5
1 2 3 4 5

30. I am only doing this because he asked me to 1 2 3 4 5
1 2 3 4 5

31. I’m the happiest woman on earth 1 2 3 4 5 1
2 3 4 5

32. I have other more important matters to

deal with 1 2 3 4 5 1 2 3 4 5

33. If I refuse to have sex, he will cheat on me 1 2 3 4 5
1 2 3 4 5

1 Address correspondence to Sandra Byers, University of New Brunswick, Psychology Department, Fredericton, New Brunswick, Canada E3B 6E4;

e-mail: byers@unba.ca

Sexual Cognitions Checklist

CHERYL A. RENAUD, Federal Medical Center Devens

E. SANDRA BYERS, 1 University of New Brunswick

The Sexual Cognitions Checklist (SCC) was developed to

assess sexual cognitions that are experienced as positive

as well as those that are experienced as negative (Renaud,

1999). Most conceptual definitions and measures of sexual cognitions (often referred to as fantasies) assume that they are pleasant, enjoyable, and deliberate (Leitenberg & Henning, 1995). However, many individuals report having negative sexual thoughts that are experienced as ego-dystonic, unwanted, and personally unacceptable (Byers, Purdon, & Clark, 1998). To fully understand sexual cognitions, it is important to distinguish between those that are experienced as positive and those that are experienced as negative.

Description The SCC consists of a checklist of 56 sexual cognitions. Forty of the items were taken from the Wilson Sex Fantasy Questionnaire (WSFQ; Wilson, 1988). The WSFQ has been used extensively in sexual fantasy research and has been found to have strong internal consistency (α = .98).

The remaining 16 items were taken from the Revised Obsessional Intrusions Inventory—Sex Version (ROII-v2), which also has demonstrated high internal consistency (α = .92; Byers et al., 1998). For the SCC, the wording of some of the items was changed so that they could be experienced as either positive or negative. The SCC is appropriate for men and women of any age and sexual orientation.

Response Mode and Timing

The SCC can be administered individually, or in a group format, and takes approximately 30 minutes to complete. Respondents are first provided with definitions of positive and negative sexual cognitions. Positive sexual cognitions are defined as purposeful or nonpurposeful cognitions that are experienced as acceptable and pleasant, are the types

of thoughts one would expect to have, and might or might not result in sexual arousal. Negative sexual cognitions are defined as purposeful or nonpurposeful cognitions that are experienced as highly unacceptable, upsetting, unpleas ant, and repugnant, and might or might not result in sexual arousal. Participants then indicate how often they have had each of the listed sexual thoughts when it was a positive thought as well as when it was a negative thought on a scale ranging from I have never had this thought (0) to I have this thought frequently during the day (6). The SCC also contains two nonoverlapping subscales, one reflecting themes of sexual dominance and one reflecting themes of sexual submission. To develop these subscales, six doctoral students in human sexuality inde pendently rated each of the 56 sexual cognitions on the SCC as reflecting sexual submission, sexual dominance, both sexual submission and sexual dominance, or neither sexual submission nor sexual dominance. Six items were judged to have dominance but not submission themes and make up the dominance cognitions subscale. Ten items were judged to reflect submission but not dominance themes and make up the sexual submission subscale.

Scoring

The total frequency scores for positive sexual cognitions (POSCOG) and negative sexual cognitions (NEGCOG)

are calculated by summing the item ratings for the 56

items. Thus, scores range from 0 to 336, with higher scores

indicating more frequent positive or negative cognitions.

Scores on the positive sexual dominance (POSDOM)

and negative sexual dominance subscales (NEGDOM)

are determined by summing frequency ratings on the six

dominance items such that scores range from 0 to 36. A simi

lar procedure is used to calculate scores on the 10 positive

sexual submission (POSSUB) and negative sexual submis

sion (NEGSUB) subscales, with scores ranging from 0 to 60.

Reliability

In a study of 148 female and 144 male undergraduate students,

Exhibit

Sexual Cognitions Checklist

We all have thoughts about sex from time to time. Sexual thoughts can be divided into different types:

Positive Sexual Thoughts. Sometimes we experience our sexual thoughts as positive. Positive sexual thoughts may include thoughts that

we purposely engage in to enhance our sexual feelings or sexual arousal. Positive sexual thoughts may also include thoughts that pop

into our heads out of the blue. Whether we purposely engage in positive sexual thoughts, or they pop into our minds out of the blue,

positive sexual thoughts are thoughts that we find acceptable and pleasant. They are the types of thoughts that we would expect to have.

We can have positive sexual thoughts while we are engaging

in masturbation, while we are engaged in sexual activity with a partner, and

while we are involved in non-sexual activities.

Negative Sexual Thoughts. Sometimes, we have sexual thoughts that we experience as negative. Negative sexual thoughts are thoughts

that we dislike having. They are the types of thoughts that we would not expect to have because they are uncharacteristic of our usual

thoughts and habits. That is, negative sexual thoughts are thoughts of things we would never want to do or say. Therefore, negative

sexual thoughts are highly unacceptable, upsetting, and unpleasant. We tend to find these thoughts disgusting and we wonder why we

are having such repugnant thoughts. However, because they are sexual in content, we may experience sexual arousal to these thoughts

even though we find them unacceptable, unpleasant, and upsetting. Like positive sexual thoughts, we can have negative sexual thoughts

while we are engaging in masturbation, while we are engaged in sexual activity with a partner, and while we are involved in non-sexual

activities.

Sometimes Positive and Sometimes Negative Sexual Thoughts. Although some thoughts are clearly positive or clearly negative for us, there

are some sexual thoughts that we experience as positive at times and as negative at other times. For example, you may have had a

thought about seeing your neighbor undress. If that thought was about the good-looking neighbor in apartment “B,” the thought might

be positive. That is, it might be the type of thought you would expect to have and it is acceptable and pleasant. On the other hand, if you

thought about the neighbor in apartment “A,” who you find disgusting, the thought might be negative. In this case, the thought is unac

ceptable, unpleasant, and not the type of thought you would expect to have. So, in this case, the same thought, “Seeing your neighbor

undress,” is sometimes positive and sometimes negative. Other factors, such as your mood or what you are doing when you have a

sexual thought, may also make a certain thought sometimes positive and sometimes negative.

INSTRUCTIONS: The questionnaire on the following few pages deals with a variety of very common sexual thoughts. On this question

naire, we would like you to indicate how often you have had each of the listed sexual thoughts when it was a positive sexual thought, and

when it was a negative sexual thought using the following scale:

0 I have never had this thought

1 I have had this thought only once or twice ever

2 I have had this thought a few times a year

3 I have had this thought once or twice a month

4 I have had this thought once or twice a week

5 I have had this thought daily

6 I have had this thought frequently during the day

Example:

Watching my neighbor undress.

How often have you had this thought when it was positive? 0 1 2 3 4 5 6

How often have you had this thought when it was negative? 0 1 2 3 4 5 6 coercive experiences and coercive attitudes.

Journal of Interpersonal Violence, 5, 464-473.

Leitenberg, H., & Henning, K. (1995). Sexual fantasy. Psychological Bulletin, 117, 469-496.

Renaud, C.A. (1999). Differentiating between positive and negative sexual cognitions. Unpublished doctoral dissertation, University of New Brunswick, Fredericton.

Renaud, C. A., & Byers, E. S. (1999). Exploring the frequency, diversity, and content of university students' positive and negative sexual cognitions. Canadian Journal of Human Sexuality, 8, 17-30.

Renaud, C. A., & Byers, E. S. (2001). Positive and negative sexual cognitions: Subjective experience and relationships to sexual adjustment. The Journal of Sex Research, 38, 252-262. Renaud, C.A., & Byers, E. S., (2005). Relationship between sexual violence and positive and negative cognitions of sexual dominance. Sex Roles, 53, 253-260. Renaud, C. A., & Byers, E. S. (2006). Positive and negative cognitions of sexual submission: Relationship to sexual violence. Archives of Sexual Behavior, 35, 483-490. Wilson, G. D. (1988). Male-female differences in sexual activity, enjoyment, and fantasies. Personality and Individual Differences, 8, 125-127. This example shows that I have had this thought a few times a year (I circled "2") when it was positive (pleasant and acceptable) and that I have had this thought once or twice a week (I circled "4") when it was negative. Please indicate how often you have had each of the following sexual thoughts. 0 I have never had this thought 1 I have had this thought only once or twice ever 2 I have had this thought a few times a year 3 I have had this thought once or twice a month 4 I have had this thought once or twice a week 5 I have had this thought daily 6 I have had this thought frequently during the day In the past year, I have had sexual thoughts of: 1. Making love out of doors in a romantic setting (e.g. field of flowers; beach at night). How often have you had this thought when it was positive? 0 1 2 3 4 5 6 a

How often have you had this thought when it was negative? 0 1 2 3 4 5 6 a

2. Having intercourse with a loved partner.

3. Having intercourse with someone I know but have not had sex with.

4. Having sex with an anonymous stranger.

5. Engaging in a sexual act with someone who has authority over me.

6. Being pressured into engaging in sex.

7. Engaging in a sexual act with someone who is “taboo” (family member, religious figure).

8. Having sex with two other people at the same time.

9. Participating in an orgy.

10. Being forced to do something sexually.

11. Forcing someone to do something sexually.

12. Engaging in sexual activity contrary to my sexual orientation (e.g. homosexual or heterosexual).

13. Throwing my arms around and kissing an authority figure.

14. Lifting my skirt or dropping my pants, thereby indecently exposing myself in public.

15. Receiving oral sex.

16. Giving oral sex.

17. Watching others have sex.

18. Having sex with an animal or non-human object.

19. Being overwhelmed by a stranger’s sexual advances.

20. Being sexually victimized.

21. Receiving or giving genital stimulation.

22. Whipping or spanking someone.

23. Being whipped or spanked.

24. Taking someone’s clothes off.

25. Having my clothes taken off.

26. Engaging in a sexual act which I would not want to do because it violates my religious principles.

27. Forcing another adult to engage in a sexual act with me.

28. Making love elsewhere than the bedroom (e.g. kitchen or bathroom).

29. Being excited by material or clothing (e.g. rubber, leather, underwear).

30. Hurting a partner.

31. Being hurt by a partner.

32. Partner-swapping.

33. Being aroused by watching someone urinate.

34. Being tied up.

35. Masturbating in a public place.

36. Authority figures (minister, boss) being naked.

37. People I come in contact with being naked.

38. Having sex in a public place.

39. Tying someone up.

40. Having incestuous sexual relations (sexual relations with a family member).

41. Exposing myself provocatively.

42. Wearing clothes of the opposite sex.

Birth Control (see Contraception)

The Male Body Image Self-Consciousness Scale (M-BISC) measures body image self-consciousness during sexual intimacy, which may be defined as the extent to which one feels self-conscious about one’s body and physical features when engaged in physically intimate situations, such as sexual intercourse.

Description

Items were generated through a focus group with male participants. Conversations were recorded and transcribed verbatim, and the text was analyzed, resulting in the devel opment of 39 items. All items were written such that men, with and without sexual experience involving a partner (male or female), can respond. To reduce the number of scale items, corrected item-total and inter-item correlations were inspected. Twenty-two items were removed. To gauge the dimensionality of the 17 remaining items, an explor atory factor analysis was conducted, with unweighted least squares serving as the extraction method and parallel anal ysis in conjunction with the scree plot being used for fac tor retention. A one-factor solution provided an acceptable representation of the data (eigenvalue = 7.61, accounting for 44% of the variance).

Response Mode and Timing

Respondents indicate their answer by circling the number

that best corresponds to their agreement or disagreement

with each statement. Responses are coded on a 5-point

Likert scale (1 = Strongly Disagree; 2 = Disagree; 3 = Don't

Know; 4 = Agree; and 5 = Strongly Agree). The anchors

should be reversed for a random subset of items (i.e., 1 =

Strongly Agree; 5 = Strongly Disagree), so as to prevent

acquiescent and response set behaviors. The scale takes no

more than 5 minutes to complete. Scoring Items are summed to provide a total scale score (possible range is 17 to 85), with higher scores denoting greater levels of body image self-consciousness during physical intimacy. Reliability Cronbach's alpha for the 17-item M-BISC was .92 (95% CI = .90 to .94), which suggests good scale score reliability (McDonagh, Morrison, & McGuire, 2008). Validity To assess the construct validity of the M-BISC, five hypotheses were tested. Levels of body image self-consciousness were related to levels of body esteem, $r(131) = -.56$, $p < .001$; sexual esteem, $r(130) = -.56$, $p < .001$; sexual anxiety, $r(131) = .40$, $p < .001$; self-rated physical attractiveness, $r(130) = -.50$, $p < .001$; and the drive for muscularity, $r(131) = .26$, $p < .005$. A series of point-biserial and Pearson's correlation coefficients also revealed that higher levels of body image self-consciousness during physical intimacy were associated with being less likely to have: (a) engaged in vaginal intercourse, r pb (129) = −.24, $p < .01$, (b) performed oral sex on another person, r pb (129) = −.28, $p < .001$, or (c) received oral sex from another person, r pb (129) = .27, $p < .01$. Reference McDonagh, L. K., Morrison, T. G., & McGuire, B. E. (2008). The naked truth: Development of a scale designed to measure male body image self-consciousness during physical intimacy. Journal of Men's Studies, 16, 253–265.

Male Body Image Self-Consciousness Scale

LORRAINE K. MCDONAGH, National University of Ireland, Galway

T ODD G. MORRISON, 1 University of Saskatchewan, Canada

B RIAN E. MCGUIRE, National University of Ireland, Galway

1 Address correspondence to Todd G. Morrison, University of Saskatchewan, Saskatoon, SK, CA S7N 5A5; e-mail: todd.morrison@usask.ca

12. A person’s body image does not begin to form until 4 years of age.

13. Children can be taught that it is O.K. to masturbate in private but not in public.

14. Young children understand human sexuality best when it is taught using plants and other animals as the examples rather than talking about people.

15. Adult responses to a child’s sexual behavior have little effect upon how “good” or “bad” children think sex is.

16. Before answering a child’s question about sexuality, you should try to find out what the child thinks.

17. When answering a child’s questions about sexuality, you should only provide information and not deal with their feelings or attitudes.

18. Before responding to a child’s sexuality-related behavior, you should try to find out what meaning this behavior has to the child.

19. The most effective method for dealing with sexuality-related behavior in children is to ignore the behavior.

20. It is too upsetting for preschoolers to tell them how babies are actually born.

21. Young children that have received age-appropriate sexuality education are more likely to be sexually exploited and abused.

II. Attitudes/Beliefs About Young Children’s Sexual Learning Scale

Please circle the number which best represents your feelings or ideas toward the following statements.

Scale

1 = Strongly Agree; 2 = Agree; 3 = Uncertain; 4 = Disagree; 5 = Strongly Disagree

1. Preschool children can be sheltered from sexual messages in our society.

2. Biology is the main influence on a person's sexual attitudes and behaviors.

3. Masturbation is natural and healthy for children.

4. Sexual information is too complex for most preschool children to understand.

5. Adults/teachers must be careful not to allow little boys to act too much like girls.

6. Sexual learning for young children is primarily about where babies come from.

7. It is fine for young children to be curious about sexual topics.

8. Children receive positive messages about sexuality when adults use cute nicknames for genitals.

9. Most preschool children are too young to be able to use the correct names for their genitals (like "penis," "scrotum," "vulva," and "clitoris").

10. It is O.K. for preschool children to realize that their genitals feel good when they touch them.

11. It is better to use nonsexist language (i.e., "firefighter" instead of "fireman") with young children.

12. Children should feel positively about sexuality.

13. It is O.K. to allow children to touch their own genitals when their diapers or pants are being changed.

14. Teachers who have strong religious beliefs about sex should teach these to the children they care for.

15. It is important to begin discussing sexuality openly in early childhood.

16. Traditional gender role stereotypes discourage responsible sexual behaviors for both genders.

17. Anatomically detailed dolls or picture books promote unhealthy sexual curiosity in young children.

18. Talking about sexuality with young children encourages them to experiment.

19. Adults/teachers need to understand their own attitudes about sexual topics since these attitudes may influence their children.

20. Adults/teachers must be careful not to allow little girls to act too much like boys.

21. Seeing children of the other sex without clothes on encourages children to experiment with sexual behaviors.

22. Preschool programs should only deal with sexual information; dealing with sexual attitudes and values should be left up to parents.

23. Preschool teachers should refrain from affectionately touching their children.

24. Children have the right to choose who they want and do not want to touch their bodies.

25. A positive rather than a punitive approach is better when handling children's sexuality-related behaviors (like sex play and masturbation).

26. An early childhood sexuality program is adequate if it only deals with preventing sexual abuse.

27. Children should be encouraged to ask their teachers questions about sexuality.

28. A sexually healthy adult demonstrates tolerance for people with different sexual values, lifestyles, and orientations.

Coercion (also see Harassment, and Rape)

Exhibit

Sexual Coercion Scale

Instructions: These next questions are about unwanted sexual activity after you were 12 years old. “Unwanted” means any kind of sex

that you didn’t agree to, even if it was with someone you knew.

1. How often has someone used physical force (like punching you or holding you down) to make you have sex?

Never Once Two or More

2. How often has someone used a weapon (like a gun or a knife) to make you have sex?

Never Once Two or More

3. How often have you had sex with someone because you were afraid of them?

Never Once Two or More

4. How often have you had sex when you really didn’t want to?

Never Once Two or More

Survey of Unwanted Sexual Attention in

University Residences

KATHLEEN V. CAIRNS 1 AND JULIE WRIGHT, The University of Calgary

The Survey of Unwanted Sexual Attention in University

Residences is an amalgamation of several previous instru

ments (see below) with the addition of demographic descrip

tions and site-specific questions. It was used to identify

the types of sexual harassment and coercion problems that

occurred in undergraduate residence halls on campus and to determine how student attitudes and beliefs about sexual harassment and coercion were related to their occurrence. Specific outcomes of the study can be found in several published articles (Cairns, 1993a, 1993b, 1994a, 1994b). The narrative sections of the survey proved to be particularly valuable; qualitative analysis of the narratives confirmed and further developed the findings from the quantitative analyses.

Description

The final version of the survey contains 10 sections (only Sections D, G, H and I appear in the exhibit), each of which addresses a different set of issues relevant to sexual harassment and coercion. Each of these sections is outlined in this article. Section A. This section contains a series of general questions intended to provide a demographic picture of the sample population. The specific items selected for this section were chosen to reflect characteristics that the literature on harassment suggests may be useful in understanding variation in individual responses (i.e., age, gender) as well as information about issues unique to the residences, which might also be expected to systematically affect responses (i.e., type of residence, floor activity level, gender compo

sition of the floor, length of time the participant had lived in

residence). Additional questions elaborate on participants'

backgrounds (i.e., length of time since leaving home,

whether they had lived independently before moving into

a university residence) and inquire about how content they

were with their current living arrangements. Section B. This section contains two standardized test

instruments, the Sexual Harassment Attitude Scale (Lott,

Reilly, & Howard, 1982) and the Attitudes Toward Sex,

Dating and Rape Scale (Dull & Giacopassi, 1987). The items

on these instruments include a range of beliefs about gender

interaction and sex roles. Respondents indicate the extent of

their agreement with each statement, using a 5- point Likert

scale ranging from strongly agree to strongly disagree. Section C. This section was a modified version of

Muehlenhard and Cook (1988), which provided a series of 16 possible reasons for engaging in unwanted sexual activity. Respondents were asked to indicate whether they had ever engaged in unwanted sexual activity for any of these reasons, and, if so, what type of sexual activity was involved. Section D. Section D contains items asking specifically about a series of 10 behaviors that the research literature indicates may be widely considered to constitute sexual harassment. The 10 behaviors include the use of sexually obscene language; display of sexually explicit, offensive, or pornographic materials; putting down women as a group; putting down men as a group; discussion or spreading rumors about the sexual activities of other residents; unwanted, sexually suggestive looks or gestures; unwanted sexual teasing, jokes, comments, or questions; unwanted pressure for social contact; unwanted deliberate touching or physical closeness; and unwanted attempts to kiss or fondle (Reilly, Lott, & Gallogly, 1986). An additional question, added by residents' focus groups prior to survey administration, asks about residents

being exposed, against their wishes, to members of the opposite sex in states of undress. For each problem behavior, residents were asked about whether and with what frequency the behavior had been observed, how offensive it was considered to be, and whether the respondent thought of it as sexual harassment. For Items 6 through 11, which were considered to be more problematic forms of harassment, an additional set of questions was asked concerning frequency of occurrence; maximum number of times any one resident behaved in this manner; how upsetting the incidents were; how the person responded to the incidents; how the person thought he or she would have responded were the person precipitating the incident not another resident; whether the responding person had ever engaged in the behavior him-or herself; and how often, why, and how upsetting the respondent thought the behavior was to the other person. Section E. This section contains the Sexual Experiences Survey (Koss & Oros, 1982). Items on this instrument ask for information about eight types of unwanted sexual activity personally experienced by residents. These activities range from unwanted fondling, kissing, or petting to sexual intercourse. The questions consider possible sexual coercion, the involvement of alcohol and drugs, and the use of physical force. Because the literature indicates that offenders in these more serious types of offense are overwhelmingly likely to be men, and that victims are almost exclusively women, the sections for each gender were written accordingly. Section E

1 Address correspondence to Kathleen V. Cairns, Department of Educational Psychology, The University of Calgary, 2500 University Drive N.W., Calgary,

Alberta, Canada T2N 1N4; e-mail: kcairns@ucalgary.ca

(Female) focuses on unwanted sexual activity as recipient,

asking each woman whether she has had a particular experi

ence, and, if so, how often, when and where it occurred, to

whom (if anyone) it was reported, and whether she consid

ered it sexual assault. Section E (Male) asks about unwanted

sexual activity from the perspective of the offender, using a

comparable set of questions.

Section F. Section F requests further details about the most severe incident reported by the respondent in Section E, including the number of offenders involved, the relationship of the victim to the offender, where the offense had occurred, whether drugs or alcohol were involved, and various aspects of victim and offender perceptions of the incident. Again, this section is worded differently for female and male respondents reflecting the predominance of male offenders and female victims.

Qualitative Sections G, H, and I. Section G asks for written descriptions of incidents that the respondent felt had not been addressed in the previous sections. Section H provides descriptions of incidents of physical abuse of a nonsexual nature occurring between men and women in the residence complex. Section I requests narrative descriptions of a particular incident of sexually inappropriate behavior that the respondents felt had affected them most or that they remember best. The specific word

Exhibit

Survey of Unwanted Sexual Attention in University Residences

(Sections D, G, H, and I, Only)

Section D (adapted from Reilly, Lott, & Gallogly, 1986). In this section you will find descriptions of several behaviors. Each brief description is followed by several questions regarding your perceptions of and experience with the behavior.

Section G: Are there any other incidents that have occurred in the residence complex that you would classify as sexual harassment or

sexually inappropriate that have not been addressed in the previous two sections? If so, please describe.

Section H: Have you ever experienced or been aware of physical abuse of a non-sexual nature occurring between men and women in

the residence complex? If yes, please tell us about the incident or incidents.

Section I: Now we'd like you to think about the questions that have been asked and the types of behavior that have been addressed in

this survey. We would like you to describe in your own words a particular incident of sexually inappropriate behavior that you feel has

affected you the most or that you remember best. Please describe this incident as fully as possible (e.g., what occurred, why it occurred,

how you felt, how you responded, the consequences of your response, how it affected your life and you personally, how it affected

your relationships, etc.).

Sexual Coercion in Intimate Relationships Scale

AARON T. GOETZ, 1 California State University, Fullerton

T ODD K. SHACKELFORD, Florida Atlantic University

1 Address correspondence to Aaron T. Goetz, Department of Psychology, California State University, Fullerton, P. O. Box 6846, Fullerton, CA 92834;

e-mail: agoetz@fullerton.edu

Sexual coercion sometimes includes violence and physical

force, and in an intimate relationship also may include sub

tle tactics, such as emotional manipulation. Because rela

tionship partners have a vested interest in each other, one might expect that sexual coercion is sometimes achieved by more subtle manipulations. We developed the Sexual Coercion in Intimate Relationships Scale (SCIRS) to assess the prevalence and severity of varied forms of sexual coercion in relationships. Although other measures of sexual coercion exist, we developed the SCIRS to address limitations of these measures. Previous measures assess the lifetime occurrence of sexually coercive acts but not the frequency and severity of these acts. Also, because some measures of sexual coercion assess lifetime experience with sexual coercion, they cannot differentiate sexual coercion by an intimate partner and, for example, molestation experienced in childhood. Finally, although some measures of sexual coercion include assessments of threats as coercive tactics, they are not able to differentiate types of threats (e.g., threats of physical harm, threats to terminate the relationship).

Description

The 34 SCIRS items assess communicative tactics, such as hinting and subtle manipulations, in addition to tactics such as use of force. The SCIRS assesses use of psychological and behavioral tactics of sexual coercion, such as threats, withholding of resources, and violence. The SCIRS also

assesses the use of tactics that range in subtlety. The SCIRS uses a 6-point scale to assess how often in the past month each of 34 acts has occurred in the participant's relationship. Values are: 0 = Act did not occur, 1 = Act occurred 1 time, 2 = Act occurred 2 times, 3 = Act occurred 3 to 5 times, 4 = Act occurred 6 to 10 times, 5 = Act occurred 11 or more times. A male version of the SCIRS assesses men's self-reports of their own sexually coercive behaviors, whereas a female version assesses women's reports of their partner's sexually coercive behaviors. Studies using the SCIRS have secured data primarily from heterosexual young adults (mean age 24 years) residing in North America.

Response Mode and Timing

The SCIRS is a self-administered survey but can be adapted for an interview, and standardized instructions make self-administration uncomplicated. When self-administered, the SCIRS takes about 10 minutes to complete. Although the SCIRS assesses men's sexual coercion in the past month, one can adjust this period to assess the success of an intervention program, for example. Scoring Full-scale scores are calculated by summing response values (0–5) for each item in the entire scale. The full scale has a range of 0 to 170 (34 acts × 5). Shackelford and Goetz (2004) conducted a component analysis that produced three components: Resource Manipulation/ Violence, Commitment Manipulation, and Defection Threat. Resource Manipulation/Violence includes coercive acts in which men withhold or give gifts and benefits and threaten or use violence and physical force. Commitment Manipulation includes coercive acts in which men manipulate their partners by telling them that the couple's relationship status obligates sexual access. Defection Threat includes coercive acts in which men threaten to pursue relationships with other women. Reliability In all studies in which the SCIRS has been used, acceptable reliabilities

have been observed, using male samples, female samples, and a combination of both. For example, alpha reliabilities for the three components (Resource Manipulation/Violence, Commitment Manipulation, and Defection Threat) and the total scale were .92, .91, .95, and .96, respectively, in the development and initial validation of the SCIRS (Shackelford & Goetz, 2004).

Validity A valid measure of sexual coercion might be expected to (a) illustrate that women who are sexually coerced are less satisfied with their relationships, (b) reflect personality differences between men who sexually coerce and those who do not, and (c) differentiate men who would be more upset from those who would be less upset by their partners' denials of sexual access. These predictions have received support. Relationships between men's sexual coercion and women's relationship satisfaction are negative (Shackelford & Goetz, 2004); men who are lower

(relative to men who are higher) on conscientiousness

are more likely to sexually coerce their partners (Goetz

& Shackelford, 2009); and the more that men report being

upset if their partners denied them sexual access, the more

sexually coercive these men are (Shackelford & Goetz,

2004).

The SCIRS also has demonstrated convergent and dis

criminative validity. Correlations between SCIRS scores

and scores on a sexual coercion subscale of the Violence

Assessment Index are positive and statistically signifi

cant, according to men's self-reports and women's part

ner-reports (Shackelford & Goetz, 2004). Correlations

between SCIRS scores and scores on the Controlling

Behavior Index (Dobash, Dobash, Cavanagh, & Lewis,

1995), Violence Assessment Index (Dobash et al., 1995),

Injury Assessment Index (Dobash et al., 1995), Women's

Experience with Battering Scale (Smith, Earp, & DeVellis, 1995), Mate Retention Inventory (Buss, Shackelford, & McKibbin, 2008), and Partner-Directed Insults Scale (Goetz, Shackelford, Schipper, & Stewart-Williams, 2006) are uniformly positive but do not share more than 20% of the response variance, providing evidence of convergent and discriminative validity of the SCIRS (Buss et al., 2008; Goetz & Shackelford, 2006; Shackelford & Goetz, 2004; Starratt, Goetz, Shackelford, McKibbin, & Stewart Williams, 2008; Starratt, Popp, & Shackelford, 2008; Starratt, Shackelford, Goetz, & McKibbin, 2009). These correlations suggest that the SCIRS measures behaviors that are related to, but distinct from, nonsexual violence

Exhibit

Sexual Coercion in Intimate Relationships Scale

Instructions: Sexuality is an important part of romantic relationships and can sometimes be a source of conflict. Your honest responses

to the following questions will contribute profoundly to what is known about sexuality in romantic relationships and may help couples

improve the sexual aspects of their relationships. We appreciate that some of the questions may be uncomfortable for you to answer,

but keep in mind that your responses will remain confidential.

Below is a list of acts that can occur in a romantic relationship. Please use the following scale to indicate HOW OFTEN in the past ONE

month these acts have occurred in your current romantic relationship. Write the number that best represents your response in the

blank space to the left of each act.

0 = Act did NOT occur in the past month

1 = Act occurred 1 time in the past month

2 = Act occurred 2 times in the past month

3 = Act occurred 3 to 5 times in the past month

4 = Act occurred 6 to 10 times in the past month

5 = Act occurred 11 OR MORE times in the past month

____ 1. My partner hinted that he would withhold benefits that I depend on if I did not have sex with him.

____ 2. My partner threatened to withhold benefits that I depend on if I did not have sex with him.

____ 3. My partner withheld benefits that I depend on to get me to have sex with him.

____ 4. My partner hinted that he would give me gifts or other benefits if I had sex with him.

____ 5. My partner gave me gifts or other benefits so that I would feel obligated to have sex with him.

____ 6. My partner reminded me of gifts or other benefits he gave me so that I would feel obligated to have sex with him.

____ 7. My partner persisted in asking me to have sex with him, even though he knew that I did not want to.

____ 8. My partner pressured me to have sex with him against my will.

____ 9. My partner initiated sex with me when I was unaware (for example, I was asleep, drunk, or on medication) and continued against my will.

____ 10. My partner threatened to physically force me to have sex with him.

____ 11. My partner physically forced me to have sex with him.

____ 12. My partner made me feel obligated to have sex with him.

____ 13. My partner hinted that he would have sex with another woman if I did not have sex with him.

____ 14. My partner threatened to have sex with another woman if I did not have sex with him.

____ 15. My partner told me that other couples have sex more than we do, to make me feel like I should have sex with him.

____ 16. My partner hinted that he might pursue a long-term relationship with another woman if I did not have sex with him.

____ 17. My partner threatened to pursue a long-term relationship with another woman if I did not have sex with him.

____ 18. My partner hinted that if I were truly committed to him I would have sex with him.

____ 19. My partner told me that if I were truly committed to him I would have sex with him.

____ 20. My partner hinted that if I loved him I would have sex with him.

____ 21. My partner told me that if I loved him I would have sex with him.

____ 22. My partner threatened violence against me if I did not have sex with him.

____ 23. My partner threatened violence against someone or something I care about if I did not have sex with him.

____ 24. My partner hinted that other women were interested in a relationship with him, so that I would have sex with him.

____ 25. My partner told me that other women were interested in a relationship with him, so that I would have sex with him.

____ 26. My partner hinted that other women were interested in having sex with him, so that I would have sex with him.

____ 27. My partner told me that other women were interested in having sex with him, so that I would have sex with him.

____ 28. My partner hinted that other women were willing to have sex with him, so that I would have sex with him.

____ 29. My partner told me that other women were willing to have sex with him, so that I would have sex with him.

____ 30. My partner hinted that it was my obligation or duty to have sex with him.

____ 31. My partner told me that it was my obligation or duty to have sex with him.

____ 32. My partner hinted that I was cheating on him, in an effort to get me to have sex with him.

____ 33. My partner accused me of cheating on him, in an effort to get me to have sex with him.

____ 34. My partner and I had sex, even though I did not want to.

Sexual Beliefs Scale

CHARLENE L. MUEHLENHARD, 1 University of Kansas

ALBERT S. FELTS, San Marcos, Texas

1 Address correspondence to Charlene Muehlenhard, Department of Psychology, University of Kansas, 426 Fraser Hall, 1415 Jayhawk Blvd., Lawrence,

KS 66045-7556; e-mail: charlene@ku.edu

We developed the Sexual Beliefs Scale (SBS) to measure

five beliefs related to rape: the beliefs (a) that women often

indicate unwillingness to engage in sex when they are actu

ally willing (the Token Refusal, or TR, subscale); (b) that

if a woman “leads a man on,” behaving as if she is willing to engage in sex when in fact she is not, then the man is justified in forcing her (the Leading On Justifies Force, or LOJF, subscale); (c) that women enjoy force in sexual situations (the Women Like Force, or WLF, subscale); (d) that men should dominate women in sexual situations (the Men Should Dominate, or MSD, subscale); and (e) that women have a right to refuse sex at any point, at which time men should stop their sexual advances (the No Means Stop, or NMS, subscale). There were existing measures of raperelated beliefs that yielded one global score (e.g., Burt’s Rape Myth Acceptance Scale, 1980) or that measured one belief (e.g., Burt’s Adversarial Sexual Beliefs Scale, 1980), but we could find no scales that yielded separate scores for different beliefs. Description The short form of the SBS is a 20-item scale consisting of five 4-item subscales; the long form is a 40-item scale consisting of five 8-item subscales. Each item is rated on a 4-point scale, from Disagree Strongly (0) to Agree Strongly (3). Many respondents found the long form repetitious, and correlations between the short and long forms were high, ranging from .96 to .98 for the five subscales. Thus, we recommend the short form for most purposes.

Response Mode and Timing

The SBS can be administered using numerous formats (e.g., as a paper-and-pencil questionnaire or online questionnaire). The short form requires less than 5 minutes to complete; the long form requires less than 10 minutes.

Scoring

Items on each subscale are summed, yielding five subscale

scores ranging from 0 to 12 (short form) or from 0 to 24 (long form). Higher scores reflect greater agreement with the belief measured by the subscale.

Reliability

For a sample of 337 male and female undergraduates, Cronbach's alphas for the short and long forms, respectively, were as follows: TR, .71 and .84; LOJF, .90 and .92; WLF, .92 and .95; MSD, .85 and .93; NMS, .94 and .96. In other samples, Milhausen, McBride, and Jun (2006) found alphas for the five subscales ranging from .62 to .86, with a median of .80 (N = 261). Dill, Brown, and Collins (2008) found alphas ranging from .71 (TR) to .94 (NMS); the alpha for the 20-item composite was .83 (N = 180).

Validity

Muehlenhard and Hollabaugh (1988) found that women who had engaged in token refusal of sexual intercourse—indicating no but meaning yes—scored higher than other women on the TR subscale, indicating that they regarded token refusal as a widespread behavior.

Muehlenhard and MacNaughton (1988) compared women whose LOJF scores fell at the lowest, middle, and highest 15% of the distribution. Compared with low-LOJF women, high-LOJF women rated a hypothetical rape victim as more responsible for the rape, rated the rape as more justified, and so forth. Medium- and high-LOJF women

were more likely than low-LOJF women to report engag

ing in unwanted intercourse because a man had become so

aroused that they felt it was useless to stop him; perhaps

they believed that they had “led him on” and thus were obli

gated to satisfy him.

Muehlenhard, Andrews, and Beal (1996) compared men

with high LOJF scores (LOJF men), men with low LOJF

but high TR scores (TR men), and men with low LOJF

and TR scores (Low-Myth men). LOJF men scored higher

than TR men, and both scored higher than Low-Myth men,

on self-rated likelihood of attempting intercourse with a

woman after she said no. When asked to assume that she

really had meant no, TR men no longer differed signifi

cantly from Low-Myth men, suggesting that TR men really

Muehlenhard, C. L., & Hollabaugh, L. C. (1988). Do women sometimes say no when they mean yes? The prevalence and correlates of women’s token resistance to sex. Journal of Personality and Social Psychology, 54, 872–879.
Muehlenhard, C. L., & MacNaughton, J. S. (1988). Women’s attitudes toward women who “lead men on.” Journal of Social and Clinical Psychology, 7, 65–79.

Exhibit

Sexual Beliefs Scale

Below is a list of statements regarding sexual attitudes. Using the scale below, indicate how much you agree or disagree with each state

ment. There are no right or wrong answers, only opinions.

Disagree Strongly Disagree Mildly Agree Mildly Agree Strongly

0 1 2 3

*M 1. Guys should dominate girls in bed.

N 2. Even if a man really wants sex, he shouldn't do it if the girl doesn't want to.

L 3. Girls who are teases deserve what they get.

*W 4. By being dominated, girls get sexually aroused.

W 5. A little force really turns a girl on.

N 6. It's a girl's right to refuse sex at any time.

T 7. Girls usually say No even when they mean Yes.

L 8. When a girl gets a guy obviously aroused and then says No, he has the right to force sex on her.

W 9. Girls really want to be manhandled.

*M 10. Men should decide what should happen during sex.

*L 11. A man is justified in forcing a woman to have sex if she leads him on.

M 12. A man's masculinity should be proven in sexual situations.

*T 13. Girls generally want to be talked into having sex.

*W 14. Girls think it is exciting when guys use a little force on them.

*N 15. A guy should respect a girl's wishes if she says No.

M 16. The man should be the one who dictates what happens during sex.

T 17. Girls say No so that guys don't lose respect for them.

W 18. Feeling dominated gets girls excited.

L 19. A girl who leads a guy to believe she wants sex when she really doesn't deserves whatever happens.

*T 20. Women often say No because they don't want men to think they're easy.

*N 21. When girls say No, guys should stop.

M 22. During sex, guys should be in control.

*L 23. When a girl toys with a guy, she deserves whatever happens to her.

T 24. Girls just say No so as not to look promiscuous.

*N 25. At any point, a woman always has the right to say No.

*M 26. Guys should have the power in sexual situations.

*W 27. Women really get turned on by men who let them know who's boss.

*T 28. Girls just say No to make it seem like they're nice girls.

*L 29. Girls who tease guys should be taught a lesson.

*M 30. The man should be in control of the sexual situation.

L 31. Girls who act like they want sex deserve it when the guy follows through.

*N 32. Even if a man is aroused, he doesn't have the right to force himself on a woman.

*L 33. Girls who lead guys on deserve what they get.

N 34. If a woman says No, a man has no right to continue.

M 35. Men should exercise their authority over women in sexual situations.

*T 36. When girls say No, they often mean Yes.

W 37. It really arouses girls when guys dominate them in bed.

N 38. If a girl doesn't want sex, the guy has no right to do it.

T 39. Girls who act seductively really want sex, even if they don't admit it.

*W 40. Girls like it when guys are a little rough with

them.

Note. T = Token Refusal subscale; L = Leading On Justifies Force subscale; W = Women Like Force subscale; M = Men Should Dominate subscale;

N = No Means Stop subscale.

* These items are on the short form.

Communication

Exhibit

Dyadic Sexual Communication Scale

Instructions: Now I am going to read a list of statements different people have made about discussing sex with their primary partner.

As I read each one, please tell me how much you agree or disagree with it.

1. My partner rarely responds when I want to talk about our sex life.

2. Some sexual matters are too upsetting to discuss with my sexual partner.

3. There are sexual issues or problems in our sexual relationship that we have never discussed.

4. My partner and I never seem to resolve our disagreements about sexual matters.

5. Whenever my partner and I talk about sex, I feel like she or he is lecturing me.

6. My partner often complains that I am not very clear about what I want sexually.

7. My partner and I have never had a heart to heart talk about our sex life together.

8. My partner has no diffi culty in talking to me about his or her sexual feelings and desires.

9. Even when angry with me, my partner is able to appreciate my views on sexuality.

10. Talking about sex is a satisfying experience for both of us.

11. My partner and I can usually talk calmly about our sex life.

12. I have little difficulty in telling my partner what I do or don’t do sexually.

13. I seldom feel embarrassed when talking about the

details of our sex life with my partner.

Note. The short, four-item questionnaire used in the NABS study includes Items 2, 8, 10, and 12. The six-item version used in the AMEN and adolescent

study includes Items 1, 2, 3, 8, 10, and 12. Questions in the original study have been modified for respondents who participated in subsequent studies.

The exact wording of the shortened, four-item versions of the DSC scale are as follows: 1. Do you find some sexual matters too difficult to discuss with

your spouse? 2. Does your spouse have difficulty in talking to you about what he/she likes during sex? 3. Is talking about sex with your spouse fun for the

both of you? 4. Do you find that it is easy for you to tell your spouse what you do or do not like to do during sex?

The exact wording of the six-item versions of the DSC scale is as follows: 1. I find some sexual matters are too upsetting to talk about with my primary

partner. 2. I think it is difficult for my primary partner to tell me what (he/she) likes to do sexually. 3. It is easy for me to tell my primary partner what I

do or don’t like to do during sex. 4. My primary partner hardly ever talks to me when I want to talk about our sex life. 5. My primary partner really cares

about what I think about sex. 6. Talking about sex with my primary partner is usually fun for the both of us.

1 Address correspondence to Terri D. Fisher, The Ohio State University at Mansfield, 1760 University Drive, Mansfield, OH 44906; e-mail:

fisher.16@osu.edu

Weighted Topics Measure of Family Sexual

TERRI D. FISHER, 1 The Ohio State University at Mansfi eld

The Weighted Topics Measure of Family Sexual

Communication (WTM) was developed to enable research

ers to assess quickly and objectively the amount of commu

nication about sexuality that has occurred between parents

and their adolescent children. This scale combines a rela

tively objective measure (number of topics discussed) with

a more subjective one (extent of discussion).

Description

This measure asks respondents to indicate the extent to

Exhibit

Weighted Topics Measure of Family Sexual Communication

Using a scale from 1 to 4 with 0 = None and 4 = A Lot,
please indicate how much discussion you have had with your
child about the

following topics.

None 0 1 2 3 4 A Lot

_____ Pregnancy

_____ Fertilization

_____ Intercourse

_____ Menstruation

_____ Sexually Transmitted Disease [originally Venereal
Disease]

_____ Birth Control

_____ Abortion

_____ Prostitution

_____ Homosexuality

1 Address correspondence to Alexandra McIntyre-Smith or
William Fisher, Department of Psychology, The University of
Western Ontario, London,

Ontario, Canada N6A 5C2; e-mail: amcsmith@gmail.com or

fisher@uwo.ca

Female Partner's Communication During Sexual Activity Scale

ALEXANDRA MCINTYRE-SMITH 1 AND WILLIAM A. FISHER,
University of Western Ontario

This scale assesses female respondents' perceptions of how easy it is to communicate with a partner during sexual activity, and how frequently they communicate their sex their partners.

Description

The scale is composed of three items measuring how easy it is for respondents to communicate with a partner during sexual activity, rated on a 7-point scale from Very Difficult to Very Easy, and three items measuring the frequency of use of different verbal and nonverbal communication strategies, rated on a 6-point scale ranging from 0% of the time to 100% of the time.

Scale development followed an iterative process, whereby items were developed and refined over a series of three studies. An initial pool of 20 items was developed and administered to 198 female undergraduate students. Items were subject to individual item analyses and exploratory factor analyses. Fourteen items were deleted owing to poor

Exhibit

Female Partner's Communication During Sexual Activity Scale

Instructions: The following questions ask about your thoughts and feelings concerning sexual activities with a partner and your sexual

experiences. You are asked to rate each item on the scale provided. Please check off one box per item to indicate your response.

1. Telling my partner what to do to stimulate me during intercourse would be:

Very Diffi cult Moderately Slightly Diffi cult Neither Easy Slightly Easy Moderately Easy Very Easy

Diffi cult nor Diffi cult

2. Showing my partner what to do to stimulate me during intercourse would be:

Very Diffi cult Moderately Slightly Diffi cult Neither Easy Slightly Easy Moderately Easy Very Easy

Diffi cult nor Diffi cult

3. Asking my partner to stimulate me to orgasm (i.e., by massaging my genitals/clitoris) when I have intercourse with my partner

would be:

Very Diffi cult Moderately Slightly Diffi cult Neither Easy Slightly Easy Moderately Easy Very Easy

Diffi cult nor Diffi cult

4. When having sex with a partner, how often do you tell your partner what feels good?

0% of the time

1-25% of the time

26-50% of the time

51-75% of the time

76-99% of the time

100% of the time

5. When having sex with a partner, how often do you show your partner what feels good?

0% of the time

1–25% of the time

26–50% of the time

51–75% of the time

76–99% of the time

100% of the time

6. When having sex with a partner, how often do you ask your partner to stimulate your clitoris to orgasm?

0% of the time

1–25% of the time

26–50% of the time

51–75% of the time

76–99% of the time

100% of the time

Hayes, R. D., Dennerstein, L., Bennett, C. M., Sidat, M., Gurrin, L. C., & Fairley, C. K. (2008). Risk factors for female sexual dysfunction in the general population: Exploring factors associated with low sexual function and sexual distress. Journal of Sexual Medicine, 5, 1681–1693.

Henry, J. D., & Crawford, J. R. (2005). The short-form version of the

Depression Anxiety Stress Scales (DASS-21): Construct validity

and normative data in a large non-clinical sample. British Journal of

Clinical Psychology, 44, 227–239.

Hinkin, T. R. (1998). A brief tutorial on the development of measures for

use in survey questionnaires. Organizational Research Methods, 1, 104–121. Netemeyer, R. G., Bearden, W. O., & Sharma, S. (2003). Scaling procedures: Issues and applications. Thousand Oaks, CA: Sage. Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., et al. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. Journal of Sex and Marital Therapy, 26, 191–208. Streiner, D. L. & Norman, G. R. (2008). Health measurement scales: A practical guide to their development and use (4th ed.). New York: Oxford University Press.

The Partner Communication Scale (PCS) was developed to assess frequency of communicating about sexual topics with a male sex partner among African American adoles cent females (Milhausen et al., 2007).

Description

The PCS was developed as part of an NIMH-funded inter vention grant (Milhausen et al., 2007). Domains pertinent to sexual communication were selected based on a review of the empirical literature. These were (a) pregnancy; (b) STDs; (c) HIV/AIDS; (d) condom use; and (e) partner's sex history. Focus groups of African American adolescent females were conducted to verify that these topics were rel evant in their sexual relationships. Thirty-six items were created to assess communication in these domains. Health educators assessed face validity of the items. The mea sure was pilot-tested on 15 African American adolescent females, 14 to 18 years of age. Based on their suggestions, items were revised to enhance reading comprehension.

Items that were highly correlated and thought to assess

the same construct, as well as items that decreased the Cronbach's alpha below .90, were deleted, leaving a 5-item scale. Data from three studies were used to validate the measure (Milhausen et al., 2007). Though the PCS was designed for, and validated with, samples of African American adolescent females, the items are likely more broadly applicable to individuals of other racial or ethnic backgrounds, to other age groups, and, as well, to males.

Response Mode and Timing

A single stem is used for all items, "During the past 6 months, how many times have you and your sex partner discussed . . ." Each item requires a response based on a Likert-type scale: 0 (Never); 1 (Sometimes, 1–3 Times); 2 (Often, 4–6 Times); 3 (A Lot, 7 or More Times). The scale typically takes less than 5 minutes to complete.

Scoring

All items are coded so that higher values indicate more frequent sexual communication. Scores on the five items are summed to create a scale score. Scores range from 0 to 15. The mean score for participants in Study 1 was 8.47 (SD = 4.31); in Study 2 the mean score was 7.59 (SD = 5.04; Milhausen et al., 2007). In Study 3, the mean score was 6.46 (SD = 4.32; Milhausen et al., 2007). Reliability Stability of the measure was assessed by Pearson correlation. Because it has been suggested that the length of time between reliability assessments should mirror the length of time in intervention studies (Gliner, Morgan, & Harmon, 2001), measurement stability was assessed with 6 months between administrations. In Study 1, baseline and 6-month follow-up responses were correlated at .44. Baseline and 12-month follow-up responses were correlated

at .38 (Milhausen et al., 2007). In Study 2, baseline and 6-month follow-up responses were correlated at .37. Correlations may be low because participants were referring to different partners at each completion point. In Study 1, the Cronbach's alpha was .80 at baseline (N = 522), .87 at 6month follow-up, and .87 at 12-month follow-up. In Study 2, the Cronbach's alpha for the PCS was .90 (N = 243). In Study 3, the Cronbach's alpha was .84 at baseline (N = 715) and .89 at 6-month follow-up (N = 313; Milhausen et al., 2007). Validity The PCS was correlated with other related constructs in the direction that was predicted in both Study 1 and Study 2 (Milhausen et al., 2007). Specifically, in Study 1, the PCS was correlated with frequency of sexual communication with a parent (Sales et al., 2008) and sexual communication self-efficacy (with new partner and boyfriend), and the effect sizes were moderate (Cohen, 1988). Small but significant positive correlations were found between the PCS and relationship satisfaction and self-esteem. Small but significant negative correlations were found between the PCS and fear of consequences of condom negotiation and partner-related barriers to condom use (St. Lawrence et al., 1999). The PCS was correlated positively with condom use at last vaginal sex with steady and nonsteady partners, condom use during the past 30 days with steady Partner Communication Scale ROBIN R. MILHAUSEN, 1 University of Guelph J ESSICA MCDERMOTT SALES, Emory University R ALPH J. DICLEMENTE, Emory University

1 Address correspondence to Robin R. Milhausen, Department of Family Relations and Applied Nutrition, Room 217 MINS Building, University of

Guelph, Guelph, Ontario, N1G 2W1, Canada; e-mail: rmilhaus@uoguelph.ca

and nonsteady partners, and condom use with a steady

partner over the previous 6 months. Discriminant valid

ity was assessed by correlating the PCS with measures of

watching movies or television. These correlations were

not significant. In Study 2, the PCS was correlated with

sexual communication with parents (Sales et al., 2008),

self-esteem (Rosenberg, 1965, 1989), sexual refusal

self-efficacy, and receiving sex education in schools (Milhausen et al., 2007). In Study 2, the PCS did not correlate significantly with partner-related barriers to condom use (St. Lawrence et al., 1999).

Other Information

The PCS is a brief, self-administered behavioral scale measuring frequency of sexual communication with a male partner, suitable for low-literate samples (requiring a fourth grade reading level). Researchers may find the PCS particularly useful in sexual health education interventions, assessing frequency of sexual communication pre- and postintervention to evaluate intervention efficacy. The authors would appreciate receiving information about the

Exhibit

Partner Communication Scale

During the past six months, how many times have you and your sex partner discussed . . .	Never (1–3 Times)	Sometimes (4–6 Times)	Often (7 or More Times)	A Lot
. . . how to prevent pregnancy	0	1	2	3
. . . how to use condoms	0	1	2	3
. . . how to prevent the AIDS virus	0	1	2	3
. . . how to prevent STDs	0	1	2	3
. . . your partner’s sex history	0	1	2	3

The Parent-Adolescent Communication Scale (PACS) was developed to assess adolescent girls’ frequency of sexual

communication with their parents (Sales et al., 2008).

Description

The PACS was developed as part of an NIMH-funded intervention grant (Sales et al., 2008). Domains pertinent to sexual communication were selected based on a review of the empirical literature. These included (a) pregnancy, (b) STDs, (c) HIV/AIDS, (d) condom use, and (e) general information about sex. Focus groups of African American adolescent females were conducted to verify that these topics were relevant in their sexual relationships.

Thirty-six items were created to assess communication in these domains. Health educators assessed face validity of the items. The measure was pilot-tested on 15 African American adolescent females 14 to 18 years of age. Based on their suggestions, items were revised to enhance reading comprehension. Items that were highly correlated and thought to assess the same construct, as well as items that decreased the Cronbach's alpha below .90, were deleted, leaving a 5-item scale. Data from one longitudinal evaluation study were used to validate the measure (Sales et al., 2008). Though the PACS was designed for adolescent females, and validated with an African American female sample, the items are likely more broadly applicable to individuals of other racial or ethnic backgrounds, other age groups, and males.

Response Mode and Timing

A single stem is used for all items: “In the past 6 months,

how often have you and your parent(s) talked about the

following things . . .” Each item requires a response based

on a Likert-type scale: 1 (Never); 2 (Rarely); 3 (Sometimes);

4 (Often). The scale typically takes less than 5 minutes to

complete.

Scoring

All items are coded so that higher values indicate more fre

quent sexual communication with parents. Scores on the

five items are summed to create a scale score. Scores range from 5 to 20. The mean score for participants in our validation sample was 14.20 (SD = 4.79; Sales et al., 2008). Reliability Stability of the measure was assessed by Pearson correlation. Because it has been suggested that the length of time between reliability assessments mirrors the length of time in intervention studies (Gliner, Morgan, & Harmon, 2001), measurement stability was assessed with 6 months between administrations. The intercorrelation between baseline and 6-month follow-up scores was significant ($r = .58$, $p < .001$), as was the intercorrelation between baseline and 12-month follow-up scores ($r = .53$, $p < .001$; Sales et al., 2008). Validity The PACS was correlated with other related constructs in the predicted directions (Sales et al., 2008). Concurrent validity was assessed by correlating frequency of sexual communication with parent(s) as measured by PACS at baseline and other related constructs also assessed at baseline. Specifically, the PACS was positively associated with frequency of sexual communication with partner (Milhausen et al., 2007) and sexual communication self-efficacy (with new partner), family support (Zimet, Dahlem, Zimet, & Farley, 1988), and perceived parental knowledge about their whereabouts. In addition, PACS scores were negatively associated with depressive symptoms. Also, the PACS was positively correlated with recent condom use (last vaginal sex, past 30 days, and past 6 months) with steady partners and was inversely correlated

with frequency of vaginal intercourse (past 30 days). The correlations were all significant, and effect sizes were small to moderate (Cohen, 1988). Predictive validity was assessed by correlating baseline PACS scores to related constructs assessed at 6- and 12-month follow-up assessments. At the 6-month follow-up interval, baseline PACS scores were significantly positively associated with frequency of sexual communication with partner (Milhausen et al., 2007) and sexual communication self-efficacy with a new partner. Also, the PACS was significantly positively associated with condom use during the intervening 6 months between the baseline and 6-month follow-up assessment. At the 1 Address correspondence to Jessica McDermott Sales, Emory University, Rollins School of Public Health, Department of Behavioral Sciences and Health Education, 1520 Clifton Rd., NE, Room 266, Atlanta, GA 30322; e-mail: jmcderm@emory.edu Parent-Adolescent Communication Scale JESSICA MCDERMOTT SALES, 1 Emory University R OBIN R. MILHAUSEN, University of Guelph R ALPH J. DICLEMENTE, Emory University

12-month follow-up interval, baseline PACS scores were

significantly positively associated with frequency of sex

ual communication (Milhausen et al., 2007) and condom

use during the intervening 6 months between the 6-month

and 12-month follow-up assessments. Discriminant valid

ity was assessed by correlating the PACS with measures of

watching movies or television. These correlations were not

significant.

Other Information

The PACS is a brief, self-administered behavioral scale mea

suring frequency of sexual communication with a parent or

parents, suitable for low-literate samples (requiring a fourth

grade reading level). Researchers may find the PACS particu

larly useful in sexual health education interventions, particu

larly family-level interventions, for assessing frequency of

Exhibit

Parent–Adolescent Communication Scale

In the past 6 months, how often have you and your Never Rarely Sometimes Often

parent(s) talked about the following things . . .

. . . sex 1 2 3 4

. . . how to use condoms 1 2 3 4

. . . protecting yourself from STDs 1 2 3 4

. . . protecting yourself from AIDs 1 2 3 4

. . . protecting yourself from becoming pregnant 1 2 3 4

1 Address correspondence to Clay Warren, Department of Organizational Sciences and Communication, The George Washington University, 600 21st

Street NW, Washington, DC, 20052; e-mail: claywar@gwu.edu

Family Sex Communication Quotient

CLAY WARREN, 1 The George Washington University

The Family Sex Communication Quotient (FSCQ) was

developed as a diagnostic tool to measure a general fam

ily orientation to discussion about sex between parents and

children (Warren & Neer, 1982, 1983). This orientation is

assessed across three dimensions: comfort, information,

and value. The comfort dimension was chosen as a main

FSCQ measure because people positively experience sup

portive climates regarded as essential to the exchange of

sex-related information between parents and children. The

Exhibit

Family Sex Communication Quotient

Directions: The following statements represent personal feelings about family discussions of sex. Please circle one of the five response

categories that best describes your opinion: SA = Strongly Agree, A = Agree, N = Neutral (or Don’t Know), D = Disagree, SD =

Strongly Disagree. Also, please answer these questions regardless of whether you have ever talked about sex with your parents. Don’t

spend much time on any one question; make a choice and move to the next. Don’t ask others how they are answering their questions,

or how they think you should answer yours.

1. Sex should be one of the most important topics for parents and children to discuss. SA A N D SD

2. I can talk to my parents about almost anything related to sex. SA A N D SD

3. My parents know what I think about sex. SA A N D SD

4. It is not necessary to talk to my parents about sex. SA A N D SD

5. I can talk openly and honestly with my parents about sex. SA A N D SD

6. I know what my parents think about sex. SA A N D SD

7. The home should be a primary place for learning about sex. SA A N D SD

8. I feel comfortable discussing sex with my parents. SA A N D SD

9. My parents have given me very little information about sex. SA A N D SD

10. Sex is too personal a topic to discuss with my parents. SA A N D SD

11. My parents feel comfortable discussing sex with me. SA A N D SD

12. Much of what I know about sex has come from family discussions. SA A N D SD

13. Sex should not be discussed in the family unless there is a problem to resolve. SA A N D SD

14. Sex is too hard a topic to discuss with my parents. SA A N D SD

15. I feel better informed about sex if I talk to my parents. SA A N D SD

16. The least important thing to discuss with my parents is sex. SA A N D SD

17. I feel free to ask my parents questions about sex. SA A N D SD

18. When I want to know something about sex, I generally ask my parents. SA A N D SD

Scoring: The FSCQ measures a general orientation toward discussion about sex in the family unit along three dimensions: Comfort (Items 2, 5, 8, 11,

14, and 17), Information (Items 3, 6, 9, 12, 15, and 18), and Value (Items 1, 4, 7, 10, 13, and 16). You can give each SA answer a “5,” A answer a “4,” N

answer a “3,” D answer a “2,” and SD answer a “1.” Six of the questions need to be reverse scored (Items 4, 9, 10, 13, 14, and 16). Reverse scoring means

the 5 and 1 weights are interchanged, the 4 and 2 weights are interchanged, and the 3 remains the same. It is used in questionnaire design to detect

set-response behavior—a tendency of some folks to not think about the questions and, thus, to use the same answers regardless of the question asked.

After pairing a number with the 18 questions, you can total the numbers for your FSCQ score. Range levels of orientation have been generalized as low

(18–39), moderate (40–69), and high (70–90).

Warren, C. (1987, May). Family sex communication in Denmark. Paper

presented at International Communication Association conference,

Montreal.

Warren, C. (1992). Perspectives on international sex practices and

American family sex communication relevant to teenage sexual

behavior in the United States. Health Communication, 4, 121–136.

Warren, C. (1995). Parent-child communication about sex. In T. J. Socha

& G. Stamp (Eds.), Parents, children, and communication: Frontiers

of theory and research (pp. 173–201). Hillsdale, NJ: Lawrence

Erlbaum.

Warren, C. (2000). Talking with your children about sex. In C. G. Waugh,

W. I. Gorden, & K. M. Golden (Eds.), Let’s talk: A cognitive skills

approach to interpersonal communication (pp. 292–295 & 451).

Dubuque, IA: Kendall/Hunt.

Warren, C. (2006). Communicating about sex with parents and partners. In

K. M. Galvin & P. J. Cooper (Eds.), Making connections: Readings in relational communication (4th ed., pp. 319–326). New York: Oxford University Press. Warren, C., & Neer, M. (1982, May). Family sexual communication: A preliminary study of patterns of interaction. Paper presented at International Communication Association conference, Boston. Warren, C., & Neer, M. (1983, May). Determinants and effects of family sexual communication. Paper presented at International Communication Association conference, Dallas. Warren, C., & Neer, M. (1986). Family

sex communication orientation. Journal of Applied Communication Research, 14, 86–107. Warren, C., & Olsen, N. (2005, November). A paired analysis of parent-child communication about sex. Paper presented at National Communication Association conference, Boston. Zamboni, B. D., & Silver, R. (2009). Family sex communication and the sexual desire, attitudes, and behavior of late adolescents. American Journal of Sexuality Education, 4, 58–78.

Compulsion

1 Address correspondence to Eli Coleman, Professor and Director, Program in Human Sexuality, Department of Family Practice and Community Health,

Medical School, 1300 South 2nd Street, Suite 180, Minneapolis, MN 55454; e-mail: colem001@umn.edu Exhibit Compulsive Sexual Behavior Inventory CSBI (English Version) Circle the answer that most accurately describes your response. 1. How often have you had trouble controlling your sexual urges? 1 2 3 4 5 2. Have you felt unable to control your sexual behavior? 1 2 3 4 5 3. How often have you used sex to deal with worries or problems in your life? 1 2 3 4 5 4. How often have you felt guilty or shameful about aspects of your sexual behavior? 1 2 3 4 5 5. How often have you concealed or hidden your sexual behavior from others? 1 2 3 4 5 6. How often have you been unable to control your sexual feelings? 1 2 3 4 5 7. How often have you made pledges or promises to change or alter your sexual behavior? 1 2 3 4 5 8. How often have your sexual thoughts or behaviors interfered with the formation of friendships? 1 2 3 4 5 9. How often have you developed excuses and reasons to justify your sexual behavior? 1 2 3 4 5 10. How often have you missed opportunities for productive and enhancing activities because of your sexual activity? 1 2 3 4 5 11. How often have your sexual activities caused financial problems for you? 1 2 3 4 5 12. How often have you felt emotionally distant when you were engaging in sex with others? 1 2 3 4 5 13. How often have you had sex or masturbated more than you wanted to? 1 2 3 4 5 14. Have you forced anyone against his or her will to have sex? 1 2 3 4 5 15. Have you ever hit, kicked, punched, slapped, thrown, choked, restrained, or beaten any of your sexual partners? 1 2 3 4 5 16. Have you given others physical pain for sexual pleasure? 1 2 3 4 5 17. In fighting, have you been hit, kicked, punched, slapped, thrown, choked, restrained, or beaten by your current or most recent partner? 1 2 3 4 5 18. Have you received physical pain for sexual pleasure? 1 2 3 4 5 19. Have you received money to have sex? 1 2 3 4 5 20. Have you been forced to have sex with your husband, wife, or lover? 1 2 3 4 5 21. Have you been watched masturbating or having sex without giving permission? 1 2 3 4 5 Compulsive Sexual Behavior Inventory (CSBI) © Eli Coleman, Ph.D. Program in Human Sexuality Inventario de Comportamiento Sexual Compulsivo (Spanish Version) Circule la respuesta que más aplique. 1. ¿Con qué frecuencia ha tenido usted dificultad en controlar

sus impulsos sexuales? 1 2 3 4 5 2. ¿Se ha sentido usted incapaz de controlar su comportamiento sexual? 1 2 3 4 5 3. ¿Con qué frecuencia ha usado usted el sexo para tratar sus preocupaciones o problemas? 1 2 3 4 5 4. ¿Con qué frecuencia se ha sentido usted culpable o avergonzado acerca de los aspectos de su comportamiento sexual? 1 2 3 4 5 5. ¿Con qué frecuencia ha ocultado usted su comportamiento sexual a otros? 1 2 3 4 5 6. ¿Con qué frecuencia se ha sentido usted incapaz de controlar sus sentimientos sexuales? 1 2 3 4 5 7. ¿Con qué frecuencia ha hecho usted compromisos o promesas de cambiar o de alterar su comportamiento sexual? 1 2 3 4 5 N e v e r R a r e l y O c c a s i o n a l l y F r e q u e n t l y V e r y F r e q u e n t l y N u n c a R a r a O c a s i o n a l F r e c M u y F r e c

8. ¿Con qué frecuencia sus pensamientos o comportamientos sexuales han interferido con la formación

de amistades? 1 2 3 4 5

9. ¿Con qué frecuencia ha inventado usted excusas y razones para justificar su comportamiento sexual? 1 2 3 4 5

10. ¿Con qué frecuencia ha perdido usted la oportunidad para hacer actividades productivas debido a su

actividad sexual? 1 2 3 4 5

11. ¿Con qué frecuencia su actividad sexual le ha causado a usted problemas financieros? 1 2 3 4 5

12. ¿Con qué frecuencia se ha sentido emocionalmente distante cuando ha tenido sexo con otros? 1 2 3 4 5

13. ¿Con qué frecuencia ha tenido sexo o masturbación más de lo que usted ha querido? 1 2 3 4 5

14. ¿Con qué frecuencia ha sido arrestado o legalmente sancionado por su comportamiento sexual? 1 2 3 4 5

15. ¿Ha obligado usted a algún hombre/mujer hacer algo en contra de su voluntad? 1 2 3 4 5

16. ¿Alguna vez ha golpeado, empujado, cacheteado, lanzado, sofocado, sometido o le ha pegado

usted a alguna de sus parejas sexuales? 1 2 3 4 5

17. ¿Le ha causado usted a otras personas dolor físico por

placer sexual? 1 2 3 4 5

18. En peleas, ¿ha sido usted golpeado, pateado, empujado, cacheteado, ha sido tirado, estrangulado,

frenado, o le ha pegado su pareja actual o la más reciente? 1 2 3 4 5

19. ¿Ha recibido usted dolor físico por placer sexual? 1 2 3 4 5

20. ¿Ha recibido dinero por tener sexo? 1 2 3 4 5

21. ¿Ha sido obligado a tener sexo con su esposo, esposa u amantes? 1 2 3 4 5

22. ¿Ha sido usted visto masturbándose o teniendo sexo sin dar su permiso? 1 2 3 4 5

Inventario de Comportamiento Sexual Compulsivo (ICSC)

© Eli Coleman, Ph.D.

Program in Human Sexuality

Sexual Compulsivity Scale

SETH C. KALICHMAN, 1 University of Connecticut

1 Address correspondence to Seth C. Kalichman, Department of Psychology, 406 Babbidge Road, University of Connecticut, Storrs, CT 06269; e-mail:

seth.k@uconn.edu

The Sexual Compulsivity Scale was designed to serve as a

brief psychometric instrument to assist in the assessment of

insistent, intrusive, and uncontrolled sexual thoughts and

behaviors. Sexual compulsivity is conceptually and clinically

similar to sexual addiction. Clinically, sexually compulsive

individuals may present with an array of social problems that

stem from their sexual preoccupation and conduct, including

disturbances in their interpersonal relationships, occupation,

and other facets of daily living. Sexual compulsivity can

lead to sexual assault and other criminal behavior, especially

when the compulsivity occurs in the context of a paraphilia.

However, the Sexual Compulsivity Scale is not intended to

detect paraphilias. Most available research has examined

sexual compulsivity as a correlate of risks for sexually trans

mitted infections, including HIV/AIDS. The scale content

concentrates on sexual preoccupations rather than acting as

an indicator of overt sexual behaviors.

Description

The Sexual Compulsivity Scale was originally derived

Exhibit

Sexual Compulsivity Scale

A number of statements that some people have used to describe themselves are given below. Read each statement and then circle the

number to show how well you believe the statement describes you.

Not at all Like Me Slightly Like Me Mainly Like Me Very Much Like Me

1. My sexual appetite has gotten in the way of my relationships. 1 2 3 4

2. My sexual thoughts and behaviors are causing problems in 1 2 3 4

my life.

3. My desires to have sex have disrupted my daily life. 1 2 3 4

4. I sometimes fail to meet my commitments and. 1 2 3 4

responsibilities because of my sexual behaviors

5. I sometimes get so horny I could lose control. 1 2 3 4

6. I find myself thinking about sex while at work. 1 2 3 4

7. I feel that my sexual thoughts and feelings are stronger than 1 2 3 4

I am.

8. I have to struggle to control my sexual thoughts and behavior. 1 2 3 4

9. I think about sex more than I would like to. 1 2 3 4

10. It has been diffi cult for me to fi nd sex partners who desire 1 2 3 4

having sex as much as I want to.

Cognitive and Behavioral Outcomes of Sexual

Behavior Scale

KIMBERLY R. MCBRIDE, 1 MICHAEL REECE, AND STEPHANIE A. SANDERS, Indiana University

1 Address correspondence to Kimberly R. McBride, Department of Psychological and Brain Sciences, Indiana University, Bloomington, IN 47405; e

mail: kmcbride@indiana.edu

The term sexual compulsivity (SC) is used to describe

sexual behaviors that may be beyond an individual’s con

trol and that subsequently could lead to impairment in

functioning as well as a range of negative outcomes. The

Society for the Advancement of Sexual Health (SASH)

has offered a list of outcomes that may occur if a person or behaviors are sexually compulsive. This outcomes-based understanding of sexual compulsivity would suggest that individuals and their behaviors (including behaviors that they do alone, such as masturbation, as well as those that they do with other people, such as having intercourse) could lead to negative consequences in various domains, including social, emotional, physical, legal, financial/occupational, and spiritual areas of life (Reece, Dodge, & McBride, 2006). The Cognitive and Behavioral Outcomes

Exhibit

Cognitive and Behavioral Outcomes of Sexual Behavior

Below is a list of things that some people worry about as a result of their sexual activities (including things people do alone and those

they do with others). Please indicate the extent to which the following apply to you:

Never = A Sometimes = B Often = C Always = D

I am worried that the things I have done sexually:

1. might have placed me or one of my sex partners at risk for pregnancy. a

2. might have placed me or one of my sex partners at risk for a sexually transmitted infection (like herpes, gonorrhea, or crabs).

3. might have placed me or one of my sex partners at risk for HIV.

4. might have resulted in pain, injury, or other problems for one of my sex partners.

5. might have resulted in pain, injury, or other problems for myself.

6. might have presented the potential for serious physical injury or death.

7. might be leading to problems with my friends.

8. might be leading to problems with my family members.

9. might be leading to problems with my boyfriend/girlfriend/spouse.

10. might have placed me at risk of being arrested.

11. might have been against the law.

12. might have led to financial problems.

13. might have caused me to waste my money.

14. were interfering with my ability to complete tasks for work or school.

15. might have presented the potential for me to lose my job.

16. could lead to school-related problems, such as probation, expulsion, or other sanctions.

17. were inconsistent with my spiritual beliefs.

18. were inconsistent with my religious values.

19. were making me feel guilty.

20. were making me ashamed of myself.

Instructions: Below is a list of things that sometimes happen to people as a result of their sexual activities (including those they do alone

and those they do with others). Please indicate whether these things have happened to you during the last year as a result of your sexual

activities.

In the past year, as a result of the things you have done sexually, did the following happen to you:

21. I or my sexual partner(s) became pregnant.

A. Yes

B. No

22. I contracted a sexually transmitted infection. a

23. I contracted HIV.

24. I gave someone else a sexually transmitted infection.

25. I gave someone else HIV.

26. I caused pain, injury, or other physical problems for myself.

27. I caused pain, injury, or other physical problems for a sex partner.

28. My relationships with friends and/or family members were damaged.

29. My relationships with a spouse or other relationship partner were damaged.

30. I was arrested.

31. I experienced financial problems.

32. I experienced problems at school.

33. I experienced problems at work.

34. I experienced spiritual distress.

35. I was embarrassed or ashamed of myself.

36. I felt guilty.

a The response scale directly above is repeated after each item.

The Sexuality Scale (SS; Snell & Papini, 1989) is an objec

tive, self-report instrument designed to measure of three

aspects of human sexuality: sexual esteem, defined as posi

tive regard for and confidence in the capacity to experience

one's sexuality in a satisfying and enjoyable way; sexual depression, defined as the experience of feelings of sadness, unhappiness, and depression regarding one's sex life; and sexual preoccupation, defined as the tendency to think about sex to an excessive degree. Factor analysis confirmed that the items on the SS form three conceptual clusters corresponding to the three concepts (Snell & Papini, 1989). Other results indicated that all three subscales had clearly acceptable levels of reliability.

Additional findings indicated that whereas there were no gender differences on the measures of sexual esteem and sexual depression, men reported higher levels of sexual preoccupation than did women. Other evidence showed that among both women and men, sexual esteem was negatively related to sexual depression, with the relationship being quite substantial among male subjects. Also Snell and Papini (1989) found that women's sexual esteem was positively associated with sexual preoccupation, whereas among men sexual depression was directly related to their sexual preoccupation.

Description

The SS consists of 30 items arranged in a format allowing respondents to indicate how much they agree (versus disagree) with that statement. A 5-point Likert scale is used, with responses for each item being scored from +2 to −2:

agree (+2), slightly agree (+1), neither agree nor disagree (0), slightly disagree (−1), disagree (−2). To create subscale scores (discussed below), the items on each subscale are summed. Higher positive scores thus correspond to greater agreement with the statements, and more extreme negative scores indicate greater disagreement with the statements. To confirm the three conceptual dimensions assumed to underlie the SS, the 30 items were subjected to a principal components factor analysis. A three-factor solution was specified and rotated to orthogonal simple structure with the varimax procedure. The first factor had an eigenvalue of 8.39 and accounted for 56% of the common variance; the first factor was characterized by the items on the sexual-esteem subscale. All 10 sexual-esteem items loaded on this factor with coefficients ranging from .52 to .82 (average coefficient, .69). The second factor had an eigenvalue of 4.75 and accounted for 32% of the common variance. All 10 of the sexual-preoccupation items loaded substantially on this factor (i.e., greater than .41), with an average loading of .65 (range = .41 to .86). The third factor, accounting for 13% of the common variance and having an eigenvalue of 1.88, dealt with the sexual-depression items; 8 of the 10 items on this sexual-depression subscale had loadings ranging from .48 to .84; average coefficient = .67. The other two items had loadings less than .20, and thus it was decided to consider them “filler items.” Response Mode and Timing In most instances, people respond to the 30 items by marking their answers on separate machine-scoreable answer sheets. The scale usually requires about 15–20 minutes to complete. Scoring After several items are reverse coded (designated with an “R”), the relevant items on each subscale are then coded so that A = −2; B = −1; C = 0; D = +1; and E = +2. Next, the items on each subscale are summed, so that higher

scores correspond to greater sexual esteem, sexual depression, and sexual preoccupation. Scores on the sexual-esteem and sexual-preoccupation scales can range from −20 to +20; scores on the sexual-depression scale range from −16 to +16. The items on the three SS subscales are: sexual esteem (Items 1, 4, 7, 10R, 13R, 16, 19R, 22, 25R, 28R); sexual depression (Items 2, 5R, 8, 17, 20, 23R, 26, 29R); and sexual preoccupation (Items 3, 6, 9R, 12, 15, 18, 21R, 24R, 27R, 30R). An abbreviated version of the three subscales was developed by Wiederman and Allgeier (1993). The 15-item SS short-form includes the following items: sexual esteem (Items 1, 4, 16, 19R, 22); sexual depression (Items 2, 5R, 8, 17, 23R); and sexual preoccupation (Items 3, 6, 12, 15, 18). Reliability The internal consistency of the three subscales on the SS was determined by calculating Cronbach alpha coefficients, using a sample of 296 participants (209 females and 87 males) drawn from lower division psychology courses at a small midwestern university (Snell & Papini, 1989). The average age of the women in this study was 23.5 years (SD = 5.9), with a range of 19 to 53; the males averaged 23.7 Sexuality Scale WILLIAM E. SNELL, JR., 1 Southeast Missouri State University 1 Address correspondence to William E. Snell, Jr., Department of Psychology, Southeast Missouri State University, One University Plaza, Cape Girardeau, MO 63701; e-mail: wesnell@semo.edu

years of age (SD = 4.4), with a range of 19 to 37. The alpha

coefficients were computed for each of the three subscales

for women and men separately and together. Each coef

ficient was based on 10 item scales, except for the measure

of sexual depression which consists of eight items. The

alphas for the sexual-esteem scale were: .92 for women,

.93 for men, and .92 for all subjects. For the sexual-depres

sion subscale, the alpha for women was .88 and the alpha

for men was .94 (combined alpha = .90). The alphas for the

sexual-preoccupation scale were: .88 for women, .79 for

men, and .88 for all subjects.

Snell, Fisher, and Schuh (1992) also provided additional

reliability evidence for the SS: sexual esteem (alpha range =

.91 to .92), sexual depression (alpha range = .85 to .93), and

sexual preoccupation (alpha range = .87 to .91). Test-retest

reliability, as reported by Snell et al. (1992), was sexual

esteem (range = .69 to .74), sexual depression (range = .67

to .76), and sexual preoccupation (range = .70 to .76). In

brief, the three subscales had more than adequate internal

consistency and test-retest reliability.

The 15-item short-form SS, 5 items per subscale, had

Cronbach alphas for men and women, respectively, of .92

and .94 for sexual esteem, .89 and .89 for sexual depres

sion, and .96 and .92 for sexual preoccupation (Wiederman

& Allgeier, 1993).

Validity

Evidence for the validity of the SS comes from a variety

Exhibit

Sexuality Scale

Instructions: The statements listed below describe certain attitudes toward human sexuality which different people may have. As such,

there are no right or wrong answers, only personal responses. For each item you will be asked to indicate how much you agree or disagree

with the statement listed in that item. Use the following scale to provide your responses:

(A) (B) (C) (D) (E)

Agree Slightly Neither Slightly Disagree

agree agree nor disagree

disagree

1. I am a good sexual partner.

2. I am depressed about the sexual aspects of my life.

3. I think about sex all the time.

4. I would rate my sexual skill quite highly.

5. I feel good about my sexuality. (R)

6. I think about sex more than anything else.

7. I am better at sex than most other people.

8. I am disappointed about the quality of my sex life.

9. I don’t daydream about sexual situations. (R)

10. I sometimes have doubts about my sexual competence. (R)

11. Thinking about sex makes me happy.

12. I tend to be preoccupied with sex.

13. I am not very confident in sexual encounters. (R)

Sanders, S. A., Graham, C. A., Yarber, W. L., Crosby, R. A., Dodge, B., & Milhausen, R. R. (2003). Condom use errors and problems among women who put condoms on their male partners. Journal of the American Medical Women's Association, 58, 95–98.

Sanders, S. A., Milhausen, R. R., Crosby, R. A., Graham, C. A., & Yarber, W. L. (2009). Do phosphodiesterase type 5 inhibitors protect against condom-associated erection loss and condom slippage? Journal of Sexual Medicine, 6, 1451–1456.

Steiner, M., Cates, W., & Warner, L. (1999). The real problem with male condoms in non-use. Sexually Transmitted Diseases, 26, 459–462. Warner, D. L., & Hatcher, R. A. (1999). Male condoms. In R. A. Hatcher, W. Cates, Jr., J. Trussell, F. Stewart, F. Guest, G. K. Stewart, et al. (Eds.), Contraceptive technology (17th ed., pp. 325–352). New York: National Academy Press. Yarber, W. L., Graham, C. A., Sanders, S. A., & Crosby, R. A. (2004). Correlates of condom breakage and slippage among university students. International Journal of STD and AIDS, 15, 467–472. Yarber, W. L., Kennedy, J., Sanders, S. A., Crosby, R. A., Graham, C. A., Heckman, T. G., et al. (2005). Prevalence of condom use errors and problems among Indiana rural men: An exploratory telephone survey. The Health Education Monograph, 22(3), 36–38.

Exhibit

Condom Use Errors/Problems Survey

Condom Use Errors/Problems Survey—Men (M-CUES)

Directions: The questionnaire is designed for a man who has used male condoms at least three times in the past three months for

_____ [Researchers choose penile-vaginal (penis in vagina) or penile-anal (penis in rectum/butt)] intercourse and who put the

condom on his penis all of the three times. Thinking about the last three times you (not your partner) put the condom on your penis,

indicate whether or not you engaged in the behavior or if the event happened and, if so, how often it occurred.

1. For the last three times you used a condom for _____ [Researchers choose: penile-vaginal or penile-anal] intercourse, did you check for visible damage before having _____ intercourse?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on all 3 occasions

2. For the last three times you used a condom for _____ intercourse, did you put it on the wrong side up and have to flip it over?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

3. For the last three times you used a condom for _____ intercourse, did you leave space at the tip of the condom when putting it on?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

4. For the last three times you used a condom for _____ intercourse, did you squeeze the air out after putting it on?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

5. For the last three times you used a condom for _____ intercourse, did you lose or start to lose your erection while putting it on?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

6. For the last three times you used a condom for _____ intercourse, did you use a condom without a water-based lubricant such as K-Y jelly or spermicidal cream (meaning the condom did not have lubricant on it and you or your partner did not put any on it)?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

7. For the last three times you used a condom for _____ intercourse, did you also use an oil-based lubricant, such as Vaseline or baby oil, with the condom?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

8. For the last three times you used a condom for _____ intercourse, did you lose or start to lose your erection after _____ intercourse had begun while using the condom?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

9. For the last three times you used a condom for _____ intercourse, did you let it contact sharp jewelry, fingernails, piercings, or teeth anytime before or during _____ intercourse?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

10. For the last 3 times you used a condom for _____ intercourse, did you start having _____ intercourse without the condom and then put it on later and continued _____ intercourse?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

11. For the last time you used a condom for _____ intercourse, did you start having intercourse with it on and then take it off and continue having _____ intercourse without it on?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

12. For the last three times you used a condom for _____ intercourse, did it break during _____ intercourse?

___ no

___ if yes, did it do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it did it on 1 occasion

___ it did it on 2 occasions

___ it did it on 3 occasions

13. For the last three times you used a condom for _____ intercourse, did it slip off during _____ intercourse?

___ no

___ if yes, did it do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it did it on 1 occasion

___ it did it on 2 occasions

___ it did it on 3 occasions

14. For the last three times you used a condom for _____ intercourse, did it slip off as you were taking your penis out of the _____ [vagina or anus/rectum/butt]?

___ no

___ if yes, did it do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it did it on 1 occasion

___ it did it on 2 occasions

___ it did it on 3 occasions

15. For the last three times you used a condom for _____ intercourse, did you have any problems with the way it fit?

___ no

___ if yes, did I on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did on 1 occasion

___ I did on 2 occasions

___ I did on 3 occasions

16. For the last three times you used a condom for _____ intercourse, did you or your partner have any problems with the way it felt?

___ no

___ if yes, did it happen on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it happened on 1 occasion

___ it happened on 2 occasions

___ it happened on 3 occasions

Directions: The questionnaire is designed for a woman who has used a male condom at least three times in the past three months for

_____ [Researchers choose penile-vaginal (penis in vagina) or penile-anal (penis in rectum/butt)] intercourse and who put the

condom on her partner's penis all of the three times. Thinking about the last three times you (not your partner) put the condom on his

penis, indicate whether or not you engaged in the behavior or if the event happened and, if so, how often it occurred.

1. For the last three times you used a condom for _____ [Researchers choose: penile-vaginal or penile-anal] intercourse, did you check for visible damage before having _____ intercourse?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on all 3 occasions

2. For the last three times you used a condom for _____ intercourse, did you put it on the wrong side up and have to flip it over?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

3. For the last three times you used a condom for _____ intercourse, did you leave space at the tip of the condom when putting it on?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

4. For the last three times you used a condom for _____ intercourse, did you squeeze the air out after putting it on?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

5. For the last three times you used a condom for _____ intercourse, did your partner lose or start to lose his erection while you were putting it on his penis?

___ no

___ if yes, did he do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ he did it on 1 occasion

___ he did it on 2 occasions

___ he did it on 3 occasions

6. For the last three times you used a condom for _____ intercourse, did you use a condom without a water-based lubricant such as K-Y jelly or spermicidal cream (meaning the condom did not have lubricant on it and you or your partner did not put any on it)?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

7. For the last three times you used a condom for _____ intercourse, did you also use an oil-based lubricant, such as Vaseline or baby oil, with the condom?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

8. For the last three times you used a condom for _____ intercourse, did your partner lose or start to lose his erection after _____ intercourse had begun while using the condom?

___ no

___ if yes, he did on 1 occasion, on 2 occasions, or on all 3 occasions?

___ he did it on 1 occasion

___ he did it on 2 occasions

___ he did it on 3 occasions

___ not sure

9. For the last three times you used a condom for _____ intercourse, did you let it contact sharp jewelry, fingernails, piercings, or teeth anytime before or during _____ intercourse?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or

on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

10. For the last three times you used a condom for _____ intercourse, did you start having _____ intercourse without the condom and then put it on later and continued _____ intercourse?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

11. For the last time you used a condom for _____ intercourse, did you start having intercourse with it on and then take it off and continue having _____ intercourse without it on?

___ no

___ if yes, did you do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ I did it on 1 occasion

___ I did it on 2 occasions

___ I did it on 3 occasions

12. For the last three times you used a condom for _____ intercourse, did it break during _____ intercourse?

___ no

___ if yes, did it do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it did it on 1 occasion

___ it did it on 2 occasions

___ it did it on 3 occasions

___ not sure

13. For the last three times you used a condom for _____ intercourse, did it slip off during _____ intercourse?

___ no

___ if yes, did it do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it did it on 1 occasion

___ it did it on 2 occasions

___ it did it on 3 occasions

___ not sure

14. For the last three times you used a condom for _____ intercourse, did it slip off while your partner was taking his penis out of your _____ [vagina or anus/rectum/butt]?

___ no

___ if yes, did it do it on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it did it on 1 occasion

___ it did it on 2 occasions

___ it did it on 3 occasions

___ not sure

15. For the last three times you used a condom for _____ intercourse, did your partner have any problems with the way it fit?

___ no

___ if yes, did he on 1 occasion, on 2 occasions, or on all 3 occasions?

___ he did on 1 occasion

___ he did on 2 occasions

___ he did on 3 occasions

___ not sure

16. For the last three times you used a condom for _____ intercourse, did you or your partner have any problems with the way it felt?

___ no

___ if yes, did it happen on 1 occasion, on 2 occasions, or on all 3 occasions?

___ it happened on 1 occasion

___ it happened on 2 occasions

___ it happened on 3 occasions

Correct Condom Use Self-Effi cacy Scale

RICHARD A. CROSBY, 1 University of Kentucky

C YNTHIA A. GRAHAM, University of Oxford

ROBIN R. MILHAUSEN, University of Guelph

S TEPHANIE A. SANDERS AND WILLIAM L. YARBER, 2 Indiana University

Consistent and correct male condom use has been noted

as one effective method for preventing the transmission

of HIV and reducing the risk of other STDs (Centers for

Disease Control and Prevention, 2009). Although a num

ber of psychosocial constructs have been associated with

condom use, a central construct, from a theoretical and an

empirical perspective, has been condom use self-efficacy.

Bandura (1994) defined self-efficacy as beliefs about one’s

capabilities to produce designated levels of performance and suggested that self-efficacy largely determined how individuals feel, think, motivate themselves, and behave. Condom use self-efficacy, therefore, refers to an individual's confidence in the ability to exert control over his or her motivation, behavior, and social environment to use condoms (Forsyth & Carey, 1998).

A number of previous measures of self-efficacy assess knowledge, behavioral intentions, or attitudes, but not an individual's perception about his or her ability to perform specific behaviors (e.g., Goldman & Harlow, 1993; Lux & Petosa, 1994; Schaalma, Kok, & Peters, 1993). Other measures of self-efficacy are limited by their conceptualization of self-efficacy as a stable trait across different contexts (e.g., St. Lawrence, Brasfield, Jefferson, Alleyne, & Shirley, 1994) as opposed to a more domain-specific behavior. Many researchers also have relied on a single item measure of self-efficacy that may limit the precision of measurement (e.g., Wulfert & Wan, 1993). Therefore, a scale that measures individuals' perceptions of their ability to perform behaviors specific to correct condom use would have utility in public health research.

Description

The Correct Condom Use Self-Efficacy Scale (CCUSS)

is a 7-item scale designed to measure an individual's per

ception of the ease or difficulty with which he or she can

apply and use male condoms correctly. This scale emerged

from our earlier research on the prevalence and predictors

of male condom use errors and problems (e.g., Crosby,

Milhausen, Sanders, Graham, & Yarber, 2008; Crosby,

Sanders, Yarber, Graham, & Dodge, 2002; Graham et al.,

2006; Milhausen et al., 2009; Sanders et al., 2003; Sanders,

1 Authors listed alphabetically.

2 Address correspondence to William L. Yarber, Department of Applied Health Science, Indiana University, Bloomington, Indiana 47405; e-mail:

yarber@indiana.edu

Exhibit

Correct Condom Use Self-Efficacy Scale

Directions: Please circle the number that represents how easy or difficult it would be to do what each question asks. For example, if you

thought a behavior in the statement would be very easy, you would circle number "5."

1. How easy or difficult would it be for you to find condoms that fit you properly?

Very Difficult Very Easy

1 2 3 4 5

2. How easy or difficult would it be for you to apply condoms correctly?

Very Difficult Very Easy

1 2 3 4 5

3. How easy or difficult would it be for you to keep a condom from drying out during sex?

Very Difficult Very Easy

1 2 3 4 5

4. How easy or difficult would it be for you to keep a condom from breaking during sex?

Very Difficult Very Easy

1 2 3 4 5

5. How easy or difficult would it be for you to keep an erection while using a condom?

Very Difficult Very Easy

1 2 3 4 5

6. How easy or difficult would it be for you to keep a condom on when withdrawing after sex?

Very Difficult Very Easy

1 2 3 4 5

7. How difficult would it be for you to wear a condom from start to finish of sex with your partner?

Very Difficult Very Easy

1 2 3 4 5 condom errors and problems reported by men attending an STI clinic. AIDS and Behavior, 12, 412-418.

Crosby, R. A., Sanders, S. A., Yarber, W. L., Graham, C. A., & Dodge, B. (2002). Condom use errors and problems among college men. Sexually Transmitted Disease, 29, 552-557.

Forsyth, A. D., & Carey, M. P. (1998). Measuring self-efficacy in the context of HIV risk reduction: Research challenges and recommendations. Health Psychology, 17, 559-568.

Goldman, J. A., & Harlow, L. L. (1993). Self-perception variables that mediate AIDS-preventive behavior in college students. Health Psychology, 12, 489-498.

Graham, C. A., Crosby, R. A., Yarber, W. L., Sanders, S. A., McBride, K., Milhausen, R. R., et al. (2006). Erection loss in association with condom use among young men attending a public STI clinic: Potential correlates and implications for risk behavior. Sexual Health, 3, 255- 260.

Lux, K. M., & Petosa, R. (1994). Using the health belief model to predict safer sex intentions of incarcerated youth. Health Education Quarterly, 21, 487-497.

Milhausen, R. R., Wood, J., Crosby, R. A., Graham, C. A., Sanders, S. A., & Yarber, W. L. (2009). A novel home-based intervention to promote condom use among young heterosexual males: A pilot study. Manuscript in preparation. Sanders, S. A., Graham, C. A., Yarber, W. L., Crosby, R. A., Dodge, B., & Milhausen, R. R. (2003). Condom use errors and problems among women who put condoms on their male partners. Journal of the American Medical Women's Association, 58, 95-98. Sanders, S. A., Milhausen, R. R., Crosby, R. A., Graham, C. A., & Yarber, W. L. (2009). Do phosphodiesterase type 5 inhibitors protect against condom-associated erection loss and condom slippage? Journal of Sexual Medicine, 6, 1451-1456. Schaalma, H., Kok, G., & Peters, L. (1993). Determinants of consistent condom use by adolescents: The impact of experience of sexual intercourse. Health Education Research, 8, 255-269. St. Lawrence, J. S., Brasfield, T. L., Jefferson, K. W., Alleyne, E., & Shirley, A. (1994). Social support as a factor in African American adolescents' sexual risk behavior. Journal of Adolescent Health, 9, 292-310. Wulfert, E., & Wan, C. K. (1993). Condom use: A self-efficacy model. Health Psychology, 12, 346-353. Yarber, W. L., Graham, C. A., Sanders, S. A., & Crosby, R. A. (2004). Correlates of condom breakage and slippage among university students. International Journal of STD and AIDS, 15, 467-472. Yarber, W. L., Kennedy, J., Sanders, S. A., Crosby, R. A., Graham, C. A., Heckman, T. G., et al. (2005). Prevalence of condom use errors and problems among Indiana rural men: An exploratory telephone survey. The Health Education Monograph, 22(3), 36-38.

The purpose of the UCLA Multidimensional Condom

Attitudes Scale (MCAS) is to measure condom attitudes

in five independent areas: (a) the reliability and effective

ness of condoms, (b) the sexual pleasure associated with

condom use, (c) the stigma associated with people propos ing or using condoms, (d) the embarrassment about nego tiating and using condoms, and (e) the embarrassment about purchasing condoms. The scale can be used with individuals who do and do not have personal experience with condoms.

Description

The 25-item MCAS assesses five independent factors associated with condom use. The MCAS was found to be reliable and valid in three studies using ethnically diverse samples of UCLA undergraduates (Helweg-Larsen & Collins, 1994). As of August 2008 it had been cited 97 times; the scale has been used in 31 of these articles (see companion website at www.routledge.com/text books/9780415801751 to view the complete list). The scale has been used with a range of populations, such as HIV-positive individuals from urban clinics in California (Milam, Richardson, Espinoza, & Stoyanoff, 2006), Chinese and Filipina American college women (Lam & Barnhart, 2006), sexually active adult cocaine or heroin users (Rosengard, Anderson, & Stein, 2006), cocaine abusing, opioid-dependent HIV-positive adults entering a methadone program (Avants, Warburton, Hawkins, & Margolin, 2000), individuals in a large public psychi atric hospital diagnosed primarily with schizophrenia

and mood disorders (Weinhardt, Carey, & Carey, 1997), American Indian men in New York City who identified as gay/bisexual/two-spirit and heterosexual (Simoni, Walters, Balsam, & Meyers, 2006), and HIV-positive Zambian women (Jones, Ross, Weiss, Bhat, & Chitalu, 2005). Furthermore, the MCAS has been translated to Spanish (DeSouza, Madrigal, & Millan, 1999; Unger & Molina, 1999), Japanese (Kaneko, 2007), and various Zambian languages such as Bemba, Nyanja, and Nsenga (Jones et al., 2005). Overall, the body of research using the MCAS shows that it has been a reliable and valid mea sure of condom attitudes in a wide range of participants. A complete list of studies which have used the MCAS may be found at the companion website for this book (http://www.routledge.com/textbooks/9780415801751). Scoring We found that the five dimensions of the MCAS cannot meaningfully be summed to generate a single global score because the factors are independent. The statistical independence of the five factors was established via factor analyses and confirmatory factor analysis in structural equation modeling which showed that a model with five independent factors was superior in fitting the data compared to a unidimensional model (all 25 questions averaged). Thus, it is important that the five factors are scored separately. If researchers do not have room to use all 25 questions, they may select one or several of the factors that they are particularly interested in and use all 5 questions in that factor. Another option is to select a few questions from each of the five factors; Table 1 in Helweg-Larsen and Collins (1994) shows factor loadings (separately for men and women) that can guide researchers in the selection of questions. Our research indicates that important information is lost if questions are added together across factors. Our research also demonstrated the importance of examining condom attitudes separately for men and women. First, results indicated

gender differences on several of the five factors; compared to women, men were less embarrassed about purchasing condoms but more concerned about stigma. Second, the MCAS factors showed different patterns of correlations with criterion variables for men and women. For example, women's past condom use was not correlated with any of the five MCAS factors, whereas men's past condom use was correlated with positive attitudes toward pleasure and embarrassment about buying condoms. Some of the MCAS items are worded negatively (i.e., indicate a negative attitude toward condoms), and the score must therefore be reversed before adding or averaging the scores (higher scores will then indicate more positive condom attitudes). The scoring for these items is as follows: 1. Reliability and Effectiveness of Condoms: Reverse score Questions 6 and 14; then add Questions 4, 6, 9, 14, and 20. 2. Pleasure Associated With Condoms: Reverse score Questions 2, 8, and 25; then add Questions 2, 8, 15, 19, and 25. 3. Stigma Associated With Condoms: Reverse score Questions 3, 13, 18, 22, and 24; then add Questions 3, 13, 18, 22, and 24.

UCLA Multidimensional Condom Attitudes Scale

MARIE HELWEG-LARSEN, 1 Dickinson College

1 Address correspondence to Marie Helweg-Larsen, PhD, Department of Psychology, Dickinson College, Carlisle, PA 17013; e-mail:

helwegm@dickinson.edu

Exhibit

MCAS Multidimensional Condom Attitudes Scale

Please respond to all questions even if you are not sexually active or have never used (or had a partner who used) condoms. In such cases

indicate how you think you would feel in such a situation.

Choose a number on the scale below that best represents your feelings about each statement. There are no right or wrong responses

to any of these statements. Write the number that best represents your opinion in the blank beside each question.

Strongly Disagree Disagree Slightly Disagree Slightly Agree

Agree Strongly Agree 1 2 3 4 5
6 7

_____ 1. It is really hard to bring up the issue of using condoms to my partner.

_____ 2. Use of a condom is an interruption of foreplay.

_____ 3. Women think men who use condoms are jerks.

_____ 4. Condoms are an effective method of preventing the spread of AIDS and other sexually transmitted diseases.

_____ 5. I always feel really uncomfortable when I buy condoms.

_____ 6. Condoms are unreliable.

_____ 7. When I suggest using a condom I am almost always embarrassed.

_____ 8. Condoms ruin the sex act.

4. Embarrassment About Negotiation and Use of Condoms: Reverse score Questions 1, 7, and 16; then add Questions 1, 7, 12, 16, and 21.

5. Embarrassment About Purchasing Condoms: Reverse score Questions 5, 11, 17, and 23; then add Questions 5, 10, 11, 17, and 23.

Reliability

We established internal consistency in three independent

samples (separately for men and women) using factor anal

ysis and confirmatory factor analysis in structural equation

modeling (Helweg-Larsen & Collins, 1994). Acceptable

Cronbach’s alpha values for each factor have been found

in many subsequent studies (e.g., Maisto et al., 2004;

Rosengard et al., 2006).

Validity

We established construct validity for the MCAS by show

ing that gender and sexual experience were associated with the five factors of the MCAS (Helweg-Larsen & Collins, 1994). Furthermore, past and intended condom use was related to the five factors of the MCAS, again showing dif ferent patterns for men and women. The MCAS has also been validated in a sample of low-acculturated Hispanic women (Unger & Molina, 1999) and among Mexican undergraduate students (DeSouza et al., 1999).

Avants, S. K., Warburton, L. A., Hawkins, K. A., & Margolin, A. (2000). Continuation of high-risk behavior by HIV-positive drug users: Treatment implications. Journal of Substance Abuse Treatment, 19, 15–22. DeSouza, E., Madrigal, C., & Millan, A. (1999). A cross-cultural validation of the Multidimensional Condom Attitudes Scale. Interamerican Journal of Psychology, 33, 191–204. Helweg-Larsen, M., & Collins, B. E. (1994). The UCLA Multidimensional Condom Attitudes Scale: Documenting the complex determinants of condom use in college students. Health Psychology, 13, 224–237. Jones, D. L., Ross, D., Weiss, S. M., Bhat, G., & Chitalu, N. (2005). Influence of partner participation on sexual risk behavior reduction among HIV-positive Zambian women. Journal of Urban Health: Bulletin of the New York Academy of Medicine, 82, iv92–iv100. Kaneko, N. (2007). Association between condom use and perceived barriers to and self-efficacy of safe sex among young women in Japan. Nursing and Health Sciences, 9, 284–289. Lam, A. G., & Barnhart, J. E. (2006). It takes two: The role of partner ethnicity and age characteristics on condom negotiations of heterosexual Chinese and Filipina American college women. AIDS Education and Prevention, 18, 68–80. Maisto, S. A., Carey, M. P., Carey, K. B., Gordon, C. M., Schum, J. L., & Lynch, K. G. (2004). The relationship between alcohol and individual differences variables on attitudes and behavioral skills relevant to sexual health among heterosexual young adult men. Archives of Sexual Behavior, 33, 571–584. Milam, J., Richardson, J. L., Espinoza, L., & Stoyanoff, S. (2006). Correlates of unprotected sex among adult heterosexual men living with HIV. Journal of Urban Health—Bulletin of the New York Academy of Medicine, 83, 669–681. Rosengard, C., Anderson, B. J., & Stein, M. D. (2006). Correlates of condom use and

reasons for condom non-use among drug users. The American Journal of Drug and Alcohol Abuse, 32, 637-644. Simoni, J. M., Walters, K. L., Balsam, K. F., & Meyers, S. B. (2006). Victimization, substance use, and HIV risk behaviors among gay/ bisexual/two-spirit and heterosexual American Indian men in New York City. American Journal of Public Health, 96, 2240-2245. Unger, J. B., & Molina, G. B. (1999). The UCLA Multidimensional Condom Attitudes Scale: Validity in a sample of low-acculturated Hispanic women. Hispanic Journal of Behavioral Sciences, 21, 199- 211. Weinhardt, L. S., Carey, M. P., & Carey, K. B. (1997). HIV risk reduction for the seriously mentally ill: Pilot investigation and call for research. Journal of Behavior Therapy and Experimental Psychiatry, 28, 87-95.

_____ 9. I think condoms are an excellent means of contraception.

_____ 10. I don't think that buying condoms is awkward.

_____ 11. It is very embarrassing to buy condoms.

_____ 12. It is easy to suggest to my partner that we use a condom.

_____ 13. If a couple is about to have sex and the man suggests using a condom, it is less likely that they will have sex.

_____ 14. Condoms do not offer reliable protection.

_____ 15. Condoms are a lot of fun.

_____ 16. I never know what to say when my partner and I need to talk about condoms or other protection.

_____ 17. It would be embarrassing to be seen buying condoms in a store.

_____ 18. People who suggest condom use are a little bit geeky.

_____ 19. The use of condoms can make sex more stimulating.

_____ 20. Condoms are an effective method of birth control.

_____ 21. I'm comfortable talking about condoms with my partner.

_____ 22. Men who suggest using a condom are really boring.

_____ 23. When I need condoms, I often dread having to get them.

_____ 24. A woman who suggests using a condom does not trust her partner.

_____ 25. Condoms are uncomfortable for both parties.

Source. Copyright © 1994 by the American Psychological Association. Adapted with permission. The official citation that should be used in referencing

this material is Helweg-Larsen, M., & Collins, B. E. (1994). The UCLA Multidimensional Condom Attitudes Scale: Documenting the complex determi

nants of condom use in college students. Health Psychology, 13, 224-237.

Condom Fit and Feel Scale

MICHAEL REECE, 1 DEBBY HERBENICK, AND BRIAN DODGE, Indiana University

1 Address correspondence to Michael Reece, Center for Sexual Health Promotion, HPER 116, Indiana University, Bloomington, IN 47405; e-mail:

mireece@indiana.edu

Those who promote condoms in their sexual health pro

motion efforts have been challenged by the assertion from

some men that their resistance to condoms is based upon

their perceptions that they do not fit properly or feel com

fortable during use. The Condom Fit and Feel Scale was

developed to provide the field with an empirical measure

for assessing men’s perceptions of the extent to which con

doms fit and feel comfortable along specific points of the

penis (e.g., base, shaft, glans). The scale was designed for

use by both sexual health researchers and sexual health

practitioners (e.g., clinicians, educators, therapists, and community-based organization staff and volunteers). For researchers, the scale is designed to provide a quantitative assessment of men's perceptions of condom fit and feel and can be used for studies that seek to include a construct such as "perceived condom fit and feel" in their work related to condom use, condom attitudes, and other cognitive, affective, and behavioral aspects of using condoms. For practitioners, the scale was designed to be a useful tool that would help condom-resistant men to articulate their specific concerns with the fit and feel of condoms in a way that is sensitive to the challenges that both men and providers may face during discussions related to male sexual anatomy. For practitioners involved in the promotion of correct and consistent condom use, the scale can be quickly scored or individual items can be reviewed in order to assist providers with making recommendations for specific condoms that are designed for men with varying penile dimensions or that have properties (e.g., shape, texture, lubricant type) that men may perceive as better fitting or more comfortable given their particular concerns. Description The Condom Fit and Feel Scale is a 14-item Likert-type scale on which men indicate their experiences with the fit and feel of condoms. Items were developed by sexual health researchers in collaboration with sexual health practitioners, condom manufacturers, and condom distributors based upon the specific issues that men have presented during sexual health interventions and upon the specific issues with condom fit and feel that men have expressed to condom companies and condom retailers when seeking condom recommendations. The scale has five subscales, including Condoms Fit Fine, Condoms Feel Too Loose, Condoms Feel Too Tight, Condoms Are Too Long, and Condoms Are

Too Short. Each item is assessed using a 4-point response option (1 = Never Applies to Me; 2 = Sometimes Applies to Me; 3 = Often Applies to Me; 4 = Always Applies to Me).

Response Mode and Timing

Respondents are asked to read a series of 14 statements and to indicate the extent to which the specific perception of condom fit and feel has applied to them over the course of their past sexual activities during which condoms were used. The scale is preceded by the instruction: “Please rate the extent to which each of the following statements has applied to you as you have used condoms for sexual activi ties in the past.” Completion of the scale takes approxi mately 5 minutes.

Scoring

A mean score for each subscale is calculated by summing the scores on items within each subscale and dividing the total subscale score by the number of items in each sub scale. The subscale mean scores can be used independently to assess men’s experiences with specific aspects of con dom fit and feel. One can also calculate an overall score of Condom Fit and Feel Problems by reverse scoring the two positive items in the Condoms Fit Fine subscale and creat ing a summed score.

Reliability

Reliability coefficients of the subscales have ranged from

.60 (Condoms Are Too Long subscale) to .89 (Condoms

Feel Too Loose subscale) during administration to samples

of heterosexual, bisexual, and gay men (Reece, Dodge,

Herbenick, Fisher, & Alexander, 2007; Reece, Herbenick,

& Dodge, 2009). In addition to the English version of the

scale, similar levels of reliability have been demonstrated

Exhibit

Condom Fit and Feel Scale

Please rate the extent to which each of the following statements has applied to you as you have used condoms for sexual activities in

the past.

Response Options:

1. Never Applies to Me

2. Sometimes Applies to Me

3. Often Applies to Me

4. Always Applies to Me

Scale Items by Subscale (subscale titles provided for information, not to be included in the actual scale when administered).

Condoms Fit Fine

Condoms fit my penis just fine.

Condoms feel comfortable once I have them on my penis.

Condoms Are Too Long

Condoms are too long for my penis.

I have some unrolled condom left at the base of my penis after I unroll it.

Condoms Are Too Short

Condoms are too short for my penis.

Condoms will not roll down far enough to cover my penis completely.

Condoms Feel Too Tight

Condoms are too tight on my penis.

Condoms feel too tight along the shaft of my penis.

Condoms feel too tight on the head of my penis.

Condoms feel too tight around the base of my penis.

Condoms Feel Too Loose

Condoms are too loose on my penis.

Condoms feel too loose along the shaft of my penis.

Condoms feel too loose around the head of my penis.

Condoms feel too loose around the base of my penis.

Condom Embarrassment Scale

KAREN VAIL-SMITH 1 AND THOMAS W. DURHAM, East Carolina University

H. ANN HOWARD, University of North Carolina at Chapel Hill

1 Address correspondence to Karen Vail-Smith, Department of Health Education and Promotion, East Carolina University, Greenville, NC 27858; e-mail:

vailsmithk@ecu.edu

Embarrassment as a construct inhibiting effective con

traceptive use has been supported in the literature (Baffi,

Schroeder, Redican, & McCluskey, 1989; Beckman, Harvey,

& Tiersky, 1996; Bell, 2009; Dahl, Gorn, & Weinberg,

1998; Herold, 1981; Hingson, Strunin, Berlin, & Heeren,

1990; Hughes & Torre, 1987; Kallen & Stephensen, 1980; Moore, Dahl, Gorn, & Weinberg, 2006; Moore et al., 2008; Valdiserri, Arena, Proctor, & Bonati, 1989). The Condom Embarrassment Scale (CES) was developed to measure the level of embarrassment in college men and women regarding condom use (Vail-Smith, Durham, & Howard, 1992). Condom embarrassment is here defined as the psychological discomfort, self-consciousness, and feeling of being ill at ease associated with condom use. The researchers hypothesized that this psychological discomfort would be experienced when an individual makes an acquisition of condoms, negotiates with a partner to use condoms, and actually uses a condom as a part of a sexual encounter. Description The 18-item CES employs a Likert scale (5-point) with response options labeled from Strongly Disagree to Strongly Agree. From the responses of a sample of 256 college students, a principal factor analysis with varimax rotation revealed three major components of condom embarrassment that accounted for 59.4% of the total variance. Items 1, 2, 3, 4, 5, 6, 7, and 12 loaded heavily on the first factor. This factor accounted for 45.0% of the shared variance explained by the three factors and appears to be characterized by embarrassment associated with acquiring, purchasing, obtaining or possessing condoms. Items 14, 15, 16, 17, and 18 loaded on the second factor, which accounted for 30.1% of the common variance and appears to be associated with actually using condoms. Items 8, 9, 10, 11, and 13 loaded on the third factor. Factor three appears to be associated with negotiating the use of condoms and accounts for 24.9% of the explainable variance.

Response Mode and Timing

Respondents indicate their level of agreement with each item by circling the letter (A-E) corresponding with their answer choice. The CES requires approximately 10 minutes to complete.

Scoring

Each item on the CES is scored from 1 to 5 with 1 corresponding to Strongly Disagree (low embarrassment) and 5 corresponding to Strongly Agree (high embarrassment). Point values for all answers were summed to provide the CES score. The possible range of CES scores is from 18 to 90, with 90 indicating the highest embarrassment and 18 indicating the lowest. Among the 256 college students who participated in the original study, the mean score on the CES was 44.88 (SD = 14.85). Women (M = 46.54, SD = 14.65) scored significantly higher than men (M = 41.81, SD = 14.74), $t(254) = 2.48$, $p = .01$.

Reliability

To assess the stability of the test over time, a Pearson product-moment correlation coefficient was computed using the scores from the 226 college students who completed two administrations of the CES. The obtained reliability coefficient was .78, $p < .001$. The Cronbach's alpha for the summed scores from the 18 items was .92.

Validity

As expected, Vail-Smith, Durham, and Howard (1992) found that the summed score of the CES was significantly correlated with the Sex Anxiety Inventory (Janda & O'Grady, 1980), $r = .39$. It was also predicted that those persons with greater knowledge about condom use and sexually transmitted diseases (STDs) would feel less embarrassed about buying, discussing, and using condoms. When comparing the scores on an STD/condom knowledge test (Solomon & DeJong, 1989) and the CES across both men and women, the Pearson product-moment correlation for these two variables was .34, $p < .01$, also indicating a significant correlation in the predicted direction. The relationship of CES scores with the STD/condom knowledge test scores differs by gender, however. For the 163 women, the correlation between the two variables was −.35, $p < .001$, indicating

Exhibit

Condom Embarrassment Scale

Instructions: The following items assess how embarrassed you do feel (or would feel) about condom use. Using the following scale, please respond to each of the items listed below.

A = Strongly Disagree

B = Disagree

C = Neither Agree nor Disagree

D = Agree

E = Strongly Agree

1. I am embarrassed or would be embarrassed about buying a condom from a drug store near campus.

2. I am embarrassed or would be embarrassed about buying a condom from a drug store close to where my parents live.

3. I am embarrassed or would be embarrassed about buying a condom from a place where I could be certain no one I know would see me.

4. I am embarrassed or would be embarrassed about obtaining condoms from Student Health Services (School Infirmary).

5. I am embarrassed or would be embarrassed about obtaining condoms from a local health department.

6. I am embarrassed or would be embarrassed about asking a pharmacist or drug store clerk where condoms are located in the store.

7. I am embarrassed or would be embarrassed about asking a doctor or other health care professional questions about condom use.

8. I am embarrassed or would be embarrassed about stopping during foreplay and asking my partner to use a condom.

9. I would be embarrassed if a new partner insisted that we use a condom.

10. I am embarrassed or would be embarrassed to tell my partner during foreplay that I am not willing to have sexual intercourse unless we use a condom.

11. I am embarrassed or would be embarrassed about being prepared and providing a condom during lovemaking if my partner didn't have one.

12. I am embarrassed or would be embarrassed about carrying a condom around in my wallet/purse.

13. I am embarrassed or would be embarrassed about talking to my partner about my thoughts and feelings about condom use.

14. I am embarrassed or would be embarrassed if my partner watched me dispose of a condom after we had used it.

15. I am embarrassed or would be embarrassed about watching my partner put on a condom OR if my partner watched me put on a condom.

16. I am embarrassed or would be embarrassed about helping my partner put on a condom OR if my partner helped me put on a condom.

17. I am embarrassed or would be embarrassed about watching my partner remove a condom OR if my partner watched me remove a condom.

18. I am embarrassed or would be embarrassed about helping my partner remove a condom OR if my partner helped me remove a condom.

Conflict

Exhibit

Sexual Situation Questionnaire for Men (Reluctant Woman Version) a

Instructions: We are interested in learning more about communication in dating situations in which you, a man, wished to engage in a

higher level of sexual activity than your date, a woman, wanted to engage in at that time. For example, you may have wanted to kiss a

woman when she did not wish to kiss you. Another example would be if you wanted to have intercourse and your date only wanted to

go as far as sexual fondling. Notice that we are interested in communication about all levels of sexual activity from holding hands and

kissing to intercourse. And, while we use the term “date,” we are interested in any sexual situation that you are in with a member of

the other sex, even if it is not part of what you may consider to be a true “date.” Also, when we use the term “disagreement,” we are

referring to those situations in which you indicate a desire to engage in a higher level of sexual activity than a woman wanted-even if

she later changed her mind and engaged in the sexual activity anyway or she was convinced to engage in the sexual activity some other

way. In other words, the term “disagreement” means that you and your date differed in the level of sexual activity desired. It does not

imply that you argued or fought about this issue.

1. Have you ever been on a date where you wanted to engage in a higher level of sexual activity than your date, a woman, did? _ ____ Yes _____ No

If No, then you do not need to complete the rest of the

questionnaire.

If Yes, please complete the rest of the questionnaire for the most recent time that this occurred.

2. How long ago was the most recent time that you wanted to engage in a higher level of sexual activity than your date did?

_____ (specify number and whether it was days, weeks, or months).

3. Prior to the disagreement, how many previous dates had you and this woman had together? _____

4. What type of relationship did you have with your date prior to the disagreement?

_____ first date

_____ casual date

_____ steady date

5. Where were you and your date at the time of the disagreement?

_____

6. The sexual activity that you wished to engage in but your date did not wish to engage in was: (check all that apply)

_____ hugging

_____ a kiss

_____ necking

_____ you fondling or kissing your date's breasts

_____ you fondling your date's genitals

_____ your date fondling your genitals

_____ oral sex (male to female)

_____ oral sex (female to male)

_____ intercourse

_____ anal sex

_____ other (please specify) _____

7. Why did your date not wish to engage in this sexual activity?

_____

8. Had you ever engaged in this sexual activity before with this woman?

_____ Yes _____ No

9. The sexual activity (or activities) that you and your date were engaging in immediately prior to the disagreement was (were): (check as many as apply)

_____ no sexual activity

_____ hugging

_____ a kiss

_____ necking

_____ you fondling or kissing your date's breasts

_____ your date fondling your genitals

_____ you fondling her genitals

_____ oral sex (male to female)

_____ oral sex (female to male)

_____ intercourse

_____ anal sex

_____ other (please specify)
_____

10. How clearly did you indicate to your date that you wanted to engage in the higher level of sexual activity that you specified in Question 6?

_____ extremely clearly

_____ moderately clearly

_____ somewhat clearly

_____ somewhat unclearly

_____ moderately unclearly

_____ extremely unclearly

11. What did you say and/or do to indicate that you wanted to engage in the higher level of sexual activity that you specified in Question 6? (Please write the exact words you used [if any] and/or describe the actions that you used [if any] to indicate that you wanted to engage in the sexual activity.)

I said: _____

_____

I did: _____

_____

12. How clearly did your date indicate that she did not want to engage in this sexual activity?

_____ extremely clearly

_____ moderately clearly

_____ somewhat clearly

_____ somewhat unclearly

_____ moderately unclearly

_____ extremely unclearly

13. What did she say and/or do to indicate that she did not want to engage in this sexual activity? (Please write the exact words she used [if any] and/or describe the actions that she used [if any] to indicate that she did not want to engage in the sexual activity.)

She said: _____

_____

She did: _____

_____

14. How did you respond after she had indicated that she did not want to engage in this sexual activity? (Please write the exact words you used [if any] and/or describe the actions that you used [if any] after she had indicated that she did not want to engage in the sexual activity.)

I said: _____

_____

I did: _____

_____

15. Did you and your date end up engaging in the sexual activity that you had disagreed upon?

Yes, then _____

Yes, later on that date _____

No, not on that date _____

16. Please indicate which of the following behaviors you used (if any) in attempting to influence your date to engage in the higher level

of sexual activity once she had indicated that she did not want to by placing a check mark in the left hand column below.

Then, for each behaviour you used, indicate the impact of the behaviour on your date at that time. Use a “P” if the impact of the

behavior was positive or pleasing to your date, a “D” if the impact of the behavior was negative or displeasing, or an “N” if the

impact of the behavior was neutral. (Check as many behaviours as occurred.)

Did you Impact on woman

use this? (P, D, or N)

_____ _____ asked her if she found you sexually attractive

_____ _____ pouted, sulked, or refused to talk

_____ _____ told her that you were too sexually aroused to stop

said things to her that you did not really mean (e.g., told her

_____ _____ that you loved her and you do not)

talked about your real feelings toward her (e.g., told her that

_____ _____ you loved her and you do)

_____ _____ threats (e.g. to end the date, end the relationship or tell others)

_____ _____ discontinued all sexual activity

_____ _____ complimented her on her body or sexuality

made negative comments (e.g. about her sexuality, her

_____ _____ personality, her appearance or the relationship)

_____ _____ pinched, poked her

_____ _____ tickled her

_____ _____ pleaded

_____ _____ tried to reason with her

_____ _____ bargained, negotiated, or suggested a compromise

_____ _____ took off or loosened clothing

_____ _____ flirted

pretended to become disinterested in the sexual activity that

_____ _____ you had wanted to engage in previously

_____ _____ cried

_____ _____ grabbed her or used some other form of physical

pressure

_____ _____ touched, stroked her

_____ _____ tried to get her drunk, stoned

_____ _____ started an argument

_____ _____ made positive comments about her appearance

_____ _____ made positive comments about her personality

_____ _____ made positive comments about the relationship

_____ _____ told her how enjoyable it would be

_____ _____ made her feel guilty

_____ _____ used humor

_____ _____ moved away from her

_____ _____ made her jealous (e.g., flirted with someone else)

ignored refusal and engaged in the higher level of sexual

_____ _____ activity anyway

_____ _____ asked her why she didn't want to do it

_____ _____ put on clothing, music that you hoped she would find arousing

_____ _____ danced, moved seductively

_____ _____ other (please specify) _____

17. At the time when you wanted to engage in the higher level of sexual activity than your date did, how pleasurable was it being with

your date?

_____ extremely unpleasant

_____ moderately unpleasant

Consent

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhi & J. Beckmann (Eds.), Action-control: From cognition to behavior (pp. 11-39). Heidelberg, Germany: Springer.

Ajzen, I. (2001). Attitudes. Annual Review of Psychology, 52, 27-58.

Ajzen, I. (2005). Attitudes, personality, and behavior (2nd ed.). Milton Keynes, UK: Open University Press/McGraw-Hill.

Humphreys, T. P. (2004). Understanding sexual consent: An empirical investigation of the normative script for young heterosexual adults. In M. Cowling & P. Reynolds (Eds.), Making sense of sexual consent (pp. 209-225). Aldershot, UK: Ashgate. Humphreys, T. P., & Brousseau, M. (2009). The Sexual Consent Scale— Revised: Development, reliability, and preliminary validity. The Journal of Sex Research, 46, 1-9. Humphreys, T. P., & Herold, E. (2007). Sexual consent in heterosexual dating relationships: Attitudes and behaviours of university students. Sex Roles, 57, 305-315. Hurlbert, D. F. (1991). The role of assertiveness in female sexuality: A comparative study between sexually assertive and sexually nonassertive women. Journal of Sex and Marital Therapy, 17(3), 183-190. Kalichman, S. C., & Rompa, D. (1995). Sexual sensation seeking and sexual compulsivity scales: Reliability, validity, and predicting HIV risk behavior. Journal of Personality Assessment, 65, 586-601. Morokoff, P. J., Quina, K., Harlow, L. L., Whitmire, L., Grimley, D. M., Gibson, P. R., et al. (1997). Sexual assertiveness scale (SAS) for women: Development and validation. Journal of Personality and Social Psychology, 73, 790-804.

Factor 3: Relationship Length Norms

19. I believe that the need for asking for sexual consent decreases as the length of an intimate relationship increases.

20. I think that obtaining sexual consent is more necessary in a casual sexual encounter than in a committed relationship.

21. I think that obtaining sexual consent is more necessary in a new relationship than in a committed relationship.

22. If a couple has a long history of consenting sexual activity with each other, I do not believe that they need to ask for consent during each sexual encounter.

23. I believe that partners are less likely to ask for sexual consent the longer they are in a relationship.

Factor 4: (Pro) Assuming Consent

24. I think it is okay to assume consent and proceed sexually until the partner indicates “no.”

25. If a sexual request is made and the partner indicates “no,” I feel that it is okay to continue negotiating the request.

26. I think nonverbal behaviors are as effective as verbal communication to indicate sexual consent.

27. Not asking for sexual consent is not really a big deal.

28. In making a sexual advance, I believe that it is okay to assume consent unless you hear a “no.”

29. I believe it is enough to ask for consent at the beginning of a sexual encounter.

30. I believe that sexual intercourse is the only sexual activity that requires explicit verbal consent.

Factor 5: Indirect Behavioral Approach

31. Typically I communicate sexual consent to my partner using nonverbal signals and body language.

32. Typically I ask for consent by making a sexual advance and waiting for a reaction, so I know whether or not to continue.

33. It is easy to accurately read my current (or most recent) partner’s non-verbal signals as indicating consent or non-consent to sexual activity.

34. I always verbally ask for consent before I initiate a sexual encounter [R].

35. I don’t have to ask or give my partner sexual consent because my partner knows me well enough.

36. I don’t have to ask or give my partner sexual consent

because I have a lot of trust in my partner to “do the right thing.”

Factor 6: Awareness of Consent

37. I have discussed sexual consent issues with a friend.

38. I have heard sexual consent issues being discussed by other students on campus.

39. I have discussed sexual consent issues with my current (or most recent) partner at times other than during sexual encounters.

40. I have not given much thought to the topic of sexual consent [R].

Note. The scale follows each of the statements.

Reasons for Consenting to Unwanted Sex Scale

TERRY P. HUMPHREYS & DEBORAH J. KENNETT, 1 Trent University

1 Address correspondence to either Terry P. Humphreys or Deborah J. Kennett, Psychology Department, Trent University, 1600 West Bank Drive,

Peterborough, Ontario, Canada, K9J 7B8; e-mail: terryhumphreys@trentu.ca or dkennett@trentu.ca

The purpose of the Reasons for Consenting to Unwanted

Sex Scale (RCUSS; Humphreys & Kennett, 2008; Kennett,

Humphreys, & Patchell, 2009) is to assess the amount of

endorsement women give to a variety of reasons for why

they have voluntarily consented to engage in sexual activ

ity they did not desire. This scale was normed on hetero

sexual undergraduate females.

Description

The RCUSS was developed on the basis of past research

that suggested women voluntarily give in to sexual activ

ity, even though they may have little or no sexual desire or would rather not engage in sexual activity (Meston & Buss, 2007; O'Sullivan & Allgeier, 1998). For example, Zimmerman, Sprecher, Langer, and Holloway (1995) found that, when asked how sure they were that they could say "no" if a boyfriend was trying to talk them into having sex, only 61% of females reported that they could definitely say no to unwanted sex. In a diary study, O'Sullivan and Allgeier (1998) found that 50% of the undergraduate women sampled wrote that they had consented to unwanted sexual activity, ranging from kissing to sexual intercourse, during a 2-week period. The items of the RCUSS were chosen on the basis of past literature, suggesting that women consent to unwanted

sexual activity for a variety of reasons, including to satisfy

their partner's needs, promote intimacy, avoid tension, pre

vent a partner from losing interest in the relationship and/or

fulfill perceived relationship obligations (Impett & Peplau,

2002; O'Sullivan & Allgeier, 1998; Shotland & Hunter,

1995). Items of the RCUSS reflect how characteristic it

is for a woman to voluntarily consent to unwanted sexual

activity for these reasons. The RCUSS is an 18-item, self-report questionnaire.

Factor analysis with varimax rotation revealed a unidimen

sional scale that included all 18 items (no factor loadings

below .30) accounting for 59.2% of the variance.

Response Mode and Timing

Two alternative modes are possible. When it is a pencil

and-paper survey, respondents circle a number from 0 to

8 corresponding to the degree to which they feel the state

ment is characteristic of themselves. When it is an online

survey (using an internal or external service), respondents click on the bullet response from 0 to 8 corresponding to the degree to which they feel the statement is characteristic of themselves. The scale takes approximately 10 minutes to complete.

Scoring

Items are scored 0 for Not at all Characteristic of Me to 8 for Very Characteristic of Me. There are not any reverse scored items. Scores are summed. Total scores can range from 0 to 144. The mean scores on this inventory for our two samples were M = 41.2, SD = 33.5 (Kennett et al., 2009) and M = 35.9, SD = 32.5 (Humphreys & Kennett, 2008), respectively.

Reliability

Based on two female undergraduate datasets, the reli ability for the whole RCUSS was .96 (N = 150), with an average inter-item correlation of .75 (ranging from .46 to .85; Kennett et al., 2009) and .96 (N = 152), with an aver age inter-item correlation of .55 (ranging from .18 to .85; Humphreys & Kennett, 2008), respectively. Over a 6-week period, test-retest reliability in a female student sample (N = 63) was .85 (Humphreys & Kennett, 2008).

Validity

Construct validity was examined by comparing the RCUSS

to a number of relationship variables: a previously estab

lished scale, the Sexual Experiences Survey (SES; Koss &

Oros, 1982); and two newly designed scales, Sexual Self

Efficacy and Sexual Giving-in Experiences (Kennett et al.,

2009). The RCUSS is positively correlated with both number

Exhibit

Reasons for Consenting to Unwanted Sex Scale

Instructions: When answering these questions, please think of all the times in which you have consented to unwanted sexual activity.

Rate each statement as to how characteristic it is of you as your reason for consenting to unwanted sexual activity using the scale

provided. a 0 1 2 3 4 5 6 7
8

Not at all Somewhat Very

Characteristic Characteristic Characteristic

of Me of Me of Me

1. I felt that I would be jeopardizing our relationship if I did not engage in the unwanted sexual activity

2. As his girlfriend, I am obligated to engage in the unwanted sexual activity

3. He verbally pressured me to participate in the unwanted sexual behavior

4. He begged me to engage in the unwanted sexual activity until I could not argue anymore

5. I had been drinking or had consumed other types of drugs

6. I felt guilty for not participating in the unwanted sexual activity

7. I feared that I would lose my boyfriend if I did not consent to the unwanted sexual activity

8. I wanted to avoid tension in our relationship

9. I wanted to prevent my partner from losing interest in our relationship

10. I consented to the unwanted sexual activity to promote intimacy

11. I felt it was necessary to satisfy my partner’s needs

12. I felt that I needed to because I consented to the sexual activity before

13. I didn’t want to hurt my partner’s feelings

14. He physically would not let me leave

15. I didn’t want him to feel rejected

16. I felt that, if I consented to the unwanted sexual activity, he would like/love me

17. I wanted to feel accepted by my partner

18. He sweet talked me into it

a This scale follows each of the scale statements.

Koss, M. P., & Oros, C. J. (1982). Sexual experiences survey: A research

instrument investigating sexual aggression and victimization. Journal

of Consulting and Clinical Psychology, 50, 455-457.

Meston, C. M., & Buss, D. M. (2007). Why humans have sex. Archives of

Sexual Behavior, 36, 477-507.

O’Sullivan, L. F., & Allgeier, E. R. (1998). Feigning sexual desire:

Consenting to unwanted sexual activity in heterosexual dating relationships. The Journal of Sex Research, 35, 234-243. Shotland, R. L., & Hunter, B. A. (1995). Women’s “token resistant” and compliant sexual behaviors are related to uncertain sexual intentions and rape.

Personality and Social Psychology Bulletin, 21, 226–236.
Zimmerman, R. S., Sprecher, S., Langer, L. M., & Holloway, C. D. (1995). Adolescents' perceived ability to say "no" to unwanted sex. Journal of Adolescent Research, 10, 383–399.

Contraception (also see Condoms)

Contraceptive Attitude Scale

KELLY J. BLACK, 1 University of Washington

1 Address correspondence to Kelly Black, University of Washington, WaNPRC, Box 357330, Seattle, WA 98109; e-mail: kellyblack@wanprc.org

Exhibit

Contraceptive Attitude Scale

Below are several statements about the use of contraceptives (birth control). We are interested in knowing your opinion about each

statement. Using the scale below, please indicate your level of agreement or disagreement with each statement. Keep in mind that there

are no right or wrong answers. Also remember that we are interested in your personal opinion. Therefore, we want to know how you

feel about these statements and not how you think your family or friends might feel about these statements. SA = Strongly agree; A = Agree; U = Undecided; D = Disagree; SD = Strongly disagree

_____ 1. I believe that it is wrong to use contraceptives.

_____ 2. Contraceptives reduce the sex drive.

_____ 3. Using contraceptives is much more desirable than having an abortion.

_____ 4. Males who use contraceptives seem less masculine than males who do not.

_____ 5. I encourage my friends to use contraceptives.

_____ 6. I would not become sexually involved with a person who did not accept contraceptive responsibility.

_____ 7. Teenagers should not need permission from their parents to get contraceptives.

_____ 8. Contraceptives are not really necessary unless a

couple has engaged in intercourse more than once.

_____ 9. Contraceptives make sex seem less romantic.

_____ 10. Females who use contraceptives are promiscuous.

_____ 11. I would not have intercourse if no contraceptive method was available.

_____ 12. I do not believe that contraceptives actually prevent pregnancy.

_____ 13. Using contraceptives is a way of showing that you care about your partner.

_____ 14. I do not talk about contraception with my friends.

_____ 15. I would feel embarrassed discussing contraception with my friends.

_____ 16. One should use contraceptives regardless of how long one has known his/her sexual partner.

_____ 17. Contraceptives are difficult to obtain.

_____ 18. Contraceptives can actually make intercourse seem more pleasurable.

_____ 19. I feel that contraception is solely my partner's responsibility.

_____ 20. I feel more relaxed during intercourse if a contraceptive method is used.

_____ 21. I prefer to use contraceptives during intercourse.

_____ 22. In the future, I plan to use contraceptives any time I have intercourse.

_____ 23. I would practice contraception even if my partner did not want me to.

_____ 24. It is no trouble to use contraceptives.

_____ 25. Using contraceptives makes a relationship seem too permanent.

_____ 26. Sex is not fun if a contraceptive is used.

_____ 27. Contraceptives are worth using, even if the

monetary cost is high.

_____ 28. Contraceptives encourage promiscuity.

_____ 29. Couples should talk about contraception before having intercourse.

_____ 30. If I or my partner experienced negative side effects from a contraceptive method, we would use a different method.

_____ 31. Contraceptives make intercourse seem too planned.

_____ 32. I feel better about myself when I use contraceptives.

The Contraceptive Utilities, Intention, and Knowledge Scale (CUIKS) was developed to test a social psychological model of contraceptive behavior developed by Condelli (1984). This model combined elements of the health belief model (Rosenstock, 1974), Luker's (1975) model of contraceptive risk taking, and Fishbein and Ajzen's (1975) behavioral intention model. Consequently, it is appropriate for use when examining any of these models or the unified model. It can also be used to study women's knowledge and perceptions about contraceptive methods, their attitudes about pregnancy, and to measure intention to use contraception.

Description

The scale is designed to be used with women and is divided into three parts. Part one has nine items (Questions 1–6 in the Exhibit) and measures perceived likelihood of becoming pregnant, both when the respondent is using her chosen method of contraception and with unprotected intercourse.

It also asks the likelihood she will use her method at each act of intercourse over the next year. This item is designed to measure intention to use contraception. One item measures attitude about becoming pregnant at the present time. This part of the scale also has the respondent rate the degree of subjective social support she expects from “people who are most important” to her for using each of four methods of contraception (diaphragm, IUD, the pill, and condoms). Part one also includes an item asking the respondent to state her current method of contraception. Part two of the scale (Questions 7 and 8 in the Exhibit) has 16 items and measures respondent attitudes about four methods of contraception. The respondent indicates her perceptions of the effectiveness of each method. Her concerns about effects from using each method are also measured. The third part of the scale is a multiple-choice knowledge test. This test is divided into two parts. The first part is an 8 item test of general knowledge of conception and contraception. The second part is a 4 item test that measures

Contraceptive Utilities, Intention, and Knowledge Scale

LARRY CONDELLI, 1 University of California, Santa Cruz

1 Address correspondence to Larry Condelli, American Institutes for Research, 1000 Thomas Jefferson Street, NW, Washington, DC 20007; e-mail:

LCondelli@air.org

the respondent’s knowledge of the primary birth control

method she is currently using. Although the test contains

four items for each of the four methods of contraception, 2

the respondent answers only the four questions dealing

with her method. The CUIKS was developed to be used in a family plan

ning clinic. It was tested at the clinic on over 600 women

of highly diverse age and educational backgrounds.

Consequently, it can be used on any population of women.

Response Mode and Timing

The scale is designed to be self administered either individu

ally or in a group setting. Respondents indicate their answers

by circling the number that best represents their feelings.

For the knowledge scale portion, respondents circle the let

ter that indicates what they believe to be the correct answer.

The scale requires an average of 15 minutes to complete.

Scoring

For parts one and two of the scale, the number circled on

the scale is used as the respondent’s score on the item. Items

1 and 4 represent the respondent’s perceived susceptibility to

becoming pregnant, with higher scores indicating a greater

likelihood. Item 3 measures intention to use the chosen con

traceptive method; Item 6 measures the degree of subjec

tive normative support expected by the respondent for using

each method. Both items are positively scaled. Item 5 mea

sures the perceived severity of pregnancy for the respondent

and is scored by assigning a value of 7 to the first, most

negative statement (It would be the worst thing that could

happen) and a value of 1 to the last, most positive statement

(It would be the best thing that could happen). The inter

mediate statements decrease in value consecutively accord

ing to their order listed in the item (e.g., the third

statement

down, It would be sort of bad but not terrible, is assigned a

value of 5, the following statement a 4, etc.). For part two of the scale, the value circled by the respon

dent is the score for that item. The scores for Item 7 on effec

tiveness and convenience of the methods are reverse scored. For the knowledge portion of the scale, items are scored

as correct or incorrect. Two scores are then derived by sum

ming the number of correct answers. Items 1 through 8

comprise the general knowledge subscale; the four items

relating to the respondent's chosen contraceptive method

make up the specific knowledge subscale. A total score is

computed by adding general and subscale scores. The cor

rect answers are indicated by an asterisk in the Exhibit. No

response on an item is scored as incorrect.

Reliability and Validity

The reliability of the knowledge scale was computed using

responses from 632 women visiting a suburban family

planning clinic. For the total knowledge scale, Condelli

2 In the original instrument, there were four items for the IUD. Because of the infrequent use of the IUD by women in the U.S. today, these items have

been removed from this edition of the Exhibit, to save space.

Exhibit

The Contraceptive Utilities, Intention, and Knowledge Scale Attitude Survey

1. If you were not to use birth control, how likely do you think it is that you would become pregnant during the next year?

(Circle one category)

1 2 3 4 5

Very Somewhat Neutral Somewhat Very

unlikely unlikely neither likely likely likely

or unlikely

2. What form of birth control have you chosen to use?
_____

3. How likely do you think it is that you will use the above method every time you have intercourse over the next year?

1 2 3 4 5

Very Somewhat Neutral Somewhat Very

unlikely unlikely neither likely likely likely

or unlikely

4. If you were to continue using this form of birth control, how likely do you think it is that you would become pregnant during the

next year? (Circle one category)

1 2 3 4 5

Very Somewhat Neutral Somewhat Very

unlikely unlikely neither likely likely likely

or unlikely

5. Below are a number of statements about how you might feel about becoming pregnant within the next year. Please place a check in

front of the one that best represents how you feel. (Check one only)

If I were to get pregnant within the next year:

___ It would be the worst thing that could happen to me.

___ It would be very bad.

___ It would be sort of bad but not terrible.

___ It would be O.K.

___ It would be sort of good but not terrific.

___ It would be very good.

___ It would be the best thing that could happen to me.

6. People who are important to you may have feelings about the type of birth control you might use. For each birth control method

below, please indicate how the people who are most important to you would feel about your using that form of contraception.

(Circle the number from 1-5 that best represents their feelings.)

They would be:

1 = Very much opposed (would discourage use)

2 = Somewhat opposed

3 = Neither opposed nor in favor (neutral)

4 = Somewhat in favor

5 = Very much in favor (would encourage use)

Foam/condoms 1 2 3 4 5

Diaphragm 1 2 3 4 5

IUD 1 2 3 4 5

Birth control pills 1 2 3 4 5

7. Different birth control methods vary in how effective or ineffective they are in preventing pregnancy. They also vary in how convenient

they are to use. For each birth control method listed below, please rate how effective you think they would be in preventing you from

becoming pregnant, and how convenient or inconvenient they would be for you to use. (Circle the number from 1-5 that best repre

sents your feelings).

1 = Very effective 1 = Very convenient

(definitely prevents pregnancy) (no trouble at all)

2 = Pretty effective 2 = pretty convenient

3 = Unsure 3 = Unsure

4 = Pretty ineffective 4 = Pretty inconvenient

5 = Ineffective 5 = Very inconvenient

(would not prevent pregnancy) (too much trouble to use)

Effectiveness Convenience

Foams/condoms 1 2 3 4 5 1 2 3 4 5

Diaphragm 1 2 3 4 5 1 2 3 4 5

IUD 1 2 3 4 5 1 2 3 4 5

Birth control pills 1 2 3 4 5 1 2 3 4 5

8. Different forms of birth control vary in terms of how likely they are to have side effects. Some side effects may be minor, such as irritation of or skin problems, while others may be major, such as increasing risk of serious illness. For each method of birth control below, please rate how concerned you would be about the occurrence of both minor and major side effects. (Circle the number from 1-5 that best represents your feelings.)

1 = Not at all concerned

2 = Slightly unconcerned

3 = Unsure

4 = Pretty concerned

5 = Very concerned

Minor side effects Major side effects

Foams/condoms 1 2 3 4 5 1 2 3 4 5

Diaphragm 1 2 3 4 5 1 2 3 4 5

IUD 1 2 3 4 5 1 2 3 4 5

Birth control pills 1 2 3 4 5 1 2 3 4 5 Knowledge Survey

Circle the correct response.

1. The pill:

*a. prevents ovulation

b. keeps cervical mucus very thin

c. changes the lining of the uterus to make implantation unlikely

d. both a & c

e. all of the above

2. According to the most accepted current thought, the IUD's effectiveness is due to:

a. changing levels of hormones

b. changed functioning of the fallopian tubes

*c. preventing implantation of the fertilized egg

d. preventing ovulation

e. all of the above

3. A diaphragm should be used:

a. without any cream or jelly

b. with any type of lubricant

*c. with spermicidal jelly or cream inside it

d. either with or without spermicidal jelly

4. Contraceptive foam is most effect in preventing pregnancy when inserted inside the vagina:

*a. right before intercourse

b. 2-4 hours before intercourse

c. right after intercourse

d. all of the above

5. The use of a condom when having sexual intercourse is recommended because:

a. if used right, it usually prevents getting or giving gonorrhea

b. it can be bought in a drug store by both men and women

c. it does not have dangerous side effects

*d. all of the above

6. A woman can get pregnant:

a. a few minutes after sexual intercourse

b. a few hours after sexual intercourse

c. a few days after sexual intercourse

*d. all of the above

e. a and b

7. Over a one year period, what is the likelihood that a sexually active woman who uses no birth control will become pregnant?

a. 1 in 10

b. 5 in 10

c. 7 in 10

*d. 9 in 10

8. A woman is most likely to become pregnant (no matter how

long or short her menstrual cycle) if she has sexual intercourse about:

a. 1 week before menstruation begins

b. 2 weeks after menstruation begins

*c. 2 weeks before menstruation begins

d. 1 week after menstruation begins

Answer these questions only if you decided on the pill as your primary method of birth control.

1. Some warning signs that may signal the onset of pill related problems are:

a. chest pain

b. yellowing of the skin

c. pain in the calf of the leg

*d. all of the above

e. none of the above

2. Medical conditions that make it dangerous for a woman to use the pill are:

a. high blood pressure

b. heavy smoking

c. diabetes

d. both a & b

*e. all of the above

3. Present evidence indicates that the most serious side effect of the pill is:

a. cancer

*b. blood clotting problems

c. chloasma

d. nausea

e. creating permanent sterility

4. Which of the following group of women has the highest risk of side effects if they use the pill?

a. women who have never had children

*b. women over 40 who smoke

c. women who have severe menstrual cramps and are 10-20 lbs. overweight

d. women who have been on the pill for more than 5 years.

This completes the survey. Thank You!

Answer these questions only if you have decided on the diaphragm as your primary method of birth control.

1. After intercourse, a diaphragm:

a. should be removed immediately to prevent infection

b. can be taken out after 2 hours

*c. must be left in place for at least 8 hours

d. must be left in place for at least 12 hours

2. A problem that may result from using a diaphragm is:

a. increased pelvic infection

b. increased cervical infection

*c. increased urinary tract infection

d. all of the above

e. none of the above

3. When a diaphragm is properly in place:

*a. the woman will not be able to feel it

b. the woman will be able to feel it

c. both partners will be able to feel it

d. both b & c

4. A diaphragm must be fitted by a health professional because:

a. the risk of complication is high

*b. it must fit properly over the cervix

c. it is a difficult and risky medical procedure

d. all of the above

e. both a and b

This completes the survey. Thank You!

Answer these questions only if you have decided on the foam and/or condoms as your primary method of birth control.

1. The actual user effectiveness rate of foam and condoms is equal to or better than the actual user rates of:

a. an IUD

b. a diaphragm

c. the pill

*d. all of the above

e. none of the above

2. To use a condom correctly, a person must:

a. leave some space at the tip for the sperm

b. use one every time sexual intercourse occurs

c. hold it on the penis while withdrawing from the vagina

*d. all of the above

3. When having sexual intercourse, the use of both contraceptive foam and condoms is recommended because:

a. the man and the woman are sharing the responsibility for avoiding pregnancy

b. the woman is less likely to become pregnant than if only

one of these is used

c. they can both be purchased at the drug store without prescriptions

*d. all of the above

e. a and c

4. Contraceptive (birth control) foam is most effective for the repeated acts of sexual intercourse:

a. if a single application is used

*b. if an additional application is used before each act of sexual intercourse

c. if a woman douches after each act of intercourse

d. all of the above

e. b and c

This completes the survey. Thank You!

The Contraceptive Self-Efficacy (CSE) scale assesses moti

vational barriers to contraceptive use among sexually active

teenage women. The self-efficacy construct has been used

by Bandura and his associates to understand motivations for

apparently dysfunctional or avoidance behavior (Bandura,

1990; Bandura, Adams, Hardy, & Howells, 1980; Kazdin,

1974; McAlister, Perry, & Maccoby, 1979; Rosenthal &

Bandura, 1978; Strecher, DeVellis, Becker, & Rosenstock,

1986). The nonuse of contraceptives by sexually active

teenage women who say that they do not desire a pregnancy

is similar to other types of phobic behaviors. Thus, teen

age women’s contraceptive behavior is treated as a special

behavioral domain for application of the construct.

According to the self-efficacy construct, a person's expectations about whether she should and can execute a component behavior will determine initiation and persistence in achieving a desired goal (Bandura, 1977; Fishbein & Ajzen, 1975). The CSE scale measures the strength of a sexually active teenage woman's conviction that she should and can control sexual and contraceptive situations in order to make contraceptive protection a priority. Stressors are embedded within items to ascertain individual differences among young women who may have different issues that inhibit feelings of self-efficacy. The scale was designed to be used both diagnostically, by educators and clinicians as a tool for designing and assessing interventions, and as a research instrument.

Description

CSE statements evaluate the respondent's perceptions of her ability to take responsibility for sexual and contraceptive behaviors across a variety of situations. CSE is assessed using 18 items, which respondents rate on a 5-point Likert type scale ranging from (1) Not at all True of Me to (5) Completely True of Me. The scale has been significantly and independently correlated with contraceptive use among diverse samples of young girls and women ranging in age from 13 to 45 years old, and including inner-city African

American youth, predominantly White French Canadian

youth, Brazilian youth, Hong Kong Chinese women, and

suburban European American and Latina American youth.

Research settings have included family planning clinics, high

school and college classrooms, hospitals, and institutional

ized youth. The results, spanning a 25-year period, indicate

that a variety of methods for assessing CSE (e.g., either the

sum or the average of the 18-item CSE scale, a four-factor

solution, or a LISREL solution) have been predictive of con

traceptive behavior among all groups of women (Bilodeau, Forget, & Tétreault, 1994; Heinrich, 1993; Hovsepian, Blais, Manseau, Otis, & Girard, in press; Levinson, 1986, 1995; Levinson, Beamer, & Wan, 1998; Louise, 2005; Nordeen, Mann, & Sullivan, 2005; Wright, 1992). To determine the best measure of the CSE scale, we explored the scale's relationship to contraceptive behavior with four diverse samples (for a description of the samples, see Levinson et al., 1998). A series of correlational analyses were conducted with each sample to examine scale properties. A pattern of low correlations among CSE items emerged (averaging near .15 with a small standard deviation), indicating that use of the total item set separately as the basis for CSE was warranted. Zero-order and partial correlations revealed which CSE items were correlated with contraceptive behavior, as well as which items explained unique variance in contraceptive behavior for each sample. This analytic strategy was used owing to the fact that the dependent measure assessing contraceptive behavior was on a different metric in each sample. These results suggest that diverse groups of women and girls have different issues that inhibit their ability to use contraceptives effectively or to postpone unprotected sexual activity. It is recommended that the CSE scale be used prior to interventions in order to appropriately align interventions to the particular needs of the participants as assessed by the individual items and by the four factors. Another finding of the 1998 study was that Item 8 was consistently predictive of contraceptive behavior across three of the four samples.

The predictive power of this one item suggests that the "discourse of desire" (Fine, 1988) is a very important aspect to be explored in sexuality education for the development of healthy sexual behaviors and skills (Levinson et al., 1998). Other items that were uniquely related to contraceptive behavior were those items assessing confidence in the ability to confront oneself or significant others (e.g., parents, partner, pharmacist) about issues related to sexual needs (e.g., Items 2, 3, 6, 10, 11, 12, 13c, 14). These findings dovetail with earlier research outcomes and have been largely confirmed by subsequent researchers (Nordeen et al., 2005; Hovsepian et al., in press; Louise, 2005), highlighting persistent issues that impact young women's contraceptive behavior. Educational implications for different samples have been discussed in the research cited above. Response Mode and Timing Respondents circle the number indicating how true or not true that statement is for them. The CSE scale requires approximately 10 minutes to complete.

Contraceptive Self-Effi cacy Scale

RUTH ANDREA LEVINSON, 1 Skidmore College

1 Address correspondence to Ruth Andrea Levinson, 1511 Peaceable Street, Ballston Spa, NY 12020; e-mail: rlevinso@skidmore.edu

Scoring

The scale is scored such that higher scores represent higher

CSE. The scoring direction requires that Items 2, 5, 6, 8, 9,

11, 12, 14, and 15 be reverse scored.

Reliability

Reliability estimated across research investigations has

yielded a Cronbach's alpha of .73 or higher.

Validity

In the initial phases of instrument construction, CSE items

were scrutinized for face and content validity. The valid

ity of the instrument was inspected according to two major

criteria: (a) Did the items simulate the events that were both

common and critical to teenage women's successful use

of contraceptives, and (b) were the content and response

formats of each item conducive to collecting information

on expected behavior in a manner that corresponds to self

efficacy assessments of that behavior? The appearance and

content of the original CSE instrument were changed sev

eral times based on information derived from pretesting the

instrument within different populations and from personal

communication with Bandura and associates, experts in

self-efficacy assessment (Bandura, 1977; Bandura et al.,

1980). Additional methods of testing validity have been

used when translating the scale into languages other than

English (Bilodeau et al., 1994; Louise, 2005). In current research with the CSE scale, items pertaining

to obsolete or infrequently used methods of birth control

are deleted from the content of the scale items as presented

here (e.g., the sponge, Encare Ovals). We are exploring add

ing to the scale items content that pertains to more acces

sible methods of birth control (e.g., the condom, Norplant,

Depo-Provera, the hormonal patch, and emergency contra

ception). The impact of drug use on CSE and contraceptive

behavior is under investigation. In addition, a gender

neutral CSE scale and a male version of the CSE scale have

been used to explore contraceptive and sexual behavior in

young men. Basically, the gender-neutral scale replaces

the word “boyfriend” with “partner” and the male pronoun

“him” is replaced with “him/her.”

Other Information

The instrument is copyrighted by the author and is repro

Exhibit

Contraceptive Self-Efficacy Scale

The items on the following page are a list of statements. Please rate each item on a 1 to 5 scale according to how true the statement is

of you. Using the scale, circle one number for each question: 1 = Not at all True of Me 2 = Slightly True of Me 3 = Somewhat True of Me 4 = Mostly True of Me 5 = Completely True of Me

1. 1 2 3 4 5 When I am with a boyfriend, I feel that I can always be responsible for what happens sexually with him.

2. 1 2 3 4 5 Even if a boyfriend can talk about sex, I can’t tell a man how I really feel about sexual things.

3. 1 2 3 4 5 When I have sex, I can enjoy it as something that I really wanted to do.

4. 1 2 3 4 5 If my boyfriend and I are getting “turned on” sexually and I don’t really want to have sexual intercourse (go all the way, get down), I can easily tell him “no” and mean it.

5. 1 2 3 4 5 If my boyfriend didn’t talk about the sex that was happening between us, I couldn’t either.

6. 1 2 3 4 5 When I think about what having sex means, I can’t have sex so easily.

7. 1 2 3 4 5 If my boyfriend and I are getting “turned on” sexually and I don’t really want to have sexual intercourse (go all the way, get down), I can easily stop things so that we don’t have intercourse.

8. 1 2 3 4 5 There are times when I’d be so involved

sexually or emotionally that I could have sexual intercourse even if I weren't protected (using a form of birth control).

9. 1 2 3 4 5 Sometimes I just go along with what my date wants to do sexually because I don't think I can take the hassle of trying to say what I want.

10. 1 2 3 4 5 If there were a man (boyfriend) to whom I was very attracted physically and emotionally, I could feel comfortable telling him that I wanted to have sex with him.

11. 1 2 3 4 5 I couldn't continue to use a birth control method if I thought my parents might find out.

12. 1 2 3 4 5 It would be hard for me to go to the drugstore and ask for foam (Encare Ovals, a diaphragm, a pill prescription, etc.) without feeling embarrassed.

13. If my boyfriend and I were getting really heavily into sex and moving towards intercourse and I wasn't protected . . . a. 1 2 3 4 5 I could easily ask him if he had protection (or tell him that I didn't). b. 1 2 3 4 5 I could excuse myself to put in a diaphragm or foam (if I used them for birth control). c. 1 2 3 4 5 I could tell him that I was on the pill or had an IUD (if I used them for birth control). d. 1 2 3 4 5 I could stop things before intercourse, if I couldn't bring up the subject of protection.

14. 1 2 3 4 5 There are times when I should talk to my boyfriend about using contraceptives, but I can't seem to do it in the situation.

15. 1 2 3 4 5 Sometimes I end up having sex with a boyfriend because I can't find a way to stop it.

(Thank you very much for your time and thought. The answers you gave will help us prepare better services for others.)

Deception (see Self-Disclosure and Deception)

Exhibit

Decreased Sexual Desire Screener ©

Please answer the following questions:

Name: Age: Date: / /

NO YES

1. In the past, was your level of sexual desire or interest good and satisfying to you? □ □

NO YES

2. Has there been a decrease in your level of sexual desire or interest? □ □

NO YES

3. Are you bothered by your decreased level of sexual desire or interest? □ □

NO YES

4. Would you like your level of sexual desire or interest to increase? □ □

5. Please check all the factors that you feel may be contributing to your current decrease in

sexual desire or interest:

NO YES

A. An operation, depression, injuries, or other medical condition □ □

B. Medications, drugs or alcohol you are currently taking □ □

C. Pregnancy, recent childbirth, menopausal symptoms □ □

D. Other sexual issues you may be having (pain, decreased arousal or orgasm) □ □

E. Your partner’s sexual problems □ □

F. Dissatisfaction with your relationship or partner □ □

G. Stress or fatigue □ □ Goldfischer ER, Clayton AH, Goldstein I, Lewis-D'Agostino DJ, Pyke R. Decreased Sexual Desire Screener © (DSDS ©) for diagnosis of Hypoactive Sexual Desire Disorder in women. Poster presented at the ACOG annual meeting, 3-7 May 2008, New Orleans, USA. ©Boehringer Ingelheim International GmbH 2005. All rights reserved. Any use or reproduction of this questionnaire by a commercial organization without written authorization prohibited. Brief Diagnostic Assessment for Generalized Acquired Hypoactive Sexual Desire Disorder (HSDD) Clinician: Verify with the patient each of the answers she has given. The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision® characterizes Hypoactive Sexual Desire Disorder (HSDD) as a deficiency or absence of sexual fantasies and desire for sexual activity, which causes marked distress or interpersonal difficulty, and which is not better accounted for by a medical, substance-related, psychiatric, or other sexual condition. HSDD can be either generalized (not limited to certain types of stimulation, situations, or partners) or situational, and can be either acquired (develops only after a period of normal functioning) or lifelong. To determine if symptoms are acquired, ask if there was a period of normal functioning at any time in the past. If the patient answers "NO" to any of the questions 1 through 4, then she does not qualify for the diagnosis of generalized, acquired HSDD. If the patient answers "YES" to all of the questions 1 through 4, and your review confirms "NO" answers to all of the factors in question 5, then she does qualify for the diagnosis of generalized, acquired HSDD. If the patient answers "YES" to all of the questions 1 through 4 and "YES" to any of the factors in question 5, then decide if the answers to question 5 indicate a primary diagnosis other than generalized, acquired HSDD. Comorbid conditions such as arousal or orgasmic disorder do not rule out a concurrent diagnosis of HSDD. Based on the above, does the patient have generalized acquired Hypoactive Sexual Desire Disorder? YES NO □ □ Thank you. Goldfischer ER, Clayton AH, Goldstein I, Lewis-D'Agostino DJ, Pyke R. Decreased Sexual Desire Screener© (DSDS©) for diagnosis of Hypoactive Sexual Desire Disorder in women. Poster presented at the ACOG annual meeting, 3-7 May 2008, New Orleans, USA. ©Boehringer Ingelheim International GmbH 2005. All rights reserved. Any use or reproduction of this questionnaire by a commercial organization without written authorization prohibited. The Hurlbert Index of Sexual Desire (HISD) is described by Apt

and Hurlbert (1992). Reference Apt, C. & Hurlbert, D. F. (1992). Motherhood and female sexuality beyond one year postpartum: A study of military wives. Journal of Sex Education and Therapy, 18, 104-114. Hurlbert Index of Sexual Desire DAVID F. HURLBERT, 1 U.S. Department of Health and Human Services 1 Address correspondence to David F. Hurlbert, 140 Farnworth Lane, Roswell, Georgia 30075; e-mail: david.hurlbert@acf.hhs.gov

Exhibit

Hurlbert Index of Sexual Desire

1. Just thinking about having sex with my partner excites me. (R)

2. I try to avoid situations that will encourage my partner to want sex.

3. I daydream about sex. (R)

4. It is difficult for me to get in a sexual mood.

5. I desire more sex than my partner does. (R)

6. It is hard for me to fantasize about sexual things.

7. I look forward to having sex with my partner. (R)

8. I have a huge appetite for sex. (R)

9. I enjoy using sexual fantasy during sex with my partner. (R)

10. It is easy for me to get in the mood for sex. (R)

11. My desire for sex should be stronger.

12. I enjoy thinking about sex. (R)

13. I desire sex. (R)

14. It is easy for me to go weeks without having sex with my partner.

15. My motivation to engage in sex with my partner is low.

16. I feel I want sex less than most people.

17. It is easy for me to create sexual fantasies in my

mind. (R)

18. I have a strong sex drive. (R)

19. I enjoy thinking about having sex with my partner. (R)

20. My desire for sex with my partner is strong. (R)

21. I feel that sex is not an important aspect of the relationship I share with my partner.

22. I think my energy level for sex with my partner is too low.

23. It is hard for me to get in the mood for sex.

24. I lack the desire necessary to pursue sex with my partner.

25. I try to avoid having sex with my partner.

Note. (R) = reverse scored items. Scoring system responses: 0 points = all of the time, +1 point = most of the time, +2 points = some of the time, +3 points

= rarely, +4 points = never.

1 Address correspondence to Ilana P. Spector, Behavioral Psychotherapy and Research Unit, Department of Psychiatry, SMBD Jewish General Hospital,

4333 Cote St. Catherine Road, Montreal, Quebec, Canada, H3T 1E4; e-mail: ilana.spector@mcgill.ca

The Sexual Desire Inventory (SDI) is a self-administered

questionnaire developed to measure sexual desire. To date,

sexologists have had difficulty measuring this construct.

Previous measurement of sexual desire involved either indi

rect measurement through examining frequency of sexual

behavior, or by broad self-report of cognitions such as “rate

your level of sexual desire.” Both these methods are less

accurate measures of sexual desire because first, sexual

desire is theoretically a multidimensional construct, and second, no empirical data are available to suggest that sexual desire and behavior are perfectly correlated. For the purposes of this questionnaire, sexual desire was defined as interest in sexual activity, and it was measured as primarily a cognitive variable through amount and strength of thought directed toward approaching or being receptive to sexual stimuli.

Sexual Desire Inventory

ILANA P. SPECTOR, 1 SMBD Jewish General Hospital

MICHAEL P. CAREY, Syracuse University

Exhibit

Sexual Desire Inventory

This questionnaire asks about your level of sexual desire. By desire, we mean interest in or wish for sexual activity. For each item, please

circle the number that best shows your thoughts and feelings. Your answers will be private and anonymous.

1. During the last month, how often would you have liked to engage in sexual activity with a partner (for example, touching each other’s genitals, giving or receiving oral stimulation, intercourse, etc.)?

0) Not at all 4) Twice a week

1) Once a month 5) 3 to 4 times a week

2) Once every two weeks 6) Once a day

3) Once a week 7) More than once a day

2. During the last month, how often have you had sexual thoughts involving a partner?

0) Not at all 4) 3 to 4 times a week

1) Once or twice a month 5) Once a day

2) Once a week 6) A couple of times a day

3) Twice a week 7) Many times a day

3. When you have sexual thoughts, how strong is your desire to engage in sexual behavior with a partner?

0 1 2 3 4 5 6 7 8

No desire Strong desire

4. When you first see an attractive person, how strong is your sexual desire?

0 1 2 3 4 5 6 7 8

No desire Strong desire

5. When you spend time with an attractive person (for example, at work or school), how strong is your sexual desire?

0 1 2 3 4 5 6 7 8

No desire Strong desire

6. When you are in romantic situations (such as a candle-lit dinner, a walk on the beach, etc.), how strong is your sexual desire?

0 1 2 3 4 5 6 7 8

No desire Strong desire

7. How strong is your desire to engage in sexual activity with a partner?

0 1 2 3 4 5 6 7 8

No desire Strong desire

8. How important is it for you to fulfill your sexual desire through activity with a partner?

0 1 2 3 4 5 6 7 8

Not at all Extremely

important important

9. Compared to other people of your age and sex, how would you rate your desire to behave sexually with a partner?

0 1 2 3 4 5 6 7 8

Much less Much more

desire desire

10. During the last month, how often would you have liked to behave sexually by yourself (for example, masturbating, touching your genitals etc.)?

0) Not at all 4) Twice a week

1) Once a month 5) 3 to 4 times a week

2) Once every two weeks 6) Once a day

3) Once a week 7) More than once a day

Double Standard

Exhibit

Sexual Double Standard Scale a

Disagree Strongly Disagree Mildly Agree Mildly Agree Strongly

0 1 2 3

1. It’s worse for a woman to sleep around than it is for a man.

2. It’s best for a guy to lose his virginity before he’s out of his teens.

3. It’s okay for a woman to have more than one sexual relationship at the same time.

4. It is just as important for a man to be a virgin when he marries as it is for a woman.

5. I approve of a 16-year-old girl’s having sex just as much as a 16-year-old boy’s having sex.

6. I kind of admire a girl who has had sex with a lot of guys.

7. I kind of feel sorry for a 21-year-old woman who is still a virgin.

8. A woman’s having casual sex is just as acceptable to me as a man’s having casual sex.

9. It’s okay for a man to have sex with a woman he is not in love with. b

10. I kind of admire a guy who has had sex with a lot of girls.

11. A woman who initiates sex is too aggressive.

12. It’s okay for a man to have more than one sexual relationship at the same time.

13. I question the character of a woman who has had a lot of sexual partners.

14. I admire a man who is a virgin when he gets married.

15. A man should be more sexually experienced than his wife.

16. A girl who has sex on the first date is “easy.”

17. I kind of feel sorry for a 21-year-old man who is still a virgin.

18. I question the character of a man who has had a lot of sexual partners. b

and then as her partner—would have completed it at the

time. As predicted, women rated their partners as having

higher SDSS scores in TR situations than in OA situations.

Women’s own SDSS scores did not differ significantly

between the two situations. Bay-Cheng and Zucker (2007) found that self-identified

feminists had significantly lower SDSS scores than those

who rejected the feminist label. Gillen, Lefkowitz, and

Shearer (2006) found positive correlations between SDSS

scores and orientation toward physical appearance (a com

ponent of body image) among both men and women. In a sample of intercourse-experienced undergradu

ates, Boone and Lefkowitz (2004) found that high SDSS

scores were related to more frequent condom use. Boone

and Lefkowitz speculated that higher-SDSS men would

have had more sexual partners, and higher-SDSS women

would expect this, so the couple would use condoms to

protect the woman. This result might seem contradic

tory to Muehlenhard and Quackenbush’s (1996) findings;

however, the significant predictor in Muehlenhard and

Quackenbush’s study was women’s perceptions of how

their partners would have completed the SDSS, whereas Boone and Lefkowitz used participants' own SDSS scores. Furthermore, Muehlenhard and Quackenbush found different patterns for women and men, but Boone and Lefkowitz's analysis combined women's and men's data. The validity of the SDSS is also supported by its correla

tions with other scales. Higher SDSS scores were associated

Drive (see Desire, Excitability/Excitation)

Locke, H. J., & Wallace, K. M. (1959). Short marital-adjustment and prediction tests: Their reliability and validity. Marriage and Family Living, 21, 251–255.

Meston, C. M. (2003). Validation of the Female Sexual Function Index (FSFI) in women with Female Orgasmic Disorder and in women with Hypoactive Sexual Desire Disorder. Journal of Sex and Marital Therapy, 29, 39–46.

Nappi, R., van Lunsen, R., Tignol, J., Goldmeier, D., Pyke, R., & Staehle, H. (2008). Validation of the Sexual Interest and Desire Inventory–Female © (SIDI-F ©) in European women. Sexologies, 17 (Suppl. 1). Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., et al. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. Journal of Sex and Marital Therapy, 26, 191–208. Sills, T., Wunderlich, G., Pyke, R., Segraves, R. T., Leiblum, S., Clayton, A., et al. (2005). The Sexual Interest and Desire Inventory–Female (SIDI-F): Item response analyses of data from women diagnosed with Hypoactive Sexual Desire Disorder. Journal of Sexual Medicine, 2, 801–818.

1 Address correspondence to Leonard Derogatis, Johns Hopkins Department of Psychiatry and Behavioral Sciences–Center for Sexual Medicine at

Sheppard Pratt, Baltimore, MD 21285; e-mail: Lderogatis@sheppardpratt.org

The Female Sexual Distress Scale–Revised (FSDS-R) is a

self-administered questionnaire designed to assess distress

related to sexual dysfunction in women with Hypoactive

Sexual Desire Disorder (HSDD), and other sexual dysfunc

tions.

Description

The FSDS-R is a self-administered questionnaire consist

ing of 13 items that relate to different aspects of sex-related

personal distress in women. Responses are based on the

frequency with which each problem has bothered the sub

ject or caused them distress within different recall periods

(past 7 or 30 days). The FSDS-R is an extended version of the 12-item

Female Sexual Distress Scale (FSDS; Derogatis, Rosen,

Leiblum, Burnett, & Heiman, 2002). The FSDS was

developed by a national group of experts in human sexu

ality under the auspices of the American Foundation for

Urologic Disease (AFUD). The FSDS-R includes an addi

tional question (Item 13) that specifically assesses distress

related to low sexual desire. The FSDS-R is for use in both

pre- and postmenopausal women. Response Mode Respondents read a list of feelings and problems that women sometimes have concerning their sexuality and circle the number that best describes how often that problem has bothered them or caused them distress during the past 30 days. They are provided with an example before completing the questionnaire and are free to ask any questions they may have. Scoring All items are rated in terms of the frequency with which that problem has bothered the individual or caused her distress in the past 30 days. Respondents rate every item from 0 to 4: (Never [(0]), Rarely [(1]), Occasionally [(2]), Frequently [(3]), or Always [(4])). The total score ranges from 0 to 52, with higher scores indicating more distress. A total score of ≥ 11 or more indicates a clinical level of sexual distress. Reliability The FSDS was tested for reliability and validity in three studies involving over 500 women with and without

Female Sexual Distress Scale—Revised

LEONARD R. DEROGATIS, 1 Center for Sexual Medicine at Sheppard Pratt, Baltimore, MD

ROBERT PYKE, Boehringer Ingelheim Pharmaceuticals, Inc., Ridgefi eld, CT

JULIE MCCORMACK, ADRIA HUNTER, AND GALE HARDING, United BioSource Corporation,

Bethesda, MD

Exhibit

Sexual Interest and Desire Inventory—Female

This measure may be viewed in its entirety at the companion website for this book: http://www.routledge.com/textbooks/9780415801751

sexual dysfunction (Derogatis et al., 2002). The reliability

and the validity of the FSDS-R were established in a mul

ticenter, 4-week, nontreatment study, conducted in adult

North American women with generalized acquired HSDD

(n = 136), other Female Sexual Dysfunction (FSD; Female

Sexual Arousal Disorder [FSAD] or Female Orgasmic

Disorder [FOD], n = 48); or no FSD (n = 75; Derogatis,

Clayton, Lewis-D'Agostino, Wunderlich, & Fu, 2008).

Cronbach's coefficient alpha was used to measure the

internal consistency of the FSDS-R. Cronbach's alpha

was > .88 for subjects with HSDD, other FSD, and no FSD

on days 0, 7, and 28 (Derogatis, Clayton, et al., 2008).

Intraclass correlation coefficient (ICC) was used to esti

mate test-retest reliability. For all subjects, the ICC for the

FSDS-R total and Item 13 scores between days 0 and 28

wasere .88 and .83, respectively (Derogatis, Clayton, et al.,

2008). A version that was identical except for using 7-day

recall gave equivalent results to the standard 30-day recall version in reliability.

Validity

In the validation study, mean FSDS, FSDS-R, and FSDS-R Item 13 scores were significantly higher in women with HSDD or other FSD than in women with no FSD ($p < .001$ at all time points), demonstrating that all these tests had discriminant validity (Derogatis, Clayton, et al., 2008). Receiver operating characteristic analyses of FSDS and FSDS-R total scores confirmed these findings (Derogatis, Clayton, et al., 2008). A version that was identical except for using 7-day recall gave equivalent results to the stan dard 30-day recall version in discriminant validity.

The content validity (relevance, clarity, and compre hensiveness) of the FSDS-R (7-day recall version) and the potential of Item 13 (bothered by low sexual desire) as a stand-alone measure of distress associated with decreased sexual desire were assessed through saturation interviewing

Exhibit

Female Sexual Distress Scale—Revised

Instructions: Below is a list of feelings and problems that women sometimes have concerning their sexuality. Please read each item carefully,

and circle the number that best describes HOW OFTEN THAT PROBLEM HAS BOTHERED YOU OR CAUSED YOU DISTRESS DURING THE PAST 30 DAYS

INCLUDING TODAY. Circle only one number for each item, and take care not to skip any items. If you change your mind,

erase your first

circle carefully. Read the example before beginning, and if you have any questions please ask about them.

Example: How often did you feel: Personal responsibility for your sexual problems.

Never Rarely Occasionally Frequently Always

0 1 2 3 4

HOW OFTEN DID YOU FEEL:

1. Distressed about your sex life 0 1 2 3 4

2. Unhappy about your sexual relationship 0 1 2 3 4

3. Guilty about sexual difficulties 0 1 2 3 4

4. Frustrated by your sexual problems 0 1 2 3 4

5. Stressed about sex 0 1 2 3 4

6. Inferior because of sexual problems 0 1 2 3 4

7. Worried about sex 0 1 2 3 4

8. Sexually inadequate 0 1 2 3 4

9. Regrets about your sexuality 0 1 2 3 4

10. Embarrassed about sexual problems 0 1 2 3 4

11. Dissatisfied with your sex life 0 1 2 3 4

12. Angry about your sex life 0 1 2 3 4

13. Bothered by low sexual desire 0 1 2 3

Copyright © 2000 by American Foundation for Urological Disease Inc.

Attitudes Related to Sexual Concerns Scale

PATRICIA BARTHALOW KOCH, 1 The Pennsylvania State University

C RAIG R. COWDEN, Tacoma Community College

The Attitudes Related to Sexual Concerns Scale (ASCS) was developed to measure those attitudes that have been conceptually, empirically, or clinically associated with specific sexual concerns/dysfunctions of men and women. Although a number of scales have previously been developed to measure overall sexual attitudes or some particular attitudes, none targeted those attitudes that were specifically associated with sexual concerns/dysfunctions. The ASCS can be used as a research tool in examining the attitudes of various subsamples of differing gender, sexual orientation, age, relationship status, ethnicity, and so forth (Cowden & Koch, 1995). It could also serve as a clinical tool for counselors and therapists in assessing the attitudes related to the sexual concerns/dysfunctions their clients are experiencing.

Description

The ASCS consists of 30 items with responses on a 5 point Likert format ranging from 1 (Strongly Agree) to 5

(Strongly Disagree). Each statement is written in a personalized manner to measure the most proximal attitude, rather than a generalized one, because proximal attitudes are more closely related to one's own personal behavior (Ajzen & Fishbein, 1980). Through pilot testing with approximately 400 college students, principal components factor analysis with promax rotation extracted eight factors that were identified as attitudes toward (a) sexual self-understanding (14% explained variance), (b) body image (8%), (c) gender roles (4%), (d) commitment (6%), (e) communication with a sexual partner (10%), (f) masturbation (42%), (g) sexual guilt (11%), and (h) sexual performance (5%; Cowden & Koch, 1995; Koch, 1983). Response Mode and Timing The respondent is instructed to indicate the choice (Strongly Agree =1, Agree = 2, Uncertain = 3, Disagree = 4, Strongly Disagree = 5) that best represents his or her attitudes toward each statement. The statements represent attitudes that might be expressed in a variety of situations. The respondents are instructed that, if they have never personally been in such a situation, they are to imagine themselves in it and think of how they might react. The term partner refers to whomever the respondent might share his or her sexuality with. The scale takes approximately 15 minutes to complete. Scoring Scores on the ASCS range from 30, indicating the least negative attitudes, to 150, indicating the most negative attitudes. Thus, the higher a person's score, the more she or he exhibits attitudes associated with experiencing high levels of various relationship and sexual functioning concerns. The subscales consist of the following items (those with an asterisk must be reversed scored): Body Image (1, 9, ∗17); Sexual Self-Understanding (∗2, 10, ∗18, 25), Gender Roles (∗3, ∗11, 19), Communication (∗4, 12, ∗20, ∗26), Guilt (∗5, ∗13, 21, 27), Commitment (6, ∗14, ∗22, ∗28), Masturbation (7, 15, ∗23), and Sexual Performance (∗8, ∗16, ∗24, ∗29 [for females only]/∗30 [for males only]). In administering the scale to homosexually- oriented respondents, the

1 Address correspondence to Patricia Barthalow Koch,

Professor of Biobehavioral Health, The Pennsylvania State University, 304B Health and Human

Development Building East, University Park, PA 16802; e-mail p3k@psu.edu

Gender Roles subscale is deleted because some items refer

to other-gender pairings.

Reliability

Internal reliability has been examined with two very differ

ent samples: one from a major, predominately White north

eastern university (Cowden & Koch, 1995) and another

from a racially/ethnically diverse sample from smaller col

leges in Washington, D.C. and North Carolina (Cowden &

Bradshaw, 2007). Cronbach alpha reliability coefficients

for the entire scale, as well as the subscales, were as follows

for these two different samples, respectively: Overall Scale,

.70, .80; Body Image, .74, .80; Sexual Self-Understanding,

.84, .67; Gender Roles, .64, .63; Communications, .73, .66;

Guilt, .75, .67; Commitment, .80, .66; Masturbation, .91,

.90; and Sexual Performance, .66, .60.

Validity

Content validity was ensured by performing a content anal

ysis of over 40 major sexuality education, counseling, and

therapy textbooks and over 250 scientific articles written

about sexual concerns/dysfunctions. Repeated pilot testing

was used to determine the most reliable and valid subscales

and items. Construct validity was established through fac

tor analysis (described above). Concurrent validity for the

ASCS was determined through its significant positive cor

relations with other established questionnaires measuring

various sexual attitudes, including the Mosher Sex Guilt

Inventory (Mosher, 1966), the Derogatis Sexual Attitudes

Scale (Derogatis & Melisaratos, 1979), and the Sex

Exhibit

Attitudes Related to Sexual Concerns Scale

Respond to the following statements by circling the choice which best represents your attitudes. These statements represent feelings

that might be experienced in a variety of situations. If you have not been in such a situation, imagine yourself in it and think of how you

might feel. The term “partner” refers to whomever you might choose to share your sexuality with.

1 = Strongly Agree

2 = Agree

3 = Uncertain

4 = Disagree

5 = Strongly Disagree

1. Overall, I feel that my body is sexually attractive. a

2. It is difficult for me to explain my sexual thoughts, attitudes, and feelings to someone else because I really don’t understand them myself.

3. When a male and female are having a sexual relationship, I feel it is the female’s responsibility to set the sexual limits since the male will try to get as much as possible.

4. I would feel very uncomfortable expressing my negative

feelings about our sexual relations to a partner.

5. I would feel guilty if I did not follow religious pronouncements about sexual behavior.

6. I would not be afraid of becoming involved in a committed relationship at this point in time.

7. I would not feel ashamed to use masturbation as a sexual release.

8. I would worry that my partner would leave me if I did not do what she or he wanted me to do in bed.

9. I feel a partner would be sexually attracted to my nude body.

10. I am not confused about my sexual feelings.

11. It is more acceptable to me for a male to have a one-night stand than for a female to have a one-night stand.

12. It would not be difficult for me to make suggestions to a partner on ways to improve his or her sexual techniques.

13. I would feel guilty if I did not follow my family's teachings about sexual behavior.

14. I would feel trapped if I was in a committed relationship at this time.

15. I would feel good about exploring and learning about my own body through masturbation.

16. If my partner did not reach orgasm, I would feel like a failure.

17. Because of the way my body looks, I would feel uncomfortable in the nude with a sexual partner.

18. It bothers me that I really do not understand why I behave sexually as I do.

19. I do not believe that males usually use love to get sex and females usually use sex to get love.

20. I would feel hurt if a sexual partner told me that something I do during lovemaking turns her or him off.

21. I would not feel guilty if I had genital sexual relations (such as intercourse) with a partner.

22. I am afraid to trust anyone in a sexual relationship at this time in my life.

23. I would feel guilty about masturbating.

24. I would worry that if I did not perform well sexually my partner would look for someone else.

25. It is not difficult for me to sort out my sexual feelings, values, and behaviors.

26. There probably would be some aspects of our sexual relationship that I just could not talk about with my partner.

27. I would not feel guilty fantasizing about sexual experiences.

28. I would feel like a failure if I found out that my sexual partner also engaged in solitary masturbation.

Females Only

29. I would feel inadequate if I could not reach orgasm during vaginal penetration (such as vaginal intercourse) and needed other kinds of stimulation in order to reach an orgasm.

Males Only

30. I would feel humiliated if I was unable to get an erection during a sexual encounter.

a A scale from 1 to 5 follows each item.

The Sexual Problems Self-Assessment Questionnaire

(SPSAQ) was designed to assess sexual and relationship

satisfaction levels in couples presenting for sex therapy; it

is a clinical evaluation tool that offers a brief, comprehen

sive assessment of adult clients' levels of satisfaction in

their sexual relationships. Scoring forms provide client

profiles. When used with a

couple, a couple's form lists each partner's scores so that

they can be compared. The instrument was not designed

as a research tool and has not been tested for validity or

reliability beyond the clinical applications it was designed

to assess. Clients presenting with sexual difficulties often focus so narrowly on presenting issues that other, relevant and germane issues are not discovered until later in therapy. Even without numerical scores, a paper-andpencil-marked questionnaire is useful in quickly providing a comprehensive assessment of problem domains. Description The SPSAQ was developed from the classification system presented in A New View of Women's Sexual Problems (Kaschak & Tiefer, 2001). In developing the item content, we sought advice from a variety of colleagues. Leonore Tiefer

1 Address correspondence to Elizabeth Rae Larson, Seattle Institute for Sex Therapy, Education and Research, 100 NE 56th Street, Seattle WA 98105;

e-mail: therapy@sextx.com

Sexual Problems Self-Assessment Questionnaire

ELIZABETH RAE LARSON, 1 Seattle Institute for Sex Therapy, Education and Research

MALCOLM H. MCKAY, Private Practitioner

and the New View listserve have helped in the wording,

design, and use of the instrument, as have other therapists

and health practitioners. Prior to designing a computer

administered version, we hand scored questionnaires.

The entire form contains 73 items. The New View

nosology (Kaschak & Tiefer, 2001) provides a more mul

tidomain description of client experience than do the cat

egories of the Diagnostic and Statistical Manual of Mental

Disorders (American Psychiatric Association, 1994; DSM IV, pp. 493–502). Items are organized into four domains. The domains as identified in the New View nosology are (a) Socio-Cultural, Political, or Economic, (b) Relationships, (c) Psychological Factors, and (d) Medical and Physiologic Factors. 2 In the SPSAQ, we shortened "Medical and Physiologic Factors" to "Physical Factors." Items in the SPSAQ have also been expanded to include male sexual concerns (Klein & Morin, 2005; Larson, 2005) and an additional domain, Overall Satisfaction, which containstwo items: Sex Life and Emotional Intimacy (Larson, 2005).

The SPSAQ is administered by computer, with individ ual respondents completing the assessment by keyboard and mouse. Upon completion, a paper printout of the results is immediately available. In our clinical setting, neither the individual's responses nor identifying data is are electroni cally stored. The clinician is provided with a printed answer sheet with ample space for interview notes. For couples, an additional form provides space to list each partner's scores and facilitates comparison.

The instrument measures the subjective perceptions of each individual at the time of administration. The responses should not be confused with an objective measure of a symptom. The SPSAQ provides practitioners with quick,

comprehensive feedback regarding clients' subjective state of relational and sexual satisfaction.

Response Mode and Timing

Using a hidden 100-point Likert-type scale, individuals respond to statements by marking a continuum usually ranging from Yes to No. The left–right direction of the high score is varied by the wording of the statements affirma tively or negatively throughout the instrument. Items ask for a level of agreement or disagreement. An example is the mock item used in the instructions: "I feel I have adequate access to chocolate" (see Exhibit).

Respondents can choose to mark any items as "Skip" and can change their responses to any items up until they click "Finished."

Timing is not rigid and respondents typically take 12 to 25 minutes to complete the computerized version, which provides an immediate printout of the results.

Scoring

The computer program translates the mark along the

2 Marty Klein and Jack Morin (2005), in applying the "New View" nosology to a unified classification of women's and men's sexual problems, expanded

the original Medical category to a more inclusive Physical Factors which we found more descriptive of respondents' subjective reports.

Kaschak, E., & Tiefer, L. (2001). A new view of women's sexual problems. Binghamton, NY: The Haworth Press.

Klein, M., & Morin, J. (2005, July). The new view: Men are from earth, women are from earth. Paper presented at the New View Conference, Montreal, Canada.

Larson, E. R. (2005, May). Using the New View of Women's Sexuality in clinical practice. Paper presented at the meeting of the Western Region of the Society for the Scientific Study of Sexuality, San Francisco, CA. Larson, E. R., & McKay, M. H. (2006, November). Use of the New View diagnostic system in couple sex therapy. Paper presented at the Annual Meeting of the Society for the Scientific Study of Sexuality, Las Vegas, NV.

Exhibit

Sexual Problems Self-Assessment Questionnaire

1. This questionnaire is part of a research and development project; it is unfinished and there are no scoring norms. It is being explored as a tool to aid in making a comprehensive assessment of sexual issues in women and men.

2. This information is intended for two uses:

a. Feedback to your educator or clinician; and

b. Data to a research project to measure the effectiveness of this questionnaire.

Your answers might be shared anonymously with scientific, educational, or clinical professionals.

3. If you are a client or patient, know that you have the right to decline to answer all or part of the questionnaire and it will not negatively affect standard practice of treatment.

GENERAL QUESTIONS

A. FEEDBACK

1. Are you taking this survey to provide feedback to your service provider?

___ Yes ___ No

2. Enter service provider's name:

_____

3. Please create your code number with the first letter of
your mother's maiden name and the last four digits of your
Social Security Number. Or you may, instead, create
another 5-character code that you will remember.

___ ___ ___ ___ ___

4. To assist us in long-term research, do you agree to have
a second report sent to Seattle Institute?

___ Yes ___ No

B. DEMOGRAPHICS

1. Sex: _____ Female _____ Male _____ Other

2. Age _____

3. Are you in a relationship? _____

4. If so, how long? _____

C. INSTRUCTIONS AND SAMPLE QUESTION

Answer each question by placing an "X" on the dotted line
at the place that best describes how you feel.

Example: 1. I feel I have adequate access to chocolate.

Yes.....X.....

D. OVERALL SATISFACTION

1. In general, I am satisfied with my sex life.

2. In general, I am satisfied with the emotional intimacy
in my life.

I. SOCIO-CULTURAL, POLITICAL, OR ECONOMIC FACTORS

A. I feel uninformed about sexuality due to inadequate sex
education.

Yes.....

B. I think my vocabulary is adequate to describe subjective
or physical sexual experience. a

C. I have adequate information about human sexual biology and women’s changes with age.

D. I have adequate information about human sexual biology and men’s changes with age.

E. I think I lack information about how gender roles influence men’s and women’s sexuality.

F. I have adequate access to information and services for birth control.

G. I have adequate access to information and services for prevention and treatment of sexually transmitted infections.

H. I have adequate access to information and services for rape or sexual trauma.

I. I have adequate access to information and services for domestic violence.

J. I avoid having sex or experience distress during sex because I feel I don’t live up to the ideals of my culture regarding sexuality or

desirability.

K. I feel anxiety or shame about my body, sexual attractiveness, or sexual responses.

L. I feel confusion or shame about my sexual orientation or identity.

N. I feel that there are conflicts between my sexual values and those of my partner.

O. I feel that there are conflicts between my sexual values and those of my peer group.

P. I feel that there are conflicts between my sexual values and those of the mainstream culture.

Q. I feel a lack of interest, fatigue, or lack of time for sex due to family, work, or other obligations.

II. RELATIONSHIPS

A. I currently experience sexual inhibition, avoidance, or distress because of betrayal by or dislike of my partner.

Yes.....

B. I currently experience sexual inhibition, avoidance, or distress because I fear my partner. a

C. I currently experience sexual inhibition, avoidance, or distress because of abuse by my partner.

D. I currently experience inhibition, avoidance, or distress arising from unequal power between myself and my partner.

E. I currently experience sexual inhibition, avoidance, or distress because of my partner’s negative communication patterns.

F. I have experienced sexual inhibition, avoidance, or distress arising from betrayal, dislike, fear, or abuse in a previous

relationship.

G. There are discrepancies between myself and my partner in frequency of desire for sexual activity.

I. I trust my partner to be sensitive to my wants.

J. I have lost sexual interest as a result of conflicts with my partner over commonplace issues such as money, schedules, or

relatives.

K. I have experienced loss of sexual interest due to traumatic experiences, such as infertility or the death of a child.

L. My partner’s health and/or sexual problems interfere with my sexual arousal, enjoyment, or spontaneity.

M. I experience sexual aversion, mistrust, or inhibition of sexual pleasure due to my partner’s personality, such as problems with

rejection, cooperation, closeness, or criticalness.

N. I experience sexual aversion, mistrust, or inhibition of sexual pleasure due to my partner’s depression or anxiety.

III. PSYCHOLOGICAL FACTORS

A. I experience inhibition of sexual pleasure or response that I believe is due to a history of physical, sexual, or emotional trauma.

Yes.....

B. I avoid sexual activity or fail to experience sexual pleasure because of fears of rejection or intimacy. a

C. I avoid sexual activity or fail to experience sexual pleasure because of anger toward my partner.

D. I experience sexual aversion, mistrust, or inhibition of sexual pleasure due to depression or anxiety.

E. I experience sexual inhibition due to fear of sexual acts or their possible consequences, for example pain during intercourse,

pregnancy, sexually transmitted infections, etc.

F. I limit my sexual feelings due to my fear of losing my partner.

G. I engage in sexual behavior that feels inappropriate and out of control.

IV. PHYSICAL FACTORS

A. I experience pain or lack of physical response during sexual activity due to medical condition(s) affecting my body.

Yes.....

B. I believe my sexual experience and pleasure are limited by the following medical conditions (check all that apply):

1. _____ Diabetes 5. _____ Headaches

2. _____ Multiple Sclerosis 6. _____ Epilepsy

3. _____ Parkinson’s Disease 7. _____ Arthritis

4. _____ Lupus 8. _____ Other

C. (men) I have been treated for prostate cancer. ___ Yes ___ No

D. (women) I have had a hysterectomy or had my ovary(ies) removed. ___ Yes ___ No

E. I have taken female hormones (estrogen, progesterone, etc.) at some time in my life. ___ Yes ___ No

F. I have taken male hormones (testosterone, DHEA, etc.) at some time in my life. ___ Yes ___ No

G. I experience pain or lack of physical response during sexual activity due to the following medical conditions:

1. Pregnancy

Yes.....

2. Childbirth a

3. Menopause

4. Sexually Transmitted Disease

5. Physical Injury

6. Side effects of drugs, medications, or treatment for a medical condition.

7. (women) Involuntary contractions of the vagina (vaginismus).

H. I am satisfied with my ability to control my ejaculation/orgasm.

I. I experience pain during arousal (erection, lubrication).

J. I experience pain during orgasm.

K. I experience pain during intercourse or other sexual contact for undiagnosed reasons.

L. I take medication/substance(s) (prescribed, herbal, or illegal) to enhance my sexual experience.

M. I lead a physically healthy lifestyle.

N. I smoke.

O. I drink more than 1 alcoholic beverage per day (women) or more than 2 drinks per day (men).

P. Regarding my weight, I am:

Too

Q. I am exposed to solvents or volatile substances, e.g.,
exhaust, chemical odors, etc.

Daily.....

R. I regularly engage in vigorous physical exercise.

Daily.....

Note. This questionnaire has been derived from the
diagnostic classification system created by The Working
Group on a New View of Women’s Sexual

Problems and developed by Seattle Institute for Sex
Therapy, Education and Research (Elizabeth Rae Larson,
Malcolm McKay, Laura Tsang, Ann Manly

[Editor] and Ian Hagemann [Web Page Design]), with
gratefully acknowledged critical feedback and generous
assistance from Joy Davidson, Leonore

Tiefer, Gerald Weeks, Marilyn McIntyre, Jack Morin, and
Marty Klein. The New View of Women’s Sexual Problems (2000)
Working Group members

were Linda Alperstein, Carol Ellison, Jennifer R. Fishman,
Marny Hall, Lisa Handwerker, Heather Hartley, Ellyn
Kaschak, Peggy J. Kleinplatz, Meika Loe,

Laura Mamo, Carol Tavris, and Leonore Tiefer.

a The response option is repeated for each item.

The Sexual Dysfunction Scale (SDS) is designed to evalu

ate the factors associated with each of the sexual dysfunc

tions among males and females. Respondents are asked a
general question about which sexual dysfunctions they are
experiencing, and then they complete a set of more specific
questions on their particular sexual dysfunction(s).

Sexual Dysfunction Scale

MARITA P. MCCABE, 1 Deakin University

1 Address correspondence to Marita P. McCabe, School of Psychology, Deakin University, 221 Burwood Highway, Burwood, Victoria, Australia 3125; e-mail:

marita.mccabe@deakin.edu.au

Description

The SDS consists of the following eight sections (see Table 1 for additional detail): (a) nature of the problem, (b) premature ejaculation, (c) erectile problems, (d) retarded ejaculation, (e) orgasmic dysfunction, (f) female unresponsiveness, (g) vaginismus, and (h) lack of sexual interest.

For each dysfunction, respondents answer questions about medical and lifestyle factors, quality of the respondent's relationship (if the person is in a relationship), length of time the dysfunction has been in place, the frequency and severity of the dysfunction, attitudes to sexual activities and responses to these activities, response to the dysfunction, and impact of the dysfunction on the respondent's relationship (if relevant).

The SDS was developed during a 10-year process in the late 1980s and 1990s. The items were initially drawn from the factors that were claimed in the literature to be associated with each particular sexual dysfunction. This resulted in the construction of a guided interview measure that elicited responses to open-ended questions.

Subjects were also asked about whether the questions were relevant to their particular sexual dysfunction. This instrument was tested on 55 people with sexual dysfunction (with at least 6 subjects within any particular dysfunctional category). The measure was then converted into a forced-choice format and administered to a sexually dysfunctional population (both clinical and nonclinical subjects; McCabe, 1994a, 1994b). The scale was further modified as a result of these studies and administered to an additional 120 clinically dysfunctional subjects. This third draft of the scale is the one included in this compendium.

Response Mode and Timing

The scale is completed as a questionnaire measure and, depending upon the number of sexual dysfunctions experienced by the respondent, takes from 10 minutes to 50 minutes to complete. All items are objectively scored and consist of either yes/no responses or 5-point Likert-scale responses.

Scoring

Responses on items may be summed to provide an index of severity (nature of problem x length of time problem has been in place x frequency of problem). There are also

Education

Exhibit

Family Life Sex Education Goal Questionnaire II

This questionnaire lists goals which some people have described as important for a family life sex education program. Some goals may

be of lesser importance than others. For each of the goals listed, we would like you to indicate (on the 5-point scale provided)

whether or not you view the goal as important for a family life sex education program in the _____ (specify program, school, grade

level, etc.).

Instructions: In the column to the right of the goals listed on the pages which follow, indicate the importance of each goal by using the

following scale:

1 2 3 4 5

Very Somewhat Neutral Somewhat Very

Unimportant Unimportant Importance Important Important

Here is an example of how to use the scale:

Example Items

A. To teach children about how to stay physically healthy as they grow. 1 2 3 4 5

B. To teach children how to play a musical instrument. 1 2 3 4 5

If, in your opinion, the first goal (“To teach children about how to stay physically healthy as they grow”) is somewhat important (number

“4” on the scale) for a family life sex education program, you would circle “4” next to the goal statement in the column on the right. If,

in your opinion, the second goal (“To teach children how to play a musical instrument”) is very unimportant for a family life sex education

program, you would circle the number “1” in the column to the right.

Remember, you may see some goals as more important than others. Please circle your opinion by circling the number that best repre

sents your views beside each goal statement.

1. To help adolescents feel good about their physical appearance. a

2. To help adolescents to appreciate their special qualities and personality as well as that of other boys and girls.

3. To reduce guilt and fear about sexuality.

4. To provide information about abnormal sexual development and behavior.

5. To help adolescents understand how sexual development affects other aspects of personal growth and development.

6. To provide complete information about male and female genitalia (sex organs) and other physical differences between men and women.

7. To involve parents in selecting instruction materials and planning the curriculum of the family life sex education program.

8. To provide information about abortion and its effects on the body.

9. To provide information about the biology of human reproduction and birth.

10. To discuss ways of coping with an unexpected pregnancy.

11. To help adolescents develop skills in getting along with members of the opposite sex.

12. To provide information about how to be good parents.

13. To help adolescents learn to understand and communicate

with each other better.

14. To make youth aware of community services related to health and prenatal care.

15. To emphasize the importance of the family as the keystone of American life.

16. To help adolescents understand their responsibilities to self, family, and friends as they grow up.

17. To inform youth of community services related to birth control and sexual decision-making.

18. To counsel adolescents to make their own decisions about how far to go in their sexual activities.

19. To encourage adolescents to talk more openly with their parents about sexuality.

20. To discuss the role of the family in personal growth and development.

21. To encourage adolescents to use contraceptives if they decide to have sexual intercourse.

22. To discuss ways in which families work out conflicts and solve problems.

23. To help adolescents understand people's feelings and points of view.

24. To educate adolescents about peer pressure and how to deal with it.

25. To provide information about sexually transmitted infections including HIV and AIDS.

26. To teach about abstention as a form of contraception.

27. To encourage discussion of personal family experiences in the classroom.

28. To provide special courses about family life and sexuality for disabled students.

29. To encourage adolescents to think about alternatives to abortion.

30. To bring in outside speakers to talk to youth about

sexuality.

31. To counsel boys who are expectant fathers.

32. To correct myths and misinformation about the body.

33. To help adolescents to view the growth changes in their bodies as normal and healthy.

34. To discuss how the attitudes toward growth and development may be different for different ethnic groups and cultures in our society.

35. To provide information about alternative sexual behaviors and lifestyles, such as homosexuality.

36. To discuss abortion as a form of contraception.

37. To provide workshops to assist parents in talking more openly with their adolescent children about sexuality.

38. To encourage grooming and thoughtfulness about personal appearance.

39. To counsel girls who are pregnant.

40. To demonstrate how to put on a condom using a plastic teaching model or banana.

41. To refer students with special needs to social service agencies.

42. To make adolescents aware of the negative effects of sex role stereotypes.

43. To provide information about good prenatal care.

44. To provide information about contraceptives and how they work, and describe their effects on the body.

45. To teach about biological changes during puberty.

46. To provide individual counseling to students with low self-esteem or those who feel embarrassed about their bodies.

47. To meet with parents about a child who is having difficulties with sexual issues and stresses.

Egalitarianism

Exhibit

Global Measure of Equity and Multi-Trait Measure of Equity

Calculating Equity

Technically, equity is defined by a complex formula (Traupmann et al., 1981; Walster, 1975). Respondents' perceptions of the equitable

ness of their dating relationships or marriages are computed by entering their estimates of Inputs and Outcomes of Persons A and B

(I A , I B , O A , and O B) into the equity formula: a

(O A − I A) = (O B − I B) _____ _____ (| I A |) KA (| I B |) KB)

Respondents are classified as "overbenefited" if their relative gains exceed those of their partners. They are classified as "equitably

treated" if their relative gains equal those of their partners, and as "underbenefited" if their relative gains fall short of those of their

partners.

In practice, however, the equity of love relationships can reliably and validly be assessed with the use of two simple measures: the

Global Measure of Equity and the Multi-Trait Measure of Equity.

Global Measure of Equity

Women were asked: "Considering what you put into your dating relationship or marriage, compared to what you get out of it . . . and

what your partner puts in, compared to what (s)he gets out of it . . . how does your dating relationship or marriage 'stack up'?"

Possible responses are:

+3 = I am getting a much better deal than my partner.

+2 = I am getting a somewhat better deal.

+1 = I am getting a slightly better deal.

0 = We are both getting an equally good, or bad, deal.

-1 = My partner is getting a slightly better deal.

-2 = My partner is getting a somewhat better deal.

-3 = My partner is getting a much better deal than I am.

On the basis of their answers, persons can be classified as overbenefited (receiving more than they deserve), equitably treated, or

underbenefited (receiving less than they deserve).

Multi-Trait Measure of Equity

Introduction: Explanation of Concepts

“We’re interested in the give-and-take that goes on in a dating relationship or marriage. We’d like to ask you a few questions about the

things you put into your relationship . . . and the kinds of things you get out of it. We know that most people don’t ordinarily keep careful

track of exactly what they’re giving and getting from their dating relationships or marriages. They certainly don’t pull their relationship apart

and think about the various aspects of their relationship, one by one. But in order for us to get some idea of what goes on in dating and mari

tal relationships, we have to ask you and the other people we’re interviewing to spell out some of the give-and-take that naturally occurs.

“Let us look at some of the critical areas in any dating relationship or marriage. Look over this list. [Hand respondent list.] We’d like

to ask about you and your partner’s Personal Concerns, your Emotional Concerns, your Day-to-Day Concerns, and a little

about the

things the two of you feel you gain or lose—simply by dating or being married. We'd like you to read each item.

"[Each item is read through, aloud if interviewer is used. After reading each item, respondent is asked]: Considering what you put

into your dating relationship or marriage (in this area), compared to what you get out of it . . . and what your partner puts in compared

to what he or she gets out of it, how does your dating relationship/marriage 'stack up'?"

+3 = I am getting a much better deal than my partner.

+2 = I am getting a somewhat better deal.

+1 = I am getting a slightly better deal.

0 = We are both getting an equally good or bad deal.

-1 = My partner is getting a slightly better deal.

-2 = My partner is getting a somewhat better deal.

-3 = My partner is getting a much better deal than I am.

Areas Involved in Dating/Marital Give-and-Take

Personal Concerns

Social Grace

1. Social Grace: Some people are sociable, friendly, relaxed in social settings. Others are not.

Intellect

2. Intelligence: Some people are intelligent and informed.

Appearance

3. Physical Attractiveness: Some people are physically attractive.

4. Concern for Physical Appearance and Health: Some people take care of their physical appearance and conditioning,

through atten

tion to such things as their clothing, cleanliness, exercise, and good eating habits.

Emotional Concerns

Liking and Loving

5. Liking: Some people like their partners and show it. Others do not.

6. Love: Some people feel and express love for their partners.

Understanding and Concern

7. Understanding and Concern: Some people know their partner's personal concerns and emotional needs and respond to them.

Acceptance

8. Accepting and Encouraging Role Flexibility: Some people let their partners try out different roles occasionally, for example letting their partner be a "baby" sometimes, a "mother," a colleague or a friend, an aggressive as well as a passive lover, and so on.

Appreciation

9. Expressions of Appreciation: Some people openly show appreciation for their partner's contributions to the relationship—they don't take their partner for granted.

Physical Affection

10. Showing Affection: Some people are openly affectionate—touching, hugging, kissing.

Sex

11. Sexual Pleasure: Some people participate in the sexual aspect of a relationship, working to make it mutually satisfying and fulfilling.

12. Sexual Fidelity: Some people live up to (are "faithful" to) their agreements about extramarital relations.

Security/Freedom

13. Commitment: Some people commit themselves to their partners and to the future of their relationship together.

14. Respecting Partner's Need to be a Free and Independent Person: Some people allow their partners to develop as an individual in the way that they choose: for example, they allow their partners freedom to go to school or not; to work at the kind of job or career they like; to pursue outside interests; to do things by themselves or with friends; to simply be alone sometimes.

Plans and Goals for the Future

15. Plans and Goals for the Future: Some people plan for and dream about their future together.

Day-to-Day Concerns

Day-to-Day Maintenance

16. Day-to-Day Maintenance: Some people contribute time and effort to household responsibilities such as grocery shopping, making dinner, cleaning, and car maintenance. Others do not.

Finances

17. Finances: Some people contribute income to the couple's "joint account."

Sociability

18. Easy to Live With: Some people are easy to live with on a day-to-day basis; that is, they have a sense of humor, aren't too moody, don't get drunk too often, and so on.

19. Companionship: Some people are good companions, who suggest interesting activities for both of them to do together, as well as going along with their partner's ideas about what they might do for fun.

20. Conversation: Some people tell partners about their day's events and what's on their mind . . . and are also interested in hearing about their partner's concerns and daily activities.

21. Fitting in: Some people are compatible with their partner's friends and relatives; they like the friends and relatives, and the friends and relatives like them.

Decision-Making

22. Decision-Making: Some people take their fair share of the responsibility for making and carrying out decisions that affect both partners.

Remembering Special Occasions

23. Remembering Special Occasions: Some people are thoughtful about sentimental things, such as remembering birthdays, your anniversary, and other special occasions.

Opportunities Gained and Lost

Opportunities Gained

24. Chance to be Dating or Married: Dating and marriage give many people the opportunity to partake of the many life experiences that depend upon dating or being married, for example the chance to become a parent and even a grandparent, the chance to be included in “married couple” social events, and, finally, having someone to count on in old age.

Ejaculation

2. Yes, most of the time produces pleasurable feelings

3. Yes, sometimes produces pleasurable feelings

4. No

At what age did you first conclude that this sensitive area exists inside your vagina?

_____ years old

If no sensitive area exists in vagina, go to Question ____:

Under what bladder circumstances are the pleasurable sensations associated with this sensitive area in your vagina most easily

detectable? (Circle number)

1. Bladder full

2. Bladder partially full

3. Bladder empty

4. Not associated with condition of bladder

5. Not aware of bladder condition when pleasurable sensations occur

6. Other

When during your menstrual cycle are the pleasurable sensations associated with this sensitive area in your vagina most easily detect

able? (Circle number)

1. Just before menstrual period

2. During menstrual period

3. Just after menstrual period

4. Midway between menstrual periods

5. No difference during menstrual cycle

6. No difference, had hysterectomy with removal of uterus only

7. No difference, had hysterectomy with removal of ovaries and uterus

8. Not aware of difference in menstrual cycle when pleasurable sensations occur

When speculum is inserted and opened in your vagina during a pelvic examination, does it ever stimulate this sensitive area in your

vagina so that it produces pleasurable sensations? (Circle number)

1. Never

2. Rarely

3. Occasionally

4. Frequently

5. Very frequently

6. Always

Sensitive Area—Orgasm

In your opinion, does such a sensitive area exist inside the vagina which, if stimulated, can produce an orgasm without any clitoral contact

and/or stimulation? (Circle number)

1. No

2. Yes, for all females

3. Yes, for some females

If never had an orgasm go to Question ____:

Does stimulating this sensitive area in your vagina during sexual arousal produce an orgasm?

(Circle number)

1. Yes, always

2. Yes, most of the time

3. Yes, sometimes

4. No

If stimulated, sensitive area in vagina does not produce orgasm go to Question ___:

Is it possible for you and/or your sex partner to stimulate this sensitive area to produce an orgasm without causing clitoral contact to

be made? (Circle number)

1. Yes 2. No 3. Never tried to stimulate sensitive area 4. Other_____ (Please specify) If yes: Please describe how it is possible to stimulate this sensitive area to produce an orgasm independent of any clitoral stimulation. (Note: A larger space is necessary for open-ended response.) What is the location of this sensitive area inside your vagina which, if stimulated, will produce an orgasm? Describe its specific, perceived location in relationship to the other genital and pelvic structures using the terminology from the diagram. Please do not just circle the terminology on the diagram and do not draw arrows. (Note: A larger space is necessary for the open-ended response.) Which of the following factors play a role in whether this sensitive area in the vagina can be stimulated to produce an orgasm during sexual activity including masturbation, petting (mutual masturbation and/or oral-genital sex), or sexual intercourse. (Circle numbers for all applicable categories) 1. Not using diaphragm as a contraceptive technique 2. Long penis for vaginal penetration 3. Long internal vibrator or dildo for vaginal penetration

4. Large diameter penis for vaginal penetration

5. Large diameter internal vibrator or dildo for vaginal penetration

6. Degree of emotional involvement with sex partner

7. Angle of entry of erect penis, dildo, or vibrator during vaginal penetration

8. Use of your fingers to provide extra stimulation inside vagina

9. Use of your partner’s fingers to provide extra stimulation inside vagina

10. Ability of partner to rotate pelvis during sexual activity

11. Ability to rotate your pelvis during sexual activity

12. Use of waterbed for sexual intercourse

13. Position used for sexual intercourse

14. Other _____ (Please specify)

Which position for sexual intercourse, if any, is most likely to result in stimulation of the sensitive area to produce orgasm? (Circle

number)

1. Face-to-face/Male above

2. Face-to-face/Male above with legs of female over shoulders of male

3. Face-to-face/Female above

4. Face-to-face/Side

5. Prone (female lying face down)/Rear entry with vaginal penetration

6. Prone (female lying face down)/Rear entry with anal penetration

7. Kneeling/Rear entry with vaginal penetration

8. Kneeling/Rear entry with anal penetration

9. Sitting/Face-to-face

10. Sitting/Rear entry with vaginal penetration

11. Sitting/Rear entry with anal penetration

12. Standing/Face-to-face

13. Side/Rear entry with vaginal penetration

14. Supine (lying on back)/Male kneeling

15. Supine (lying on back)/Male standing

16. Side/Rear entry with anal penetration

17. Rear entry with vaginal penetration/Male on back/Female above

18. Male on side/Female on back, with knees bent

19. Other _____ (Please specify)

Sensitive Area—Ejaculation

In your opinion, does the process of ejaculation (sudden spurt of fluid at the moment of orgasm) exist in some females? (Circle

number)

1. No 2. Yes

If yes: At what approximate age did you first conclude that ejaculation at the time of orgasm exists for some females?

_____ years old

At the time that you experience orgasm, do you suddenly experience a spurt of fluid (i.e., ejaculation) in the genital area? (Circle

number)

1. Never

2. Rarely

3. Sometimes

4. Almost Always

5. Always

If never experience spurt of fluid during orgasm go to Question _____:

How does this spurt of fluid seem to be released at the time of your orgasm? (Please describe in your own words.)

(Note: A larger space is necessary for the open-ended response.) What do you believe to be the source of this spurt of fluid at the time of your orgasm? (Please describe.) (Note: A larger space is necessary for the open-ended response.) In your own words, describe the difference, if any, between vaginal lubrication during your sexual arousal and the spurt of fluid at the moment of your orgasm. (Note: A larger space is necessary for the open-ended response.) During masturbation and/or sexual intercourse, are you able to consciously contract the muscles surrounding the vagina to grasp a phallic substitute (if utilized) or the penile shaft of your sex partner? (circle number) 1. Yes 2. No Sensitive Area—Urination/Pubococcygeus Musculature Do you ever prolong the act of urination by starting and stopping the flow of urine because of pleasurable sensations associated with contracting of the muscles involved in bladder control? (Circle number) 1. Yes 2. No Have you ever held back from experiencing an orgasm due to the fear of urinating? (Circle number) 1. Yes 2. No If never experienced orgasm go to Question _____: Have you ever thought that you have urinated during your orgasm? (Circle number) 1. Yes 2. No If yes: How often do you think you have urinated during orgasm? (Circle number) 1. Very frequently 2. Frequently 3. Occasionally 4. Seldom Are you aware of the existence of the pubococcygeus muscle located at the vaginal entrance? (Circle number) 1. Yes 2. No Can you consciously identify your pubococcygeus muscle through voluntary contractions? (Circle number) 1. Yes 2. No If yes: Do you periodically exercise your pubococcygeus muscle through Kegel exercises or by another related method, such as starting and stopping the flow of urine? (Circle number) 1. Yes 2. No

Elderly (see Aging)

Exhibit

Emotional Promiscuity Scale

1 2 3 4 5

Strongly Disagree Disagree Neither Agree nor Disagree Agree Strongly Agree

Rate your agreement using the above guidelines

1. I fall in love easily.

2. For me, romantic feelings take a long time to develop.

3. I feel romantic connections right away.

4. I love the feeling of falling in love.

5. I am not the type of person who falls in love.

6. I often feel romantic connections to more than one person at a time.

7. I have been in love with more than one person at the same time.

8. I fall in love frequently.

9. I tend to jump into relationships.

10. During your entire life, how many people have you fallen in love with?

A = None B = 1 C = 2 D = 3 E = 4 or More

Equality (see Egalitarianism)

Fisher, W. A., Byrne, D., White, L. A., & Kelley, K. (1988). Erotophobia

erotophilia as a dimension of personality. The Journal of Sex Research,

25, 123-151.

Goldberg, L. R. (1999). A broad-bandwidth, public domain, personal

ity inventory measuring the lower-level facets of several five-fac

tor models. In I. Mervielde, I. Deary, F. De Fruyt, & F. Ostendorf

(Eds.), Personality psychology in Europe, 7 (pp. 7-28). Tilburg, The

Netherlands: Tilburg University Press.

Larsen, K. S. (1998). Heterosexual attitudes toward homosexuality scale.

In C. M. Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L.

Davis (Eds.), Handbook of sexuality-related measures (pp. 394-395).

Thousand Oaks, CA: Sage. Lawrance, K., & Byers, E. S. (1992). Sexual satisfaction: A social exchange perspective. Paper presented at the Annual Meeting of the Canadian Psychological Association, Quebec. Lawrance, K., & Byers, E. S. (1995). Sexual satisfaction in long-term heterosexual relationships: The Interpersonal Exchange Model of Sexual Satisfaction. Personal Relationships, 2, 267-285. Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. Behaviour, Research and Therapy, 33, 335-343. Purdon, C., & Gordon, C. (2005, November). Development of the Sexual Anxiety Scale. Poster presented at the Association for the Advancement of Behavior and Cognitive Therapies Annual Meeting, Washington, DC. Rust, J., & Golombok, S. (1998). The GRISS: A psychometric scale and profile of sexual

dysfunction. In C. M. Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L. Davis (Eds.), Handbook of sexuality-related measures (pp. 192–194). Thousand Oaks, CA: Sage.

Exhibit

Sexual Anxiety Scale

For each item presented below, you are asked to rate how much discomfort you would experience using the following scale:

How much discomfort would you feel in each situation? (Place this rating under column “D”)

0 10 20 30 40 50 60 70 80
90 100

Extremely Neutral Extremely

Pleasurable Discomforting

D

1. Wearing clothes that show off my sexually attractive features c ___

2. Seeing two people kissing or fondling each other a ___

3. Watching a movie scene from a major box office movie in which people were naked a ___

4. Talking with my friends about my sex life ___

5. Masturbating a ___

6. Looking at hardcore or pornographic photos in a magazine (explicit scenes of the genitals and penetration) a ___

7. Using sex toys, such as a vibrator, during sex with my partner a ___

8. Exploring the erogenous, or sexually exciting, parts of my partner’s body c ___

9. Hearing about someone engaging in a consensual sexual act that I personally would never want to engage in a ___

10. Discussing my sexual fantasies with my partner c ___

11. Having arousing sexual thoughts that are unrelated to my current sexual partner a ___

12. Hearing about a woman who enjoyed sex and was sexually adventurous a ___

13. Watching a “hardcore” or “pornographic” film a ___

14. Being exposed to information about sexually transmitted infections b ___

15. Kissing or fondling my partner in a public place ___

16. Vocalizing my pleasure during sex with my partner c ___

17. Watching a movie scene from a major box office movie in which people were kissing or fondling each other c ___

18. Hearing about someone who has a biological sexual abnormality, such as undescended testicles, or a fertility problem b ___

19. Reading books with sexually explicit passages c ___

20. Agreeing to try sexual activities or positions that I find unusual but my partner suggests c ___

21. Using sex toys, such as a vibrator, when I am alone a ___

22. Engaging in foreplay with my partner c ___

23. Finding myself becoming sexually aroused in response to something I never would have expected myself to be aroused by c ___

24. Visiting Internet sites that feature erotic or softcore photos or video clips a ___

25. Having arousing sexual thoughts that are related to my current sexual partner c ___

26. Talking with my partner about his/her sexual fantasies c ___

27. Talking with my friends about general matters of a sexual nature, such as menstruation, pregnancy, childbirth b ___

28. Changing my clothes in a public change room that does not have privacy cubicles b ___

29. Being exposed to information about contraceptive devices that require intimate genital contact (e.g., diaphragm, sponge, foam) b ___

30. Overhearing other people (not parents) having sex a ___

31. Watching a scene from a major box office movie in which people were engaging in sex a ___

32. Exploring erogenous, or sexually exciting, parts of my body when I am alone a ___

33. Someone knowing that I look at/watch erotic photos/films a ___

34. Suggesting new sexual activities or positions to my partner c ___

35. Visiting Internet sites that features hardcore or pornographic photos or video clips a ___

36. Engaging in a casual sexual encounter (e.g., a one-night stand) a ___

37. Being invited by an acquaintance/friend/partner to engage in an unusual sexual act a ___

38. Hearing about sexual issues or matters from the newspaper or TV b ___

39. Fantasizing about arousing sexual acts during sex with my partner in order to enhance my sexual excitement c ___

40. Disclosing to my friends that I have a sexual problem b ___

41. Answering questions about sexual matters such as conception b ___

42. Someone overhearing me and my partner having sex a ___

43. Being around others who are changing their clothes ___

44. Being exposed to information about diseases of the sex organs, such as cervical cancer, testicular cancer, prostate cancer, breast cancer b ___

45. Watching an “erotic” or “softporn” film (no explicit scenes of the genitals or penetration) a ___

46. Allowing my partner to explore my erogenous, or sexually exciting, parts of my body c ___

47. Someone knowing that I look at/watch pornographic photos/films a ___

48. Changing activities or positions during sex with a partner to help ensure that I have an orgasm c ___

49. Looking at erotic or softcore photos in a magazine a ___

50. Telling my partner what pleases me and does not please me sexually c ___

51. Hearing about people I don’t consider to be sexual engaging in sex, such as the elderly, my parents, disabled people b ___

52. Having a conversation with my friends about their sex lives b ___

53. Fantasizing about arousing sexual thoughts during masturbation in order to enhance my sexual excitement a ___

54. Watching coverage of the Gay Pride Day parade b ___

55. Being exposed to information about contraceptives and contraceptive use b ___

56. Completing questionnaires about my sexuality b ___

a Solitary and Impersonal Sexual Expression (Factor 1)

b Exposure to Information (Factor 2)

c Sexual Communication (Factor 3)

1 Address correspondence to B. J. Rye, Department of Psychology, St. Jerome’s University, 290 Westmount Road North, Waterloo, Ontario, Canada N2L

3G3; e-mail: bjrye@uwaterloo.ca

Sexual Opinion Survey

B. J. RYE, 1 St. Jerome's University at the University of Waterloo

G LENN J. MEANEY, Wilfrid Laurier University

W ILLIAM A. FISHER, University of Western Ontario

The personality dimension of erotophobia-erotophilia is conceptualized as a learned disposition to respond to sexual stimuli with negative-to-positive affect and evaluation and is believed to determine avoidance or approach responses to sexual stimuli. The Sexual Opinion Survey (SOS) is a measure of this trait (Fisher, Byrne, White, & Kelley, 1988). Description The SOS (see Exhibit 1) consists of 21 items intended to assess affective and evaluative responses to sexual stimuli (autosexual, homosexual, heterosexual behavior; sexual fantasy; visual sexual stimuli). Each item depicts a sexual situation and an affective response to it; individuals are asked to indicate degree of agreement or disagreement with the statement (scale development is described in Fisher, 1998, and Fisher et al., 1988). Terminology in some items was updated by Fisher (1998) because some of the original wording was no longer in use or had changed meaning. Translations of the SOS into Hebrew, French, Finnish, German, Portuguese, and Japanese are available; recently, it has also been translated into Spanish (Sierra, Ortega, & Zubeidat, 2006) and Dutch (Dodge, Sandfort, Yarber, & de Wit, 2005).

A short form of the SOS was developed by Semph (1979; see Exhibit 2) using five items established as strong predictors of full scale scores (e.g., Table 2, Sample 1: r = .84).

A scale conceptually based on the SOS was designed for use with very young adolescent girls (Rye et al., 2008; see Exhibit 3) and highly correlated with the SOS in a sample of first-year university students (r = .74, n = 55).

Extensive construct validity for the SOS was reported by Fisher et al. (1988) and Fisher (1998); therefore, we will focus on literature published since 1998. The SOS has been used extensively with North American university students and has been used to assess erotophobia-erotophilia in university students in Australia (Beatson & Halloran, 2007), Israel (Birnbaum & Gillath, 2006), and the Netherlands (Dodge et al., 2005), as well as nonstudent populations including adult women (Graham, Sanders, & Milhausen, 2006), high-school men (Sierra et al., 2006), incarcerated men (Garland, Morgan, & Beer, 2005), women who have had an abortion and nonpregnant women at health clinics (Bradshaw & Slade, 2005), and users and nonusers of erotica (Lawyer, 2008). Normative data from these studies, when available, are summarized in Table 1; the current authors' normative data are summarized in Table 2.

Response Mode and Timing

Completion of the SOS usually takes 10 minutes or less. General instructions are provided (see Exhibit 1); additional instructions may be added for participants unfamiliar with Likert-type responding.

Scoring

Fisher (1998) specified the following scoring scheme: First, score responses from 1 (Strongly Disagree) to 7 (Strongly Agree); second, add scores from Items 2, 5, 6, 12, 13, 14, 15, 16, 19, and 20; third, subtract the sum of Items 1, 3, 4, 7, 8, 9, 10, 11, 17, 18, and 21; fourth, add 67. This scheme results in a number between 0 (erotophobic) and 126 (erotophilic); missing data can be handled for positively and negatively worded items by substituting the mean score for the other

TABLE 1

Normative Data From Published Research

Study Subsamples N M SD Group Scoring a High Score Notes

Differencesa

Barak et al. (1999) n/a 31 73.36 17.21 n/a Fisher
Erotophilia Undergraduate

men

Bogaert & Sadava n/a 792 83.97 22.16 n/a 22 to 137
Erotophilia Adults

(2002)

Bradshaw & Slade Abortion 98 76 19 Significant Fisher
Erotophilia Women from

(2005) No abortion 51 69 21 difference health clinics

Dodge et al. (2005) United States 133 3.07 1.03 Significant
Average Erotophobia Undergraduate

Netherlands 109 2.61 1.00 difference men

Forbes et al. (2003) n/a 211 2.68 .70 No gender 1 to 6
Erotophilia University

difference Average students; short

version

Garcia (1999) Men 77 5.7 ± 19.1 n/a No significant Fisher
−67 Erotophilia Introductory

Women 84 −6.7 ± 19.3 n/a difference −67 to +59 psychology

students

Geer & Robertson Men 115 66.72 23.89 Significant Not
described Erotophilia Psychology

(2005) Women 137 59.56 19.32 difference undergraduates

Hogben et al. (2001) Men 177 59.88 11.86 Significant
Items: Erotophilia Introductory

Women 176 71.15 15.96 difference 1 to 6 psychology

students

Lawyer (2008) Erotica users 34 93.3 22.7 No significant Not described Erotophilia Men and

Erotica 37 84.9 22.1 difference women

non-users

Sanders et al. (2006) Condom 102 3.9 1.2 Significant Average Erotophobia Sexually active

appliers difference women

Condom 220 4.2 1.1

non-appliers

Shim et al. (2007) n/a 151 76 19 n/a Fisher Erotophilia Introductory

communications

students

a Scoring information based on published literature or personal communication with authors. “Fisher” indicates that scores were calculated as specified by Fisher (1998) and

in the Scoring section. “Average” indicates that negatively worded items were reverse coded and then all items were averaged. All items were scored on a 7-point Likert-type

scale except where noted.

positively or negatively worded items, respectively (stipu

lating completion of half the relevant items). In practice, some researchers simply add the items after

reverse coding negatively worded items (resulting in a

score from 21 to 147), or average across all items (with

negatively worded items reverse coded, resulting in a score

from 1 to 7). There are advantages to each scoring scheme.

Averaging the items, for example, results in a score on the

same scale as the individual items (i.e., 1 to 7) and mini
mizes the impact of missing data (i.e., a few missing items
can be omitted). However, researchers conducting cross
study comparisons should be aware that scores from dif
ferent studies may not be directly comparable. Scoring
schemes should not affect relationships between the SOS
and other variables.

Reliability

Since Fisher (1998) reported on the reliability of the SOS,
high internal consistency has been found among various
samples of university students (Cronbach's α = .76 to .89;
(α = .85; Birnbaum & Gillath, 2006); internal consistency is
about equal for men and women (e.g., Smith & Nave, 2007).
Lower internal consistency (α = .63) was found for the short
version (Beatson & Halloran, 2007). A scale conceptually
based on the SOS designed for very young adolescent girls
had similar internal consistency (α = .63; Rye et al.,
2008).

Substantial test-retest reliability of the full scale was
found
with a sample of university students over an interval of
several weeks (Table 2, Sample 2: r = .61, n = 35).
Although the SOS is highly internally consistent, some
researchers have attempted to identify subscales. Sierra et
al. (2006), using a Spanish sample, reported four factors
(erotophilia, erotophobia, homophobia, and unconventional
sex); a similar factor structure was reported using a
Norwegian sample (Rise, Traeen, & Kraft, 1993). Based on
our analysis (Table 2, Sample 1), we recommend a twofactor
solution when investigation of factors is desired: (a)

open sexual display and sexual variety, and (b) homoeroticism—a refinement of the three-factor solution suggested by Gilbert & Gamache, 1984). Further investigation is required to demonstrate the generality and stability of sets of factors and the utility of factor-based subscales. Validity Since publication in the previous edition of the Handbook of Sexuality-Related Measures (Fisher, 1998), the construct validity of the SOS continues to be well established through research with theoretically relevant variables. In particular, SOS scores are predictive of prior sexual media exposure (Bogaert, 2001), subjective sexual arousal (Nobre et al., 2004), sexual arousal and anxiety (and, indirectly, sexual self-schema; Cyranowski & Andersen, 1998), selfreported sexual behavior (i.e., masturbation, multiple partners, unprotected sex; Durant, Carey, & Schroder, 2002), implicit sexual attitudes (Geer & Robertson, 2005), perceptions of consumer items as a means of attracting sexual partners or enhancing sex (Gould, 1995), sexual excitation and inhibition (Graham et al., 2006; Janssen, Vorst, Finn, & Bancroft, 2002a, 2002b; Wilson, Holm, Bishop, & Borowiak, 2002), homonegativity (Mahaffey, Bryan, & Hutchison, 2005), condom application (i.e., women

TABLE 2

Normative Data From the Authors' Research

Sample Subsamples N M SD Group Differences Notes

1 Men 854 3.83 .50 Significant difference Introductory human sexuality

Women 2007 3.60 .57 students; 23 classes enrolled

Heterosexual a 2657 3.63 .55 Significant difference between 1999 and 2007

Queer a 207 4.07 .52

2 Men 27 4.37 .83 No significant Introductory psychology

Women 39 4.05 .91 difference students agreed to participate

in sex study

3 n/a 135 4.14 1.15 n/a Introductory psychology

students department

mass-testing

4 Men 43 4.92 1.18 Significant Homophobia awareness

Women 70 4.31 1.11 difference workshop (Rye & Meaney,

2009); short version without

Item 21

5 Heterosexual 49 4.39 .67 Lesbians more Adult women

AIS b 44 4.59 .76 erotophilic than

Lesbian 45 4.85 .63 heterosexuals

Note. Except where noted, all samples completed the full, 21-item SOS. Scoring: Individual items were rated on a 1 to 7 scale, except for Sample 1 (1 to 5). Negatively worded

items were reverse scored. Then, all items were averaged. Higher scores indicate erotophilia. Missing data were ignored provided completion of half the items.

a 5-point self-identification scale: 1–2 = heterosexual, 3–5 = queer (bisexual or homosexual)

b AIS = Androgen Insensitivity Syndrome

who applied condoms on their male partners were more

erotophilic than those who did not; Sanders et al., 2006),

“short-term, unrestricted mating orientation” (Schmitt,

Shackelford, Duntley, Tooke, & Buss, 2001), willingness

to be exposed to unsolicited Internet pornography (Shim,

Lee, & Paul, 2007), and sexual fantasy (Sierra et al., 2006).

Garcia (1999) found that participants higher in erotophilia

were more likely to rate themselves as sexually experi

enced, sexually deviant, holding liberal or permissive sex

ual attitudes, and being sexually responsive.

In our research (Table 2, Sample 1), SOS scores were weakly to moderately correlated with a variety of sexual attitudes (e.g., approval of premarital sexual intercourse, accessibility of birth control), sexual behaviors with others (e.g., number of sexual partners, having orally stimulated a partner's genitals), and autosexual behavior (e.g., use of mechanical aids, frequency of masturbation, also reported by Zamboni & Crawford, 2002). The SOS did not predict self-reported sexual dysfunction. Erotophilia correlated moderately with being gay or lesbian, attitudes toward homosexuality, and having gay friends or acquaintances. Although previous research has found erotophobia erotophilia to be a consistent predictor of sexual health behaviors (see Fisher, 1998), little current research has investigated this connection. Our data (Table 2, Sample 1) suggest that the SOS was generally unrelated to sexual health behaviors, with a few exceptions—for example, ero tophilia predicted self-reported likelihood of pap exams and breast self-examination (but not testicular self-examina tion). Wilkinson, Holahan, and Drane-Edmundson (2002) found that erotophilia predicted safer-sex behaviors for people with cooperative partners, but not for people with uncooperative partners.

Erotophobia-erotophilia has been found to correlate with authoritarianism (Bogaert, 2001; Hogben, Byrne,

Hamburger, & Osland, 2001), sensation-seeking (Bogaert, 2001), and anxious (Bogaert & Sadava, 2002) and dismissive (Schmitt et al., 2001) attachment styles. Hogben et al. (2001) found that SOS scores were related to aggression (although Bogaert did not) and gender-typing for men (again, not found by Bogaert). Our data (Table 2, Sample 4) indicate that SOS scores moderately predict authoritarianism, religiosity, and knowledge of sexual anatomy.

Discriminant validity is provided by evidence that the SOS does not correlate with social desirability, aggression, dominance, intelligence, or psychoticism (Bogaert, 2001). Our own data (Table 2, Sample 4) suggest that erotophobia erotophilia is uncorrelated with social desirability.

Other Information

Although intended to measure an affective disposition, the SOS is generally used as an indicator of general attitudes toward sexuality. Erotophobia-erotophilia tends to be used as one of several potential predictors of an outcome measure of interest, and is occasionally used as an outcome

Exhibit 1

Sexual Opinion Survey

Please respond to each item as honestly as you can. There are no right and wrong answers, and your answers will be completely anonymous.

1. I think it would be very entertaining to look at

hard-core erotica.

I strongly agree I strongly disagree a

2. Erotica is obviously filthy and people should not try to describe it as anything else.

3. Swimming in the nude with a member of the opposite sex would be an exciting experience.

4. Masturbation can be an exciting experience.

5. If I found that a close friend of mine was a homosexual, it would annoy me.

6. If people thought I was interested in oral sex, I would be embarrassed.

7. Engaging in group sex is an entertaining idea.

8. I personally find that thinking about engaging in sexual intercourse is arousing.

9. Seeing an erotic movie would be sexually arousing to me.

10. Thoughts that I may have homosexual tendencies would not worry me at all.

11. The idea of my being physically attracted to members of the same sex is not depressing.

12. Almost all sexually explicit material is nauseating.

13. It would be emotionally upsetting to me to see someone exposing themselves publicly.

14. Watching an exotic dancer of the opposite sex would not be very exciting.

15. I would not enjoy seeing an erotic movie.

16. When I think about seeing pictures showing someone of the same sex as myself masturbating, it nauseates me.

17. The thought of engaging in unusual sex practices is highly arousing.

18. Manipulating my genitals would probably be an arousing experience.

19. I do not enjoy daydreaming about sexual matters.

20. I am not curious about explicit erotica.

21. The thought of having long-term sexual relations with more than one sex partner is not disgusting to me.

Note. Score the survey as follows: First, score responses from 1 = I strongly agree to 7 = I strongly disagree. Second, add scores from Items 2, 5, 6, 12, 13,

14, 15, 16, 19, and 20. Third, subtract from this total the sum of Items 1, 3, 4, 7, 8, 9, 10, 11, 17, 18, and 21. Fourth, add 67 to this quantity. Scores range

from 0 (most erotophobic) to 126 (most erotophilic). For the short form, administer Items 12, 4, 13, 17, and 21 (in this order, renumbered 1–5). Score

responses from 1 = I strongly agree to 7 = I strongly disagree. To reflect current usage, the terms pornography and pornographic from the original scale have been replaced with erotic or sexually explicit material and

stripper has been replaced with exotic dancer.

a The scale is repeated after each item. blink to measure the affective component of antigay bias. Basic and Applied Social Psychology, 27, 37–45.

Nobre, P. J., Wiegel, M., Bach, A. K., Weisberg, R. B., Brown, T. A., Wincze, J. P., et al. (2004). Determinants of sexual arousal and the accuracy of its self-estimation in sexually functional males. The Journal of Sex Research, 41, 363–371.

Rise, J., Traeen, B., & Kraft, P. (1993). The Sexual Opinion Survey Scale: A study on dimensionality in Norwegian adolescents. Health Education Research, 8, 485–492.

Rye, B. J. & Meaney, G. J. (2009). Impact of a homonegativity awareness workshop on attitudes toward homosexuality. Journal of Homosexuality, 56(1), 31–55.

Rye, B. J., Yessis, J., Brunk, T., McKay, A., Morris, S., & Meaney, G. J. (2008). Outcome evaluation of Girl Time: Grade 7/8 Healthy Sexuality Program. Canadian Journal of Human Sexuality, 17, 15–36.

Sanders, S. A., Graham, C. A., Yarber, W. L., Crosby, R. A., Dodge, B., & Milhausen, R. R. (2006). Women who put condoms on male partners: Correlates of condom application. American Journal of Health Behavior, 30, 460–466.

Schmitt, D. P., Shackelford, T. K., Duntley, J., Tooke, W., & Buss, D. M. (2001). The desire for sexual variety as a key to understanding basic human mating strategies. Personal Relationships. Special Issue: Evolutionary Approaches to Relationships, 8, 425–455. Semph, M. E. (1979). Emotional orientation towards sexuality: Its relation to expecting and perceiving contraceptive side effects. Unpublished honors thesis. University of Western Ontario, Department of Psychology, London, Ontario, Canada. Shim, J. W., Lee, S., & Paul, B. (2007). Who responds to unsolicited sexually explicit materials on the Internet? The role of individual differences. CyberPsychology and Behavior, 10, 71–79. Sierra, J. C., Ortega, V., & Zubeidat, I. (2006). Confirmatory factor analysis of a Spanish version of the sex fantasy questionnaire: Assessing gender differences. Journal of Sex and Marital Therapy, 32, 137–159. Smith, G. E., & Nave, C. S. (2007). Illness transmission mode and perceiver personality: Factors affecting stigmatized perceptions of patients and sexual illness. Social Behavior and Personality, 35, 853–860. Wilkinson, A.V., Holahan, C. J., & Drane-Edmundson, E. W. (2002). Predicting safer sex practices: The interactive role of partner cooperation and cognitive factors. Psychology and Health, 17, 697–709. Wilson, B. A., Holm, J. E., Bishop, K. L., & Borowiak, D. M. (2002). Predicting responses to sexually aggressive stories: The role of consent, interest in sexual aggression, and overall sexual interest. The Journal of Sex Research, 39, 275–283. Zamboni, B. D., & Crawford, I. (2002). Using masturbation in sex therapy: Relationships between masturbation, sexual desire, and sexual fantasy. Journal of Psychology and Human Sexuality, 14(2/3), 123–141.

Exhibit 2

Sexual Opinion Survey—Short Form

1. Almost all sexually explicit material is nauseating.

I strongly agree I strongly disagree a

2. Masturbation can be an exciting experience.

3. It would be emotionally upsetting to me to see someone

exposing themselves publicly.

4. The thought of engaging in unusual sex practices is highly arousing.

5. The thought of having long-term sexual relations with more than one sex partner is not disgusting to me.

Note. Score as follows: Score responses from 1 = I strongly agree to 7 = I strongly disagree; then reverse code items 1 and 3; then add all responses. Scores

can range from 5 (most erotophilic) to 35 (most erotophobic). To reflect current usage, the terms pornography and pornographic from the original scale

have been replaced with erotic or sexually explicit material.

a The scale is repeated after each item.

Exhibit 3

Comfort With Sexuality Matters for Very Young Adolescent Girls

Please respond to each item as honestly as you can. There are no right and wrong answers, and your answers will be completely anony

mous.

1. It is not OK for a person to have more than one sex partner during their lifetime.

I strongly disagree I strongly agree a

2. It is OK for a person to masturbate if it makes him/her feel good.

3. It is OK for two men to have sex with each other or two women to have sex with each other.

4. It is not OK for people to have sexual intercourse unless they are in a committed relationship.

5. It is OK to enjoy being sexually aroused (turned on) by a sexy story, picture, or movie.

6. Oral sex b is disgusting to me.

Note. Score as follows: First, score responses from 1 (I strongly disagree) to 7 (I strongly agree); second, reverse code Items 1, 4, and 6; third, average all 6

items. Scores range from 1 (least comfortable) to 7 (most comfortable). Missing data can be ignored provided participants complete at least half of the

items.

a The scale is repeated after each item.

b Our initial sample of Grade 7 girls generally did not know what “oral sex” was. The term was defined briefly by the project manager.

1 Address correspondence to Deanna L. Carpenter, Christopher Newport University, Department of Psychology, 1 University Place, Newport News, VA

23606; e-mail: deanna.carpenter@cnu.edu

The central assumption of the dual control model (Bancroft

& Janssen, 2000) is that sexual arousal and response result

from a balance between inhibitory and excitatory mecha

nisms of the central nervous system. The Sexual Inhibition/

Sexual Excitation Scales (SIS/SES; Janssen, Vorst, Finn, & Bancroft, 2002) consist of 45 items and feature one sexual excitation factor (SES) and two inhibition-related factors: one relevant to the threat of performance failure (SIS1) and one relevant to the threat of performance consequences (SIS2). The SIS/SES has been found to be relevant to the

Sexual Inhibition/Sexual Excitation Scales—Short Form

DEANNA L. CARPENTER, 1 Christopher Newport University

ERICK JANSSEN, The Kinsey Institute for Research in Sex, Gender, and Reproduction

CYNTHIA A. GRAHAM, Warneford Hospital, Oxford

HARRIE VORST AND JELTE WICHERTS, University of Amsterdam

prediction of various aspects of sexual response and behav

ior (for a review, see Bancroft, Graham, Janssen, & Sanders, 2009). Several studies have reported gender differences in SIS/SES scores. Women tend to score higher on sexual inhibition and lower on sexual excitation compared with men, and not all SIS/SES items may be equally relevant to men's and women's arousal (Carpenter, Janssen, Graham, Vorst, & Wicherts, 2008). The SIS/SES—Short Form (SIS/SES-SF) was designed by selecting items that represent the three-factor structure equally well for women and men.

Description

Data were provided by 2,045 Indiana University under graduates (1,067 women and 978 men; mean age = 19.8) who completed the 45-item SIS/SES. A series of factor analyses using LISREL revealed a three-factor solution with equal factor loadings for men and women, involving 19 SIS/SES items. Several SIS/SES items showed differ ences in measurement characteristics between females and males, as evidenced by differences in item intercepts and residual variances. Therefore, only items that were fully "measurement invariant" for men and women were selected. This procedure yielded a 14-item solution that highlights SIS/SES themes of shared relevance to men and women. Shared SES themes included sexual arousal stem ming from social interactions (vs. less relational activities

like sexual fantasy or erotica). SIS1 themes for both women and men included distraction, focus on sexual performance, and past problems with arousal. SIS1 themes of greater relevance to men (excluded from the SIS/SES-SF) included concerns about pleasing partners sexually. For both men and women, SIS2 themes included risk of getting caught or contracting an STD. In contrast, concerns about pregnancy/pain were more relevant to women and are not represented on the SIS/SES-SF. Men scored higher on SES ($M = 17.1$, $SD = 2.8$), lower on SIS1 ($M = 8.2$, $SD = 1.9$), and lower on SIS2 ($M = 10.5$, $SD = 2.1$) than women ($M = 15.0$, $SD = 2.8$; $M = 8.7$, $SD = 1.8$; $M = 12.0$, $SD = 2.3$, respectively; for all, $p < .001$). Correlations between the 45-item SIS/SES and the 14-item Short Form were identical for men and women for SES ($r = .90$), SIS1 ($r = .80$) and SIS2 ($r = .80$).

Response Mode and Timing

The SIS/SES-SF consists of 14 items rated on a 4-point scale (1 = Strongly Agree to 4 = Strongly Disagree). Completion of the questionnaire takes approximately 5 minutes. General instructions are provided (see Exhibit).

Scoring

To score the SIS/SES-SF: first, recode all items so that 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly Agree (i.e., 1 = 4, 2 = 3, 3 = 2, 4 = 1). Then, add responses

to Items 1, 3, 8, 10, 11, and 14 for SES; add responses to

Items 4, 9, 12, and 13 for SIS1; and add responses to Items

2, 5, 6, and 7 for SIS2. This scheme will result in scores ranging from 6 to 24 for SES, and 4 to 16 for SIS1 and SIS2. Missing data can be handled by substituting the mean score for remaining items from that subscale, but discarding incomplete data is preferable. Reliability A subset of our participants (50 men and 51 women) completed the SIS/SES on two occasions, at an average interim of 32 days for women and 48 days for men. After removal of three outliers, for women the test-retest reliability of the SIS/SES-SF was r = .61 for SES, r = .61 for SIS1, and r = .63 for SIS2. For men, test-retest reliability of the Short Form was r = .75 for SES, r = .66 for SIS1, and r = .65 for SIS2. Validity A subset of participants (141 women and 532 men) completed Neuroticism and Extraversion/Introversion Scales of the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975), the Harm Avoidance Scale of the Minnesota Personality Questionnaire (Tellegen & Waller, 1994), the Social Desirability Scale (Hays, Hayashi, & Stewart, 1989), the Behavioral Inhibition/Behavioral Activation Scales (Carver & White, 1994), the Sexual Opinion Survey (Fisher, Byrne, White, & Kelley, 1988), and the Sociosexual Orientation Inventory (Simpson & Gangestad, 1991). These data suggest that convergent and discriminant validity of the SIS/SES-SF resembles that of the 45-item measure (see Table 1). TABLE 1 Correlations of SES, SIS1, and SIS2 With Other Measures SES SIS1 SIS2 Women Men Women Men Women Men Social Desirability Scale (SDSR-5) −.23 .05 −.08 −.06 −.04 .10 Behavioral Inhibition/ Activation Scales BIS .13 .25 a −.03 .20 a .13 .28 a BAS—Reward Responsiveness .04 .35 a −.26 −.05 −.10 −.02 BAS—Drive .14 .24 a .06 −.01 −.06 −.03 BAS—Fun Seeking .26 .25 a −.23 −.14 −.27 −.16 a Eysenck Personality Questionnaire (EPQ) Neuroticism .18 .21 a .19 .23 a .08 −.15 a Extraversion .04 −.01 −.24 −.10 −.13 −.13 Harm Avoidance Subscale (MPQ) −.10 −.04 −.04 .20 a .21 .27 a Sexual Opinion Survey (SOS) .52 a .39 a −.20 −.13 −.31 a −.28 a Sociosexual Orientation Inventory (SOI) .36 a .26 a −.22 .07 −.36 a −.29 a a $p \leq .01$; Holm's sequential Bonferroni procedure (Holm, 1979).

Other Information

In addition to the SIS/SES-SF, two measures assessing dual

control model processes have been reported, including the

original SIS/SES (validated in men by Janssen et al., 2002, and in women by Carpenter et al., 2008) and the SESII-W (validated in women by Graham, Sanders, & Milhausen, 2006). Although gender differences exist in factors that influence sexual excitation and inhibition, many central themes are clearly shared. The SIS/SES-SF focuses on items with similar psychometric properties in women and men. When a measure of broader scope may be preferred, the 45-item version of the SIS/SES and the 36-item SESII W remain good alternatives.

Bancroft, J., Graham, C., Janssen, E., & Sanders, S. (2009). The dual con trol model: Current status and future directions. The Journal of Sex Research, 46, 121–142.

Bancroft, J., & Janssen, E. (2000). The dual control model of male sexual response: A theoretical approach to centrally mediated erectile dys function. Neuroscience and Biobehavioral Reviews, 24, 571–579.

Carpenter, D., Janssen, E., Graham, C. A., Vorst, H., & Wicherts, J. (2008). Women’s scores on the Sexual Inhibition/Sexual Excitation Scales (SIS/SES): Gender similarities and differences. The Journal of Sex Research, 45, 36–48. Carver, C. S., & White, T. L. (1994). Behavioral inhibition, behavioral activation, and affective responses to impending reward and punishment: The

BIS/BAS Scales. Journal of Personality and Social Psychology, 67, 319–333. Eysenck, H. J., & Eysenck, S. B. G. (1975). Manual for the Eysenck Personality Questionnaire. London: Hodder & Stoughton. Fisher, W. A., Byrne, D., White, L. A., & Kelley, K. (1988). Erotophobiaerotophilia as a dimension of personality. The Journal of Sex Research, 25, 123–151. Graham, C. A., Sanders, S., & Milhausen, R. R. (2006). The Sexual Excitation/Sexual Inhibition Inventory for Women: Psychometric properties. Archives of Sexual Behavior, 35, 397–409. Hays, R. D., Hayashi, T., & Stewart, A. L. (1989). A five-item measure of socially desirable response set. Educational and Psychological Measurement, 49, 629–636. Holm, S. (1979). A simple sequentially rejective multiple test procedure. Scandinavian Journal of Statistics, 6, 65–70. Janssen, E., Vorst, H., Finn, P., & Bancroft, J. (2002). The Sexual Inhibition (SIS) and Sexual Excitation (SES) Scales: I. Measuring sexual inhibition and excitation proneness in men. The Journal of Sex Research, 39, 114–126. Simpson, J., & Gangestad, S. (1991). Individual differences in sociosexuality: Evidence for convergent and discriminant validity. Personality and Individual Differences, 6, 870–883. Tellegen, A., & Waller, N. G. (1994). Exploring personality through test construction: Development of a multidimensional personality questionnaire. In S. R. Briggs & J. M. Cheek (Eds.), Personality measures: Development and evaluation (Vol. 1, pp. 133–161). Greenwich, CT: Jai Press.

Exhibit

SIS/SES Questionnaire—Short Form

Instructions: In this questionnaire you will fi nd statements about how you might react to various sexual situations, activities, or

behaviors. Obviously, how you react will often depend on the circumstances, but we are interested in what would be the most likely

reaction for you. Please read each statement carefully and decide how you would be most likely to react. Then circle the number

that corresponds with your answer. Please try to respond to every statement. Sometimes you may feel that none of the responses

seems completely accurate. Sometimes you may read a

statement that you feel is “not applicable.” In these cases, please circle the

response you would choose if it were applicable to you. In many statements you will fi nd words describing reactions such as “sexually

aroused,” or sometimes just “aroused.” With these words we mean to describe “feelings of sexual excitement,” feeling “sexually

stimulated,” “horny,” “hot,” or “turned on.” Don’t think too long before answering. Please give your fi rst reaction. Try to not skip

any questions. Try to be as honest as possible.

Strongly Agree Disagree Strongly

Agree Disagree

1. When a sexually attractive stranger accidentally touches me, I easily become aroused. A B C D

2. If I am having sex in a secluded, outdoor place and I think that someone is nearby, A B C D

I am not likely to get very aroused.

3. When I talk to someone on the telephone who has a sexy voice, I become sexually A B C D

aroused.

4. I cannot get aroused unless I focus exclusively on sexual stimulation. A B C D

5. If I am masturbating on my own and I realize that someone is likely to come into the A B C D

room at any moment, I will lose my erection/my sexual arousal.

6. If I realize there is a risk of catching a sexually transmitted disease, I am unlikely to stay A B C D

sexually aroused.

7. If I can be seen by others while having sex, I am unlikely to stay sexually aroused. A B C D

8. When I think of a very attractive person, I easily become sexually aroused. A B C D

9. Once I have an erection, I want to start intercourse right away before I lose my A B C D

erection/Once I am sexually aroused, I want to start intercourse right away before

I lose my arousal.

Excitability/Excitation

Exhibit

Sexual Excitation/Sexual Inhibition Inventory for Women (SESII-W)

Instructions

This questionnaire asks about things that might affect your sexual arousal. Other ways that we refer to sexual arousal are feeling “turned

on,” “sexually excited,” and “being in a sexual mood.” Women describe their sexual arousal in many different ways. These can include

genital changes (being “wet,” tingling sensations, feelings of warmth, etc.) as well as non-genital sensations (increased heart rate, tem

perature changes, skin sensitivity, etc.) or feelings (anticipation, heightened sense of awareness, feeling “sexy” or “sexual,” etc.). We are interested in what would be the most typical reaction for you now. You may read a statement that you feel does not apply

to you, or may have applied to you in the past but doesn’t now. In such cases please indicate how you think you would respond, if you

were currently in that situation. Some of the questions sound very similar but are in fact different. Please read each statement carefully

and then circle the number to indicate your answer. a Don’t think too long before answering. Please give your first reaction to each question.

Sexual Excitation Factor (Higher-Order Factor)

Arousability

Item Number and Item Content

Loading Direction

15 Seeing an attractive partner’s naked body really turns me on.

17 Just being physically close with a partner is enough to turn me on.

19 I get very turned on when someone really wants me sexually.

20 Fantasizing about sex can quickly get me sexually excited.

24 When I think about someone I find sexually attractive, I easily become sexually aroused.

25 With a new partner I am easily aroused.

26 If I see someone dressed in a sexy way, I easily become sexually aroused.

30 Certain hormonal changes definitely increase my sexual arousal.

32 Sometimes I am so attracted to someone, I cannot stop myself from becoming sexually aroused.

Partner Characteristics

Item Number and Item Content

Loading Direction

5 Someone doing something that shows he/she is intelligent turns me on.

8 If I see a partner interacting well with others, I am more easily sexually aroused.

10 Seeing a partner doing something that shows his/her talent can make me very sexually aroused.

12 Eye contact with someone I fi nd sexually attractive really turns me on.

Sexual Power Dynamics

Item Number and Item Content

Loading Direction

2 It turns me on if my partner “talks dirty” to me during sex.

6 Feeling overpowered in a sexual situation by someone I trust increases my arousal.

-27 If a partner is forceful during sex, it reduces my arousal.

28 Dominating my partner sexually is arousing to me.

Smell

Item Number and Item Content

Loading Direction

22 Particular scents are very arousing to me.

23 Often just how someone smells can be a turn-on.

Setting (Unusual or Unconcealed)

Item Number and Item Content

Loading Direction

3 Having sex in a different setting than usual is a real turn-on for me.

-4 If it is possible someone might see or hear us having sex, it is more difficult for me to get aroused.

-7 I find it harder to get sexually aroused if other people are nearby.

13 I get really turned on if I think I may get caught while having sex.

Sexual Inhibition Factor (Higher-Order Factor)

Concerns about Sexual Function

Item Number and Item Content

Loading Direction

9 If I am concerned about being a good lover, I am less likely to become aroused.

18 If I think about whether I will have an orgasm, it is much harder for me to become aroused.

29 Sometimes I feel so “shy” or self-conscious during sex that I cannot become fully aroused.

31 If I am worried about taking too long to become aroused, this can interfere with my arousal.

Arousal Contingency

Item Number and Item Content

Loading Direction

34 It is difficult for me to stay sexually aroused.

35 When I am sexually aroused the slightest thing can turn me off.

36 Unless things are “just right” it is diffi cult for me to become sexually aroused.

Relationship Importance

Item Number and Item Content

Loading Direction

1 If I think that a partner might hurt me emotionally, I put the brakes on sexually.

11 It would be hard for me to become sexually aroused with someone who is involved with another person.

14 If I think that I am being used sexually it completely turns me off.

16 It is easier for me to become aroused with someone who has “relationship potential.”

21 If I am uncertain about how my partner feels about me, it is harder for me to get aroused.

33 I really need to trust a partner to become fully aroused.

a The response choices for each question are: 1 Strongly Disagree; 2 Disagree; 3 Agree; 4 Strongly Agree.

The Hurlbert Index of Sexual Excitability (HISE) is

described by Hurlbert, Apt, and Rabehl (1993). Reference Hurlbert, D. F., Apt, C., & Rabehl, S. M. (1993). Key

variables to understanding female sexual satisfaction: An examination of women in nondistressed marriages. Journal of Sex & Marital Therapy, 19, 154–165.

Hurlbert Index of Sexual Excitability

DAVID F. HURLBERT, 1 U.S. Department of Health and Human Services

1 Address correspondence to David F. Hurlbert, 140 Farnworth Lane, Roswell, Georgia 30075; e-mail: david.hurlbert@acf.hhs.gov

Exhibit

Hurlbert Index of Sexual Excitability

1. I quickly become sexually excited during foreplay. (R)

2. I find sex with my partner to be exciting. (R)

3. When it comes to having sex with my partner, I experience orgasms. (R)

4. It is difficult for me to become sexually aroused.

5. During sex, I seem to lose with initial level of sexual excitement.

6. I feel I take too long to get sexually aroused.

7. It is hard for me to become sexually excited.

1 Address correspondence to Erick Janssen, The Kinsey Institute for Research in Sex, Gender, and Reproduction, Indiana University, Morrison Hall 313,

1165 East Third Street, Bloomington, Indiana 47405-3700; e-mail: ejanssen@indiana.edu

Sexual Inhibition/Sexual Excitation Scales

ERICK JANSSEN 1 AND JOHN BANCROFT, The Kinsey Institute for Research in Sex, Gender, and

Reproduction

C YNTHIA A. GRAHAM, Warneford Hospital, Oxford, England

DEANNA L. CARPENTER, Christopher Newport University

8. Sex is boring.

9. I quickly become sexually excited when my partner performs oral sex on me. (R)

10. Just thinking about sex turns me on. (R)

11. I find anal sex to be exciting. (R)

12. When it comes to sex, I am easily aroused by my partner touching me. (R)

13. I find masturbation to be sexually stimulating. (R)

14. I seem to lose my sexual excitement too fast.

15. Kissing is sexually arousing for me. (R)

16. Even when I am in the mood, it is difficult for me to get excited about sex.

17. Sexual foreplay is exciting for me. (R)

18. When it comes to sex, it seems to take me a long time to get sexually aroused.

19. Pleasing my partner is sexually exciting for me. (R)

20. I have difficulty maintaining my sexual excitement.

21. I find sexual intercourse to be exciting. (R)

22. When it comes to sex, I think my level of sexual excitement is low.

23. Even when I desire sex, it seems hard for me to become excited.

24. Giving my partner oral sex is sexually exciting for me. (R)

25. In general, sex is satisfying for me. (R)

Note. (R) = Reverse-scored items. Scoring system responses: all of the time = 0 points; most of the time = +1 point; some of the time = +2 points; rarely =

+3 points; never = +4 points.

The Sexual Inhibition/Sexual Excitation Scales (SIS/SES) assess a person's propensity for sexual inhibition and excitation. The underlying theoretical model postulates that sexual response and associated behaviors depend on dual control mechanisms, involving excitatory and inhibi tory neurophysiological systems (Bancroft & Janssen, 2000). Sexual inhibition and excitation, as measured by these scales, have been found to be predictive of sexual desire and arousal, sexual functioning, sexual risk tak ing, sexual compulsivity, sexual aggression, sexual infi delity, and the effects of negative mood on sexuality (see Bancroft, Graham, Janssen, & Sanders, 2009, and Janssen & Bancroft, 2007, for reviews).

Description

The SIS/SES, although initially developed for men (Janssen, Vorst, Finn, & Bancroft, 2002a, 2002b), can be used in both male and female samples. A facet design approach was used to guide scale development (e.g., Shye & Elizur, 1994). The majority of items were written in an "if-then" form. A variety of facets are covered, including the type of stimulus (e.g., social, imaginary, visual, tactile) and type of response (sexual arousal or genital response). Inhibition is conceptualized to play a specific role in the modification of sexual responses in the avoidance or reduction of threat. Threats can be intrapersonal or interpersonal in nature and can involve norms and values, physical and psychological harm, etc. Factor analysis on the data from a sample of 408 sexually functional, heterosexual men (mean age = 23 years) identified 10 factors (Janssen et al., 2002a). A further factor analysis of the subscale scores identified a single excitation factor (SES), but differentiated sexual inhibition into two factors: Inhibition Due to Threat of Performance Failure (SIS1) and Inhibition Due to the

Threat of Performance Consequences (SIS2). SES consists of 20 items and four subscales, SIS1 consists of 14 items and three subscales,

and SIS2 consists of 11 items and three subscales. The fac

tor loadings were between .6 and .9 and the three factors

together accounted for 60% of the variance. Multigroup

confirmatory factor analyses on the data from a second

sample of 459 men (mean age = 21 years) and a third sam

ple of 313 men (mean age = 46 years) further supported the

use of the higher-level factor structure.

The three scales showed close to normal distributions in

all three samples. SES and SIS1 were related to age (e.g., r

= −.24 and .34, respectively, in the third sample). In addi

tion, correlations between SES and the two inhibition fac

tors were low (e.g., SES-SIS1: r = −.07; SES-SIS2: r =

−.11 in the first sample), suggesting that sexual excitation

and inhibition are relatively independent. A significant but

modest correlation (r = .28, first sample) revealed limited

overlap between the two inhibition scales.

A later study (Carpenter, Janssen, Graham, Vorst, &

Wicherts, 2008) compared 978 men (mean age = 20 years)

with 1,067 heterosexual women (mean age = 19 years), and

confirmatory factor analysis suggested an acceptable fit of

the three-factor structure in women.

Response Mode and Timing

Respondents are asked to indicate what their “most likely

reaction" would be to a series of statements and to provide a

rating on a 4-point scale (1 = Strongly Agree to 4 = Strongly

Disagree) to a total of 45 questions. Completion of the

questionnaire takes approximately 10 minutes.

Scoring

To compute scores, all but two (Items 17 and 45; see

Exhibit) of the items first need to be reversed (1 = 4, 2 = 3,

3 = 2, 4 = 1). Missing values can be replaced with the mean

of the other items making up the lower-level factor to which

the missing item belongs (see Exhibit). It is recommended

that no scores are computed if more than 10 out of the 45

items are missing, and that missing values are assigned to

SES if more than 5 SES items are missing, to SIS1 if more

than 4 SIS1 items are missing, and to SIS2 if more than 3

SIS2 items are missing. SES consists of the sum of Items 1,

3, 4, 6, 7, 11, 13, 14, 16, 25, 26, 29, 30, 32, 35, 37, 38, 39,

43, and 44. SIS1 consists of the sum of Items 5, 9, 10, 17

(not recoded), 19, 20, 21, 23, 33, 36, 40, 41, 42, and 45 (not

recoded). SIS2 consists of the sum of Items 2, 8, 12, 15, 18,

22, 24, 27, 28, 31, and 34.

Reliability

Cronbach alpha scores for the three male samples were

.89, .89, and .88 for SES; .81, .78, and .83 for SIS1; and .73, .69, and .75 for SIS2 (Janssen et al., 2002a). In women (Carpenter et al., 2008), the corresponding alphas were .87, .76, and .70.

A sample of 50 men (Janssen et al., 2002a) and 51 women (Carpenter et al., 2008) completed the SIS/SES questionnaire on two occasions. The average number of weeks between sessions was 7 for men and a little under 5 for women. Test-retest correlations were .76 (SES), .67 (SIS1), and .74 (SIS2) for men, and .70 (SES), .68 (SIS1), and .60 (SIS2, after removal of two outliers) for women. Validity In evaluating the scales' discriminant and convergent validity (see Carpenter et al., 2008; Janssen et al., 2002a), we found a small degree of overlap with measures of traits of behavioral inhibition, neuroticism, harm avoidance, and reward responsivity, suggesting that the SES scale is related to aspects of reward responsivity and the SIS scales (especially SIS2) tap aspects of behavioral inhibition (see Table 1). However, the limited degree of overlap supports the idea that the SIS/SES questionnaire predominantly measures propensities that are specific to sexual responsivity. For more information on validity, including associations with sexual functioning and sexual risk taking, see Bancroft et al. (2009) and Janssen and Bancroft (2007). Other Information The SIS/SES and additional information, including an SPSS file for scoring, can be found online at http://www.indiana.edu/~sexlab. There are no fees attached to its use.

TABLE 1 Correlations of SES, SIS1, and SIS2 With Other Measures

	SES		SIS1		SIS2	
	Women	Men	Women	Men	Women	Men
Social Desirability Scale (SDSR-5)	−.23	.02	−.18	−.11	−.01	.17 a
Behavioral Inhibition/ Activation Scales						
BIS	.16	.23 a	−.01	.13	.16	.21 a
BAS—Reward Responsiveness	.11	.37 a	−.19	−.12 a	−.08	−.01
BAS—Drive	.15	.25 a	.06	−.01	−.09	−.07
BAS—Fun Seeking	.27 a	.25 a	−.19	−.18	−.31 a	−.17 a
Eysenck Personality Questionnaire (EPQ)						
Neuroticism	.16	.22 a	.18	.20 a	.07	−.09
Extraversion	.03	−.01	−.20	−.14 a	−.12	−.10
Harm Avoidance Subscale (MPQ)	−.10	−.05	−.08	.19 a	.23	.26 a
Sexual Opinion Survey (SOS)	.58 a	.42 a	−.08	−.10	−.33 a	−.28 a
Sociosexual Orientation Inventory (SOI)	.38 a	.20 a	−.12	.08	−.47 a	−.33 a

Note. Women: N = 141 for all measures except SDSR-5: N = 1,040. Men: N = 531 for all measures except SDSR-5: N = 971. Table taken from Carpenter et al. (2008). a $p \leq .01$; Holm's sequential

Bonferroni procedure (Holm, 1979).

Exhibit

SIS/SES Scales

Instructions: In this questionnaire you will find statements about how you might react to various sexual situations, activities, or behaviors.

Obviously, how you react will often depend on the circumstances, but we are interested in what would be the most likely reaction for

you. Please read each statement carefully and decide how you would be most likely to react. Then circle the number that corresponds

with your answer. Please try to respond to every statement. Sometimes you may feel that none of the responses seems completely

accurate. Sometimes you may read a statement which you feel is “not applicable.” In these cases, please circle a response which you

would choose if it were applicable to you. In many statements you will find words describing reactions such as “sexually aroused,”

or sometimes just “aroused.” With these words we mean to describe “feelings of sexual excitement,” feeling “sexually stimulated,”

“horny,” “hot,” or “turned on.” Don’t think too long before answering; please give your first reaction. Try not to skip any questions.

Try to be as honest as possible.

Item # Item Lower-Level Factor

1. When I look at erotic pictures, I easily become sexually aroused. SES_2

2. If I feel that I am being rushed, I am unlikely to get very aroused. SIS2_3

3. If I am on my own watching a sexual scene in a film, I quickly become sexually aroused. SES_2

4. Sometimes I become sexually aroused just by lying in the sun/Sometimes just lying in the sun sexually SES_4

arouses me.

5. Putting on a condom can cause me to lose my erection/Using condoms or other safe-sex products SIS1_1

can cause me to lose my arousal.

6. When a sexually attractive stranger accidentally touches me, I easily become aroused. SES_1

7. When I have a quiet candlelight dinner with someone I find sexually attractive, I get aroused. SES_1

8. If there is a risk of unwanted pregnancy, I am unlikely to get sexually aroused. SIS2_2

9. I need my penis to be touched to maintain an erection/I need my clitoris to be stimulated to SIS1_1

continue feeling aroused.

10. When I am having sex, I have to focus on my own sexual feelings in order to keep my erection/stay SIS1_1

aroused.

11. When I feel sexually aroused, I usually have an erection/I usually have a genital response (e.g., vaginal SES_3

lubrication, being wet).

12. If I am having sex in a secluded, outdoor place and I think that someone is nearby, I am not likely to SIS2_1

get very aroused.

13. When I see someone I find attractive dressed in a sexy way, I easily become sexually aroused. SES_1

14. When I think someone sexually attractive wants to have sex with me, I quickly become sexually SES_1

aroused.

15. If I discovered that someone I find sexually attractive

is too young, I would have difficulty getting SIS2_3

sexually aroused with him/her.

16. When I talk to someone on the telephone who has a sexy voice, I become sexually aroused. SES_1

A short (14-item) version is also available (see this

volume).

Bancroft, J., Graham, C, Janssen, E., & Sanders, S. (2009). The dual control model: Current status and future directions. The Journal of Sex Research, 46, 121-142.

Bancroft, J., & Janssen, E. (2000). The dual control model of male sexual response: A theoretical approach to centrally mediated erectile dysfunction. Neuroscience and Biobehavioral Reviews, 24, 571-579.

Carpenter, D. L., Janssen, E., Graham, C. A., Vorst, H., & Wicherts, J. (2008). Women's scores on the Sexual Inhibition/Sexual Excitation Scales (SIS/SES): Gender similarities and differences. The Journal of Sex Research, 45, 36-48. Holm, S. (1979). A simple sequentially rejective multiple test procedure. Scandinavian Journal of Statistics, 6, 65-70. Janssen, E., & Bancroft, J. (2007). The dual control model: The role of sexual inhibition and excitation in sexual arousal and behavior. In E. Janssen (Ed.), The psychophysiology of sex (pp. 197-222). Bloomington: Indiana University Press. Janssen, E., Vorst, H., Finn, P., & Bancroft, J. (2002a). The Sexual Inhibition (SIS) and Sexual Excitation (SES) Scales: I. Measuring sexual inhibition and excitation proneness in men. The Journal of Sex Research, 39, 114-126. Janssen, E., Vorst, H., Finn, P., & Bancroft, J. (2002b). The Sexual Inhibition (SIS) and Sexual Excitation (SES) Scales: II. Predicting psychophysiological response patterns. The Journal of Sex Research, 39, 127-132. Shye, S., & Elizur, D. (1994). Introduction to facet theory: Content design and intrinsic data analysis in behavioral research. Thousand Oaks, California: Sage.

17. When I notice that my partner is sexually aroused, my own arousal becomes stronger. [This item SIS1_2

should not be recoded]

18. If my new sexual partner does not want to use a condom, I am unlikely to stay aroused/If my new SIS2_2

sexual partner does not want to use a condom/safe-sex product, I am unlikely to stay aroused.

19. I cannot get aroused unless I focus exclusively on sexual stimulation. SIS1_1

20. If I feel that I'm expected to respond sexually, I have difficulty getting aroused. SIS1_3

21. If I am concerned about pleasing my partner sexually, I easily lose my erection/If I am concerned SIS1_2

about pleasing my partner sexually, it interferes with my arousal.

22. If I am masturbating on my own and I realize that someone is likely to come into the room at any SIS2_1

moment, I will lose my erection/my sexual arousal.

23. It is difficult to become sexually aroused unless I fantasize about a very arousing situation. SIS1_1

24. If I can be heard by others while having sex, I am unlikely to stay sexually aroused. SIS2_1

25. Just thinking about a sexual encounter I have had is enough to turn me on sexually. SES_3

26. When I am taking a shower or a bath, I easily become sexually aroused. SES_4

27. If I realize there is a risk of catching a sexually transmitted disease, I am unlikely to stay sexually SIS2_2

aroused.

28. If I can be seen by others while having sex, I am unlikely to stay sexually aroused. SIS2_1

29. If I am with a group of people watching an X-rated film, I quickly become sexually aroused. SES_2

30. When a sexually attractive stranger looks me straight in the eye, I become aroused/When a sexually SES_1

attractive stranger makes eye-contact with me, I become aroused.

31. If I think that having sex will cause me pain, I will lose my erection/my arousal. SIS2_3

32. When I wear something I feel attractive in, I am likely to become sexually aroused. SES_4

33. If I think that I might not get an erection, then I am less likely to get one/If I am worried about being SIS1_3

too dry, I am less likely to get lubricated.

34. If having sex will cause my partner pain, I am unlikely to stay sexually aroused. SIS2_3

35. When I think of a very attractive person, I easily become sexually aroused. SES_1

36. Once I have an erection, I want to start intercourse right away before I lose my erection/Once I am SIS1_1

sexually aroused, I want to start intercourse right away before I lose my arousal.

37. When I start fantasizing about sex, I quickly become sexually aroused. SES_3

38. When I see others engaged in sexual activities, I feel like having sex myself. SES_2

39. When I see an attractive person, I start fantasizing about having sex with him/her. SES_1

40. When I have a distracting thought, I easily lose my erection/my arousal. SIS1_1

41. I often rely on fantasies to help me maintain an erection/my sexual arousal. SIS1_1

42. If I am distracted by hearing music, television, or a conversation, I am unlikely to stay aroused. SIS1_3

43. When I feel interested in sex, I usually get an erection/I usually have a genital response (e.g., vaginal SES_3

lubrication, being wet).

44. When an attractive person flirts with me, I easily become sexually aroused. SES_1

45. During sex, pleasing my partner sexually makes me more aroused. [This item should not be recoded] SIS1_2

Note. When different item versions are used for men and women, both versions are given (male/female). Answer categories are 1 = Strongly Agree,

2 = Agree, 3 = Disagree, 4 = Strongly Disagree.

The Sexual Excitation/Sexual Inhibition Inventory for

Women and Men (SESII-W/M) was developed to assess

propensity for sexual excitation (SE) and sexual inhibition

(SI) in response to a broad range of stimuli and sexual situ

ations in both women and men.

Description

The theoretical model underlying the SESII-W/M is the

dual control model of sexual response (Bancroft, 1999;

Bancroft, Graham, Janssen, & Sanders, 2009; Bancroft

& Janssen, 2000). The model suggests that sexual arousal

depends upon the relative activation of SE and SI, sepa

rate and independent systems (Bancroft, 1999; Bancroft &

Janssen, 2000). Two questionnaires assessing propensity for SE and

SI were developed prior to the SESII-W/M. The Sexual

Inhibition/Sexual Excitation Scales (SIS/SES; Janssen,

Vorst, Finn, & Bancroft, 2002) were developed for

men; however, because the SIS/SES was thought to lack

factors that could be particularly important to women’s

sexual arousal, the Sexual Excitation/Sexual Inhibition

Inventory for Women (SESII-W; Graham, Sanders, &

Milhausen, 2006) was developed based on qualitative data from focus groups of women (Graham, Sanders, Milhausen, & McBride, 2004). Many of the issues raised by women in the focus groups seemed also relevant for men's arousal (e.g., self-esteem, negative mood, emotional connection to a partner, context for sexual encounter). Indeed, results from a recent focus group study of men suggest that these factors can facilitate or interfere with men's sexual arousal (Janssen, McBride, Yarber, Hill, & Butler, 2008). Exploratory factor analysis (EFA) was conducted on the original SESII-W items, using a sample of 530 undergraduate and graduate men and women randomly selected from a list of 4,000 students attending a large, midwestern university (Milhausen, Graham, Sanders, Yarber, & Maitland, in press). EFA identified eight factors, but two factors comprised only two items and were thus removed from the confirmatory factor analysis (CFA) model. The final six-factor solution includes the following: Inhibitory Cognitions (the potential for arousal to be disrupted by worries or negative thoughts about sexual functioning and performance), Relationship Importance (reflecting the need for sex to occur within a specific relationship context), Arousability (the tendency to become sexually aroused in a variety of situations), Partner Characteristics and Behaviors (the tendency for a partner's personality or behavior to enhance arousal), Setting (Unusual or Unconcealed; the tendency for arousal to be increased by the possibility of being seen or heard having sex or having sex in a novel situation), and Dyadic Elements of the Sexual Interaction

(the tendency for negative partner dynamics during the sexual interaction to inhibit sexual arousal). Twenty of the 30 items on the SESII-W/M are also found on the SESII-W, and five of the factors (Inhibitory Cognitions, Relationship Importance, Arousability, Partner Characteristics and Behaviors, and Setting [Unusual/Unconcealed]) are highly similar to factors on the SESII-W. The questionnaire is appropriate for use with women and men of different sexual orientations and varying degrees of sexual experience, and can be completed by persons who are not in a current sexual relationship. Response Mode and Timing The response format is a 4-point, Likert-type rating scale, from Strongly Disagree to Strongly Agree. For full instructions, see the Exhibit. Items should be scrambled so that items on a subscale do not appear together. The questionnaire typically takes between 10 and 15 minutes to complete. Scoring Items are scored in the following way: 1= Strongly Disagree; 2 = Disagree; 3 = Agree; 4 = Strongly Agree. Items denoted with an asterisk should be reverse coded. Using the items coded as indicated above, a mean score is then generated for each of the subscales. Reliability Reliability and validity were assessed with a sample of men and women recruited from distance education classes at a Canadian university. The subscales had Cronbach's alphas between .66 and .76, with an average of .73. Test-retest

1 Address correspondence to Robin R. Milhausen, Department of Family Relations and Applied Nutrition, Room 217 MINS Building, University of

Guelph, Guelph, Ontario N1G 2W1, Canada; e-mail: rmilhaus@uoguelph.ca

Sexual Excitation/Sexual Inhibition Inventory for

Women and Men

ROBIN R. MILHAUSEN, 1 University of Guelph

C YNTHIA A. GRAHAM, Warneford Hospital, Oxford, England

S TEPHANIE A. SANDERS, The Kinsey Institute for Research in Sex, Gender, and Reproduction

reliability correlations ranged from r = .66 to r = .82, with a

mean correlation of .76 (Milhausen et al., in press).

Validity

Convergent and discriminant validity was demonstrated and the pattern of correlations generally matched those based on the SESII-W (Graham et al., 2006). Most correla tions between the SESII-W/M factors and the Behavioral Inhibition/Behavioral Activation Scales (BIS/BAS; Carver & White, 1994), the Sexual Opinion Survey (SOS; Fisher, 1998) and the Sexual Sensation Seeking Scale (SSSS; Kalichman & Rompa, 1995) were low to moderate and in the expected direction. No correlation was found between the Social Desirability Scale (SDSR; Hayes, Hayashi, & Stewart, 1989) and any of the SESII-W/M scales (Milhausen et al., in press).

Other Information

In the validation study, men's and women's scores on the subscales were significantly different at $p < .001$ (Milhausen et al., in press); effect sizes were moderate and very large (Hyde, 2005). Women scored higher on Inhibitory Cognitions, Relationship Importance, Partner Characteristics and Behaviors, and Dyadic Elements of the Sexual Interaction. Men scored higher on Arousability and Setting (Unusual or Unconcealed; Milhausen et al., in press).

The SESII-W/M will likely be a useful measure in inves tigations in which propensity for sexual inhibition and

excitation in response to specific situations or stimuli must

be measured identically for men and women. Researchers

are encouraged to use the SESII-W/M for this purpose. The

authors would appreciate receiving information about the

results obtained with the measure.

Additional affiliation information: Robin R. Milhausen,

The Kinsey Institute for Research in Sex, Gender, and

Reproduction; Rural Center for AIDS/STD Prevention,

Indiana University, Bloomington. Cynthia A. Graham,

The Kinsey Institute for Research in Sex, Gender, and

Exhibit

Sexual Excitation/Sexual Inhibition Inventory for Women and Men

The next set of items asks about things that might affect your sexual arousal. Other ways that we refer to sexual arousal are feeling

“turned on,” “sexually excited,” and “being in a sexual mood.” Men and women describe their sexual arousal in terms of genital changes

(being “hard,” being “wet,” tingling sensations, feelings of warmth, etc.). Men and women also mention non-genital sensations (increased

heart rate, temperature changes, skin sensitivity, etc.) or feelings (anticipation, feeling “open,” etc.).

We are interested in what would be the most typical reaction for you now. You might read a statement that you feel is not applicable

to you, or a statement that refers to a situation that may have occurred in the past but is not likely to occur now. In such cases please

indicate how you think you would respond, if you were in

that situation. Some of the questions sound very similar, but are different;

please read each question carefully and then mark the response which indicates your answer. Don’t think too long before answering.

Please give your first reaction to each question. a

Inhibitory Cognitions

Sometimes I have so many worries that I am unable to get aroused.

If I feel that I am expected to respond sexually, I have difficulty getting aroused.

Sometimes I feel so “shy” or self-conscious during sex that I cannot become fully aroused.

If I think about whether I will have an orgasm, it is much harder for me to become aroused.

If I am worried about taking too long to become aroused, this can interfere with my arousal.

When I am having sex, I have to focus on my own sexual feelings in order to stay aroused.

If I am concerned about being a good lover, I am less likely to become aroused.

Unless things are “just right” it is diffi cult for me to become sexually aroused.

Relationship Importance

It would be hard for me to become sexually aroused with someone who is involved with another person.

I really need to trust a partner to become fully aroused.

If I am very sexually attracted to someone, I don’t need to be in a relationship with that person to become sexually aroused.*

If I think that I am being used sexually it completely turns me off.

If I think that a partner might hurt me emotionally, I put

the brakes on sexually.

Arousability

When I think about someone I find sexually attractive, I easily become sexually aroused.

I think about sex a lot when I am bored.

Sometimes I am so attracted to someone, I cannot stop myself from becoming sexually aroused.

Just talking about sex is enough to put me in a sexual mood.

Just being physically close with a partner is enough to turn me on.

Partner Characteristics and Behaviors

Someone doing something that shows he/she is intelligent turns me on.

Seeing a partner doing something that shows his/her talent can make me very sexually aroused.

If I see a partner interacting well with others, I am more easily sexually aroused.

If a partner surprises me by doing chores, it sparks my sexual interest.

I fi nd it arousing when a partner does something nice for me.

Setting (Unusual or Unconcealed)

If it is possible someone might see or hear us having sex, it is more difficult for me to get aroused.*

I get really turned on if I think I may get caught while having sex.

I find it harder to get sexually aroused if other people are nearby.*

Having sex in a different setting than usual is a real turn-on for me.

Dyadic Elements of the Sexual Interaction

While having sex, it really decreases my arousal if my partner is not sensitive to the signals I am giving.

If interferes with my arousal if there is not a balance of giving and receiving pleasure during sex.

If I am uncertain how my partner feels about me, it is harder for me to get aroused.

a The response choices for each question are: 1 Strongly Disagree; 2 Disagree; 3 Agree; 4 Strongly Agree.

*Items should be reverse coded when scoring.

Experience (see Behavior)

Exhibit

Extramarital Behavioral Intentions Scale

Would you engage in the following behavior with another man/woman if the opportunity were to present itself?

1. flirting

a. certainly not

b. probably not

c. maybe not

d. uncertain

e. maybe yes

f. probably yes

g. certainly yes

2. sexual intercourse a

3. light petting

4. a long-term sexual relationship

5. falling in love

a The seven response options are repeated for each item

Intentions Towards Infi delity Scale

DANIEL NELSON JONES, 1 University of British Columbia

S ALLY GAYLE OLDERBAK AND AURELIO JOSÉ FIGUEREDO, University of Arizona

1 Address correspondence to Daniel N. Jones, 2136 West Mall, Department of Psychology, UBC, Vancouver, BC, Canada, V6T 1Z4; e-mail:

jonesdn@gmail.com

Infidelity is one of the leading causes of divorce and

relationship dissolution (Daly, Wilson, & Weghorst, 1982). Thus, being able to predict who will be unfaithful in the future would be critical to assessing relationship longevity and fidelity. We created the Intentions Towards Infidelity Scale (ITIS) in order to predict who is likely to stay faithful to a romantic partner.

Description

Infidelity causes emotional pain and turmoil in addition to concerns of exposing, or actually exposing, a current partner to a sexually transmitted infection. Attitudes towards infidelity only provide some evidence for who will be unfaithful in the future, because attitudes do not always directly translate into behavior as well as behavioral intentions (Ajzen & Fishbein, 2005). Certain individual differences, such as personality, also can predict infidelity. However, such scales are long and measure global dispositions towards negative interpersonal behavior rather than specifically targeting infidelity (Hall & Fincham, 2005). As a result, we created a brief scale that measures behavioral intentions in order to assess the likelihood of engaging in infidelity behaviors (e.g., intentions to hide the relationship from an attractive other or be unfaithful in the future).

Response Mode and Timing

The ITIS is a self-report questionnaire with responses rang

ing from -3, Not at all Likely, to +3, Extremely Likely. The ITIS takes less than a minute to complete.

Scoring and Reliability

The ITIS consists of seven items. Once the third item is reverse scored, the items should then be averaged to create a single score. The ITIS has one common factor, on which all items consistently load. The Cronbach's alpha internal reliability is also consistently good across samples (Jones, 2009; Olderbak, 2008; Olderbak & Figueredo, 2009), rang ing from .70 to .81. To date, there is no test-retest reliability information available on the scale.

Validity

Convergent and Discriminant Validity

The ITIS is a new scale, which demonstrates good valid ity in preliminary samples (Jones, 2009; Olderbak, 2008; Olderbak & Figueredo, 2009). At present, the only validity data available are on college-aged samples, although we argue that the scale is appropriate for anyone who is in a committed romantic relationship.

The ITIS shows strong overall correlations with previous and current self-reports of frequency of infidelity behavior with the average correlation of all the studies ranging from .50 to .60 (Jones, 2009). In addition, Jones (2009) also con ducted several studies correlating the ITIS with a number of variables related to sexual and romantic relationships. All

effect size terminology is based on Cohen’s (1988) taxon

Exhibit

Intentions Towards Infidelity Scale

Please indicate how likely or unlikely you would be to do the following things. Use the scale below to answer the following questions.

Not at all Likely Extremely Likely

-3 -2 -1 0 +1 +2
+3

1. How likely are you to be unfaithful to a partner if you knew you wouldn’t get caught?

2. How likely would you be to lie to a partner about being unfaithful to them?

3. How likely would you be to tell a partner if you were unfaithful to them? [R]

4. How likely do you think you would be to get away with being unfaithful to a partner?

5. How likely would you be to hide your relationship from an attractive person you just met?

6. How likely do you think you are to be unfaithful to future partners?

7. How likely do you think you are to be unfaithful to your present or future husband or wife?

Daly, M., Wilson, M., & Weghorst, S. J. (1982). Male sexual jealousy. Ethology and Sociobiology, 3, 11-27.

Hall, J. H., & Fincham, F. D. (2005). Relationship dissolution following infidelity. In M. Fine & J. Harvey (Eds.), The handbook of divorce and romantic relationship dissolution (pp. 153-168). Mahwah, NJ: Erlbaum.

Jones, D. N. (2009). The personality of a cheater. Manuscript in preparation.

Olderbak, S. G. (2008). Predicting relationship satisfaction in heterosexual couples longitudinally.

Unpublished master’s thesis, Department of Psychology, University of Arizona. Olderbak, S. G., & Figueredo, A. J. (2009). Predicting romantic relationship satisfaction from life history strategy. Personality and Individual Differences, 46, 604–610. Zuckerman, M., Kulhman, M. D., Joireman, J., Teta, P., & Kraft, M. (1993). A comparison of three structural models for personality: The Big Three, the Big Five, and the Alternative Five. Journal of Personality and Social Psychology, 65, 757–768.

Reiss Extramarital Sexual Permissiveness Scale

IRA L. REISS, 1 University of Minnesota

This scale was designed to measure whether people would accept extramarital coitus for themselves under any of four culturally relevant situations.

Description

The four questions combine two important aspects of an extramarital relationship: One aspect focuses on whether the extramarital relation is pleasure-centered or love-centered, and the other aspect focuses on whether one’s mate accepts or rejects their partner having that sort of extramarital relationship. Together these aspects produce a way of classifying four types of extramarital relationships and measuring the degree of extramarital sexual permissiveness. One can then check responses by gender and other demographic variables. The scale can be answered by those in a marital relationship or by those not married. The unmarried people can answer in terms of how they think they would respond if they were married. I suggest that all respondents be asked to answer the same four questions in two formats—one assuming the marriage they are in is unhappy and the other assuming that the marriage is happy. The differences in these responses would be a measure of the importance of

marital happiness. In research I carried out on four national samples, I found that three factors had a direct impact on what is accepted or rejected in extramarital attitudes: educational level, attitude toward premarital sexuality, and level of marital happiness (Reiss, 2006; Reiss, Anderson, & Sponaugle, 1980). I would suggest that any research into extramarital sexuality probe these three powerful predictors of extramarital sexual permissiveness as well as other predictors that can be tested (Buunk & Bakker, 1995; Hansen, 1987; Reiss & Miller, 1979; Weis & Jurich, 1985; Weis & Slosnerick, 1981).

1 Address correspondence to Ira L. Reiss, 5932 Medicine Lake Road, Minneapolis, MN 55422; e-mail: irareiss@comcast.net

Exhibit

Reiss Extramarital Sexual Permissiveness Scale

Answer in terms of your personal values concerning what you would accept in your marriage under the conditions stated. If you are

not currently married, answer in terms of a possible future marriage.

1. Would you accept extramarital sexual intercourse in which physical pleasure is your focus even though your mate would not accept

your having such a relationship?

Response Mode and Timing

There are four response categories to each of the four

questions: (a) Definitely, (b) Probably, (c) Unlikely, (d)

Never. Assuming that you would ask these four questions

twice—once asking the respondent to assume that he/she is

in a happy marriage and once assuming that he/she is in an

unhappy marriage—it would take a respondent about 5 or 6

minutes to answer all the questions.

Scoring

Respondents do seem to like having four answer catego
ries but, for scaling purposes, I suggest dichotomizing the
answers by counting “Definitely” or “Probably” as an affir
mative response and counting “Unlikely” or “Never” as a
rejecting response and giving one point for each question
that the respondent affirms. I would, of course, do this
scor
ing separately for the unhappy marriage condition and the
happy marriage condition. So the top score in each of the
two scales would be 4 and the lowest score would be 0. I
would add that one could gain a rough measure of the equal
itarianism of the respondents by asking them if they would
have any problem if their mates gave the same answers as
they did. Further, if you were studying married couples, it
would be worthwhile to compare the scale scores of the two
people in the marriage.

Reliability

Reliability can be established by noting that the scales
have
always met the general Guttman criteria concerning the
coefficient of reproducibility and the coefficient of scal
ability.

Validity

My colleagues and I analyzed four different nationally
representative samples from four different years to test for
the best predictors of extramarital sexual permissiveness

(Reiss et al., 1980). The national samples were carried out by the National Opinion Research Center. Our results were tested and supported by these different samples.

Construct validity was also established by finding the expected differences between men and women and between religiously devout and nondevout groups of peo ple (Banfield & McCabe, 2001; Sponaugle, 1993). In addi

Famlily

Exhibit

Parent Outcome Expectancy Scale

Read these statements about talking with your child about sex. Talking with your child about sex includes topics such as how babies are

made, names of the genitals, physical changes of puberty, menstruation, wet dreams, waiting to have sex until your child is older, birth

control, and HIV or AIDS. For each statement, state how much you agree or disagree.

Response Options:

1 Strongly Disagree

2 Disagree

3 Neither Disagree nor Agree

4 Agree

5 Strongly Agree

Items

1. If I talk with [my child] about sex topics, I will feel proud.

2. If I talk with [my child] about sex topics, I will feel like a responsible parent.

3. If I talk with [my child] about sex topics, I will feel that I did the right thing.

4.* If I talk with [my child] about sex topics, I will be embarrassed.

5.* If I talk with [my child] about sex topics, I will find some things difficult to talk about.

6. If I talk with [my child] about sex topics, I think [my child] will listen.

7. If I talk with [my child] about sex topics, I will feel

comfortable.

8.* If I talk with [my child] about sex topics, [my child] will do what [my child] wants no matter what I say.

9.* If I talk with [my child] about sex topics, I will feel ashamed.

10. If I talk with [my child] about sex topics, I think it will do some good.

11. If I talk with [my child] about sex topics, [my child] will be less likely to have sexual intercourse as a young teen.

12.* If I talk with [my child] about sex topics, it would be unpleasant.

13. If I talk with [my child] about sex topics, [my child] will be less likely to get pregnant or get a girl pregnant.

14. If I talk with [my child] about sex topics, I will find these issues easy to talk about.

15. If I talk with [my child] about sex topics, I will feel relieved.

16.* If I talk with [my child] about sex topics, [my child] will be embarrassed.

17.* If I talk with [my child] about sex topics, [my child] will not want to talk to me.

18. If I talk with [my child] about sex topics, I will have done what parents should do.

19. If I talk with [my child] about sex topics, [my child] will remember the discussion when [my child] is older.

20. If I talk with [my child] about sex topics, [my child] will appreciate my willingness to provide further information.

21.* If I talk with [my child] about sex topics, [my child] will be uncomfortable during the discussion.

22. If I talk with [my child] about sex topics, [my child] will be more able to resist peer pressure to have sex.

23. If I talk with [my child] about sex topics, [my child]

will know where I stand on teens having sex.

*Reverse code before summing.

Parenting Self-Effi cacy Scale

COLLEEN DIIORIO, 1 Emory University

The purpose of the Parenting Self-Efficacy Scale (PSES) is to measure parents' confidence in their ability to talk to their children about sexuality issues. Description The development of the PSES was based on the concept of self-efficacy (SE), a central construct of social cognitive theory (Bandura, 1997). Bandura defined self-efficacy as the belief in personal capability to organize and execute behaviors. People who have strong beliefs in their abilities are more likely to perform behaviors and more likely to be successful. Applied to the situation of parent-child sexual communication, this means that parents who are confident that they can talk to their children about sexuality issues are more likely to do so.

1 Address correspondence to Colleen DiIorio, Emory University, Rollins School of Public Health, Department of Behavioral Sciences and Health Education, 1518 Clifton Road NE, Atlanta, GA 30322; e-mail: cdiiori@emory.edu

Bandura (1997) noted that self-efficacy is specific to each behavior. Thus, self-efficacy scales based on his con ceptualization must be behavior-specific. For the purpose of the development of the PSES, self-efficacy was defined as parents' overall belief in their capacity to talk with

their

children and adolescents about specific sex-related topics. Based on a literature review, three aspects of sex-based discussions were identified: (a) physiological processes (e.g., menstruation), (b) practical issues (e.g., where to get condoms), and (c) safer-sex messages (e.g., should use condoms if he/she decides to have sex). Sixteen items to measure self-efficacy related to these three aspects were developed based on a literature review of sexuality discus sions and on focus groups conducted with mothers of ado lescents (DiIorio et al., 2001). Content and measurement specialists reviewed the wording of each item and the con sistency of the idea presented in each item with the concept of SE as defined by Bandura. Based on their reviews, all 16 items were retained for the final version with some minor changes in wording.

To assess the underlying dimensions of the PSES, an exploratory maximum likelihood common factor analysis with oblique rotation was conducted. The initial analysis revealed three factors with eigenvalues greater than 1.0 and explaining 51% of the variance. Only one item loaded on Factor 3. Thus, a second analysis was conducted request ing two factors. The resulting two factors provided a better interpretation of the data and together accounted for 44% of the variance. The first factor was composed of 10 items

representing all three pre-specified aspects of sex-based discussions—physiological events, practical issues, and safer-sex messages and was labeled Basic Information. The second factor was named Relationship-Based Information, because it was composed of six items addressing relation ship issues such as how to encourage a partner to wait, how to tell a partner no, and how to have fun without sex. Because the Relationship-Based Information factor had a slightly less than adequate reliability coefficient (.67), one new item was written to further define the factor; thus the current PSES has 17 items.

Response Mode and Timing

Each item is worded positively and rated on a 7-point scale anchored with the terms Not Sure at all (1) and Completely Sure (7). The midpoint of the scale is defined as Moderately Sure. Each item begins with the stem “I can always explain to [my child]. . . .” In an interview situation or when using computer-assisted interviewing, the name of the child can be substituted by the interviewer/computer for [my child]. The PSES takes about 5–10 minutes to complete. The items do not usually require explanation. Scoring All 17 items are positively worded. Total scores are found by summing responses to individual items. Total possible scores range from 17 to 119 with higher scores corresponding to a higher degree of self-efficacy to discuss sex-related issues with adolescents. Reliability The original 16-item PSES was assessed for reliability using scale responses from a sample of 491 mothers of 11- to 14-year-old adolescents (DiIorio et al., 2001). Cronbach’s alpha for the total PSES was .85, indicating a moderately high level of internal consistency among scale items. The mean

inter-item correlation was .28, with item-to-total correlations ranging from .24 to .61. Means of individual items ranged from 4.46 to 6.76 with standard deviations ranging from .78 to 2.25. The Cronbach's alphas for two subscales (Basic Information and Relationship-Based Information) were .84 and .67 and indicated low to moderate levels of internal consistency. The 16-item POES was used in a study with mothers of 6- to 12-year-old children (Pluhar, DiIorio, & McCarty, 2008). Cronbach's alpha coefficient for responses from the 277 father participants was .94. The 17-item PSES was used in a randomized controlled study of an HIV prevention intervention for fathers and their adolescent boys. Cronbach's alpha coefficient for responses from the 277 father participants was .85 (DiIorio, McCarty, & Denzmore, 2006). Validity The 16-item PSES was assessed for validity using the same sample of 491 mothers as used for initial reliability assessment (DiIorio et al., 2001). Construct validity was assessed by examining the association of the total PSES scores with the theoretically relevant variables of sex-based communication, general communication, parenting, and self-esteem. All correlations between the PSES and these scales were significant and in the predicted directions. Further analysis revealed that mothers of daughters reported higher levels of parenting SE than did mothers of sons, as was expected based on the literature. In a descriptive study of correlates of sexuality communication, the PSES was significantly and positively correlated with sexuality discussions, meaning that mothers who had more positive SE were more confident in talking with their children about sexuality issues (Pluhar et al., 2008). Other Information The format of the scale can be modified to use with computer-assisted interview (CAI) programs or face-to-face

Exhibit

Parenting Self-Efficacy Scale

Read each statement about talking to your child about sexuality issues. Then chose a number on the scale from 1 (Not Sure at all) to 7

(Completely Sure) to say how sure you are about your ability to talk about each topic with [my child] as he/she grows up. Remember,

1 means Not Sure at all, 4 means Moderately Sure, and 7 means Completely Sure. You can also answer with the numbers in between.

For example, a 5 or 6 would mean somewhere between Moderately Sure and Completely Sure.

Response Options:

1 Not Sure at all

2

3

4 Moderately Sure

5

6

7 Completely Sure

Items

1. I can always explain to [my child] what is happening when a girl has her period.

2. I can always explain to [my child] why a person should use a condom when he or she has sex.

3. I can always explain to [my child] ways to have fun without having sexual intercourse.

4. I can always explain to [my child] why [my child] should wait until [my child] is older to have sexual intercourse.

5. I can always explain to [my child] that [my child] should use condoms if [my child] decides to have sexual intercourse.

6. I can always explain to [my child] why wet dreams occur.

7. I can always explain to [my child] how to put on a condom.

8. I can always explain to [my child] how to use birth control pills.

9. I can always explain to [my child] how birth control pills keep girls from getting pregnant.

10. I can always explain to [my child] what I think about

young teens having sex.

11. I can always explain to [my child] how to tell someone no if [my child] does not want to have sex.

12. I can always explain to [my child] how to make a partner wait until [my child] is ready to have sex.

13. I can always explain to [my child] how someone can get AIDS if they don't use a condom.

14. I can always explain to [my child] where to buy or get condoms.

15. I can always explain to [my child] where to buy or get birth control pills.

16. I can always explain to [my child] how to tell if a girl or boy really loves [my child].

17. I can always explain to [my child] how to resist peer pressure to have sex.

interviews. If used with CAI programs, the term [my child]

can be linked with the child's first name and appear in each

item as it is presented on the screen. For paper versions,

the stem of each item (I can always explain to [my child])

can be placed at the top of the list of items and deleted from

each of the statements.

Bandura, A. (1997). Self-efficacy: The exercise of control. New York: W. H. Freeman and Company. DiIorio, C., Dudley, W. N., Wang, D., Wasserman, J., Eichler, M., Belcher, L., et al. (2001). Measurement of parenting self-efficacy and outcome expectancy related to discussions about sex. Journal of Nursing Measurement, 9, 135–49. DiIorio, C., McCarty, F., & Denzmore, P. (2006). An exploration of social cognitive theory mediators of father-son communication about sex. Journal of Pediatric Psychology, 31, 917–927. Pluhar, E. I., DiIorio, C. K., & McCarty, F. (2008). Correlates of sexuality communication among mothers and 6–12-year-old children. Child Care and Health Development, 34, 283–290.

Campagna, A. F. (1975). The function of men's erotic fantasies during masturbation. Unpublished doctoral dissertation, Yale University, New Haven, CT.

Giambra, L. M. (1977-1978). Adult male daydreaming across the lifespan: A replication, further analyses, and tentative norms based upon retrospective reports. International Journal of Aging and Human Development, 8, 197-228. Giambra, L. M. (1979-1980). Sex differences in daydreaming and related mental activity from the late teens to the early nineties. International Journal of Aging and Human Development, 10, 1-34. Giambra, L. M. (1980). A factor analysis of the items for the Imaginal Processes Inventory. Journal of Clinical Psychology, 36, 383-409. Giambra, L. M. (1983a). Daydreaming in 40- to 60-year-old women: Menopause, health, values, and sexuality. Journal of Clinical Psychology, 39, 11-21. Giambra, L. M. (1983b). Sexual daydreams in 40- to 60-year old women: The influence of menopause, sexual activity, and health. In J. E. Shorr, G. Gobel-Whittington, P. Robin, & J. Connella (Eds.), Imagery: Theoretical and clinical applications (Vol. 3, pp. 297-302). New York: Plenum. Giambra, L. M., & Martin, C. E. (1977). Sexual daydreams and quantitative aspects of sexual activity: Some relations for males across adulthood. Archives of Sexual Behavior, 6, 497-505. Huba, G. J., Aneshensel, C. S., & Singer, J. L. (1981). Development of scales for three second-order factors of inner experience. Multivariate Behavioral Research, 16, 181-206. Rosenberg, L. G. (1983). Sex-role identification, erotic fantasy and sexual behavior: A study of heterosexual, bisexual and homosexual males. Unpublished predissertation research, Yale University, New Haven, CT. Singer, J. L., & Antrobus, J. S. (1963). A factor analytic study of daydreaming and conceptually related cognitive and personality variables [Monograph]. Perceptual and Motor Skills, 17 (Suppl. 3-V17), 187-209. Singer, J. L., & Antrobus, J. S. (1972). Daydreaming, imaginal processes, and personality: A normative study. In P. Sheehan (Ed.), The function and nature of imagery (pp. 175-202). New York: Academic Press.

Exhibit

Sexual Daydreaming Scale

1. My daydreams about love are so vivid, I actually feel they are occurring.

2. I imagine myself to be physically attractive to people of the opposite sex.

3. While working intently at a job, my mind will wander to thoughts about sex.

4. Sometimes on my way to work, I imagine myself making love to an attractive person of the opposite sex.

5. My sexual daydreams are very vivid and clear in my mind.

6. While reading, I often slip into daydreams about sex or making love to someone.

7. While traveling on a train or bus [or airplane], my idle thoughts turn to love.

8. Whenever I am bored, I daydream about the opposite sex.

9. Sometimes in the middle of the day, I will daydream of having sexual relations with someone I am fond of.

10. In my fantasies, I arouse great desire in someone I admire.

11. Before going to sleep, my idle thoughts turn to love-making.

12. My daydreams tend to arouse me physically.

Note. Item 7 has been modified from the original by addition of the material in brackets.

1 Address correspondence to David F. Hurlbert, 140 Farnworth Lane, Roswell, Georgia 30075; e-mail: david.hurlbert@acf.hhs.gov

The Hurlbert Index of Sexual Fantasy is described by

Hurlbert and Apt (1993). Reference Hurlbert, D. F., & Apt, C. (1993). Female sexuality: A comparative study between women in homosexual and heterosexual relationships. Journal of Sex & Marital Therapy, 19, 315–327.

Hurlbert Index of Sexual Fantasy

DAVID F. HURLBERT, 1 U.S. Department of Health and Human Services

Exhibit

Hurlbert Index of Sexual Fantasy

1. I think sexual fantasies are healthy. (R)

2. I enjoy fantasizing about sex. (R)

3. I feel comfortable sharing my sexual fantasies with my partner. (R)

4. I enjoy using my sexual fantasies during masturbation. (R)

5. I am easily aroused by thoughts of sex. (R)

6. Even when I am in the mood for sex, it is difficult for me to think about sexual things.

7. I enjoy hearing my partner's sexual fantasies. (R)

8. It is hard for me to focus or concentrate on my sexual fantasies during sex.

9. I find my sexual fantasies to be boring.

10. My memories of past sexual experiences are negative.

11. It is difficult for me to think about sexual things during sex with my partner.

12. Thoughts about sex enter my mind without much effort. (R)

13. I believe sexual fantasy enhances sex. (R)

14. I feel uncomfortable discussing my sexual fantasies with my partner.

15. I don't like thinking about sex.

16. I feel uncomfortable telling my partner my sexual thoughts.

17. I feel guilty about my sexual fantasies.

18. I find my sexual fantasies to be simulating. (R)

19. When it comes to my past sexual experiences, my memories are negative.

20. It is hard for me to daydream about sex.

21. I find my partner’s sexual fantasies to be exciting. (R)

22. I enjoy using my sexual fantasies during sex. (R)

23. I feel guilty when I think about sex.

24. I have negative thoughts about my past sexual experiences.

25. I experience negative feelings just thinking about sex.

Note. (R) = Reverse-scored items as indicated by the responses: All Of The Time = 0 points; Most Of The Time = +1 point; Some Of The Time = +2 points;

Rarely = +3 points; Never = +4 points.

Female Sexuality

Exhibit

Women’s Sexuality Questionnaire

Section I

1. Date of interview _____

2. Assessment no. _____

Interviewer _____

3. S.S. Number _____ 4. D.O.B.
_____

5. Occupation (do not inquire about place of employment)
_____

6. Highest grade completed _____

7. Affiliative status:

Single Married Divorced Separated Cohabiting

8. Steady sexual partner: YES NO

9. Looking over your whole life, would you say your primary sexual orientation is:

bisexual heterosexual lesbian

10. What drugs do you usually take (including alcohol, caffeine, street drugs, prescribed drugs)

In what amount and how often do you take these?

_____

Are any of these taken at times you plan on having sex? If so, in what way?

_____

11. What is your present method of contraception? Do you have any problems with it?

_____

12. Have you ever been pregnant? YES NO

a. Number of full-term deliveries _____

how long ago was each? _____

Number of vaginal _____ Number of caesarean _____

b. Number of premature deliveries _____

how long ago was each? _____

Number of vaginal _____ Number of caesarean _____

c. Number of spontaneous or induced abortions _____

how long ago was each? _____

how many weeks pregnant with each? _____

13. Have you ever undergone any surgery involving the vagina, other sexual organs, or organs closely related to sexual organs (i.e., anus,

urethra, kidneys, bladder)? YES NO

If so, please describe:

_____

14. Do you have any physical problems with interfere with your sexual functioning or pleasure? YES NO

If so, please explain (including chronic illnesses, infections, vaginal tears)

_____

Specifically, do you get a lot of vaginal infections, and if so, how long do they usually last?

_____

15. Have you ever done exercises for the vaginal muscle? (Show a diagram) If so, explain and describe.

_____
_____

16. When not pregnant, do you ever leak urine when you cough or sneeze? _____

Section II

17. Masturbation:

a. How long ago did you begin to masturbate regularly?
_____

b. On an average over the last 6 months, how often have you masturbated? _____

c. How many times would you estimate you've masturbated?

_____ under ten times

_____ 10-25

_____ 26-100

_____ 101-500

_____ over 500

d. How do you usually masturbate?

_____ by inserting object into vagina

_____ by using vibrator on external genitalia

_____ by stimulating clitoral area with fingers, etc.

_____ by manipulating the mons (define if necessary)

_____ by pressure against object or pressure from thighs

_____ by stimulating the entrance of the vagina (introitus)

_____ other (please describe unless it makes you uncomfortable)

_____

Do you need to be in one particular position to reach orgasm? YES NO

If so, please describe:

_____

18. Sex with partner excluding intercourse:

a. At what age did you begin having genital sex with another person excluding intercourse (including manual, oral stimulation, etc.)? _____

b. How often do you do so now? _____

c. Roughly how many times have you done so? _____

19. Intercourse (defi ned according to woman's orientation as insertion and thrusting of penis, fi ngers, or objects by partner):

a. At what age did you begin having intercourse? _____

b. How often do you do so now? _____

c. How many times, roughly, have you done so? _____

d. What positions do you usually use? _____

Do you generally get simultaneous clitoral stimulation while in this/these positions? If so, how?
_____
_____

20. On the average, what is the duration of sex play (defi ned as prior to intercourse if you have intercourse)?

_____ no sex play _____ 11–19 minutes

_____ less than 5 minutes _____ 20 or more minutes

_____ 5–10 minutes

21. If you have intercourse, are you suffi ciently lubricated at the time of insertion so that no artifi cial lubricant is needed for your comfort? YES NO If not, to what does this seem due? Likely factors are anxiety, insuffi cient stimulation, irritation from local contraceptives, menopause, infections, vaginal deodorant sprays, overwiping after diaphragm insertion, unlubricated condoms, postpartum estrogen imbalance (particularly likely if nursing), and oral contraceptive. In addition, intercourse may be uncomfortable despite lubrication during early experiences due to tightness of the vaginal entrance. _____

Section III

22. If you have intercourse, how long does it last on the average from the beginning of thrusting until thrusting stops? (Counts as one occasion if intercourse disrupted only long enough to change position or pause to prevent ejaculation)

_____

Out of all occasions of intercourse how often do you come to an orgasm, with simultaneous clitoral stimulation (include both pressure and manipulation as clitoral stimulation):

_____ almost always 90-100% _____ sometimes 1-29%

_____ most of the time 60-89% _____ never have 0%

_____ often 30-59%

23. Out of all occasions of intercourse how often do you come to an orgasm, without simultaneous clitoral stimulation (defined as pres

sure or manipulation)?

_____ almost always 90-100% _____ sometimes 1-29%

_____ most of the time 60-89% _____ never have 0%

_____ often 30-59%

24. Out of all occasions of clitoral stimulation (defi ned as pressure or manipulation) during masturbation, how often do you come

to orgasm?

_____ almost always 90-100% _____ sometimes 1-29%

_____ most of the time 60-89% _____ never have 0%

_____ often 30-59%

25. If after having an orgasm you continue to receive stimulation, how often do you have sequential orgasms (a series of peaks and

releases of tension)?

a. During stimulation of clitoris (exclusively)?

_____ almost always 90-100% _____ sometimes 1-29%

_____ most of the time 60-89% _____ never have 0%

_____ often 30-59%

b. During intervaginal stimulation (intercourse) with clitoral stimulation (defined as pressure or manipulation)?

_____ almost always 90-100% _____ sometimes 1-29%

_____ most of the time 60-89% _____ never have 0%

_____ often 30 -59%

c. During intervaginal stimulation (intercourse) exclusively?

_____ almost always 90-100% _____ sometimes 1-29%

_____ most of the time 60-89% _____ never have 0%

_____ often 30-59%

26. Out of all occasions of clitoral stimulation by your partner (manual or oral, but excluding intercourse), how often do you come

to orgasm?

_____ almost always 90-100% _____ sometimes 1-29%

_____ most of the time 60-89% _____ never have 0%

_____ often 30-59%

27. In attaining orgasm for you, what is the most accurate statement:

_____ 1. Clitoral stimulation contributes much more than vaginal stimulation.

_____ 2. Clitoral stimulation contributes somewhat more than vaginal stimulation.

_____ 3. Clitoral and vaginal stimulation are about equal in contribution.

_____ 4. Vaginal stimulation contributes somewhat more than

clitoral stimulation.

_____ 5. Vaginal stimulation contributes much more than clitoral stimulation.

28. (If you have orgasms) which statement best describes your physical sensations during orgasm with intercourse with clitoral stimula

tion (defined as pressure or manipulation):

_____ 1. A slight pulsating feeling in the vagina

_____ 2. A distinct pulsating feeling in the vagina

_____ 3. A very strong pulsating feeling in the vagina with sensation spreading to the legs

_____ 4. An intense feeling throughout the abdomen and legs with rhythmic contractions in the vagina

_____ 5. An intense feeling traveling throughout the entire body with rhythmic contractions in the vagina

_____ 6. Other, specify:
_____

29. For me, having an orgasm during intercourse (with clitoral stimulation) is:

1 2 3 4 5 6 7

blah most intense

experience experience

possible

30. What kind of feeling do you typically experience in the vagina during intercourse without direct clitoral stimulation (defined as pres

sure or manipulation)?

_____ 1. Experience an unpleasant feeling the entire time

_____ 2. Experience an unpleasant feeling which eventually changes to no particular feeling at all

_____ 3. Experience an unpleasant feeling which eventually

increases to a pleasant feeling

_____ 4. Experience no particular feeling the entire time

_____ 5. Experience no particular feeling which eventually increases to a pleasant feeling

_____ 6. Experience a pleasant feeling the entire time

_____ 7. Experience a pleasant feeling which eventually increases to a more pleasant feeling

_____ 8. Other, specify:
_____

31. (If you have orgasms) which statement best describes your physical sensations during orgasm with intercourse without direct clitoral stimulation? (include pressure, manual manipulation, etc. as clitoral stimulation).

_____ 1. A slight pulsating feeling in the vagina

_____ 2. A distinct pulsating feeling in the vagina

_____ 3. A very strong pulsating feeling in the vagina with sensation spreading to the legs

_____ 4. An intense feeling throughout the abdomen and legs with rhythmic contractions in the vagina

_____ 5. An intense feeling traveling throughout the entire body with rhythmic contractions in the vagina

_____ 6. Other, specify:
_____

32. For me, having an orgasm during intercourse (without clitoral stimulation, (defined as pressure or manipulation)) is:

1 2 3 4 5 6 7

blah most intense

experience experience

possible

33. (If you have orgasms) when a partner stimulates your clitoris (defined as pressure or manipulation) to orgasm

(no entry into the vagina) which statement best describes your feelings?

_____ 1. A slight pulsating feeling in the vagina

_____ 2. A distinct pulsating feeling in the vagina

_____ 3. A very strong pulsating feeling in the vagina with sensation spreading to the legs

_____ 4. An intense feeling throughout the abdomen and legs with rhythmic contractions in the vagina

_____ 5. An intense feeling traveling throughout the entire body with rhythmic contractions in the vagina

_____ 6. Other, specify:
_____

34. For me, having an orgasm when a partner stimulates (defined as pressure or manipulation) my clitoris (no entry into vagina) is:

1 2 3 4 5 6 7

blah most intense

experience experience

possible

35. If you have orgasms when you stimulate your clitoris (masturbate via pressure or manipulation) (nothing in vagina) what best describes your physical sensations?

_____ 1. A slight pulsating feeling in the vagina.

_____ 2. A distinct pulsating feeling in the vagina.

_____ 3. A very strong pulsating feeling in the vagina with sensation spreading to the legs.

_____ 4. An intense feeling throughout the abdomen and legs with rhythmic contractions in the vagina.

_____ 5. An intense feeling traveling throughout the entire body with rhythmic contractions in the vagina

_____ 6. Other, specify:
_____

36. For me, having an orgasm through masturbation (nothing in vagina) is:

1 2 3 4 5 6 7

blah most intense

experience experience

possible

1 Address correspondence to J. Kenneth Davidson, Sr., 2634 Collingwood Drive, Round Rock, TX 78665; e-mail: davidsj@uwec.edu

The Self-Perceptions of Female Sexuality Survey

Instrument covers a wide range of beliefs, attitudes, feel

ings, and responses about a woman’s own sexuality and,

to a lesser extent, that of her partners. The instrument was

developed for the primary purpose of providing further

clarification of the apparently inseparable nature of clito

ral and vaginal orgasms. More specifically, the instrument

ascertains whether perceived differences exist with regard

to experiencing orgasm via masturbation, petting, and sex

ual intercourse in terms of physiological and psychological

sexual satisfaction.

Description

The complete instrument consists of 123 open-ended and

closed-form questions concerning sexual attitudes, sexual

behavior, and the female sexual response. The following

categories of items appear in the instrument:

1. Demographic variables, including age, marital status, dating status, formal education, religious preference, and

religiosity.

2. Physiological and psychological sexual satisfaction variables, including early knowledge about the pleasurable sensations of the clitoris, level of sexual adjustment, perceived levels of current physiological and psychological sexual satisfaction, and desired changes in sex life.

3. Peer communication and mass media variables, including sources of information about female orgasm, sources of information about any differences between orgasmic responses, discussion with peers regarding different kinds and/or types of orgasms, and ages at various stages of opinion formation regarding perceived differences in orgasmic responses.

4. Masturbatory attitude variables, including perceived acceptance of masturbation of self, acceptance of masturbation by acquaintances, and the relationship of masturbation to marital sexual adjustment.

5. Sexual history variables, including masturbatory, petting, and sexual intercourse experience; frequency of masturbation, petting, and sexual intercourse; experience with pretending orgasm; relationships with past and current sex partners; and frequency and preference for various sexual intercourse positions for achieving orgasm.
6. Orgasmic quality variables, including perceived differences, if any, in experiencing orgasm via masturbation, petting, and sexual intercourse; the relative contribution of clitoral versus vaginal stimulation in achieving orgasm during masturbation, petting, and sexual intercourse; and the degree of physiological and psychological satisfaction associated with orgasms achieved via masturbation, petting, and sexual intercourse. The survey instrument was first pretested with students enrolled in upper-division marriage/family and human sexuality courses. After appropriate revisions, the instrument was pretested a second time utilizing the nursing staff of a large midwestern family planning organization. After making additional changes, the instrument was then critically reviewed by 10 female professionals involved either in teaching and/or research about human sexuality and/or the delivery of community-based family planning services. The recommendations received from these reviewers were incorporated into the final version of the instrument. The survey instrument is best suited for use with populations containing women with 2 or more years of college education and who are at least 25 years of age. The level of

language sophistication found in the instrument would appear to preclude its application to populations having no college education. Furthermore, given the nature of the instrument, a woman would need to have had considerable sexual experience in order to be able to respond in a meaningful way to a substantial number of the items. It is assumed that a greater opportunity for having experienced substantial sexual activity will exist for women aged 25 years or older. To date, this survey instrument has been used for data collection from professional nurses holding at least an associate degree/diploma in nursing and from professional women in academia holding at least a baccalaureate degree. Response Mode and Timing Respondents are either to check the appropriate answer category or to answer the open-ended items in their own words within the space provided. Given the detailed personal information being sought regarding sexuality, the

Self-Perceptions of Female Sexuality Survey

Instrument

J. KENNETH DAVIDSON, SR., 1 University of Wisconsin—Eau Claire

C AROL A. DARLING, Florida State University

survey instrument should be completed in total privacy

and anonymity. Thus, this instrument is ideally suited for

distribution as a mail questionnaire using a business reply

envelope. Based on the pretest results and feedback received from

actual respondents, an average of 45 minutes is required to

complete all segments of the survey instrument.

Scoring

Although some attitudinal items do appear, it is not intended

for this survey instrument to be employed as a scale that can

stand alone. It is recommended, however, that all attitudi

nal items selected for use be arranged in a reverse/nonre

verse response pattern to help ensure that respondents give

sufficient concentration to the completion of the survey

instrument.

Reliability

The test-retest reliability of the instrument has not been

established.

Validity

Construct validity has been established by reviewing pre

Exhibit

Self-Perceptions of Female Sexuality a

1. How would you rate your current level of sexual adjustment? (Very much adjusted—Very unadjusted; 6 point)

2. At what age did you first become aware of possible pleasurable sensations of the clitoris? (PLEASE SPECIFY)

3. It is necessary for a female to achieve an orgasm in a majority of the instances when she experiences masturbation, petting (mutual masturbation), and/or sexual intercourse in order to be classified as sexually adjusted. (Strongly agree—Strongly disagree; 4 point)

4. Do you feel that most of your female friends believe that a female must experience an orgasm in order to be sexually adjusted? (Yes/No)

5. What has been your most important source of information about the female orgasm? (15 options)

6. Have you ever consciously considered the possibility that orgasms reached through masturbation while alone and/or sexual intercourse might be different? (Yes/No)

7. Have you ever read any material about different kinds and/or types of orgasms? (Yes/No)

8. If ever read materials about different kinds and/or types of orgasm: From the material that you have read, what

conclusions, if any, did the authors reach regarding different kinds and/or types of orgasm?

9. Have you ever discussed with a friend, relative, and/or acquaintance whether different kinds and/or types of orgasms exist for the female during sexual intercourse and/or masturbation while alone? (Yes/No)

10. If ever discussed different kinds and or types of orgasm:

With whom have you ever discussed different kinds and/or types of orgasm? (15 categories)

11. If ever discussed different kinds and/or types of orgasm:

At what age did you first discuss different kinds and/or types of orgasm with another person?

12. In your opinion, do different kinds and/or types of orgasm exist for the human female? (Yes/No/Uncertain)

13. If yes, or uncertain that different kinds and/or types of orgasm exist:

Would you please describe in your own words, the different kinds and/or types of orgasm that can be achieved through masturbation while alone, petting, and/or sexual intercourse.

14. Have you ever masturbated while alone? (Yes/No)

15. Have you ever achieved an orgasm? (Yes/No /Uncertain)

16. Have you ever experienced sexual intercourse? (Yes/No)

17. If ever had orgasm:

How did you first experience orgasm?

_____ 1. Masturbation while alone

_____ 2. Petting (Mutual masturbation)

_____ 3. Sexual intercourse

_____ 4. Other _____

18. If ever had orgasm:

At what age did you experience your first orgasm?

19. If ever had orgasm:

Under which of the following circumstances have you ever experienced an orgasm? (Check all applicable categories; 32 options)

20. If ever had orgasm through masturbating while alone:

At what age did you experience your fi rst orgasm through masturbating while alone?

21. If ever had orgasm through petting:

At what age did you experience your first orgasm through petting?

22. If ever had orgasm through sexual intercourse:

At what age did you experience your first orgasm through sexual intercourse?

23. If ever masturbated while alone:

How old were you the first time that you masturbated while alone?

24. If ever masturbated while alone:

How often do you experience an orgasm through masturbating while alone? (Always-Never; 5 options)

25. If ever masturbated while alone:

How many orgasms do you usually experience during a single episode of masturbating alone?

26. If masturbated while alone within the past two years:

During the past two years, about how many times per week, month, or year have you averaged masturbating while alone?

(Choose only one category and do not use range of times or check the category)

_____ 1. Times per week _____ 2. Times per month _____ 3. Times per year

27. If ever had orgasm while masturbating alone:

In what specific area of your genital region do you most feel the sensation of orgasm occurring during masturbating while alone?

28. If ever masturbated alone:

How would you rate your physiological reaction from masturbating while alone? (Intense satisfaction-No satisfaction; 5 options)

29. If ever masturbated alone:

How would you rate your psychological reaction from masturbating while alone? (No satisfaction-Intense satisfaction; 5 options)

30. If ever petted:

How often do you experience an orgasm while petting? (Always-Never; 5 options)

31. If ever had orgasm during petting:

How many orgasms do you usually experience during a single episode of petting?

32. If ever had orgasm during petting:

In what specific area of your genital region do you most feel the sensation of orgasm occurring during petting?

33. If ever had orgasm:

Do you experience a physiological need in yourself to have an orgasm prior to any sexual arousal and/or sexual activity? (Never-Always;

5 options)

34. If ever had orgasm:

Do you experience a physiological need in yourself to have more than one orgasm while engaging in masturbating while alone, pet

ting, and/or sexual intercourse? (Never-Always; 5 options)

35. If ever had orgasm:

Do you experience a psychological need in yourself to have an orgasm prior to any sexual arousal and/or sexual activity? (Never-Always;

5 options)

36. If ever had orgasm:

Do you experience a psychological need in yourself to have more than one orgasm while engaging in masturbating while alone, pet

ting, and/or sexual intercourse? (Never-Always; 5 options)

37. If ever experienced more than one orgasm during a single sexual experience, including masturbation while alone:

Do successive orgasms during a single sexual experience become stronger or weaker? (10 options)

38. If ever had sexual intercourse:

At what age did you fi rst experience sexual intercourse?

39. If had sexual intercourse within the past two years:

During the past two years, about how many times per week, month, or year have you averaged having sexual intercourse?

(Choose only one category and do not use a range of times or check the category)

_____ 1. Times per week _____ 2. Times per month _____ 3. Times per year

40. If ever had sexual intercourse:

With how many different partners have you ever had sexual intercourse?

41. If ever had sexual intercourse:

During sexual intercourse, at what point does your most recent male sex partner usually achieve his first orgasm? (6 options)

42. If ever had sexual intercourse:

Would you please indicate the most frequent position that you utilize for sexual intercourse. You are to rank the sexual intercourse positions with regard to frequency of occurrence with 1-most often, 2-second most often, and 3-third most often only. (12 options)

43. If ever had sexual intercourse:

How often do you experience an orgasm during sexual intercourse? (Always-Never; 5 options)

44. If rarely or never have orgasm during sexual intercourse:

Why do you believe that you experience difficulty in achieving orgasm during sexual intercourse?

45. If ever had orgasm during sexual intercourse:

How many orgasms do you usually experience during a single vaginal penetration while having sexual intercourse?

46. If ever had orgasm during sexual intercourse:

After having experienced orgasm during sexual intercourse, what is the typical extent of your physiological reaction? (Intense satisfaction-No satisfaction; 5 options)

47. If ever had orgasm during sexual intercourse:

After having experienced orgasm during sexual intercourse, what is the typical extent of your psychological reaction? (Intense satisfaction-No satisfaction; 5 options)

48. If ever masturbated to orgasm while alone and had sexual intercourse:

Do you prefer to masturbate to orgasm while alone rather than having sexual intercourse? (Always-Never; 5 options)

49. If ever had orgasm:

Would you please indicate the most frequent techniques that you use to achieve orgasm?

You are to rank the following techniques with regard to frequency of occurrence with 1-most often, 2-second most often, and 3-third most often only. (32 options)

50. If ever masturbated while alone, petted, had sexual

intercourse, and experienced orgasm:

Do you experience a difference between an orgasm reached during masturbating while alone, during petting, and during sexual intercourse with vaginal penetration? (Yes/No)

51. If yes, differences exist between orgasm achieved during masturbation while alone, petting, and sexual intercourse:

In your own words, please describe the difference between orgasms achieved during masturbation while alone, petting, and sexual intercourse with vaginal penetration

52. If ever had orgasm during sexual intercourse:

In what specifi c area of your genital region do you most feel the sensation of orgasm occurring during sexual intercourse with vaginal penetration?

53. If ever had orgasm during sexual intercourse:

What is the relative contribution of clitoral versus vaginal stimulation in helping you to achieve orgasm during sexual intercourse? (7 options)

54. If ever had orgasm during masturbation:

What is the relative contribution of clitoral versus vaginal stimulation in helping you to achieve orgasm during masturbating while alone: (7 options)

55. If ever had orgasm during petting:

What is the relative contribution of clitoral versus vaginal stimulation in helping you to achieve orgasm during petting? (7 options)

56. Which of the following changes, if any, would you like to have in your current sex life? (44 options)

57. How would you rate your overall personal physiological level of sexual satisfaction? (Very much satisfied-Very much dissatisfied; 6 options)

58. How would you rate your overall personal psychological level of sexual satisfaction? (Very much satisfied-Very much dissatisfied; 6 options)

a In the interest of brevity, only select items

specifically related to the orgasmic response have been included in this exhibit. Additional demographic, attitudinal, and behavioral items/variables that are critical to appropriate analyses and understanding of the perceived differences have been omitted due to space limitations.

The Sexuality of Women Survey was designed to gather information for a book about how women experience and express their sexualities. The questionnaire cover letter stated that the purpose was “to learn more about the richness and variability in the sexual development, feelings, attitudes and experiences of American women of all ages, ethnic and religious groups, and sexual orientations.”

Description

This 16-page questionnaire of primarily multiple-choice questions is divided into the following sections: A. Please tell us about yourself (demographics); B. Relationships; C. Family of origin; D. Early sexual experiences; E. Sexual partner(s); F. Self-stimulation; G. The experience of orgasm; H. Feelings during and immediately after self-stimulation and partner sex; I. Factors affecting sexual satisfaction within a relationship; J. Initiating sex and sexual communication; K. Sexual expression, sexual concerns, and problems; L. Body; M. Satisfaction and the frequency and quality of various kinds of touching activities; N. Sexuality and menstrual cycles; O. Pregnancy; P. Contraceptive method; Q. Sexually transmitted diseases;

R. Affairs; and S. Sexual life over time.

Respondents are instructed to circle the number cor
responding to the best response(s) or to fill in a blank.
They also are told to “feel free to write comments on the
questionnaire or on a separate page. . . . If a question
doesn’t accurately describe your experience, please
tell us so. We want to know how you experience your
sexuality.”

The questionnaire was designed for and primarily sur
veyed (in 1993–1994) women who had attended at least
some college. Thirty-two percent had some college or a 2
year degree; 21% had a 4-year degree; and 40% had done
some graduate work or had a graduate degree. The 2,632
women in this sample of convenience who responded to
the questionnaire were born between 1905 and 1977; 556
were age 50 or older. Even after attempts were made to
have greater ethnic diversity, 83% were Caucasian. With
respect to sexual orientation, 7% described themselves as
lesbian, 5% as bisexual, and the remainder as heterosexual.

The statistics and other research findings describe the par
ticular group of women who were surveyed, not American

1 Address correspondence to Carol Rinkleib Ellison, P. O. Box 1876, Loomis, CA 95650; e-mail: carol.ellison@att.net

2 Bernie Zilbergeld is deceased.

CAROL RINKLEIB ELLISON, 1 Loomis, CA

B ERNIE ZILBERGELD, 2 Oakland, CA

Exhibit

Sexuality of Women Survey

Instructions: Please answer each question by • CIRCLING THE NUMBER corresponding to the best response OR by • FILLING IN THE BLANK at the right hand margin.

Sometimes you also will be asked to SPECIFY SOME OTHER INFORMATION in a blank in the question itself. Some questions will ask you to circle all that apply.

If you cannot or don't want to answer a question, circle the question number and move on to the next question. Sometimes you will be directed to skip over questions that do not apply to your experience. FEEL FREE TO WRITE COMMENTS ON THE QUESTIONNAIRE or on a separate page that you fasten securely to it. If a question doesn't accurately describe your experience, please tell us so. We want to know how you experience your sexuality.

A. PLEASE TELL US ABOUT YOURSELF.

1. Year Born (WRITE THE YEAR IN THE BLANK TO THE RIGHT): 19_____

2. Ethnicity: 3. Education: The highest level of schooling

I usually describe my ethnicity as (CIRCLE ONE): I have completed is (CIRCLE ONE):

African American 1 High school 1

Asian American 2 Somec ollege 2

Caucasian 3 Vocational degree 3

Latina 4 2-year degree 4

Native American 5 4-year degree 5

Other Graduate work 6

(PLEASE SPECIFY): _____ 6 Graduate degree 7

4. Occupation: My Occupation is:

_____
5. Religion/Spirituality: The average number of times per month I attend services or other spiritual observances now, and did as a child is (PLEASE WRITE IN THE NUMBER OF TIMES): NOW CHILDHOOD NOW CHILDHOOD

Catholic _____ _____ Buddhist _____ _____

Protestant _____ _____ Atheist _____ _____

Fundamentalist Christian _____ _____ Agnostic _____ _____

Jewish _____ _____ Other spiritual

Muslim _____ _____ observances/meditations _____ _____

Other (SPECIFY)
_____
_____ _____

6. Children: The ages of the children I am raising or have raised is:

Males ___ ___ ___ ___ ___

Females ___ ___ ___ ___ ___

(PLEASE CIRCLE THE AGES OF ANY CHILDREN NOW LIVING IN YOUR HOME.)

7. Income:

a. The approximate pre-tax income I earn per year is (CIRCLE ONE): 1 2 3 4 5 6

1 Less than $12,000 2 $12,001-$25,000 3 $25,001-$50,000

4 $50,001-$75,000 5 $75,001-$120,000 6 $120,001+

b. The approximate pre-tax income per year of my family unit is: 1 2 3 4 5 6

8. Residence:

a. The State I now live in is _____

b. I have lived in the United States ___ years (WRITE THE NUMBER IN THE BLANK AT THE RIGHT): _____

9. Orientation: I think of myself as (CIRCLE ONE):

1 Heterosexual 2 Lesbian 3 Bisexual 1 2 3

B. PLEASE TELL US ABOUT YOUR RELATIONSHIP(S).

1. My current relationship and living situation is (CHOOSE ONE):

No sex partner now 1

Seeing but not living with my sex partner(s) 2

Living with a sex partner, without marriage or life commitment 3

Living with a sex partner, with marriage or life commitment 4

Other (PLEASE SPECIFY): _____ 5

2. The number of times I have ever (PLEASE WRITE IN THE NUMBER OR “0”):

a. Lived with a sex partner I didn’t later marry is _____

b. Been married is _____

c. Been divorced is _____

d. Been widowed is _____

C. PLEASE TELL US ABOUT YOUR FAMILY OF ORIGIN.

The questions in this section are about your growing up years.

Mother and Father refer to the “parent(s)” who raised you. CIRCLE “0” to mean “no mother fi gure” or “no father fi gure.”

While I was growing up (CIRCLE THE BEST ANSWER FOR EACH STATEMENT): STRONGLY STRONGLY

DISAGREE AGREE NA

1. My mother and father openly demonstrated physical affection for each other 1 2 3 4 5 6 7 0

2. a. My father affectionately touched (for example,

hugged) me 1 2 3 4 5 6 7 0

b. This affection was appropriately expressed 1 2 3 4 5 6 7 0

3. a. My mother affectionately touched me 1 2 3 4 5 6 7 0

b. This affection was appropriately expressed 1 2 3 4 5 6 7 0

4. I felt free to express my own opinions at home 1 2 3 4 5 6 7 0

5. Sexuality was often discussed in my family 1 2 3 4 5 6 7 0

6. a. My mother's attitude toward sex was generally positive 1 2 3 4 5 6 7 0

b. My father's attitude toward sex was generally positive 1 2 3 4 5 6 7 0

D. THESE QUESTIONS ARE ABOUT YOUR EARLY SEXUAL EXPERIENCES.

1. As a child or adolescent, the fi rst person with whom I engaged in an activity that

I thought of as sexual at the time was a (1 male OR 2 female) 1 2

If you have NEVER engaged in ANY sexual activity with a male, 0 CIRCLE the 0 at the right and skip to Question 4a.

2. a. As a child or adolescent, my fi rst sexual activity that I thought of at the time as sexual with a male occurred when I was ___ years old. _____ STRONGLY STRONGLY

DISAGREE AGREE NA

b. This sexual activity was with my consent. 1 2 3 4 5 6 7 0

c. The male involved was: (CHOOSE ONE BEST ANSWER)

A peer (boyfriend, schoolmate, friend) 1

A relative (PLEASE SPECIFY WHO) _____ 2

A stranger 3

Other (PLEASE SPECIFY):_____ 4

If you have NEVER had sexual intercourse, CIRCLE 0 and skip to Question 4a. 0

3. a. My fi rst sexual intercourse was when I was ___ years old. _____

STRONGLY STRONGLY

DISAGREE AGREE NA

b. My fi rst sexual intercourse was with my consent 1 2 3 4 5 6 7 0

c. The partner in my fi rst intercourse was

For many of the questions that follow you will answer by circling a number on a scale from 1 to 7:

1 = STRONGLY DISAGREE 5 = SLIGHTLY AGREE

2 = DISAGREE 6 = AGREE

3 = SLIGHTLY DISAGREE 7 = STRONGLY AGREE

4 = EQUALLY AGREE AND DISAGREE 0 = NOT APPLICABLE TO MY EXPERIENCE (NA)

A peer (boyfriend, schoolmate, friend) 1

A relative (PLEASE SPECIFY WHO) _____ 2

A stranger 3

Other (PLEASE SPECIFY): _____ 4

d. He was (CHOOSE ONE BEST ANSWER)

Someone I wasn’t then planning to marry 1

Someone I was planning to marry 2

Someone I had already married 3

None of the above 4

If you have NEVER engaged in ANY sexual activity with another female, CIRCLE “0” and skip to Question 5. 0

4. a. My fi rst sexual activity that I thought of at the time as sexual with another female occurred when I was __ years old. _____ STRONGLY STRONGLY

DISAGREE AGREE NA

b. This sexual activity was with my consent. 1 2 3 4 5 6 7 0

c. The female involved was (CHOOSE ONE):

A peer (girlfriend, schoolmate, friend) 1

A relative (PLEASE SPECIFY WHO) _____ 2

A stranger 3

Other (PLEASE SPECIFY): _____ 4

5. Compared to my female classmates, during my adolescent years: ABOUT AS MORE LESS

a. I dated (1 about as, 2 more, OR 3 less) often 1 2 3

b. I was (1 about as, 2 more, OR 3 less) sexually active 1 2 3

E. THE QUESTIONS IN THIS SECTION ARE ABOUT YOUR SEXUAL PARTNER(S).

A SEXUAL PARTNER is someone with whom you currently (or did in the past) engage in ANY kind of sexual activity.

1. The last time I engaged in any kind of sexual activity with a partner was Today 1

(PLEASE CIRCLE 1 FOR today, OR WRITE IN YOUR BEST ESTIMATE OF APPROXIMATELY or Days ago _____ HOW MANY days, months OR years ago): or Months ago _____

or Years ago _____

If you have more than one current partner, interpret “current partner” to mean your “primary partner” as you fi ll out this questionnaire.

2. a. My current or most recent sexual partner is/was

(1 male OR 2 female) 1

2

b. I have been (or was) with this partner ___ months Months
_____ OR ____ years (WRITE IN HOW MANY AT THE RIGHT): or
Years _____

3. I think of myself as currently having (a) __ male a)
Male _____

and (b) ___ female sexual partners (WRITE IN HOW MANY): b)
Female _____

4. I have had about __ sexual partners in my lifetime (
WRITE IN HOW MANY): _____

5. In my lifetime, the number of people with whom I have
engaged in what is often called “casual sex” or a
“one-night stand” (including instances where a relationship
or friendship developed after the sex) is approximately __
(WRITE IN HOW MANY:) STRONGLY STRONGLY

DISAGREE AGREE NA

6. My current or most recent sex partner has been (was) a
good partner for me (in general, not just sexually) 1 2 3
4 5 6 7 0

7. In the past, most of my sex partners were good partners
for me (in general, not just sexually) 1 2 3 4 5 6 7 0

8. In my life I have had at least one partner with whom I
had what I considered to be really fantastic sex. 1 2 3 4
5 6 7 0

9. a. In the last 3 months, the number of individuals with
whom I have engaged in sexual activity of any kind is (
WRITE IN HOW MANY): _____

If your answer to 9a is “0”, skip 9b.

b. The partner(s) and circumstances can be described as (
CIRCLE ALL THAT APPLY):

A male partner 1

A female partner 2

My “spouse” (married or life commitment) 3

A nonspouse partner I live with 4

A partner I don’t live with 5

Some one I knew at the time for more than 1 but less than 7 days 6

Some one I knew at the time for less than 24 hours 7

A partner with whom I have an on-going affair 8

A friend: we sometimes or regularly meet each other’s sexual needs 9

Someone I know, in exchange for money 10

A stranger, in exchange for money 11

Other (PLEASE SPECIFY):
_____ 12

F. THE NEXT 4 QUESTIONS ARE ABOUT SELF-STIMULATION.

1. The fi rst time I intentionally stimulated my genitals while alone (masturbated)

I was ____ years old (IF YOU DON’T KNOW, WRITE IN YOUR BEST GUESS) _____

If NEVER, circle 0 and skip to Section G 0

2. In the last month, I have intentionally stimulated my genitals when alone approximately __ times. _____

If you have NOT intentionally stimulated your genitals when alone in the LAST 3 MONTHS, circle 0 and skip to Question 4. 0

3. In the last 3 months, I intentionally stimulated my genitals when alone (CIRCLE ALL THAT APPLY):

Because self-stimulation feels good 1

Because I felt a physical urge to do so 2

To comfort myself 3

To help me sleep 4

To relieve menstrual cramps 5

To relax 6

To have one or more orgasms 7

To feel more fi nished or relieve frustration after partner sex 8

Because a partner wasn’t available right then 9

Because I was lonely 10

Because I was bored 11

Other _____ 12 STRONGLY STRONGLY

DISAGREE AGREE NA

4. I usually fantasize when I masturbate 1 2 3 4 5 6 7 0

G. THE QUESTIONS IN THIS SECTION ARE ABOUT THE EXPERIENCE OF ORGASM:

1. Please circle the number of the best answer for you:

I have never experienced an orgasm 1

I am not sure if I have ever had an orgasm 2

My fi rst orgasm was by myself 3

My fi rst orgasm was during sexual activity with a partner 4

Other (PLEASE SPECIFY):
_____ 5

If you have NEVER experienced orgasm or are NOT SURE if you have, please skip to Question 11.

2. I think my fi rst orgasm occurred when I was age __ years _____

(IF YOU DON’T KNOW FOR SURE, PLEASE WRITE IN YOUR BEST ESTIMATE OR GUESS. IF YOU WERE YOUNG, PERHAPS YOU ONLY REALIZED LATER IT WAS AN ORGASM.)

3. The following describe my experience (PLEASE CIRCLE ALL THAT APPLY):

My fi rst orgasm occurred spontaneously 1

My fi rst orgasm occurred when I was trying to have one 2

My fi rst orgasm surprised me 3

I was frightened by the sensations of my fi rst orgasm 4

I reach orgasm when alone but not when I’m with a partner 5

I have at some time awakened from sleep having an orgasm from dreaming 6

I have at some time had an orgasm from mental/emotional stimulation (such as a fantasy, recalling a past experience, reading) without also sexually touching myself 7

None of the above 0

If you have NEVER had an orgasm when alone, please circle 0 and skip to Question 7. 0 STRONGLY STRONGLY

DISAGREE AGREE NA

4. I generally reach orgasm more easily by myself than with a partner 1 2 3 4 5 6 7 0

5. I generally have more enjoyable orgasms by myself than I have had with a partner 1 2 3 4 5 6 7 0

6. The stimulation I use to reach orgasm when alone tends to be:

Always (or almost always) the same kind 1

Varied, I use different kinds of stimulation at different times 2

If you have NEVER experienced orgasm with a partner, please circle 0 and skip to Question 10. 0

7. The stimulation through which I reach orgasm with a partner tends to be:

Always (or almost always) the same kind 1

Varied, different kinds of stimulation at different times 2 STRONGLY STRONGLY

DISAGREE AGREE NA

8. I generally have (had) more enjoyable orgasms with my most satisfying sexual partner than by myself 1 2 3 4 5 6 7 0

If you have NOT experienced orgasm with a partner in the last 3 months, please circle 0 and skip to Question 10. 0

The next question is about your orgasms with a partner IN the LAST 3 MONTHS. If you have had more than one partner, answer regarding your most satisfying partner.

9. In the last 3 months when having sex with my partner

a. I wanted to orgasm in approximately __ % of the sexual episodes (PLEASE WRITE IN YOUR BEST GUESS) _____%

b. I actually orgasmed in approximately __ % of the sexual episodes in which I wanted to (WRITE IN YOUR BEST GUESS) _____% STRONGLY STRONGLY

DISAGREE AGREE

c. I am satisfi ed with the frequency I actually orgasmed 1 2 3 4 5 6 7

d. I am satisfi ed with the quality/intensity of the orgasms I had 1 2 3 4 5 6 7

10. In my life, I have (PLEASE WRITE IN YOUR BEST ESTIMATE OR GUESS OF THE NUMBER):

a. Cried during orgasm or had crying released by orgasm __ times _______

b. Laughed during orgasm or had laughter released by orgasm __ times _______

11. a. In my life, I have faked an orgasm __ times (PLEASE WRITE IN YOUR BEST ESTIMATE OR GUESS): _______

b. I have faked an orgasm with __ percent of my partners _____%

If you do not have a current partner, circle 0 and skip to Question 12. 0

c. I fake an orgasm with my current partner about __ percent of the time _____%

If you have NEVER reached orgasm during sex with a partner, please skip to the next section, Section H.

12. In addition to getting specifi c physical stimulation, I often have done the following to help me reach orgasm during sex with a partner (CIRCLE ALL THAT APPLY; SOME MAY HAVE HAPPENED SPONTANEOUSLY):

Gotten myself in a sexy mood beforehand 1

Engaged in a fantasy of my own 2

Engaged in a fantasy shared with my partner 3

Thought or imagined that I might become pregnant 4

Synchronized my breathing to my partner’s breathing 5

Synchronized the rhythm of my movements to my partner’s 6

Felt/thought how much I love my partner 7

Tightened and released my pelvic muscles 8

Paid attention to my physical sensations 9

Focused on my partner’s pleasure 10

Positioned my body to get the stimulation I needed 11

Engaged in eye contact with my partner 12

Detached from thinking about anything 13

Asked or encouraged my partner to do what I needed 14

Other (PLEASE SPECIFY): _____ 15

H. THESE QUESTIONS ARE ABOUT YOUR FEELINGS DURING AND IMMEDIATELY AFTER SELF-STIMULATION AND PARTNER SEX.

If you have NEVER masturbated, start with Question 2; skip 1 and 3. If you have NEVER had sex with a partner, start with 1, skip 2 and 4.

Below is a list of feelings you may have experienced during and immediately after sexual activity, either alone or with a partner.

1. The feelings from the list that I have experienced most typically during and immediately after masturbation are (CIRCLE THE NUMBERS IN THE COLUMN LABELED SELF OF ALL THAT APPLY):

2. The feelings that I have experienced most often during and immediately after sex with my current or most recent partner are (CIRCLE THE NUMBERS IN THE COLUMN LABELED PARTNER OF ALL THAT APPLY): SELF PARTNER SELF PARTNER SELF PARTNER Anxious 1 1 Happy 20 20 Pressured 39 39 Aroused 2 2 Helpless 21 21 Resentful 40 40 Ashamed 3 3 Inadequate 22 22 Romantic 41 41 Bored 4 4 Inhibited 23 23 Sad 42 42 Coerced 5 5 Intense 24 24 Sated 43 43 Confi dent 6 6 Judged 25 25 Satisfi ed 44 44 Desirable 7 7 Lonely 26 26 Secure 45 45 Desire 8 8 Loved 27 27 Self-loving 46 46 Desired 9 9 Loving 28 28 Sensual 47 47 Disappointed 10 10 Lusty 29 29 Separate 48 48 Dissatisfi ed 11 11 Meditative 30 30 Sexy 49 49 Dominated 12 12 Merged 31 31 Spiritual 50 50 Dominating 13 13 “Not there” 32 32 Successful 51 51 Ecstasy 14 14 Obsessed 33 33 Tense 52 52 Embarrassed 15 15 Passionate 34 34 Tired 53 53 Erotic 16 16 Peaceful 35 35 Trusting 54 54 Excited 17 17 Playful 36 36 Victimized 55 55 Frustrated 18 18 Pleasured 37 37 Vulnerable 56 56 Guilty 19 19 Powerful 38 38 Wonderful 57 57

3. If other words better describe your masturbation experiences, please write them here:

4. If other words better describe your sexual experiences with your current or most recent partner, please write them here:

5. List the numbers of up to 5 feelings from the list above (other than “satisfi ed”) that you associate with your most satisfying sexual experiences.

_____ _____ _____ _____ _____

If you have NEVER had satisfying sexual experiences either alone or with a partner, circle 0. 0

I. THIS SECTION IS ABOUT FACTORS AFFECTING YOUR SEXUAL SATISFACTION WITHIN A RELATIONSHIP.

If you have NEVER had SATISFYING sex with a partner within an ongoing relationship, please circle 0 and skip to the next section, Section J. 0

If you have EVER had SATISFYING sex with a partner within an ongoing relationship, please consider the most recent

period in your life when you had satisfying sex in a relationship:

1 a. In this period of my life in this relationship, the following were USUALLY or ALWAYS present in my most satisfying sexual experiences with my partner (CIRCLE THE NUMBERS OF ALL THAT APPLY):

Before Sex

Feeling close to my partner before sex 1

Arguing before having sex 2

Having an alcoholic drink before sex 3

Using marijuana or another recreational drug before (or during) sex 4

Partner and Situation

Feeling loved 5

Feeling safe in the relationship 6

Knowing we could take as much time as we wanted 7

Knowing there was no risk of getting or transmitting a disease 8

Knowing there was no risk of getting pregnant 9

Being aware that I might become pregnant 10

Knowing my partner would give me the physical stimulation I needed 11

Behaviors and Feelings During Sex

Talking with my partner during sex about what we were doing 12

Talking about or acting out a shared drama or fantasy 13

Focusing on a stimulating fantasy of my own 14

Feeling really attuned with my partner during sex 15

No pressure from my partner for me to have an orgasm 16

No pressure from myself to have an orgasm 17

My partner got and maintained an erection 19

My partner did not ejaculate quickly 20

Stimulation

Extended stimulation of other kinds before intercourse 21

Breast stimulation 22

Manual stimulation of my genitals 23

Oral stimulation of my genitals 24

Using a vibrator 25

Using a dildo 26

Anal stimulation 27

Having intercourse 28

Steady, reliable stimulation that continued through orgasm
29

Outcomes

One or more orgasms 30

Simultaneous orgasm with my partner 31

Knowing that I gave my partner a wonderful experience 32

Emotional closeness after sexual activity 33

Other (PLEASE SPECIFY): _____
34

b. In the period of my life I have been considering for
this question I was in my

1 Teens 2 20’s 3 30’s 4 40’s 5 50’s 6 60’s 7 70’s 8
80’s 1 2 3 4 5 6 7 8

J. THESE QUESTIONS ARE ABOUT INITIATING SEX AND SEXUAL
COMMUNICATION.

If you have not had a sexual partner in the last year,

please circle 0, skip Sections J and K, and go to Section L. 0

INITIATING SEX means letting your partner know (verbally or physically) your desire for sexual activity.

PLEASE CIRCLE THE BEST ANSWER FOR EACH STATEMENT. STRONGLY STRONGLY

DISAGREE AGREE NA

1. I initiate sex whenever I want it. 1 2 3 4 5 6 7 0

2. a. I am comfortable initiating sex with my current or most recent partner. 1 2 3 4 5 6 7 0

b. That partner is (was) comfortable with my initiating sexual activity. 1 2 3 4 5 6 7 0

3. During sex, I am comfortable telling my partner what I don't like or don't want (for example: "Ouch!" or "I don't want to do that tonight.") 1 2 3 4 5 6 7 0

4. During sex, I am comfortable telling my partner what I want and like (for example, "Would you . . ." or "A little slower . . ." or "That feels great.") 1 2 3 4 5 6 7 0

5. During sex, I communicate my desires as often as I want to. 1 2 3 4 5 6 7 0

6. One reason I don't communicate much during sex is that I usually don't know what I want. 1 2 3 4 5 6 7 0

7. My partner gives me as much feedback about his/her sexual likes and dislikes as I want. 1 2 3 4 5 6 7 0

K. THESE QUESTIONS ARE ABOUT SOME ASPECTS OF SEXUAL EXPRESSION YOU MAY HAVE EXPERIENCED IN THE PAST YEAR AND ABOUT SEXUAL CONCERNS AND PROBLEMS.

In Question 1, indicate which of the items you have experienced IN THE PAST YEAR by circling the number that indicates how often you experienced it. Skip any you have NOT experienced.

RAR = Rarely ST = Sometimes OFT = Often ALL = All the time

1. a. I have experienced the following in the last year (

CIRCLE ANY THAT APPLY): RAR ST OFT ALL

Diffi culty fi nding a partner I wanted to be sexual with
1 1 1 1

Lower sexual desire than I wanted to have 2 2 2 2

Being too tired to have sex 3 3 3 3

Being too busy to have sex 4 4 4 4

Not feeling sexually satisfi ed 5 5 5 5

My partner not as interested in sexasI was 6 6 6 6

My partner less interested incloseness after sex than I 7 7
7 7

My partner choosing inconvenient times for sex 8 8 8 8

b. During sex in the last year I have experienced:

Diffi culty getting excited/aroused 9 9 9 9

Feeling distracted 10 10 10 10

Inability to relax 11 11 11 11

Involuntary vaginal spasm so that vaginal entry and/or
intercourse was impossible or diffi cult 12 12 12 12

Insuffi cient vaginal lubrication 13 13 13 13

Pain during intercourse or other internal stimulation 14 14
14 14

Fantasizing that I am having sex with someone other than my
partner 15 15 15 15

Diffi culty in reaching orgasm 16 16 16 16

Inability to have an orgasm 17 17 17 17

Reaching orgasm too quickly 18 18 18 18

My partner seeming distracted 19 19 19 19

My partner wanting shorter foreplay than I wanted 20 20 20
20

My partner having diffi culty getting aroused 21 21 21 21

My partner ejaculating too quickly 22 22 22 22

My partner having diffi culty getting and/or maintaining an erection 23 23 23 23

Other (SPECIFY): _____ 24 24 24 24

None of the above 0 0 0 0

Some of the items in Question 1 you may think of as “the way life is.” Others you may think of as “problems.”

2. I think or thought of these items I marked in Question 1 as problems

(PLEASE WRITE THE NUMBER(S) OF THOSE ITEMS HERE OR CIRCLE 0 FOR NONE):

_____ _____ _____ _____ _____ _____ _____ _____ _____ 0

3. In the past year I have sought the following kinds of help for sexual concerns or problems (CIRCLE ALL THAT APPLY):

None 0

Talked to my partner 1

Talked to a (nonpartner) friend 2

Talked to a relative 3

Talked to a minister or teacher 4

Read a book or article that gave advice 5

Went to a medical/health practitioner (other than a therapist) 6

Went to a therapist by myself 7

Went to a therapist with my partner 8

Enrolled in a course or program 9

Other (SPECIFY):

_____ 10

4. a. In the past year, my most important sexual problem or concern was

(WRITE THE NUMBER FROM THE LIST IN QUESTION 1 OR SPECIFY)
_____

If None, circle 0 and skip 4b and 4c. 0

STRONGLY STRONGLY

DISAGREE AGREE NA

b. This problem or concern has been satisfactorily resolved
1 2 3 4 5 6 7 0

If the situation is not improved, circle 0 and skip 4c. 0

c. I attribute the improvement in this situation to (CIRCLE ALL THAT APPLY):

A solution I fi gured out for myself 1

Talking with my partner 2

Talking with a friend, relative, parent, or minister 3

Seeing a therapist 4

Seeing a medical/health practitioner 5

Surgery 6

Medication (starting, stopping, changing) 7

Passage of time 8

Advice in a book or article 9

Getting a new partner 10

Other (PLEASE SPECIFY): _____ 11

L. THE NEXT QUESTIONS ARE ABOUT YOUR BODY. STRONGLY STRONGLY

DISAGREE AGREE NA

1. Overall, I am satisfi ed with how my body looks 1 2 3 4 5 6 7

2. My current or last partner is/was satisfi ed with how my body looks 1 2 3 4 5 6 7 0

3. My feelings about my body interfere with my sexual satisfaction 1 2 3 4 5 6 7

4. a. My weight is __ pounds ____ lb.

b. My height is __ feet __ inches ____ ft. ____ in.

5. a. I have had the following surgery (PLEASE CIRCLE THE CORRESPONDING NUMBER(S) AND WRITE IN YOUR AGE AT THE TIME OF THE SURGERY): AGE AT TIME OF SURGERY

Hysterectomy (uterus removed) _____ 1

Ovaries removed _____ 2

Mastectomy _____ 3

Other surgery (PLEASE SPECIFY):
_____ 4

b. I have the following physical condition(s) (PLEASE CIRCLE THE CORRESPONDING NUMBER(S) AND INDICATE YOUR AGE WHEN THE CONDITION BEGAN): AGE OF ONSET

Diabetes _____ 5

Chronic vaginal dryness (currently) _____ 6

Chronic bladder infections (currently) _____ 7

Other illness, disability, or physical condition (PLEASE SPECIFY):

_____ _____ 8

_____ _____ 9

_____ _____ 10

None 0

6. In the past year I have taken the following medications or hormones (PLEASE CIRCLE THE CORRESPONDING NUMBER(S) AND WRITE IN APPROXIMATELY HOW LONG YOU HAVE TAKEN THEM): NO. OF YRS TAKEN

Blood pressure medication _____ 1

Antihistamine _____ 2

Antidepressant _____ 3

Antianxiety medication _____ 4

Insulin _____ 5

Birth control pills _____ 6

Other estrogen _____ 7

Other progestin/progesterone _____ 8

Other medications or hormones (SPECIFY):

_____ _____ 9

_____ _____ 10

_____ _____ 11

None 0 STRONGLY STRONGLY

DISAGREE AGREE

7. The physical condition of my body interferes with my
sexual satisfaction 1 2 3 4 5 6 7

Answer Question 8 ONLY IF you are NOT now physically able to

become pregnant. Give ages for ALL you have experienced.

8. I am not physically able to become pregnant because
(GIVE AGES FOR ALL THAT APPLY):

I reached menopause at age ___ 1 _____

I had my tubes tied when I was age ___ 2 _____

I had a hysterectomy when I was age ___ 3 _____

I had/have had endometriosis from approximately age ___ 4
_____

I had a pelvic infection when I was age ___ 5 _____

Other (PLEASE SPECIFY):

M. THESE QUESTIONS ARE ABOUT SATISFACTION AND THE FREQUENCY AND QUALITY OF

VARIOUS KINDS OF TOUCHING ACTIVITIES: STRONGLY STRONGLY

DISAGREE AGREE NA

1. I have been satisfi ed with my sex life (including self-sexual activity)

in the last 3 months 1 2 3 4 5 6 7 0

If you have NOT engaged in sexual activity (of any kind) with a partner

in the last 3 months, please circle 0 and skip to Question 6 of this section. 0

2. I have been satisfi ed with my sex life with a partner in the last 3 months 1 2 3 4 5 6 7 0

3. a. In the last 3 months, I have been satisfi ed with the quality of genital

stimulation and/or intercourse I've had with a partner 1 2 3 4 5 6 7 0

b. With respect to the frequency of this kind of activity, I would like MORE LESS SAME

(1 more, 2 less, OR 3 about the same) amount 1 2 3

4. a. In the last 3 months, I have been satisfi ed with the quality of sexual/erotic

contact I've had with a partner that did not include or lead to sustained genital

stimulation or intercourse (For example, a passionate kiss or erotic caress). 1 2 3 4 5 6 7 0

b. With respect to the frequency of this kind of activity, I would like MORE LESS SAME

(1 more, 2 less, OR 3 about the same) amount 1 2 3

5. a. In the last 3 months, I have been satisfi ed with the quality of the affectionate

nonsexual, nongenital touching I’ve had with a partner. 1 2 3 4 5 6 7 0

b. With respect to the frequency of this kind of activity, I would like MORE LESS SAME

(1 more, 2 less, OR 3 about the same) amount 1 2 3

6. a. Regarding total amount of sexual activity (anything and everything sexual),

in my current or most recent relationship:

I want(ed) more than my partner 1

My partner wants (wanted) more 2

My partner and I want(ed) about the same amount 3

If you want(ed) about the same amount, skip 6b.

b. We (have) reached a mutually satisfying compromise 1 2 3 4 5 6 7 0

N. THE NEXT QUESTIONS ARE ABOUT SEXUALITY AND YOUR MENSTRUAL CYCLES STRONGLY STRONGLY

DISAGREE AGREE NA

1. It seems to me that my sexual desire has (had) predictable variations due to my menstrual cycle 1 2 3 4 5 6 7 0

2. It seems to me that my sexual satisfaction has (had) predictable variations due to my menstrual cycle 1 2 3 4 5 6 7 0

3. I enjoy(ed) sexual activity during my menstrual fl ow 1 2 3 4 5 6 7 0

4. I engage(d) in sexual intercourse during my menstrual fl ow

1 Never 2 Rarely 3 Sometimes 4 Often 1 2 3 4

O. THE QUESTIONS IN THIS SECTION ARE ABOUT PREGNANCY:

If you have NEVER been pregnant AND never wanted to be pregnant, please circle 0 and skip to the next section,

Section P. 0

1. Please indicate if you have ever been pregnant and fi ll in any other blanks that apply:

a. I have been pregnant ___ times. _____ a

b. ___ of my pregnancies were planned. _____ b

c. ___ of my pregnancies were unplanned. _____ c

d. ___ of my pregnancies resulted in live births. _____ d

e. ___ of my pregnancies ended in spontaneous abortion or miscarriage _____ e

f. ___ of my pregnancies ended in an arranged abortion _____ f

g. ___ of my babies were given up for adoption _____ g

STRONGLY STRONGLY

DISAGREE AGREE NA

2. At some time in my life, trying to become pregnant enhanced my sexual pleasure and/or satisfaction 1 2 3 4 5 6 7 0

3. At some time in my life, I had diffi culty becoming pregnant when I wanted to 1 2 3 4 5 6 7 0

4. At some time in my life, trying to become pregnant diminished my sexual pleasure and/or satisfaction 1 2 3 4 5 6 7 0

5. At some time in my life, I have undergone medical testing and/or interventions for fertility 1 Yes 2 No 1 2

If you have NEVER been pregnant, please skip to Question 8.

6. In my life, becoming pregnant has resulted in the following (CIRCLE ALL THAT APPLY):

I got married sooner than I had planned 1

I married someone I had not previously planned to marry 2

I married someone I never would have chosen to marry

otherwise 3

I married someone at the time who was not the biological father 4

I had a baby in marriage before I felt ready 5

The biological father knew about the pregnancy but did not remain with me through it 6

The biological father never knew about the pregnancy 7

Other _____ 8

None of the above 0

7. a. I am pregnant now 1 Yes 2 No 3 Not sure 1 2 3

b. I have a baby I currently breastfeed 1 2

c. I have sometime had a baby delivered by Cesarean section 1 2

8. During, or as a result of, partner sex during the last 3 months I have felt (CIRCLE ALL THAT APPLY):

Desirous of becoming pregnant 1

Concerned or fearful that I might not become pregnant 2

Concerned or fearful that I was pregnant 3

Concerned or fearful that I might become pregnant 4

None of the above 0

P. THIS SECTION IS ABOUT YOUR CONTRACEPTIVE METHOD:

If you do NOT use a contraceptive method, circle 0 and skip to Section Q. 0

1. a. The method of contraception I use most frequently is (PLEASE WRITE IN):
_____ STRONGLY STRONGLY

DISAGREE AGREE NA

b. This method increases my sexual satisfaction 1 2 3 4 5 6 7 0

Q. THESE 4 QUESTIONS ARE ABOUT SEXUALLY TRANSMITTED DISEASES:

1. I have at some time in my life contracted a sexually transmitted disease (STD)

1 Yes 2 No 1 2

(IF YES, PLEASE SPECIFY WHAT IT WAS):
_____

If you DO NOT use a method of disease protection, circle 0 and skip to Question 3. Note the instructions above Question 3. 0

2. a. The method of protection against sexually transmitted diseases I use most frequently is

(PLEASE WRITE IN):
_____ STRONGLY STRONGLY

DISAGREE AGREE NA

b. This method increases my sexual satisfaction 1 2 3 4 5 6 7 0

If you have NOT had sex with a partner in the last 3 months,

please circle 0 and skip to the next section, section R. 0

3. In sex with my partner(s) during the last 3 months I have felt concerned that I might get an STD 1 2 3 4 5 6 7 0

4. In sex with my partner(s) during the last 3 months I have felt concerned that I might transmit an STD 1 2 3 4 5 6 7 0

R. THE QUESTIONS IN THIS SECTION ARE ABOUT AFFAIRS:

An AFFAIR, for the purposes of these questions, refers to YOU having sex outside of your relationship in a way that violates rules of the relationship against it. If you and your partner have agreed that outside sex is OK, then it’s not an affair. If you are single and having sex with someone who is married, that is NOT an affair for you.

1. The number of affairs I have had in my life is ____

If you have NEVER had an affair, circle 0 and skip to Question 3. 0

2. The most important reason(s) for my FIRST affair were (CIRCLE UP TO THREE REASONS):

Not enough sex in my primary relationship 1

Not enough closeness in my primary relationship 2

Curiosity 3

Strong attraction to the other person 4

Desire for something different 5

To make my partner jealous 6

To get back at my partner for something done to me 7

Trying to get pregnant (I couldn't get pregnant with my partner) 8

It provided a way out of an unsatisfactory relationship 9

My partner is/was unable to engage in sex (e.g. due to a medical problem) 10

Other (PLEASE SPECIFY):
_____ 11

3. With respect to my current partner (CIRCLE THE BEST ANSWER):

I have no current partner 0

I am quite certain that while in relationship with me he/she has not had an affair with someone else 1

I sometimes wonder if he/she has had or is having an affair; I am not sure 2

I am quite certain that he/she has had or is having an affair 3

4. While I was growing up, my father and mother, or the "parents" who raised me

(CIRCLE ONE ANSWER IN EACH COLUMN): FATHER MOTHER

Never had an affair that I suspected or knew about 1 1

Had 1 or more affairs that I knew about 2 2

May have had an affair, I was not sure 3 3

Not applicable 0 0

Answer Questions 5 & 6 IF you have NEVER had an affair as defi ned above

OR if you have NEVER had an affair while with your current partner.

5. The most important reason(s) I have NEVER had an affair or NOT had an affair in my current relationship are (up to THREE reasons):

I have had no desire to do so 1

I have not had an opportunity to do so 2

Having an affair is against my values 3

I am/was afraid of getting caught by my partner 4

I don’t/didn’t believe I could deal with the guilt 5

It would destroy my relationship 6

I am/was afraid of catching a sexually transmitted disease 7

Other (PLEASE SPECIFY):
_____ 8 STRONGLY STRONGLY

DISAGREE AGREE NA

6. I would be open to having an affair in the future (if currently in a relationship, answer in terms of still being in that relationship) 1 2 3 4 5 6 7 0

S. THESE FINAL QUESTIONS LOOK AT YOUR SEXUAL LIFE OVER TIME:

1. In my life, my sexual satisfaction has been/was at its peak between ages __ and __ years: ____ and ____

2. Looking back, I have at some time had a problem in my sexual life due to the following

(CIRCLE ALL THAT APPLY):

Inadequate sex education 1

Inadequate knowledge of my body and sexual feelings 2

Inadequate information about the how-to of sex 3

Inadequate knowledge of the physical consequences of sex 4

Inadequate knowledge of the emotional consequences of sex 5

Inadequate information about birth control 6

Inadequate availability of birth control 7

None of the above 0

3. Looking back over my entire life, I regret the following about my sexual life (CIRCLE ALL THAT APPLY):

I got into sex when I was too young. 1

I had sex with partners I should have turned down. 2

I did not have sex with someone with whom I wish I had 3

I had sex without protection against pregnancy 4

I had sex without protection against disease 5

I was too often not assertive enough about my needs 6

I was too inhibited 7

I was celibate for too long 8

I did not take more time to be celibate 9

I married the wrong person because of sex 10

I stayed too long in relationship with the wrong partner 11

Other (PLEASE SPECIFY): _____ 12

None of the above 0

4. Looking back, the most signifi cant sources for me of sex information in each of the two following categories

have been (CIRCLE ONE or TWO ANSWERS IN EACH COLUMN):
Helpful Misleading

or Useful or Harmful

Same age friend(s) 1 1

Older friend(s) 2 2

Sexual partner(s) 3 3

Parent(s) 4 4

Sex education book(s) 5 5

Fiction books (novels, romances, etc.) 6 6

Media (TV, movies, magazines, etc.) 7 7

Erotic or pornographic material(s) 8 8

Course(s) in school or college 9 9

Religious teachings 10 10

Relative(s) 11 11

Health practitioner(s)/therapist(s) 12 12

Other (PLEASE SPECIFY): _____ 13 13 STRONGLY
STRONGLY

DISAGREE AGREE NA

5. Looking back, I believe the information I got from the parent(s) or parent fi gure(s) who raised me prepared me to have a healthy and fulfi lling sex life 1 2 3 4 5 6 7 0

6. Compared to how I was during the year after I became sexually active for the fi rst time ever with a partner (in a genital way, whether or not intercourse was included), I have changed in sex in the following ways (CIRCLE THE NUMBER ON EACH LINE THAT BEST INDICATES HOW YOU HAVE CHANGED). If your fi rst-ever genital contact with a partner occurred less than a year ago, circle 0 and skip to question 7. 0

I now: MORE SAME LESS

a. Desire sex 1 2 3

b. Get aroused easily 1 2 3

c. Express my sexual needs 1 2 3

d. Am inhibited 1 2 3

e. Have erotic thoughts 1 2 3

f. Orgasm easily 1 2 3

g. Initiate 1 2 3

h. Am sexually satisfi ed 1 2 3

i. Have fun 1 2 3

j. Engage in casual sex 1 2 3

k. Am comfortable with sex 1 2 3

l. Focus on my partner's satisfaction 1 2 3

m. Focus on my own satisfaction 1 2 3 STRONGLY STRONGLY

AGREE DISAGREE

7. On the whole, I have been satisfi ed with my sexual life
1 2 3 4 5 6 7

Thank You!

© 1993 Carol Ellison, Ph.D., & Bernie Zilbergeld, Ph.D.

Andersen and Cyranowski (1994) view sexual self-schema as a sexually relevant, cognitive, individual difference variable. Schemas are cognitive representations of the self. They are derived from past experience and manifest in current experiences. The sexual self-view functions to interpret and organize sexually relevant actions and experi ences, provides standards for sexual behaviors, and guides decisions and inferences about future sexual circumstances.

The Sexual Self-Schema Scale (SSS) is a cognitive measure of a woman's sexual self-view. Individuals with a positive sexual self-schema tend to view themselves as emotionally romantic or passionate and behaviorally open, while reporting low levels of embarrassment or conservatism in sexual contexts. Women with negative self-descriptions report low levels of romantic or passionate emotions and low behavioral engagement in sexual and romantic relationships.

Development and Description

A construct validity method was employed in test construction, beginning with a classic approach of using trait adjectives as markers of important personality dispositions to identify a semantic representation of a "sexual" woman. Psychometric studies of internal consistency, discriminant and convergent validity, group differences, internal structure, and others were conducted. The final scale is uncorrelated with both negative affect and social desirability. Filler items were added to yield a measure for which respondents are unaware that a sexuality construct is being assessed. The scale (entitled "Describe Yourself") has 50 items, with 26 scored and 24 fillers. Multiple factor analytic studies reveal two factors with a positive valence, Passionate/Romantic (Factor 1) and Directness/Openness (Factor 2), and one with a negative valence,

Embarrassment or Conservatism (Factor 3). Use of the

total score is recommended. High scores are interpreted

as positively schematic and low scores negatively

schematic.

Response Mode and Timing

Subjects rate items on a 7-point Likert-type scale, rang

ing from 0 = Not at all Descriptive of Me to 6 = Very

Much Descriptive of Me. The scale takes 5 –10 minutes to

complete. Scoring The 26 items are summed within their factors, resulting in factor scores: Scale/Factor 1 items are 5, 11, 20, 35, 37, 39, 44, 45, 48, and 50; Scale/Factor 2 items are 2, 5, 9, 13, 16, 18, 24, 25, and 32; Scale/Factor 3 items are 3, 8, 22, 28, 31, 38, and 41. Item 45 is reverse scored. A total score is used and is calculated as follows: (scale 1 + scale 2) – scale 3. Total scores can range from –42 to 114. A normal distribution is typically found, with a slight positive skew. Means and standard deviations of total and scale scores were provided from college-aged women (N = 387) as follows: Total score: 60.47 (14.15); Scale 1: 47.44 (6.45); Scale 2: 36.26 (7.15); and Scale 3: 23.22 (5.91; Andersen & Cyranowski, 1994). Scale scores can also be used to represent a two-dimensional model. The bivariate scoring procedure uses median-split cutoffs of the positive (sum of Factors 1 and 2) and negative (Factor 3) dimensions to delineate four types of schematic representations: positive (high on positive/low on negative schema dimensions), negative (low positive/high negative), aschematic (low on both positive and negative dimensions) and co-schematic (high on both positive and negative dimensions; Andersen & Cyranowski, 1994). Reliability The authors reported Cronbach's alpha values in college women (N = 387) as follows: Total scale, .82; Scale 1, .81; Scale 2, .77; and Scale 3, .66 (Andersen & Cyranowski, 1994). Since publication, total scale internal-consistency estimates from various other samples, including older women, cancer patients/survivors, and women with sexual dysfunctions, have been in the same range (Ns 17 to 190, α = .61 to .86). Retest reliabilities provided from college samples at 2-week and 9-week intervals were .89 (N = 20) and .88 (N = 172; Andersen & Cyranowski, 1994). Validity Convergent validity data from

multiple samples from Andersen, Cyranowski and colleagues (Andersen & Cyranowski, 1994; Andersen, Woods, & Copeland, 1997; Cyranowski & Andersen, 1998, 2000) showed the SSS to predict a range of sexual cognitions, behaviors, and responses. Studies with college women (N = 220)

1 Address correspondence to Barbara L. Andersen, Department of Psychology, The Ohio State University, 1835 Neil Avenue, Columbus, OH 43210-1222;

e-mail: andersen.1@osu.edu

Sexual Self-Schema Scale—Women's Version

ANNA O. LEVIN AND BARBARA L. ANDERSEN, 1 The Ohio State University

indicate significant correlations of total scores with measures of sexual affects, behaviors, and arousal, as well as romantic relationships (rs = .14 to .36). Data from older women (N = 21) provide total score correlations with self-report measures of the sexual response cycle phases (rs = .47 to .59). Multiple regression studies showed schema scores to account for significant increments of variance beyond any contributions of other individual difference factors such as extroversion or self-esteem.

Consistent data come from other investigators. Reissing, Laliberté, and Davis (2005; N = 84) found the total score to predict sexual aversion and sexual self-efficacy (β = .22 and .13). Meston, Rellini, and Heiman (2006) found the Romantic/Passionate scale to predict negative sexual affect. Donaghue (2009; N = 91) reported significant correlations between schema scores and various

measures of subjective well-being (β = -.18 to .27).

Kuffel and Heiman's (2006) analog study investigated the role of schemas on responses to sexually explicit visual material. Analyses demonstrated significantly greater vaginal response, positive affect, and subjective sexual arousal when participants were told to adopt a positive schema in comparison to their responses following the negative schema induction.

Importantly, sexual self-schema appears relevant to sexual dysfunction and/or sexual distress. Studies of female cancer patients also find the SSS to predict a wide range of responses (e.g., Andersen et al., 1997; Donovan et al., 2007; Yurek, Farrar, & Andersen, 2000). Reissing, Binik, Khalife, Cohen, and Amsel (2003; N= 87) found that women with sexual pain disorders report a less positive score than women with no pain. Women with a sexual abuse history were

Exhibit

Sexual Self-Schema Scale

Describe Yourself

Directions: Below is a listing of 50 trait adjectives. For each word, consider whether or not the term describes you. Each adjective is to be

rated on a 7-point scale, ranging from 0 = not at all descriptive of me to 6 = very much descriptive of me. For each item, fill in the appropriate

circle on your computer answer sheet. Please be thoughtful

and honest.

Question: To what extent does the term
describe me?

Rating Scale:

Not at all Very Much

Descriptive 0 1 2 3 4 5 6
Descriptive

of Me of Me

(1) generous (26) disagreeable

(2) uninhibited (27) serious

(3) cautious (28) prudent

(4) helpful (29) humorous

(5) loving (30) sensible

(6) open-minded (31) embarrassed

(7) shallow (32) outspoken

(8) timid (33) level-headed

(9) frank (34) responsible

(10) clean-cut (35) romantic

(11) stimulating (36) polite

(12) unpleasant (37) sympathetic

(13) experienced (38) conservative

(14) short-tempered (39) passionate

(15) irresponsible (40) wise

(16) direct (41) inexperienced

(17) logical (42) stingy

(18) broad-minded (43) superficial

(19) kind (44) warm

(20) arousable (45) unromantic

(21) practical (46) good-natured

(22) self-conscious (47) rude

(23) dull (48) revealing

(24) straightforward (49) bossy

(25) causal (50) feeling

Brief Index of Sexual Functioning for Women

RAYMOND C. ROSEN, 1 JENNIFER F. TAYLOR, AND SANDRA R. LEIBLUM, University of Medicine

and Dentistry of New Jersey, Robert Wood Johnson Medical School

The Brief Index of Sexual Functioning for Women (BISF

W) was developed in response to the lack of a brief, stan

dardized self-report measure of overall sexual function in

women. Previous self-report measures have been either

overly restrictive or inappropriate for use in large-scale clin

ical trials. None of the self-report measures to date provide

a comprehensive, reliable assessment of key dimensions of

sexual function in women, including sexual desire, orgasm,

and satisfaction. Reynolds et al. (1988) have described the

Brief Sexual Function Questionnaire (BSFQ) for men, a

21-item self-report inventory of sexual interest, activity,

satisfaction, and preference. The BSFQ has been found to

be highly reliable, and to discriminate between depressed,

sexually dysfunctional, and healthy males (Howell et al., 1987; Reynolds et al., 1988). Surprisingly, no corresponding measures to the BSFQ for self-report assessment of female sexual function were available. The present questionnaire was developed to provide a comparable, brief self-report measure of sexual function for women.

Description The BISF-W consists of 22 items, assessing the major dimensions of sexual desire, arousal, orgasm, and satisfaction. Several items were adapted from the BSFQ, particularly those assessing frequency of sexual behavior, fantasy, masturbation, and sexual preference. Additional items were included to address specific issues believed to affect women's sexual functioning and satisfaction, such as body image, partner satisfaction, and sexual anxiety. Several items were designed to evaluate sexual performance difficulties in women, such as diminished arousal or lubrication, pain or tightness during intercourse, and difficulties in reaching orgasm. Items assessing the impact of health problems on sexual functioning are also included. Most items are arranged in Likert-type format to rate the frequency of occurrence of sexual desire, arousal or satisfaction associated with common sexual behaviors. Based upon a principal components analysis, three major factors were identified, which were

1 Address correspondence to Raymond C. Rosen, New England Research Institutes, Inc., 9 Galen Street, Watertown, MA 02472; e-mail:

RRosen@neriscience.com

Functioning (also see Satisfaction)

Changes in Sexual Functioning Questionnaire

ANITA H. CLAYTON 1 AND ELIZABETH L. MCGARVEY, University of Virginia School of Medicine

1 Address correspondence to Anita H. Clayton, Department of Psychiatry and Neurobehavioral Science, University of Virginia, 2955 Ivy Road, Suite 210,

Charlottesville, VA 22903; e-mail: ahc8v@virginia.edu

Assessment of sexual functioning is an important compo

nent in many clinical encounters, and in research settings it

is increasingly of interest with regard to side effects of new medications. Adequate sexual functioning for most people is an important factor for good quality of life. There is a need for brief, easy-to-use assessment instruments that provide

valid and reliable indicators of the sexual health of the indi

vidual. The Changes in Sexual Functioning Questionnaire

(CSFQ) was developed with specific versions for females

and males to assess sexual functioning in all the domains

of the sexual response cycle. It was developed to be used

in both clinical and research settings (Clayton, McGarvey,

Clavet, & Piazza, 1997).

Description

The CSFQ was initially developed from patient complaints

of sexual dysfunction and published sexual side effects of

psychotropic medications. The clinical interview (CSFQ

I) was intended for use in the diagnosis and management

of sexual dysfunction in patients who were in treatment at

an outpatient psychiatric clinic. The CSFQ-I included 35 items for females and 36 items for males, and also included a section for medical disorders and medication use. At the time of its development, most research on sexual dysfunction focused on problems among males, such as erectile dysfunction, and the available research instruments did not adequately capture specific female symptoms of sexual problems relating to reduced quality of life, such as lack of desire.

The CSFQ-I was used clinically and included a section to identify the sexual pattern of the individual, which permitted a documentation of how much sexual change the person experienced over time. In addition, information on medication use was collected. The documentation of change could be tied to the five domains of sexual functioning so that the clinician could better focus on strategically targeted treatment for the cause of the problem, which could be related to medication, illness, relationship problems, or a combination of difficulties. In addition, the CSFQ-I addressed the need for an assessment instrument that could differentiate current sexual dysfunction from previous “normal” sexual function and/or lifelong sexual dysfunction. The original CSFQ items were field tested and revised on the basis of conceptual content to ensure that five aspects of sexual functioning (i.e., sexual desire, sexual

frequency, sexual satisfaction, sexual arousal, and sexual completion) were captured. To establish face validity, other physicians, clinicians, and researchers reviewed the items for accuracy and clarity. Reliability and validity were established for the clinical interview version, with 14 scored items. Male- and female-specific self-report shorter versions were developed that included only the 14 scored items from the validation of the interview version: the CSFQ-14-F for females and the CSFQ-14-M for males (Clayton, McGarvey, & Clavet, 1997; Keller, McGarvey, & Clayton, 2006). The CSFQ has been used in studies of clinical and non clinical samples (Bobes et al., 2000; Clayton, McGarvey, Clavet, & Piazza, 1997), in a study of women survivors of gynecological cancer (Lagana, McGarvey, Classen, & Koopman, 2001), in studies on sexual dysfunction asso ciated with medications for depression (Clayton et al., 2002), and in a study on sexual functioning in menopause (Warnock, Swanson, Boren, Zipfel, & Brennan, 2005), among many others. Response Mode and Timing The CSFQ-I has items stated as questions that are rated by the clinician during a clinical interview, or for CSFQ-14-F selfscored by females and CSFQ-14-M self-scored by males in either a clinical or a research setting. Each item is scored on a 5-point scale that is linked to specific self-reported information. A “1” on the scale typically indicates Never or No Enjoyment or Pleasure, depending upon whether the response item is to determine frequency of occurrence or perception of satisfaction in a stated area, whereas a “5” indicates Every Day or Always in like manner. The response time for the CSFQ-I is between 30 and 45 minutes for the interview. The response time for the CSFQ-14-F and CSFQ14-M

is between 4 and 5 minutes. Scoring The CSFQ-I scoring booklet may be obtained from the first author. A CSFQ-14 total score for both female and male versions is obtained by summing the value of Items 1 to 14. Scores ≤ 41 for females and ≤ 47 for males indicate sexual dysfunction. In addition, five subscale scores with established thresholds are also provided for pleasure/overall satisfaction (Item 1 ≤ 4), desire/measured as frequency (Item 2 + Item 3 ≤ 6 for women and ≤ 8 for men), desire/measured as interest (Item 4 + Item 5 + Item 6 ≤ 9 for women and ≤ 11 for men), arousal/excitement (Item 7 + Item 8 + Item 9 ≤ 12 for females and ≤ 13 for males) and orgasm/completion (Item 11 + Item 12 + Item 13 ≤ 11 for females and ≤ 13 for males). Items 10 and 14 are included in the total score, but do not map to a subscale dimension. See the Exhibit for additional scoring information. Reliability and Validity For the CSFQ-I, alpha coefficients and item total correlations range from 0.45 to 0.60 with concurrent validation demonstrated using the Derogatis Interview for Sexual Functioning (Derogatis, 1997) and high test-retest reported (Clayton, McGarvey, Clavet, & Piazza, 1997). For the CSFQ-14-F and CSFQ-14-M versions, Cronbach's alpha coefficient of internal reliability for the total score and the original five subscales was established in addition to other analyses for each version of the measure. The alpha coefficient for the CSFQ-14-F was .90 and for the CSFQ-14-M was .89 (Keller at al., 2006). Other Information There are 51 linguistically validated translations of the CSFQ with validation of the Spanish version reported with norms established (Bobes et al., 2000). The CSFQ has been utilized in over 75 studies, including studies in psychiatric

populations with diagnoses of major depressive disorder,

schizophrenia, bipolar illness, OCD, ADHD, primary sex

ual disorders, alcohol dependence, and cognitive disorders.

Other medical illnesses in which the CSFQ has been admin

istered include cancer, obesity, diabetes mellitus/metabolic

syndrome, rheumatologic illness, spinal cord injury, BPH,

and vulvar pain, as well as with the administration of andro

gens. Use of the measures for clinical purposes is typically

provided upon request to Dr. Clayton. Use of the measures

for

research may be approved with or without charge, depend

ing upon the type of project being undertaken. Citation of

use is always required.

All versions of the CSFQ are under copyright to

Anita H. Clayton, MD, David C. Wilson Professor,

Department of Psychiatry and Neurobehavioral Science,

University of Virginia, 2955 Ivy Road, Suite 210,

Charlottesville, VA 22903; Tel: 434-243-4646; e-mail:

ahc8v@virginia.edu

Bobes, J., Gonzalez, M. P., Rico-Villademoros, R., Bascaran, M. T., Sarasa,

P., & Clayton, A. (2000). Validation of the Spanish version of the Changes in Sexual Functioning Questionnaire-CSFQ. Journal of Sex and Marital Therapy, 26, 119–131. Clayton, A. H., McGarvey, E. L., & Clavet, G. J. (1997). The Changes in Sexual Functioning Questionnaire (CSFQ): Development, reliability, and validity. Psychopharmacology Bulletin, 33, 731–745. Clayton, A. H., McGarvey, E. L., Clavet, G. J., & Piazza, L. (1997). Comparison of sexual functioning in clinical and non-clinical populations using the Changes in Sexual Functioning Questionnaire (CSFQ). Psychopharmacology Bulletin, 33, 747–753. Clayton, A. H., Pradko, J. F., Croft, H. A., Montano, C. B., Leadbetter, R. A., Bolden-Watson, C., et al. (2002). Prevalence of sexual dysfunction among newer antidepressants. Journal of Clinical Psychiatry, 63, 357–366. Derogatis, L. R. (1997). The Derogatis Interview for Sexual Functioning (DISF/DISF-SR): An introductory report. Journal of Sex and Marital Therapy, 23, 291–304. Keller, A., McGarvey, E. L., & Clayton, A. H. (2006). Reliability and construct validity of the Changes in Sexual Functioning Questionnaire Short-Form (CSFQ-14). Journal of Sex and Marital Therapy, 32, 43–52. Lagana, L., McGarvey, E. L., Classen, C., & Koopman, C. (2001). Psychosexual dysfunction among gynecological cancer survivors. Journal of Clinical Psychology in Medical Settings, 8, 73–84. Warnock, J. K., Swanson, S. G., Boren, R. W., Zipfel, L. M., & Brennan, J. J. (2005). Combined esterified estrogen and

methyltestosterone versus esterified estrogens alone in the treatment of loss of sexual interest in surgically-menopausal women. Menopause, 12, 374-84.

Exhibit

Changes in Sexual Functioning Questionnaire

Changes in Sexual Functioning Questionnaire for Females (CSFQ-F-C)

Note: This is a questionnaire about sexual activity and sexual function. By sexual activity, we mean sexual intercourse, masturbation,

sexual fantasies, and other activity.

1. Compared with the most enjoyable it has ever been, how enjoyable or pleasurable is your sexual life right now? □ 1 No Enjoyment or Pleasure □ 2 Little Enjoyment or Pleasure □ 3 Some Enjoyment or Pleasure □ 4 Much Enjoyment or Pleasure □ 5 Great Enjoyment or Pleasure

2. How frequently do you engage in sexual activity (sexual intercourse, masturbation, etc.) now?

□ 1 Never □ 2 Rarely (once a month or less) □ 3 Sometimes (more than once a month, up to twice a week) □ 4 Often (more than twice a week) □ 5 Every Day

3. How often do you desire to engage in sexual activity?

□ 1 Never □ 2 Rarely (once a month or less) □ 3 Sometimes (more than once a month, up to twice a week) □ 4 Often (more than twice a week) □ 5 Every Day

4. How frequently do you engage in sexual thoughts (thinking about sex, sexual fantasies) now?

□ 1 Never □ 2 Rarely (once a month or less) □ 3 Sometimes (more than once a month, up to twice a week) □ 4 Often (more than twice a week) □ 5 Every Day

5. Do you enjoy books, movies, music, or artwork with sexual content? □ 1 Never □ 2 Rarely (once a month or less) □ 3 Sometimes (more than once a month, up to twice a week) □ 4 Often (more than twice a week) □ 5 Every Day

6. How much pleasure or enjoyment do you get from thinking about and fantasizing about sex?

 1 No Enjoyment or Pleasure 2 Little Enjoyment or Pleasure 3 Some Enjoyment or Pleasure 4 Much Enjoyment or Pleasure 5 Great Enjoyment or Pleasure

7. How often do you become sexually aroused? 1 Never 2 Rarely (once a month or less) 3 Sometimes (more than once a month, up to twice a week) 4 Often (more than twice a week) 5 Every Day

8. Are you easily aroused?

 1 Never 2 Rarely (much less than half the time) 3 Sometimes (about half the time) 4 Often (much more than half the time) 5 Always

9. Do you have adequate vaginal lubrication during sexual activity?

 1 Never 2 Rarely (much less than half the time) 3 Sometimes (about half the time) 4 Often (much more than half the time) 5 Always

10. How often do you become aroused and then lose interest?

 5 Never 4 Rarely (much less than half the time) 3 Sometimes (about half the time) 2 Often (much more than half the time) 1 Always

11. How often do you experience an orgasm?

 1 Never 2 Rarely (much less than half the time) 3 Sometimes (about half the time) 4 Often (much more than half the time) 5 Always

12. Are you able to have an orgasm when you want to?

 1 Never 2 Rarely (much less than half the time) 3 Sometimes (about half the time) 4 Often (much more than half the time) 5 Always

13. How much pleasure or enjoyment do you get from your orgasms? 1 No Enjoyment or Pleasure 2 Little Enjoyment or Pleasure 3 Some Enjoyment or Pleasure 4 Much Enjoyment or Pleasure 5 Great Enjoyment or Pleasure

14. How often do you have painful orgasm?

 5 Never 4 Rarely (once a month or less) 3 Sometimes (more than once a month, up to twice a week) 2 Often

(more than twice a week) ☐ 1 Every Day

____ = Pleasure (Item 1)

____ = Desire/Frequency (Item 2 + Item 3)

____ = Desire/Interest (Item 4 + Item 5 + Item 6)

____ = Arousal/Excitement (Item 7 + Item 8 + Item 9)

____ = Orgasm/Completion (Item 11 + Item 12 + Item 13)

____ = Total CSFQ Score (Items 1 to 14)

Copyright © 1998/99 A. Clayton, Dept. of Psychiatric Medicine, University of Virginia Health Sciences Center

Changes in Sexual Functioning Questionnaire for Males (CSFQ-M-C)—sample items only

Note: This is a questionnaire about sexual activity and sexual function. By sexual activity, we mean sexual intercourse, masturbation,

sexual fantasies, and other activity.

7. How often do you have an erection related or unrelated to sexual activity?

☐ 1 Never

☐ 2 Rarely (once a month or less)

☐ 3 Sometimes (more than once a month, up to twice a week)

☐ 4 Often (more than twice a week)

☐ 5 Every Day

8. Do you get an erection easily?

☐ 1 Never

☐ 2 Rarely (much less than half the time)

☐ 3 Sometimes (about half the time)

☐ 4 Often (much more than half the time)

☐ 5 Always

Instructions for completing and scoring the CSFQ

Ask the patient to complete all 14 items on the clinical version of the CSFQ. The patient should place a check (3) in the box correspond

ing to the response for that particular item. The patient should choose only one response per item.

To score items on the CSFQ, take the numerical value or weight indicated for a particular response. For example, in Item 1, a

response of “some enjoyment or pleasure” has a numerical value of 3, whereas a response of “much enjoyment or pleasure” has a

numerical value of 4. Some items have responses that are reverse scored: for example, on Item 14 in the CSFQ-F-C version, a response

of “never” has a numerical value of 5, whereas a response of “every day” has a value of 1.

To calculate the total CSFQ score, add up the values of the responses for all 14 items. To calculate subscale scores, add up the values

for only the items that correspond to a particular subscale (see shaded box after item 14). To determine if sexual dysfunction is present,

refer to the gender-specific scoring protocols below.

Scoring for CSFQ-F-C: (Female Clinical Version)

If the female patient obtains a score at or below the following cutoff points* on any of these scales, it is indicative of sexual dysfunction:

Total CSFQ score: 41.0 (range: 14 to 70)

Sexual Desire/Frequency score: 6.0 (range: 2 to 10)

Sexual Desire/Interest: 9.0 (range: 3 to 15)

Sexual Pleasure: 4.0 (range: 1 to 5)

Sexual Arousal/Excitement: 12.0 (range: 3 to 15)

Sexual Orgasm/Completion: 11.0 (range: 3 to 15)

Scoring for CSFQ-M-C: (Male Clinical Version)

If the male patient obtains a score at or below the following cutoff points* on any of these scales, it is indicative of sexual dysfunction:

Total CSFQ score: 47.0 (range: 14 to 70)

Sexual Desire/Frequency score: 8.0 (range: 2 to 10)

Sexual Desire/Interest: 11.0 (range: 3 to 15)

Sexual Pleasure: 4.0 (range: 1 to 5)

Sexual Arousal/Excitement: 13.0 (range: 3 to 15)

Sexual Orgasm/Completion: 13.0 (range: 3 to 15)

*Based on comparisons of nondepressed participants and clinically depressed patients.

Global Sexual Functioning: A Single Summary

Score for Nowinski and LoPiccolo's Sexual History

Form (SHF)

LAURA CRETI 1 AND CATHERINE S. FICHTEN, SMBD-Jewish General Hospital

RHONDA AMSEL, McGill University

WILLIAM BRENDER, SMBD-Jewish General Hospital

L ESLIE R. SCHOVER, The Cleveland Clinic Foundation

DENNIS KALOGEROPOULOS, Royal Victoria Hospital

EVA LIBMAN, SMBD-Jewish General Hospital

The Sexual History Form (SHF: Nowinski & LoPiccolo,

1979; Schover & Jensen, 1988) is a questionnaire that eval

uates sexual functioning including desire, arousal, orgasm,

pain, frequency of sexual activities, and overall sexual

satisfaction for men and women. Originally, it was devel

oped for clinical use and to provide standardized data for

diagnosis and research (Schover, Friedman, Weiler,

Heiman, & LoPiccolo, 1982), and was limited to item-by

item analysis. We developed a new scoring system that generates a

single summary score: Global Sexual Functioning (Creti, Fichten, Libman, Amsel, & Brender, 1988; Creti, Fichten, Libman, Kalogeropoulos, & Brender, 1987), which is concise and accurate, and reflects overall level of sexual functioning. The questionnaire has been used to describe sexual functioning in different populations, in studies of various medical conditions and procedures, in sex therapy outcome, and in longitudinal assessments of the impact of chronic illness on sexuality (Creti et al., 1998; Desrosiers et al., 2008; Petersen, Ung, Holland, & Quinlivana, 2005; Weber, Walters, Schover, Church, & Piedmonte, 1999).

1 Address correspondence to Laura Creti, ICFP, Jewish General Hospital, 4333 Chemin de la Cote Ste Catherine, Montreal, Quebec, Canada, H3T 1E4;

e-mail: lcreti@mail.mcgill.ca

Description

The SHF is a self-report measure consisting of 46 multi

ple-choice items that have variable numbers of response

options and different response scales (e.g., Item 1 has 9

options; Item 18 has 6 options). Response options are num

bered and have a verbal descriptor corresponding to each

number. Normative data are available for individual items

(see Creti et al., 1998). Norms have yet to be established for

the Global Sexual Functioning score.

Response Mode and Timing

Respondents are asked to circle the number that corre
sponds to the single most appropriate response for each
question. The measure requires approximately 15 minutes
to complete.

Scoring

The Global Sexual Functioning score is based on 12 items.
Because certain items are relevant only for males, whereas
others are relevant only for females, the items used to cal
culate the male and female scores are somewhat different.
These items were selected as representative of various
domains of sexual functioning: frequency of sexual activi
ties, sexual desire, arousal, orgasmic, and erectile
abilities.

To arrive at the single summary score, SHF items are
grouped into a 12-item scale; this reflects either male or
female global sexual functioning. The single summary score
is derived by (a) converting the scores on each of the 12
items to a proportion of the maximum possible value (e.g.,
if
on Item 1, where response options are numbered 1 to 9, the
respondent answers “(4) twice a week,” this is converted to
4/9 = .44), (b) summing the 12 proportions, and (c) calculat
ing the mean by dividing the total by the number of items
that the respondent is deemed to have answered (usually
12). The resulting mean value, which is the Global Sexual

Functioning score, will be greater than 0 and less than 1.

Specified in Table 1 are the items included in the calcu

lation of the Global Sexual Functioning score. For items

with an asterisk, responses equaling 6 are considered miss

ing because this response option is have never tried; in this

case, the summed proportions are divided not by 12 but by

the number of items that are deemed to have been answered

(i.e., not missing). The scoring system is summarized in

Table 1. Lower scores indicate better functioning.

Reliability

Temporal stability for the GSF ranged from .92 (Creti et

al., 1988) to .98 (Libman et al., 1989). Internal consistency

ranged from .50 to .70 (Creti et al., 1988).

Validity

Male global sexual functioning. Data reported to date indi

cate the following: (a) The GSF score can differentiate sexually well-functioning from poorly functioning men, and it is responsive to changes with therapy (Creti et al., 1987; Kalogeropoulos, 1991); (b) the GSF score was found to be logically and significantly related to scores on measures of sexual satisfaction, sexual repertoire, sexual self-efficacy, sexual drive, sexual knowledge, and liberal attitudes (Creti et al. 1987; Creti & Libman, 1989; Meana & Nunnink, 2006); and (c) the GSF score is sensitive to age differences in sexual functioning (Brown et al., 2005; Creti et al., 1987, Creti & Libman, 1989; Libman et al., 1989, Libman et al., 1991). Female global sexual functioning. Data reported by Creti et al. (1988) indicate that (a) women with diagnosed sexual dysfunction had worse scores (M = .68, SD = .17) than women who were functioning well (M = .49, SD = .14), (b) that younger women (age 21–46) had better scores (M = .46, SD = .03) than older women (age greater than 64; M = .62, SD = .16), and (c)

that female GSF scores were logically and significantly correlated with sexual harmony, sexual drive, diversity of sexual repertoire, and sexual satisfaction. Meana and Nunnink (2006) also found significant correlations with sexual satisfaction, fantasies, experiences, and liberal attitudes. The GSF score was also found to be related to the female's sexual efficacy expectations for her male partner (Creti & Libman, 1989). Reissing, Binik, Khalif, Cohen, and Amsel (2003) found worse global sexual functioning scores in women with vaginismus and women with vulvar vestibulitis syndrome than in women with no pain (M = 38.00). Bergeron et al. (2001) found that scores significantly improved from posttreatment to 6-month follow-up in a sample of females who underwent cognitive-behavioral therapy, electromyographic biofeedback, or vestibulectomy in the treatment of dyspareunia resulting from vulvar vestibulitis. The GSF score has also been used to validate the Pelvic Organ Prolapse—Urinary Incontinence Sexual TABLE 1 Calculating the Global Sexual Functioning Score Male Female Item no. Divide by Item no. Divide by 1 9 1 9 2 9 2 9 6 9 6 9 7 9 7 9 10 6 16 5 16 5 23* 5 18 6 24* 5 19 6 25* 5 22 6 26* 5 23* 5 27* 5 24* 5 29 6 25* 5 37* 5 Note. Score as follows: (a) convert scores to proportions, (b) sum proportions, and (c) divide by number of items. Although all items included in the global sexual functioning score are present in the original 28-item version, items have been renumbered in the current 46-item version. *Responses equaling 6 are considered missing.

Questionnaire (PISQ; Rogers, Kammerer-Doak, Villarreal,

Coates, & Qualls, 2001) and its modified short form

(Rogers, Coates, Kammerer-Doak, Khalsa, & Qualls,

2003), an instrument in urogynecology that is specifically

designed to measure sexual function in women with pelvic

organ prolapse or incontinence. Psychometric properties for the male and female Global

Sexual Functioning scores suggest that these provide a

good index of the underlying construct. Even in the absence

of norms, the score is useful in research and practice. It

allows investigators to classify respondents in terms of

level of overall sexual functioning by using a mean or

median split.

Other Information

The 28-item version of the SHF has been translated into

French (Formulaire d'Histoire Sexuelle) and Spanish

(Ávila Escribano, Perez Madruga, Olazabal Ulacia, &

Lopez Fidalgo, 2004). Additional affiliations: Catherine S. Fichten, Dawson

College, McGill University; William Brender, Concordia

University; Eva Libman, McGill University.

Ávila Escribano, J. J., Perez Madruga, A., Olazabal Ulacia, J. C., & Lopez Fidalgo, J. (2004). Disfunciones sexuales en el alcoholismo. Adiccones, 16(4), 1-6.

Bergeron, S., Binik, Y. B., Khalifé, S., Pagidas, A., Glazer, H. I., Meana M., et al. (2001). A randomized comparison of group cognitive-behavioral therapy, surface electromyographic biofeedback, and vestibulectomy in the treatment of dyspareunia resulting from vulvar vestibulitis. Pain, 91, 297-306.

Brown, R., Balousek, S., Mundt, M., & Fleming, M. (2005). Methadone maintenance and male sexual dysfunction. Journal of Addictive Diseases, 24(2), 91-106.

Creti, L., Fichten, C. S., Amsel, R., Brender, W., Schover, L. R., Kalogeropoulos, D., et al. (1998). Global sexual functioning: A single summary score for Nowinski and LoPiccolo's Sexual History Form (SHF). In C. M. Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L. Davis (Eds.), Handbook of sexuality-related measures (pp. 261- 267). Thousand Oaks, CA: Sage.

Creti, L., Fichten, C. S., Libman, E., Amsel, R., & Brender, W. (1988, June). Female sexual functioning: A global score for Nowinski and LoPiccolo's Sexual History Form. Paper presented at the annual convention of the Canadian Psychological Association, Montreal. (Abstracted in Canadian Psychology, 29[2a], Abstract 164) Creti, L., Fichten, C. S., Libman, E., Kalogeropoulos, D., & Brender,

W. (1987, November). A global score for the “Sexual History Form” and its effectiveness. Paper presented at the 21st annual convention of the Association for Advancement of Behavior Therapy, Boston. Creti, L., & Libman, E. (1989). Cognitions and sexual expression in the aging. Journal of Sex and Marital Therapy, 15, 83–101. Desrosiers, M., Bergeron, S., Meana, M., Leclerc, B., Binik, Y. B., & Khalifé, S. (2008). Psychosexual characteristics of vestibulodynia couples: Partner solicitousness and hostility are associated with pain. Journal of Sexual Medicine, 5, 418–427. Kalogeropoulos, D. (1991). Vasoactive intracavernous pharmacotherapy for erectile dysfunction: Its effects on sexual, interpersonal, and psychological functioning. Unpublished doctoral dissertation, Concordia University, Montreal. Libman, E., Fichten, C. S., Creti, L., Weinstein, N., Amsel, R., & Brender, W. (1989). Transurethral prostatectomy: Differential effects of age category and presurgery sexual functioning on postprostatectomy sexual adjustment. Journal of Behavioral Medicine, 12, 469–485. Libman, E., Fichten, C. S., Rothenberg, P., Creti, L., Weinstein, N., Amsel, R., et al. (1991). Prostatectomy and inguinal hernia repair: A comparison of the sexual consequences. Journal of Sex and Marital Therapy, 17, 27–34. Meana, M., & Nunnink, S. E. (2006). Gender differences in the content of cognitive distraction during sex. The Journal of Sex Research, 43, 59–67. Nowinski, J. K., & LoPiccolo, J. (1979). Assessing sexual behaviors in couples. Journal of Sex and Marital Therapy, 5, 225–243. Petersen, R. W., Ung, K., Holland, C., & Quinlivana, J. A. (2005). The impact of molar pregnancy on psychological symptomatology, sexual function, and quality of life. Gynecologic Oncology, 97, 535–542. Reissing, E. D., Binik, Y. M., Khalif, S., Cohen, D., & Amsel, R. (2003). Etiological correlates of vaginismus: Sexual and physical abuse, sexual knowledge, sexual self-schema, and relationship adjustment. Journal of Sex and Marital Therapy, 29, 47–59. Rogers, R. G., Coates, K. W., Kammerer-Doak, D., Khalsa, E. S., & Qualls, E. C. (2003). A short form of the Pelvic Organ Prolapse/ Urinary Incontinence Sexual Questionnaire (PISQ-12). International Urogynecology Journal and Pelvic Floor Dysfunction, 14, 164–168. Rogers, R. G., Kammerer-Doak, D., Villarreal, A., Coates, K. W., & Qualls, E. C. (2001). A new instrument to measure sexual function in women with urinary incontinence or pelvic organ prolapse. American Journal of Obstetrics and Gynecology, 184, 552–558. Schover, L. R., Friedman, J. M., Weiler, J., Heiman, J. R., & LoPiccolo, J. (1982). Multiaxial problem-oriented system for sexual dysfunctions: An alternative to DSM-III. Archives of General Psychiatry, 39, 614–619. Schover, L.

R., & Jensen, S. B. (1988). Sexuality and chronic illness: A comprehensive approach. New York: Guilford. Weber, A. M., Walters, M. D., Schover, L. R., Church, J. M., & Piedmonte, M. R. (1999). Functional outcomes and satisfaction after abdominal hysterectomy. American Journal of Obstetrics and Gynecology, 181, 530-535.

Exhibit

Sexual History Form

Please circle the most appropriate response to each question.

1. How frequently do you and your mate have sexual intercourse or activity?

1) more than once a day 6) once every two weeks

2) once a day 7) once a month

3) 3 or 4 times a week 8) less than once a month

4) twice a week 9) not at all

5) once a week

2. How frequently would you like to have sexual intercourse or activity?

1) more than once a day 6) once every two weeks

2) once a day 7) once a month

3) 3 or 4 times a week 8) less than once a month

4) twice a week 9) not at all

5) once a week

3. Who usually initiates sexual intercourse or activity?

1) I always do 4) my mate usually does

2) I usually do 5) my mate always does

3) my mate and I initiate about equally often

4. Who would you ideally like to initiate sexual intercourse or activity?

1) myself, always 4) my mate, usually

2) myself, usually 5) my mate, always

3) my mate and I equally often

5. When your mate makes sexual advances, how do you usually respond?

1) I usually accept with pleasure 3) often refuse

2) accept reluctantly 4) usually refuse

6. How often do you experience sexual desire (this may include wanting to have sex, planning to have sex, feeling frustrated due to lack of sex, etc.)?

1) more than once a day 6) once every two weeks

2) once a day 7) once a month

3) 3 or 4 times a week 8) less than once a month

4) twice a week 9) not at all

5) once a week

7. How often do you masturbate (bring yourself to orgasm in private)?

1) more than once a day 6) once every two weeks

2) once a day 7) once a month

3) 3 or 4 times a week 8) less than once a month

4) twice a week 9) not at all

5) once a week

8. For how long do you and your mate usually engage in sexual foreplay (kissing, petting, etc.) before having intercourse?

1) less than 1 minute 5) 11 to 15 minutes

2) 1 to 3 minutes 6) 16 to 30 minutes

3) 4 to 6 minutes 7) 30 minutes to one hour

4) 7 to 10 minutes

9. How long does intercourse usually last, from entry of the penis to the male's orgasm/climax?

1) less than 1 minute 6) 11 to 15 minutes

2) 1 to 2 minutes 7) 15 to 20 minutes

3) 2 to 4 minutes 8) 20 to 30 minutes

4) 4 to 7 minutes 9) more than 30 minutes

5) 7 to 10 minutes

10. Does the male ever reach orgasm while he is trying to enter the vagina with his penis?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time) 6) nearly always (over 90% of the time)

11. Do you feel that premature ejaculation (rapid climax) is a problem in your sexual relationship?

1) yes 2) no

12. How satisfied are you with the variety of sexual activities in your current sex life? (This includes the different types of kissing and caressing with a partner, different positions for intercourse, etc.)

1) extremely satisfied 4) slightly unsatisfied

2) moderately satisfied 5) moderately unsatisfied

3) slightly satisfied 6) extremely unsatisfied

13. Would you like your lovemaking to include more:

Breast caressing 1) yes 2) no

Hand caressing of your genital area 1) yes 2) no

Oral caressing (kissing) of your genital area 1) yes 2) no

Different positions for intercourse 1) yes 2) no

14. If you would like a certain kind of sexual caress or activity, which way do you typically let your partner know?

1) I wait to see if my partner will do what I like without my asking

2) I show my partner what I would like by moving their hand or changing my own position

3) I tell my partner exactly what I would like

15. How have you typically learned about your partner's sexual likes and dislikes?

1) From my partner telling me exactly what they want

2) From my partner moving my hand or changing their position to signal what they would like me to do

3) From watching my partner's reactions during sex

4) From intuition

16. When you have sex with your mate do you feel sexually aroused (e.g., feeling "turned on," pleasure, excitement)?

1) nearly always (over 90% of the time) 4) seldom (about 25% of the time)

2) usually (about 75% of the time) 5) never

3) sometimes (about 50% of the time)

17. When you have sex with your mate, do you have negative emotional reactions (e.g., fear, disgust, shame or guilt)?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time 6) nearly always (over 90% of the time)

18. Does the male have any trouble getting an erection before intercourse begins?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time) 6) nearly always (over 90% of the time)

19. Does the male have any trouble keeping an erection once intercourse has begun?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time) 6) nearly always (over 90% of the time)

20. If the male loses an erection, when does that usually happen?

1) before penetrating to start intercourse

2) while trying to penetrate

3) after penetration, during the thrusting of intercourse

4) not applicable, losing erections is not a problem

21. What is the male's typical degree of erection during sexual activity?

1) 0 to 20% of a full erection 4) 60% to 80% of a full erection

2) 20% to 40% of a full erection 5) 80% to 100% of a full erection

3) 40% to 60% of a full erection

22. Does the male ejaculate (climax) without having a full, hard erection?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time) 6) nearly always

(over 90% of the time)

23. If you try, is it possible to reach orgasm (sensation of climax) through masturbation?

1) nearly always (over 90% of the time) 4) seldom (about 25% of the time)

2) usually (about 75% of the time) 5) never

3) sometimes (about 50% of the time) 6) have never tried to

24. If you try, is it possible for you to reach orgasm (sensation of climax) through having your genitals caressed by your mate?

1) nearly always (over 90% of the time) 4) seldom (about 25% of the time)

2) usually (about 75% of the time) 5) never

3) sometimes (about 50% of the time) 6) have never tried to

25. If you try, is it possible for you to reach orgasm (sensation of climax) through sexual intercourse?

1) nearly always (over 90% of the time) 4) seldom (about 25% of the time)

2) usually (about 75% of the time) 5) never

3) sometimes (about 50% of the time) 6) have never tried to

26. Can you reach orgasm (sensation of climax) through stimulation of your genitals by an electric vibrator or any other means (i.e., running water, rubbing with some object, etc.)?

1) nearly always (over 90% of the time) 4) seldom (about 25% of the time)

2) usually (about 75% of the time) 5) never

3) sometimes (about 50% of the time) 6) have never tried to

27. (Women only) Can you reach orgasm during sexual intercourse if, at the same time, your genitals are being caressed (by yourself or your mate with a vibrator, etc.)?

1) nearly always (over 90% of the time) 4) seldom (about

25% of the time)

2) usually (about 75% of the time) 5) never

3) sometimes (about 50% of the time) 6) have never tried to

28. Have you noticed a change in the intensity and pleasure of your orgasm?

1) much more intense and pleasurable than in the past 4) somewhat less intense and pleasurable than in the past

2) somewhat more intense and pleasurable than in the past 5) much less intense and pleasurable than in the past

3) the same as in the past

29. Is the female's vagina so "dry" or "tight" that intercourse cannot occur?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time 6) nearly always (over 90% of the time)

30. Do you feel pain in your genitals (sexual parts) during intercourse?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time) 6) nearly always (over 90% of the time)

31. How often does pain (genital or nongenital) interfere with your ability to feel sexual pleasure?

1) never 4) sometimes (50% of the time)

2) rarely (less than 10% of the time) 5) usually (75% of the time)

3) seldom (less than 25% of the time) 6) nearly always (over 90% of the time)

32. Have you noticed a change in the sensitivity to touch of your genitals?

1) much more sensitive than in the past 4) somewhat less sensitive than in the past

2) somewhat more sensitive than in the past 5) much less sensitive than in the past

3) about as sensitive as in the past

33. Overall, how satisfactory to you is your sexual relationship with your mate?

1) extremely unsatisfactory 4) slightly satisfactory

2) moderately unsatisfactory 5) moderately satisfactory

3) slightly unsatisfactory 6) extremely satisfactory

34. Overall, how satisfactory do you think your sexual relationship is to your mate?

1) extremely unsatisfactory 4) slightly satisfactory

2) moderately unsatisfactory 5) moderately satisfactory

3) slightly unsatisfactory 6) extremely satisfactory

35. Do you feel that your partner plays a part in causing a problem in your sex life?

1) yes 2) no

36. If your lovemaking does not go well, how does your partner usually react?

1) accepting and understanding 3) anxious and blaming self

2) frustrated or annoyed 4) neutral or uncaring

37. (Women only, men go on to Question 38) When you have sex with your mate (including foreplay and intercourse) do you notice some of these things happening: your breathing and pulse speed up, wetness in your vagina, pleasurable sensations in your breasts and genitals?

1) nearly always (over 90% of the time) 4) seldom (about 25% of the time)

2) usually (about 75% of the time) 5) never

3) sometimes (about 50% of the time) 6) have never tried to

38. (Men only) How often do you wake from sleep with a firm erection (including times when you wake up needing to urinate)?

1) daily 5) once a month

2) 3-4 times a week 6) less than once a month

3) 1-2 times a week 7) never

4) once every 2 weeks

39. (Men only) How often do you wake from sleep with a partial (semisoft) erection?

1) daily 5) once a month

2) 3-4 times a week 6) less than once a month

3) 1-2 times a week 7) never

4) once every 2 weeks

40. (Men only) How often are you able to get and keep a firm erection in your own masturbation (self-touch in private)?

1) nearly always, over 90% of the time 5) rarely, less than 10% of the time

2) usually, 75% of the time 6) never

3) sometimes, 50% of the time 7) have not tried masturbation in the past 6 months

4) seldom, less than 25% of the time

41. (Men only) What is your typical degree of erection during masturbation (self-touch in private?

1) 0% to 20% of a full erection 4) 60% to 80% of a full erection

2) 20% to 40% of a full erection 5) 80% to 100% of a full erection

3) 40% to 60% of a full erection

42. (Men only) Do you feel your erect penis has an abnormal curve to it, or have you noticed a lump or “knot” on your penis?

1) yes 2) no

43. (Men only) Do you believe your penis is abnormally small?

1) yes 2) no

44. (Men only) How does the amount of ejaculate (liquid or semen) now compare to the amount you ejaculated in the past?

1) much greater than in the past 4) somewhat less than in the past

2) somewhat greater than in the past 5) much less than in the past

3) about the same as in the past 6) I do not know

45. (Men only) Do you ever have the sensation of orgasm (climax) without any ejaculation of fluid?

1) never 4) sometimes, about 50% of the time

2) rarely, less than 10% of the time 5) usually, about 75% of the time

3) seldom, less than 25% of the time 6) nearly always, over 90% of the time

46. (Men only) Do you ever have pain and/or burning during or after ejaculation?

1) never 5) usually, about 75% of the time

2) rarely, less than 10% of the time 6) nearly always, over 90% of the time

3) seldom, less than 25% of the time 7) I do not ejaculate

4) sometimes, about 50% of the time

Note. Items 1, 2, 6, 7, 10, 16, 18, 19, 22, 23, 24, 25, 26, 27, 29, and 37 are used to compute the global sexual

functioning score.

Derogatis Interview for Sexual Functioning

LEONARD R. DEROGATIS, 1 Clinical Psychometric Research, Inc.

The Derogatis Interview for Sexual Functioning (DISF) is a brief semistructured interview designed to provide an estimate of the quality of an individual's current sexual functioning in quantitative terms. The DISF represents quality of current sexual functioning in a multidomain format, which to some degree parallels the phases of the sexual response cycle (Masters & Johnson, 1966). The 26 interview items of the DISF are arranged into fi ve domains of sexual functioning: I. Sexual Cognition/ Fantasy, II. Sexual Arousal, III. Sexual Behavior/ Experience, IV. Orgasm, and V. Sexual Drive/Relationship. In addition, the DISF total score is computed, summarizing quality of sexual functioning across the fi ve primary DISF domains. There are distinct gender-keyed versions for men and women.

In addition to the DISF interview, there is a distinct self report version of the test known as the DISF-SR. The DISF SR is also composed of 26 items and was designed to be as comparable to the DISF interview as possible. With slight modifi cations in format, the DISF-SR may also be utilized to gain evaluations of the patient's sexual performance by the patient's spouse.

The DISF and DISF-SR were developed to address the unmet need for a set of brief, gender-keyed, multi dimensional outcome measures that would represent the status of an individual's current sexual functioning, and do so at multiple levels of interpretation. The DISF/DISF-SR are designed to be interpreted at three distinct levels: the discrete item level (e.g., "A full erection upon awakening," "Your ability to have an orgasm,") the functional domain level (e.g., sexual arousal score), and the global summary level (e.g., DISF/DISF-SR total score). Because the DISF interview and the DISF-SR self report inventory are matched on an almost item-for-item basis, clinician and patient assessments of the patient's quality of sexual functioning may be obtained in both raw and standardized score formats. Both instruments may be used repeatedly throughout effi cacy or effectiveness trials, or may be implemented solely at pre- and postintervention without signifi cant "practice" effects or loss of validity. Norms have been developed for both the DISF and the DISF/SR, based in each case on several hundred nonpatient community respondents. The norms are gender-keyed (i.e., separate norms for men and women) and are represented as standardized scores in terms of area t-scores. The area standardized score possesses distinct advantages over the simple linear transformation in that the former provides accurate percentile equivalents (i.e., t-score of 30 = 2nd centile; t-score of 40 = 16th centile; t-score of 50 = 50th centile; t-score of 60 = 84th centile; t-score of 70 = 98th centile, etc.). This important characteristic is not true of linear t-scores except when the underlying raw score distribution is perfectly normal. In addition to enabling accurate comparisons across respondents, area t-scores also facilitate meaningful comparisons of strengths and weaknesses within a respondent's profile of sexual functioning. A patient may reveal a relatively

unremarkable profile with the exception of a profound decrement in a single functional domain, or may show a low-grade degradation of performance across multiple areas of functioning. Because DISF/DISF-SR domain scores are available in an equivalent standardized metric, such evaluations can help pinpoint the nature and extent of sexual dysfunctions. Response Mode and Timing The DISF and the DISF-SR are each comprised of 26 items. In the case of the former, items are cast in the format of a semistructured interview, structured via 4-point Likert-type

1 Address correspondence to Leonard R. Derogatis, Johns Hopkins Department of Psychiatry and Behavioral Sciences--Center for Sexual Medicine at

Sheppard Pratt, Baltimore, MD 21285; e-mail: LDerogatis@sheppardpratt.org

scales. The items of the DISF-SR are also represented as

4-point Likert-type scales. The DISF interview requires between 15 to 20 minutes to

complete. Time requirements for the DISF-SR are similar to

the DISF; however, in most contexts the self-report version

typically requires a few minutes less than the interview.

Time requirements drop noticeably for both versions on

successive administrations, such as in clinical effi cacy

or effectiveness trials, in which the test is administered

sequentially.

Reliability and Validity

The DISF and DISF-SR have both demonstrated favorable

profi les of psychometric characteristics. Internal consistency

coeffi cients for the subscales range from .74 to .80. Test

retest correlations over a 1-week interval are all above .80,

and interrater correlations range from .84 to .92. An important validity demonstration for multi

dimensional or multidomain psychological outcome

measures concerns the subtest intercorrelation matrix, and

domain score-total score correlation vector. The pattern

of these correlations represents a central psychometric

characteristic of the test that relates to almost all discernable

aspects of construct validity (Messick, 1995). If correlations

between dimension scores are high, concerns may be

raised that operational defi nitions of the domain constructs

are redundant. If domain scores do not correlate at least

moderately with the total score, then the possibility exists

that the domain constructs (e.g., Sexual Arousal, Orgasm),

as operationally defi ned by the test items, are not valid

components of the higher-order, more general construct

(e.g., Quality of Sexual Functioning). A theoretical optimum

would fi nd correlations between domains near zero, with

each domain score showing a moderately high correlation

with the total score. In such an ideal design, each domain

would contribute independent true variance to the total

score, with minimum redundancy or overlap. Subtest intercorrelation matrices of the DISF/DISF

SR have been constructed based on two “normal” and

one sexually dysfunctional sample. In all cases the mean

interdomain correlation coeffi cients are relatively low

(i.e., .23 to .39), whereas the average domain-total correlations for the three samples range from .60 to .71. This pattern of subtest correlations begins to approach the optimal and strongly confi rms that DISF domains are contributing relatively independent variance to the DISF total score. Much of the clinical research done with the DISF/DISF SR has involved corporate-sponsored clinical drug trials.

The Derogatis Sexual Functioning Inventory (DSFI) measures constructs believed to be fundamental to successful sexual functioning (e.g., drive, body image, sexual satisfaction) and, in addition, measures several basic indicators of general well-being (e.g., affects balance and psychological distress).

Description

The DSFI is an “omnibus” self-report inventory designed to measure the quality of the current sexual functioning of an individual. The DSFI is multidimensional in nature because the comprehensive study of sexual functioning has revealed it to be a highly multidetermined behavior. Although apparently straightforward, successful human sexual functioning rests on a complex interplay of endocrine, emotional, cognitive, and experiential factors that preclude the simple enumeration of sexual episodes, or orgasms, as meaningful forms of measuring the quality

of sexual functioning.

The individual respondent is the basis for evaluation by the DSFI in part because it represents the most parsimonious and straightforward unit to work with, and also because, regardless of context, quality of sexual functioning is ultimately appreciated by the individual. Current sexual functioning is the conceptual continuum for the DSFI because it comes closest to the central evaluative question in the clinical assessment of sexual disorder: “What is the current level and nature of the patient’s sexual functioning?”

By quantifying the principal dimensions of the patient’s sexual experience in profi le form, an insight is gained into both the nature and magnitude of the individual’s sexual dysfunction.

The DSFI is comprised of 10 substantive dimensions that are judged to refl ect the principal components of sexual behavior. The conceptual basis for the DSFI was outlined by Derogatis in 1976, and several subsequent monographs have been published on the instrument (Derogatis, 1980; Derogatis & Melisaratos, 1979). Of the 10 subtests constituting the DSFI, two of them, Psychological Symptoms and Affects are themselves complete, multidimensional tests. The Brief Symptom Inventory (BSI; Derogatis, 1993) and the Derogatis

Affects Balance Scale (ABS; Derogatis, 1975; Derogatis

& Rutigliano, 1996) provide measurement of psychological

distress and mood and affects, respectively.

Since its introduction in the mid-1970s, the DSFI has

1 Address correspondence to Leonard R. Derogatis, Johns Hopkins Department of Psychiatry and Behavioral Sciences--Center for Sexual Medicine at

Sheppard Pratt, Baltimore, MD 21285; e-mail: LDerogatis@sheppardpratt.org

Derogatis Sexual Functioning Inventory

LEONARD R. DEROGATIS, 1 Clinical Psychometric Research, Inc.

Psychological Symptoms. Psychological distress is

measured by the 53 items of the Brief Symptom Inventory

(BSI). Each symptom of the BSI is represented on a 5

point scale from not at all (0) to extremely (4). Scores are

summed across items to achieve a single Symptoms score.

The BSI may optionally be scored for the nine dimensions

(e.g., Depression, Anxiety) and global scores that underlie

the items of the BSI.

Affects. The Affects subtest is also a complete multi

dimensional test termed the Derogatis Affects Balance Scale

(DABS). The DABS measures affect and mood through 40

adjective items endorsed by the respondent. Twenty items

represent positive affects, and 20 items refl ect negative

affects. Scores include a Positive Affects total, a Negative

Affects total and the overall Affects Balance Index. The

latter is used as the affects measure for the DSFI.

Gender Role Definition. Consistent with the concept that masculinity and femininity are components of all individuals' gender role definitions, the two primary components of gender role are each measured in terms of 15 adjective items that the respondent endorses in varying degrees. A Masculinity score, a Femininity score, and a Gender Role Defi nition score are determined.

Fantasy. This subtest consists of 20 major sexual themes that have been culled from research on normal sexual fantasies as well as fantasies arising from clinical variations on routine sexual behaviors. The Fantasy score consists of a simple summation of the items endorsed.

Body Image. Body image has been demonstrated to be an integral aspect of self-concept and, as such, is an important determinant of successful sexual functioning. It is measured in the DSFI in terms of 15 items, 10 common and 5 gender keyed, that refl ect the individual's level of appreciation of his/her body. A single Body Image score is developed.

Sexual Satisfaction. The Sexual Satisfaction subtest is itself multidimensional in nature, being comprised of a number of distinct components (e.g., frequency of intercourse, quality of communication, quality of orgasm). Ten true-false items

comprise the Satisfaction subtest, each refl ecting whether

the respondent is satisfi ed with that specifi c aspect of his/her

sexual functioning. A single Satisfaction score is calculated

as a sum of endorsements indicating satisfaction with a

particular component.

SFI: The DSFI total score. The Sexual Functioning Index

(SFI) is the total or global summary score of the DSFI. It

is calculated as a direct unweighted linear combination

of the 10 subtest or principal dimension scores. Because

subtest scores are calculated along very different score

continua, and some are gender-keyed (i.e., distinct for men

and women), subtest scores are fi rst transformed to area t

Derogatis, L. R. (1975). Derogatis Sexual Functioning Inventory (DSFI):

Preliminary scoring manual. Baltimore, MD: Clinical Psychometric

Research Inc.

Derogatis, L. R., Meyer, J. K., & Dupkin, C. N. (1976). Discrimination

of organic versus psychogenic impotence with the DSFI (Derogatis

Sexual Functioning Inventory). Journal of Sex & Marital Therapy,

2, 229–240.

Derogatis, L. R. (1980). Psychological assessment of psychosexual

functioning. In J. K. Meyer (Ed.), The Psychiatric Clinics

of North

America Symposium on Sexuality (pp. 113–131). Philadelphia:

Saunders.

Derogatis, L. R. (1993). Brief Symptom Inventory:
Administration,

scoring, and procedures manual (3rd ed.). Minneapolis, MN:
National

Computer Systems.

Derogatis, L. R., & Rutigliano, P. J. (1996). Derogatis
Affects Balance

Scale. In B. Spiker (Ed.), Quality of life and
pharmacoeconomics in clinical trials (2nd ed., pp.
160–177). Philadelphia: LippincottRaven. Derogatis, L. R.,
Lopez, M. C., & Zinzeletta, E. M. (1988). Clinical
applications of the DSFI in the assessment of sexual
dysfunctions. In R. Brown & E. Roberts (Eds.), Advances in
the understanding and treatment of sexual disorders. New
York: PNA Publishing. Derogatis, L. R., & Melisaratos, N.
(1979). The DSFI: A multidimensional measure of sexual
functioning. Journal of Sex and Marital Therapy, 5,
244–281. Derogatis, L. R., Schmidt, C. W., Fagan, P. J., &
Wise, T. N. (1989). Subtypes of anorgasmia via
mathematical taxonomy. Psychosomatics, 30, 166–173.
Howell, J. R., Reynolds, C. F., Thase, M. E., Frank, E.,
Jennings, J. R., Houck, P. R., et al. (1987). Assessment
of sexual function, interest, and activity in depressed
men. Journal of Affective Disorders, 13, 61–66.

The Garos Sexual Behavior Inventory (GSBI; Garos,

2009; Garos & Stock, 1998a, 1998b) is designed to as

sist forensic specialists and mental health professionals in

making assessments and treatment decisions about indi

viduals with problems related to sexuality and sexual be

havior. The GSBI’s subscale scores can be used to evalu

ate the cognitive, affective, and behavioral dimensions of

an individual’s overall sexual adjustment. The GSBI has

been used effectively with clinical populations known to have diffi culty with sexuality and sexual behavior, such as victims of sexual abuse, individuals with substance abuse problems, those with compulsive sexual behaviors, indi viduals with paraphilic interests (Garos & Stock, 1998b), and forensic populations (Garos, Bleckley, Beggan, & Frizzell, 2004). Yet the GSBI is suffi ciently versatile that it can also be used for couples counseling to uncover dif ferences in sexual values, feelings, and comfort levels.

Description

The fi rst objective in development of the GSBI was to develop a conceptual model that would act as the basis for the investigation of constructs underlying disorders of sexual frequency and control. With consultation from ex perts in the fi eld, a series of rationally derived item elimi nation procedures was instituted to identify items that best described dimensions of the constructs of interest. To evaluate the adequacy of the conceptually derived model, initial items on the GSBI were subjected to a principle components factor analysis using the varimax procedure. In a second study, the 70-item GSBI was subjected to a maximum likelihood factor analysis with oblique rotation of the factor structure to confi rm the conceptual dimensions believed to underlie the GSBI. The GSBI consists of four main scales, and three masking scales designed to reduce the potential for defensive responding, as well as an Inconsistent Responding index. Main scales • Discordance: Overall sexual adjustment; shame, fear,

internal confl ict about sexual behavior and interests • Sexual Obsession: Preoccupation with sex and sexual stimuli • Permissiveness: Attitudes and values about sex—conservative or unconventional • Sexual Stimulation: Level of comfort with sexual arousal Masking Scales • Sexual Control Diffi culties • Sexual Excitability • Sexual Insecurity Response Mode and Timing The GSBI can be completed in just 20 to 30 minutes. Items are written at a sixth-grade reading level and are easy to understand and answer. Respondents indicate the extent of

1 Address correspondence to Sheila Garos, Psychology Department, Texas Tech University, Lubbock, TX 79409-2051; e-mail: sheila.garos@ttu.edu

SHEILA GAROS, 1 Texas Tech University

their agreement on a 5-point Likert scale ranging from 1

(Strongly Disagree) to 5 (Strongly Agree). An AutoScore

Form is designed to protect the privacy of respondents.

Test items do not appear on the AutoScore Form. Instead,

they are printed on a separate reusable Administration

Card, thereby ensuring that sensitive information remains

confi dential.

Scoring

The GSBI generates normalized T-scores for the main and

masking scales, making it easy to compare scores across

scales and across tests. Normative data are based on a

nonclinical group, spanning ages 17 to 104, with roughly

equal numbers of males and females. In addition, the test

manual provides average scores for males, females, and

clinical and correctional subgroups (sex offenders, sub

stance abusers, and sexual addicts). It has not been found

useful to obtain a total score on the GSBI, given that the subscales are relatively independent, representing different constructs of interest.

Reliability

In Study 1 (N = 500; Garos & Stock, 1998b), internal reliability coefficients for the GSBI subscales for females were .75 for Sexual Obsession, .73 for Permissiveness, .74 for Sexual Stimulation, and .80 for Discordance. For males the coefficients were .72 for Sexual Obsession, .66 for Permissiveness, .67 for Sexual Stimulation, and .85 for Discordance. In Study 2 (N = 1,000; Garos & Stock, 1998a), internal reliability coefficients for the total sample were .80 Sexual Obsession, .70 Permissiveness, .72 Sexual Stimulation, and .82 Discordance. The three masking scales have reported alpha reliabilities of Control (8 items, alpha = .85), Excitement (7 items, alpha = .82), and Insecurity (6 items, alpha = .74; Garos, 2009). In Study 2 (N = 1,000; Garos & Stock, 1998b) the following test-retest reliability coefficients for a subset of participants were reported: .62 on the Permissiveness subscale (n = 53), .84 on the Sexual Obsession subscale (n = 53), .72 for the Discordance subscale (n = 54) and .79 on the Sexual Stimulation (n = 52) subscale. All results were significant at the $p < .001$ level. The time between administrations was 19 days.

Validity

Factorial validity for the GSBI was established through equivalence of factor structures and item retention in Studies 1 and 2 (Garos & Stock, 1998a, 1998b). The final factor structure obtained in Study 1 was replicated for males and females, and for the total sample in Study 2.

To evaluate the discriminant and convergent validity of the GSBI, correlations were computed to determine the independence of GSBI subscales with related but conceptually distinct subscales of other behavioral and psychological measures (Garos & Stock, 1998a). These measures included the Sexual Addiction Screening Test (Carnes, 1992), the Sexuality Scale (Snell & Papini, 1989), the Zuckerman-Kuhlman Personality Questionnaire (Zuckerman, Kuhlman, Joireman, Teta, & Kraft, 1993), the Sexual Opinion Survey (Fisher, Byrne, White, & Kelley, 1988), the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the Rosenberg Self-Esteem Scale (Rosenberg, 1962). All scales correlated as predicted ranging from .05 to .52. A validity study was conducted with prisoners to determine how well the associated affective and cognitive characteristics of intrapsychic conflict could distinguish between incarcerated sex offenders and incarcerated nonsex offenders (Garos et al., 2004). The Discordance subscale emerged as the most significant predictor variable between sex offenders and nonoffenders (Wilks' $\lambda = .553$) $F(1,184) = 148.63$, $p < .001$. A discriminant function analysis was conducted to establish the GSBI's ability to correctly predict classification of group membership. For sex offenders, 80.6% were correctly classified, as were 88.3% of nonsex offenders. Overall, 84.2% of cases were correctly classified. In the cross-validation sample, results for placement in group membership for sex offenders remained the same (80.6%), whereas 87.2% of nonsex offenders were correctly classified. For this sample, an overall 83.7% of cases were correctly classified. These results indicated significant improvement over base rates, with the Discordance subscale emerging as the strongest of the four predictors. In the same study, a logistic regression was conducted as a second index of the

GSBI’s ability to predict group membership. A positive predictive value of 82.8% was obtained, which was a signifi cant improvement relative to the base rate of cases in the sex offender category (53%), again with Discordance emerging as the most signifi cant predictor. To test whether the Permissiveness, Sexual Stimulation, and Sexual Obsession subscales contributed signifi cantly to the predictive ability of the GSBI, a logistic regression was performed with the omission of the Discordance subscale. Although the percentage of correctly classifi ed cases decreased with the omission of Discordance relative to the base rate of cases in the sex offender category (52%), a positive predictive value of 68.4% represented a 17.6% improvement over chance. In a study of inpatients receiving experiential therapy for sexual addiction (Klontz, Garos & Klontz, 2005), two subscales of the GSBI were sensitive to a main effect of time. Male and female patients reported less sexual preoccupation and less discordance from pretreatment to posttreatment. Changes were stable at 6-month follow-up. Other Information Copyright: Western Psychological Services. Testing materials are available from Western Psychological Services,

Exhibit

Garos Sexual Behavior Inventory (Sample Items) a

Main Scales

Discordance Subscale

I feel uncomfortable about my sexual practices.

I am afraid I am not sexually attractive enough.

Sexual Obsession

It feels impossible to stop masturbating.

Once I am aroused it is diffi cult not to masturbate or have sex.

Permissiveness

Birth control should be readily available to young people.

Women’s sexual advances should be subtle.

Sexual Stimulation

I like not wearing underwear.

I enjoy being aroused by my sexual thoughts and feelings.

Masking Scales

Control

When I wake up from sexual dreams, I like to masturbate.

Sexual thoughts overpower my better judgment.

Excitement

As a child, I was more interested in sex than my friends were.

The smell of men’s cologne/ladies’ perfume makes me think of sex.

Insecurity

It is easier to have sex if my partner is the aggressor.

I feel like a failure if I cannot keep someone sexually excited.

a Sample items from the GSBI copyright © 2008 by Western Psychological Services. Reprinted for sole purpose of scholarly reference by permission

of WPS, 12031 Wilshire Boulevard, Los Angeles, California, 90025, U.S.A., www.wpspublish.com. Not to be reprinted in whole or in part for any

additional purpose without the expressed, written permission of the publisher (rights@wpspublish.com). All rights reserved.

12031 Wilshire Blvd., Los Angeles, CA 90025-1251;

Telephone: (800) 648-8857; www.wpspublish.com

Beck, A. T., Ward, A. T., Mendelson, C. H., Mock, M., & Erbaugh, J.

(1961). An inventory for measuring depression. Archives of General

Psychiatry, 4, 53-63.

Carnes, P. (1992). Out of the shadows: Understanding sexual addiction

(2nd ed.). Center City, MN: Hazelden.

Fisher, W. A., Byrne, D., White, L. A., & Kelley, K. (1988). Erotopho

bia-erotophilia as a dimension of personality. The Journal of Sex Re

search, 25, 123-151.

Garos, S. (2009). Garos Sexual Behavior Inventory test manual. Los An

geles: Western Psychological Services.

Garos, S., Bleckley, K. M., Beggan, J. K., & Frizzell, J. (2004). The rela

tionship between intrapsychic confl ict and deviant sexual behavior in

sex offenders. Journal of Offender Rehabilitation, 40, 23-38.

Garos, S., & Stock, W. A. (1998a). Investigating the discriminant validity and differentiating capability of the Garos Sexual Behavior Index. Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention, 5, 251-267. Garos, S., & Stock, W. A. (1998b). Measuring disorders of sexual frequency and control: The Garos Sexual Behavior Index. Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention, 5, 159-177. Klontz, B., Garos, S., & Klontz, P. (2005). The effectiveness of multimodal experiential therapy in the treatment of sexual addiction. Sexual Addiction and Compulsivity: The Journal of Treatment and Prevention, 12, 275-294. Rosenberg, M. (1962). The Rosenberg Self-Esteem Scale. Department of Sociology, University of Maryland, College Park. Snell, W., & Papini, D. (1989). The sexuality scale: An instrument to measure sexual esteem, sexual depression and sexual preoccupation. The Journal of Sex Research, 26, 756-763. Zuckerman, M., Kuhlman, M., Joireman, J., Teta, P., & Kraft, M. (1993). A comparison of three structural models for personality: The Big Three, the Big Five, and the Alternative Five. Journal of Personality and Social Psychology, 65, 757-768.

Sexual diaries have been shown to have excellent tempo ral stability (e.g., White, Case, McWhirter, & Mattison, 1990), but there are few widely accepted structured forms to systematically self-monitor frequency, variability, or satisfaction with sexual activity. The Jewish General Hospital (JGH) Sexual Self-Monitoring Form provides information about the frequency and quality of a range of individual and couple sexual behaviors on a daily basis. Initially a clinical instrument, the JGH Sexual Self-Moni toring Form was modifi ed to evaluate outcome in sex therapy research. The measure can also be used in process studies of sex therapy to assess the impact of various ther apeutic interventions and to monitor compliance with the treatment program. It is ideally suited to assess the sexual dysfunctions consequent to antidepressant use (Serretti & Chiesa, 2009) and equally can be used to obtain descrip tive and normative information in populations of single individuals or couples.

Description

This measure consists of eight questions asking respon dents to indicate, on a daily basis, whether they engaged in each of 18 individual or interpersonal sexual activities, whether they experienced orgasm (and during which ac tivities), how they felt about their partner and their sexual

experience, and how satisfi ed they were with the amount

of affection received.

Response Mode and Timing

The form takes less than 5 minutes to complete. Partners

are told to complete the forms individually.

Scoring

Daily responses should each be examined and scored indi

vidually. For clinical purposes, scoring is optional; a qualitative evaluation of responses may be more appropriate for monitoring therapeutic progress and tailoring therapy to specifi c clients. For research purposes, the JGH Sexual Self-Monitoring Form can be scored as follows: For Question 1, item scores can be summed for 7-day periods to provide weekly measures of frequency for each sexual activity; other sexual activities may be added to this list. Enjoyment ratings (Question 2) can also be summed for each sexual activity and divided by the number of times that the activity occurred during the week. This yields a mean enjoyment score for each sexual activity. Responses to Questions 3, 6, and 7 are also summed and divided by 7 to provide a weekly estimate of feelings about one's sexual experience, satisfaction with affection received, and feelings towards one's partner. Questions 4 and 5 examine the experience of orgasm. The weekly frequency of orgasms during each sexual activity can be counted to determine the percentage of times that the sexual activity in question resulted in orgasm (success/experience ratio: cf. Auerbach & Kilmann, 1977). If the focus of interest is not orgasmic experience but erection quality, speed of ejaculation, and so forth, Questions 4 and 5 may be replaced as needed. To simplify scoring, activities may be clustered. Our method involves the following groupings: Individual Sexual Activities (dreams, fantasies, masturbation, and reading and viewing erotica), Affectional Display (hugging, kissing, and receiving and giving nongenital manual or oral caresses), Couple Sexual Noncoital Activities (receiving and giving genital manual or oral stimulation, and anal activities), and Intercourse. Using these clusters, we calculate frequency of type of activity cluster per week, orgasm ratio (%), and enjoyment ratings (cf. Fichten, Libman, & Brender, 1983). Averaging these data over a month is recommended to eliminate the effects of weekly variability

in sexual encounters.

1 Address correspondence to Eva Libman, Behavioral Psychotherapy and Research Unit, Institute of Community and Family Psychiatry, SMBD-Jewish

General Hospital, 4333 Cote St. Catherine Rd., Montreal, Quebec, Canada H3T 1E4; e-mail: eva.libman@mcgill.ca

Jewish General Hospital Sexual Self-Monitoring

Form: Diary Evaluation of Sexual Behavior and

Satisfaction

EVA LIBMAN, 1 SMBD-Jewish General Hospital and McGill University

ILANA SPECTOR, SMBD-Jewish General Hospital and McGill University

Y ITZCHAK BINIK, McGill University and Royal Victoria Hospital

WILLIAM BRENDER, SMBD-Jewish General Hospital

C ATHERINE S. FICHTEN, SMBD-Jewish General Hospital, Dawson College, and

McGill University

Reliability and Validity

Because this measure was originally developed as a clinical

instrument (Burstein et al., 1985) rather than as a research

tool, reliability and validity information has not been sys

tematically obtained. However, the JGH Sexual Self-Moni

toring Form has been used in several studies that address

the following questions: (a) whether sexual self-monitoring

adds useful information to traditional retrospective meth

ods of measurement (Fichten, Libman, & Brender, 1986),

which concluded that self-monitoring is not redundant with

questionnaire methods; (b) whether completing self-moni
toring forms is reactive (Fichten, Libman, Takefman, &
Brender, 1988; Takefman & Brender, 1984). These fi ndings
provide preliminary evidence for the nonreactivity of sexual
self-monitoring with this instrument. Findings using other
sexual self-monitoring measures, however, do suggest the
existence of reactivity (Ochs, Meana, Mah, & Binik, 1993).
Therefore, the possible reactivity of sexual self-monitoring
should be assessed in future studies; (c) whether the JGH
Sexual Self-Monitoring Form can be used in treatment-out
come studies to verify compliance and to examine changes
in sexual behavior frequency and satisfaction (Fichten et
al., 1983, 1986; Libman, Fichten, & Brender, 1984; Takef
man & Brender, 1984). Findings indicating high degrees of
concordance between partners on behavioral frequency rat
ings provide preliminary evidence for interrater
reliability.

Results also show that (a) the JGH Sexual Self-Monitoring
Form is effective in determining differences in treatment
compliance that predict successful therapy outcome, (b)
pretreatment scores on several self-monitoring variables
predict posttreatment fi ndings, and (c) the Sexual Self
Monitoring Form can highlight differences between treat
ments and show pre- to posttherapy changes.

Other Information

The JGH Sexual Self-Monitoring Form has been includ

Exhibit

Jewish General Hospital Sexual Self-Monitoring Form

(please fi ll out alone)

NAME: _____ DATE: _____

(1) Sexual Activities (please check in column 1 if the activity occurred)

1 2 1 2

Check if Rate Check if Rate

Activity According Activity According

Occurred to Scale A Occurred to Scale A

(1-10) (1-10)

Individual activities

a) fantasies (daydreams) j) breast caressing

b) dreams k) genital touching (giving)

c) masturbation l) genital touching (receiving)

d) reading erotica m) oral stimulation (giving)

e) seeing erotica n) oral stimulation (receiving)

f) other (specify below) o) anal stimulation (giving)

Interpersonal activities p) anal stimulation (receiving)

g) kissing q) mutual masturbation

h) caressing—nongenital r) intercourse

(giving)

i) caressing—nongenital s) other (specify below)

(receiving)

(2) Please look at Scale A below and then rate each activity checked above. Write the rating in column 2 above.

Scale A

(3) How did you feel about your sexual experience today? (Put X in box)

(4) Did you experience any orgasms?
_____

(5) If yes, during which activity?
_____

(6) How satisfi ed are you with the amount of affection you received today?

(7) In general, how did you feel about your partner today?

(8) Please add, in your own words, any important information or feelings concerning yourself, your marriage, your sex life, or any

other issues you'd like to bring up in your session with your therapist. Very 1 2 3 4 5 6 7 8 9 10 Very Unenjoyable Enjoyable Very 1 2 3 4 5 Very Negative Positive Very 1 2 3 4 5 Very Dissatisfied Satisfi ed Very 1 2 3 4 5 Very Negative Positive

The Sexual Function Scale (SFS) is designed to evaluate the

contribution of attitudes and experiences from the family

of origin, the period of adolescence, and current individual

and relationship factors to a person's sexual functioning. It

may be completed by people who are sexually functional

or sexually dysfunctional. For people who are sexually

dysfunctional, it can be used as a clinical measure to

evaluate the factors that need to be addressed in therapy.

Description

The SFS consists of three major sections: Childhood;

Puberty and Adolescence; and Current Attitudes and

Behavior. There are subsections within these three sections.

These are summarized in Table 1. The SFS was originally developed as a measure to evaluate the factors that are associated with sexual dysfunction in males and females. The original questions were drawn from the literature that assessed the aetiology of sexual dysfunction. This material was used to generate a guided interview measure, with open-ended responses. This measure was used to assess the sexuality of 55 respondents with sexual dysfunction and 58 respondents who were sexually functional. The responses of these subjects allowed scales to be created for each question. Some items were removed from the scale as analyses indicated that they had no impact on their sexual functioning. The modifi ed scales were administered to a further sample of clinical sexually dysfunctional, nonclinical sexually dysfunctional, and sexually functional respondents (McCabe, 1994a, 1994b). The results of this study allowed the scale to be reorganized and modifi ed to produce the present measure. Response Mode and Timing Respondents complete the scale as a questionnaire. Some items in the scale are categorical (e.g., What type of contraception do you use?), some are yes/no responses (e.g., Did you have any unpleasant sexual experiences during adolescence?), and some are on a 5-point Likert-type scale (e.g., How often do you feel highly aroused before you have intercourse?). The questionnaire takes about 1 hour to complete. Scoring Items are scored in the same direction, so that a total score is obtained for each subsection. Some items are categorical and so do not contribute to a total score for the subsection. Because there are different numbers of items in each subsection, the highest possible score varies from one section to another. Reliability and Validity Coeffi cient alpha have been calculated for a number of the subscales. These alphas are reported in Table 1. Some of the items in the scales tap very separate aspects of a particular construct or result in categorical responses, and so it is not appropriate to add responses or expect that respondents will answer in any consistent manner. The alphas have been calculated on a sample size of 171 cases. Of these, 82 subjects (50 females, 32 males) were sexually functional, 51

1 Address correspondence to Marita P. McCabe, School of Psychology, Deakin University, 221 Burwood Highway, Burwood, Victoria, Australia 3125;

e-mail: marita.mccabe@deakin.edu.au

Sexual Function Scale

MARITA P. MCCABE, 1 Deakin University

TABLE 1

Subscales of the Sexual Function Scale

	Coeffi cient Alpha	Test-Retest
Childhood		
A. Attitudes Toward Sex in the Home (10 items)	Distinct items	
B. Emerging Sexuality (6 items)	Distinct items	
Puberty and Adolescence		
A. Sexual Education (6 items)	Distinct items	
B. Dating Behavior (2 items)	Distinct items	
C. Petting Behavior (7 items)	Distinct items	
D. Coital Experiences During Adolescence (2 items)	Distinct items	
E. (a) Homosexual Experiences (3 items)	Distinct items	
(b) Unpleasant Experiences (3 items)	.36	.71
F. Depth of Relationship (3 items)	.43	.76
Current Attitudes and Behavior		
A. Current Attitudes Towards Sex (32 items)	.85	.89

B. Sexual Identity (3 items) Distinct items

C. Lifestyle (6 items) Distinct items

D. Types of Sexual Activity

(a) Range of Sexual Activity

(16 items) .72 .88

(b) Response to Sexual Activity

and Nature of Extra

Stimulation (22 items) .78 .92

E. Sexual Communication (9 items) .80 .90

F. Sexual Satisfaction (3 items) .63 .98

G. Other Relationships (9 items) .60 .88

H. Communication (10 items) .68 .91

I. Quality of Relationship (12 items) .80 .98

J. Performance Anxiety (10 items) .85 .97

subjects (27 females, 24 males) were sexually dysfunctional

and not seeking treatment, and 38 subjects (20 females,

18 males) were clinical dysfunctional. The scale was

also completed by 30 sexually functional and 30 sexually

dysfunctional subjects on two occasions 6 weeks apart.

The test-retest reliability coeffi cients for each subscale
are

reported in Table 1. The method of scale construction has

ensured some level of construct validity. The scale needs to

be administered along with other psychometrically sound

measures of the subscales to further demonstrate the level

Professionals in research, educational, or clinical settings requiring information regarding a person's erotic development have limited resources, although their needs are various and extensive. The Personal Sentence Completion Inventory (PSCI; Miccio-Fonseca, 1997) is a versatile tool to be used in assessment, evaluation, and treatment of a variety of sexually related issues, particularly male and female sexually abusive individuals of all ages (including those who have been arrested and/or convicted of sex offenses). The PSCI can be used in group sessions (10–12 week segments) on such topics as erotic development, sexual health, sexual fantasies, and sexual behaviors (for all ages and both genders).

Description

The PSCI was based on a subject sample (N = 656) of males and females of all ages (7–75 years), who were (a) victims of sexual abuse, (b) sex offenders (who were not victims), (c) sex offenders who were also victims, and (d) individuals who were neither victims nor offenders. The subject sample was composed primarily of individuals who had received psychological evaluations and had undergone individual or group therapy or both (Miccio-Fonseca, 1996, 2000, 2001). A pilot study was completed on 185 people, ages 12–57; items were rewritten for clarification and a revised 50-item sentence-stem version of the

PSCI was formulated and readministered to another 155

individuals (males and females; ages 7–61 years). The PSCI is a paper-and-pencil inventory covering vari

ables known to be directly related to risk and/or recidivism

of sexually abusive adults and adolescents. The PSCI covers love relationships and intimacy defi cits, uncovers deviant sexual fantasies, explores erotic pleasures, and gives information on unconventional sexual history and other data related to sex disorder (i.e., paraphilias). The PSCI assesses variables related to family lovemaps (MiccioFonseca, 2006, 2007), including the quality of family relationships and early separation from natal parents prior to the age of 16, and can also provide information on inklings of dissociative features and/or paraphilic fugue states. The PSCI is an instructive, informative supplement to other tools, assisting the clinician in completing a comprehensive assessment of the individual's sexual background, sexual development, and sexual proclivities. The User's Manual for the PSCI has examples of actual responses given by others and comments to the item responses, along with research related to the particular area explored and a glossary of terms. The PSCI is empirically supported and used extensively in court-ordered psychological evaluations of sex offenders. Seasoned clinicians, aware of the literature in the fi eld of sex offenders, will fi nd the PSCI a valuable asset eliciting empirically based information related to risk and/or recidivism from the PSCI. By considering empirically supported variables distinctive to the individual, the PSCI contrasts sharply with popular actuarial tools that compare the individual's score on a variable to groups of offenders within a particular score. Response Mode and Timing Respondents to the PSCI fi ll out the 50 sentence stems of the paper-and-pencil inventory. Depending on the in

1 Address correspondence to L. C. Miccio-Fonseca, Clinic Director, Clinic for the Sexualities, 591 Camino de la Reina, Suite 705, San Diego, CA 92108;

e-mail: lcmf@cox.net

dividual, the entire form takes about 15 minutes to com

plete. The assessment's sentence completion, open-ended format is transparent to respondents and provides a valu able means of eliciting content experience from an indi vidual in the area being explored. The PSCI capitalizes on the benefi ts of the sentence completion format by making responses free-form and model-focused. However, the in ventory does require sensitivity on the part of the person administering it, as some respondents ask for assistance in formulating their completions, and some need to be en couraged to respond at all.

The PSCI provides qualitative rather than quantita tive data. The administration of the PSCI relies on the professional skills and sophistication of the examiner, particularly during the qualitative interview phase, when the examiner's task is to draw out the subject and develop a rounded, in-depth picture of his or her sexual history. During the interview, the examiner has the opportunity to observe the subject's social skills and style of communi cation in action. Clinical observations help determine the best ways to approach and uncover those areas of self disclosure that the subject did not write down in the PSCI. There is no scoring scheme for the PSCI.

Other Information

The PSCI has been used extensively in assessing male and

Exhibit

Personal Sentence Completion Inventory (Sample Items)

Sexual Dreams

19. My sex dreams are usually about

Erotic Pleasures

32. What turns me on sexually is

Sexual Discomforts

40. The thing I tried sexually once but wouldn't do again is

The Sexual Interaction System Scale (SISS) is a self

report instrument designed to measure the quality of a

heterosexual couple's sexual interaction, including spe

cifi c sexual dysfunctions. It provides a measure of each

partner's perception (i.e., individual's scores), which may

then be added for a total couple score. The SISS measures

fi ve factors believed to interact during a given sexual en

counter.

1. Sexual Functioning encompasses the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1987) classifi cation of sexual dysfunctions; the subfactors are Desire, Arousal, Orgasm, (and a fourth subfactor for females, Pain Dysfunctions). In systemic terms, sexual responses at each phase of the sexual response cycle, including physiological responses, constitute communication to which the partners are constantly reacting, in part, with their own physiological responses.

2. Attitudinal Set refers to each individual's attitudes about the purpose and focus of sexual intimacy and the level of maturity that these attitudes refl ect— whether self-focused, role focused, or individual connected.

3. Nonsexual Interaction refers to the presence of interactions around territoriality, ranking, attachment, and exploratory/sensory patterns that may either promote or

interfere with desired sexual arousal and satisfaction. This factor taps patterns that a couple has established for dealing with these issues in their overall relationship and which may emerge and be communicated during the sexual encounter.

4. Interaction Coordination refers to the partners' action language that serves to coordinate all aspects of the sexual encounter so as to lead to the desired outcome—arousal and satisfaction. It encompasses verbal and nonverbal behaviors that serve as communication exchanges that may move the couple's sexual interaction in the desired direction.

5. Postsexual Interaction refers to the emotional tenor of the relationship following sex. It consists of each partner's evaluation of the sexual encounter relative to feelings and behaviors of distance versus closeness toward the partner as a result of the sex. These feelings, and behaviors too, constitute communication that is assumed to carry over and impact on the couple's next sexual encounter. Description The SISS is distinct from prior sexual functioning inventories in that it focuses on the interaction taking place during the couple's actual sexual encounters. In spite of the fact that the couple is typically the preferred unit of treatment for sexual dysfunctions, a systemic understanding of a couple's sexual relationship is a fairly recent development (Schnarch, 1991; Woody, 1992). The fi ve factors were derived in part from Verhulst and Heiman's (1979) systemic explanation of sexual functioning as an interactional communication process. The SISS consists of 48 statements with responses to be made on a 6-point scale (0 = none, never, does not occur in our relationship to 5 = high, always, always occurs in our relationship). Of these statements, 10 items deal with Sexual Functioning, 7 with Attitudinal Set, 12 with Nonsexual Interaction, 6 with Interaction Coordination, and 10 with Postsexual Interaction. The SISS is appropriate for use with heterosexual couples in clinical practice involving sexual distress, sexual dysfunction, or general relationship problems, and for use in couple premarital and enrichment programs. Response Mode and Timing Partners are to complete the SISS independently, preferably on the same day, so that they have a common frame of reference (i.e., their most recent two or three sexual encounters with each other). Completion time is approximately 10 minutes. Responses, for hand scoring, are placed on the line in front of each item. Scoring Directions appear on the Male and Female Scoring/Profi le Sheets. These directions indicate the items for which the

response must be reversed in value before totaling the items within each factor to obtain the subfactor, factor, and individual scores. Reversed values are placed on the inventory, and these can be totaled on the inventory itself and then transferred to the Scoring/Profi le Sheets. The couple score is the sum of both partners' total individual scores. Individual scores can range from 0 to 225, with higher scores indicating more positive sexual interaction. Maximum scores possible for the factors are Sexual Functioning (50), Attitudinal Set (35), Nonsexual Interaction (60), Interaction Coordination (30), and Postsexual

1 Address correspondence to Jane D. Woody, School of Social Work, University of Nebraska at Omaha, Omaha, NE 68182-0293; e-mail:

jwoody@unomaha.edu.

JANE D. WOODY 1 AND HENRY J. D'SOUZA, University of Nebraska at Omaha

Interaction (50). Plotting scores on the profi le allows com

parison of the individual's scores to a Nonclinical sample

(N = 58) and to a Sexual Dysfunction sample (Males, N

= 20; Females, N = 24). The profi les show mean scores

for the Nonclinical sample placed at T-score = 50 and the

mean scores of the Sexual Dysfunction sample circled; the

latter suggests a cut-off score that may be seen as clini

cally signifi cant.

Reliability

In a sample of 143 couples, internal consistency, analyzed

by the fi ve SISS factors, resulted in Cronbach's alpha =

.90 (Woody & D'Souza, 1994). This coeffi cient was cho

sen because, theoretically, a systemic explanation of the

sexual encounter holds that the fi ve factors would be cor

related.

Validity

Validity was supported by several methods. Face validity

was supported by the ratings of six experts on the content

of the items of the scale. In addition, in a sample of 143

couples, signifi cant differences were found on the t test

between known groups: the Sexual Dysfunction group and

the Nonclinical group ($t = 7.14$, $p < .001$); and the Sexual

Exhibit

Sexual Interaction System Scale (sample items)

Directions. The items in this scale deal with your current sexual relationship with your spouse or regular partner. In answering each

item, think of the last few times you engaged in sex with your partner.

For each of the statements, you are to answer for yourself, that is, give a response choice that refl ects your own experience, your

own opinion, or your own impression. You will answer each item according to a response scale of 0 to 5, which is explained below.

Put your answers on the line in front of each item. Please answer all items. See the sample answers, explanations and directions

below. Response choices

For rating your experience or your opinion, select a rating from 0 to 5. The meanings of the ratings are as follows:

0 1 2 3 4 5

None or never on Extremely high

the characteristic or always on the

described. Does characteristic

not occur in our described.

relationship. Always occurs in

our relationship.

Sample Answers and Explanations

0 I express complaints or negative feelings during sex.
This answer means that you gave a rating of 0 because you believe that you never express complaints or negative feelings during sex.

Gender Identification

Exhibit

Masculine Gender Identity Scale for Females

Instructions: The following questions ask what sex role you have preferred at different times of your life, what were your childhood

fantasies and activities, and how you felt about being born a female. Try to answer questions pertaining to childhood in terms of the way

you felt then and not the way you see things now.

Please circle one and only one answer to each question. If you are not sure of the meaning of a question, you may ask the person giving

the questionnaire to explain it to you. There is no time limit for answering these questions.

Part A: Items Administered to All Females

1. Between the ages of 6 and 12, did you prefer:

a. to play with boys (2)

b. to play with girls (0)

c. didn’t make any difference (1)

d. not to play with other children (1)

e. don’t remember (1)

2. Between the ages of 6 and 12, did you:

a. prefer boys’ games and toys (soldiers, football, etc.) (2)

b. prefer girls’ games and toys (dolls, cooking, sewing, etc.) (0)

c. like or dislike both about equally (1)

d. had no opportunity to play games or with toys (1) 3. In childhood, were you very interested in the work of a garage mechanic? Was this: a. prior to age 6 (1) b. between

ages 6 and 12 (1) c. probably in both periods (1) d. do not remember that I was very interested in the work of a garage mechanic (0) 4. Between ages 6 and 14, which did you like more: romantic stories or adventure stories? a. liked romantic stories more (0) b. liked adventure stories more (2) c. it did not make any difference (1) 5. Between the ages of 6 and 12, did you like to do jobs or chores which are usually done by men? a. yes (2) b. no (0) c. don't remember (1) 6. Between the ages of 13 and 16, did you like to do jobs or chores which are usually done by men? a. yes (2) b. no (0) c. don't remember (1) 7. Between the ages of 6 and 12, when you read a story did you imagine that you were: a. the male in the story (cowboy; detective, soldier, explorer, etc.) (2) b. the female in the story (the girl being saved, etc.) (0) c. the male sometimes and the female other times (1) d. neither the male nor the female (1) e. did not read stories (1) 8. In childhood or at puberty, did you like mechanics magazines? Was this: a. between ages 6 and 12 (1) b. between ages 12 and 14 (1) c. probably in both periods (1) d. do not remember that I liked mechanics magazines (0) 9. Between the ages of 6 and 12, did you sometimes imagine yourself as being the courageous leader of others? a. yes (2) b. no (0) c. unsure (1) 10. Between the ages of 6 and 12, did you wish you had been born a boy instead of a girl? a. often (2) b. occasionally (1) c. never (0) 11. Between the ages of 13 and 16, did you wish you had been born a boy instead of a girl? a. often (2) b. occasionally (1) c. never (0) 12. Since the age of 17, have you wished you had been born a boy instead of a girl? a. often (2) b. occasionally (1) c. never (0) 13. Do you think your appearance is: a. very feminine (0) b. feminine (0) c. a little masculine (1) d. quite masculine (2) 14. In childhood did you sometimes imagine, in your fantasies, yourself physically defending someone against a monster, a dangerous animal, or "evil" people? a. prior to age 6 (1) b. between ages 6 and 12 (1) c. probably in both periods (1) d. do not remember such fantasies (0) 15. In childhood fantasies, did you sometimes wish you could go hunting big game? Was this: a. prior to age 6 (1)

b. between ages 6 and 12 (1)

c. probably in both periods (1)

d. do not remember such fantasies (0)

16. In childhood, did you wish you would become very strong physically? Was this:

a. prior to age 6 (1)

b. between ages 6 and 12 (1)

c. probably in both periods (1)

d. do not remember the desire to become very strong physically (0)

17. In childhood, was there ever a period in which you wished you would, when adult, become a dressmaker or dress designer? Was this:

a. prior to age 6 (0)

b. between ages 6 and 12 (0)

c. probably in both periods (0)

d. do not remember having this desire (1)

18. In childhood fantasies, did you sometimes imagine yourself driving a racing car? Was this:

a. prior to age 6 (1)

b. between ages 6 and 12 (1)

c. probably in both periods (1)

d. do not remember having this fantasy (0)

19. In childhood, did you ever wish to become a dancer? Was this:

a. prior to age 6 (0)

b. between ages 6 and 12 (0)

c. probably in both periods (0)

d. do not remember having this desire (1)

20. In childhood, did you ever wish to become a pilot, or did you fantasize yourself being a pilot? Was this:

a. prior to age 6 (1)

b. between ages 6 and 12 (1)

c. probably in both periods (1)

d. do not remember having such a desire (0)

Part B: Items Administered Only to Homosexual Females (Transsexual or Nontranssexual)

21. Between the ages of 6 and 12, did you put on men's underwear or clothing?

a. once a month or more, for about a year or more (2)

b. (less often, but) several times a year for about 3 years or more (1)

c. very seldom did this during this period (0)

d. never did this during this period (0)

e. don't remember (0)

22. Between the ages of 13 and 16, did you put on men's underwear or clothing?

a. once a month or more, for a least a year (2)

b. (less often, but) several times a year for at least 2 years (1)

c. very seldom did this during this period (0)

d. never did this during this period (0)

23. Since the age of 17, have you put on men's underwear or clothing?

a. once a month or more, for at least a year (2)

b. (less often, but) several times a year for at least 2 years (1)

c. very seldom did this during this period (0)

d. never did this during this period (0)

24. If you have ever wished to have a male body rather than a female one, was this:

a. mainly to please females but also for your own

satisfaction (2)

b. mainly for your own satisfaction but also to please females (2)

c. entirely for your own satisfaction (2)

d. entirely to please females (1)

e. about equally to please females and for your own satisfaction (2)

f. have never wanted to have a male body (0)

25. Have you ever felt like a man?

a. only if you were wearing a least one piece of male underwear or clothing (1)

54. I fight them for I must have complete control of my body.

After an argument . . .

55. I am disgusted that I allowed myself to become involved.

56. I usually feel better.

Obscene literature . . .

57. helps people become sexual partners.

58. should be freely published.

One should not . . .

59. lose his temper.

60. say “one should not.”

Unusual sexual practices . . .

61. are unwise and lead to trouble.

62. are all in how you look at it.

Unusual sexual practices . . .

63. are OK as long as they’re hetersexual

64. Usually aren’t pleasurable because you have preconceived

feelings about their being wrong.

I regret . . .

65. all of my sins.

66. getting caught, but nothing else.

Sex relations before marriage . . .

67. in my opinion, should not be practiced.

68. are practiced too much to be wrong.

After an outburst of anger . . .

69. my tensions are relieved.

70. I am jittery and all keyed up.

As a child, sex play . . .

71. is immature and ridiculous.

72. was indulged in.

I punish myself . . .

73. by denying myself a privilege.

74. for very few things.

Unusual sex practices . . .

75. are dangerous to one's health and mental condition.

76. are the business of those who carry them out and no one

else's.

Arguments leave me feeling . . .

77. depressed and disgusted.

78. proud, they certainly are worthwhile.

After an argument . . .

79. I am disgusted that I let myself become involved.

80. I feel happy if I won and still stick to my own views
if I lose.

When I have sexual desires . . .

81. I attempt to repress them.

82. they are quite strong.

Petting . . .

83. is not a good practice until after marriage. 84. is
justified with love. After a childhood fight I felt . . .
85. as if I had done wrong. 86. like I was a hero. Sex
relations before marriage . . . 87. help people adjust.

88. should not be recommended. If I robbed a bank . . . 89. I should get caught. 90. I would live like a king. After an argument . . . 91. I am sorry and see no reason to stay mad. 92. I feel proud in victory and under-standing in defeat. Masturbation . . . 93. is wrong and a sin. 94. is a normal outlet for sexual desire. After an argument . . . 95. I am sorry for my actions. 96. if I have won, I feel great. When anger builds inside me . . . 97. I always express it. 98. I usually take it out on myself. After a fight, I felt . . . 99. relieved. 100. it should have been avoided for nothing was accomplished. Masturbation . . . 101. is all right. 102. is a form of self destruction. Unusual sex practices . . . 103. are awful and unthinkable. 104. are all right if both partners agree. I detest myself for . . . 105. thoughts I sometimes have. 106. nothing, and only rarely dislike myself. If I had sexual relations, I would feel . . . 107. all right, I think. 108. I was being used not loved. Arguments leave me feeling . . . 109. exhausted. 110. satisfied usually. Masturbation . . . 111. is all right. 112. should not be practiced. After an argument . . . 113. it is best to apologize to clear the air. 114. I usually feel good if I won.

Harassment

1c. How did this make you feel? (check all that apply)

 Self-conscious

 Embarrassed

 Afraid/scared

 Less sure of yourself/less confident

 Confused about who you are

 Doubt whether you have what it takes to graduate

 Doubt whether you have what it takes to continue after graduation

 Doubt whether you can have a happy relationship

 Angry

 Powerless

 Flattered

 Normal

 Guilty/ashamed

 Dirty

2. Showed, gave, or left you sexual pictures, photographs, illustrations, messages, or notes.

3. Spread sexual rumors about you.

4. Said you were gay or lesbian.

5. Flashed or “mooned” you.

6. Touched, grabbed, or pinched you in a sexual way.

7. Intentionally brushed up against you in a sexual way.

8. Pulled off or down your clothing.

9. Forced you to kiss him or her.

10. Forced you to do something sexual other than kissing.

11. Called you a slut or whore.

12. Stared at a sexual part of your body.

13. Said something bad would happen to you if you did not engage in sexual relations.

14. Pulled at your clothing in a sexual way.

15. Blocked your way or cornered you in a sexual way.

a The response options following this statement section are repeated for each of the remaining items.

The Likelihood to Sexually Harass (LSH) scale was devel

oped to measure men’s proclivities to sexually harass

women (Pryor, 1987). The LSH measures a readiness

for a specific type of sexually harassing behavior, sexual

exploitation (Pryor & Whalen, 1997) or the tendency to use

social power for sexual access or gain. Researchers have

found that men’s tendency to behave in a sexually exploi

tive manner toward women may be predicted by the LSH in

combination with certain social normative factors that per

mit or condone such behavior (Pryor, Giedd, & Williams,

1995; Pryor, LaVite, & Stoller, 1993). Description The original LSH scale consists of 10 brief scenarios describing social situations in which a male protagonist has the power to sexually exploit a female with impunity. Male respondents are asked to imagine themselves in the role of the protagonist in each scenario. Following each scenario, respondents are asked to rate the likelihood that they would perform an act of quid pro quo sexual harassment. Since its initial publication in 1987, several studies have reported shorter versions of the LSH that have used a subsample

Likelihood to Sexually Harass Scale

JOHN B. PRYOR, 1 Illinois State University

ERIC D. WESSELMANN, Purdue University

1 Please address correspondence to John B. Pryor, Department of Psychology, Illinois State University, Normal, IL 61790-4620; e-mail: pryor@ilstu.edu of the original scenarios. Two-scenario (Isbell, Swedish, & Gazan, 2005; Pryor & Meyers, 2001), four-scenario (in German: Siebler, Sabelus, & Bohner, 2008), and five-scenario versions have been developed (in Italian: Dall'Ara & Maass, 1999; and in Chinese: Lam & Chan, 2007).

Response Mode and Timing Respondents typically complete the LSH scale anonymously. Ratings of the likelihood of performing sexually harassing behaviors are made on a 5-point Likert-type scale with the anchors Not at all Likely (1) and Very

Likely (5). The original LSH scale takes about 15 minutes

to complete.

Scoring

In the original 10-scenario version, the likelihood ratings

from the key items (see b items in Exhibit) are summed

to form a LSH score. Scores range from 10 to 50. In the

Italian and German versions, blatant quid pro quo items are

not used. Instead, after each scenario participants are asked

to rate the likelihood of their performing several more

subtle behaviors that could be seen as sexually harassing.

Likelihood ratings are averaged across these more subtle

items on these versions.

Reliability

Across several studies of college men reviewed by Pryor et

al. (1995), the Cronbach alpha for the original LSH scale

always exceeded .90. The two-scenario version produced

alphas ranging from .74 to .78. The four- and five-scenario versions produced alphas ranging from .74 to .83. Initial principal components analyses of the 10-scenario version produced a single-factor solution (e.g., Pryor, 1987). Although two-factor solutions have been reported sometimes (Perry, Schmidtke, & Kulik, 1998), scales based upon these factors are highly correlated. For this reason, it is recommended that the summed score of the 10 items be viewed as a homogeneous measure of men's proclivity for sexual exploitation.

Validity

Most validity studies have examined all-male samples. Across numerous studies, the LSH has been found to be correlated with self-report scales related to sexual violence, gender roles, and sexuality (Pryor et al., 1995). Some example correlations include the following (all ps < .05). With regard to sexual violence, the LSH scale has been found to correlate with Attraction to Sexual Aggression (r = .38; Pryor & Stoller, 1994) and the Rape Myth Acceptance (r = .37; Begamy & Milburn, 2002). With regard to gender roles, the LSH scale has correlated significantly with

Exhibit

Likelihood to Sexually Harass Scale

Instructions: On the sheets that follow you will find 10 brief scenarios that describe 10 different interactions

between males and females.

In each case you will be asked to imagine that you are the main male character in the scenario. Then you will be asked to rate how

likely it is that you would perform each of several different behaviors in the described social context. Assume in each scenario that, no

matter what you choose to do, nothing bad would be likely to happen to you as result of your action. Try to answer each question as

honestly as you can. Your answers will be completely anonymous. No one will ever try to discover your identity, no matter what you

say on the questionnaire.

Scenario 1

Imagine that you are an executive in a large corporation. You are 42 years old. Your income is above average for people at your job level.

You have had numerous job offers from other companies. You feel very secure in your job. One day your personal secretary decides

to quit her job and you have the task of replacing her. The personnel department sends several applicants over for you to interview. All

seem to be equally qualified for the job. One of the applicants, Michelle S., explains during her interview that she desperately needs the

job. She is 23 years old, single and has been job-hunting for about a month. You find yourself very attracted to her. She looks at you in a

way that possibly conveys she is also attracted to you. How likely are you to do the following things in this situation?

a. Would you give her the job over the other applicants? (Circle a number to indicate your response.) a

1.....2.....

Not at all Likely Very Likely

b. Assuming that you are secure enough in your job that no possible reprisals could happen to you, would you offer her the job in

exchange for sexual favors?

c. Assuming that you fear no reprisals on your job, would you ask her to meet you later for dinner to discuss her possible employ

ment?

Scenario 2

Imagine that you are the owner and manager of an expensive restaurant. One day, while going over the receipts, you discover that one

of the waitresses has made some errors in her checks. She has undercharged several customers. The mistake costs you $100. In talking

to some of the other employees, you find that the particular customers involved were friends of the waitress. You call her into your

office and ask her to explain her behavior. The waitress confesses to having intentionally undercharged her friends. She promises that

she will never repeat this dishonest act and tells you that she will do anything to keep her job. The waitress is someone you have always

found particularly attractive. She is a divorcee and about 25 years old. How likely are you to do the following things in this situation?

a. Would you let her keep her job?

b. Would you let her keep her job in exchange for sexual favors?

c. Would you ask her to meet you for dinner after work to discuss the problem?

Scenario 3

Imagine that you are the manager of a shipping company. One day your supervisor asks you to study the possibility of buying several

computers for the office. You call up several competing companies that sell computers. Each company sends a sales representative over

to your office who describes the company's products. A salesperson from company "A" calls you and asks to come to your office. You

agree and the next day a very attractive woman shows up. She can offer no real reason for buying her company's products over those

of the other companies. However, she seems very sexy. How likely are you to do the following things in this situation?

Pryor, J. B., & Stoller, L. (1994). Sexual cognition processes in men who are high in the likelihood to sexually harass. Personality and Social Psychology Bulletin, 20, 163–169.

Pryor, J. B., & Whalen, N. J. (1997). A typology of sexual harassment: Characteristics of harassers and the social circumstances under which sexual harassment occurs. In W. O'Donohue (Ed.), Sexual harassment: Theory, research, and treatment (pp. 129–151). Needham Heights, MA: Allyn & Bacon. Siebler, F., Sabelus, S., & Bohner, G. (2008). A refined computer harassment paradigm: Validation, and test of hypotheses about target characteristics. Psychology of Women Quarterly, 32, 22–35. a. Would you recommend her line of computers? b. Assuming that you are secure enough in your job that no possible reprisals could happen to you, would you agree to recommend her line of computers in exchange for sexual favors? c. Given the same assumptions as in the last question above, would you ask her to meet you later for dinner to discuss the choice of computers? Scenario 4 Imagine that you are a Hollywood film director. You are casting for a minor role in a film you are planning. The role calls for a particularly stunning actress, one with a lot of sex appeal. How likely are you to do the following things in this situation? a. Would you give the role to the actress whom you personally found sexiest? b. Would give the role to an actress who agreed to have sex with you? c. Would you ask the actress to whom you were most personally attracted to talk with you about the

role over dinner? Scenario 5 Imagine that you are the owner of a modeling agency. Your agency specializes in sexy female models used in television commercials. One of your models, Amy T., is a particularly ravishing brunette. You stop her after work one day and ask her to have dinner with you. She coldly declines your offer and tells you that she would like to keep your relationship with her “strictly business.” A few months later you find that business is slack and you have to lay off some of your employees. You can choose to lay off Amy or one of four other women. All are good models, but someone has to go. How likely are you to do the following things in this situation? a. Would you fire Amy? b. Assuming that you are unafraid of possible reprisals, would you offer to let Amy keep her job in return for sexual favors? c. Would you ask Amy to dinner so that you could talk over her future employment? Scenario 6 Imagine that you are a college professor. You are 38 years old. You teach in a large midwestern university. You are a full professor with tenure. You are renowned in your field (Abnormal Psychology) and have numerous offers for other jobs. One day following the return of an examination to a class, a female student stops in your office. She tells you that her score is one point away from an “A” and asks you if she can do some extra credit project to raise her score. She tells you that she may not have a sufficient grade to get into graduate school without the “A.” Several other students have asked you to do extra credit assignments and you have declined to let them. This particular woman is a stunning blonde. She sits in the front row of the class every day and always wears short skirts. You find her extremely sexy. How likely are you to do the following things in this situation? a. Would you let her carry out a project for extra credit (e.g. write a paper)? b. Assuming that you are very secure in your job and the university has always tolerated professors who make passes at students, would you offer the student a chance to earn extra credit in return for sexual favors? c. Given the same assumptions as in the question above, would you ask her to join you for dinner to discuss the possible extra credit assignments? Scenario 7 Imagine that you are a college student at a large midwestern university. You are a junior who just transferred from another school on the East coast. One night at a bar you meet an attractive female student named Rhonda. Rhonda laments to you that she is failing a course in English Poetry. She tells you that she has a paper due next week on the poet Shelley, and fears that she will fail since she has not begun to write it. You remark that you wrote a paper last year on Shelley at your former school. Your paper was given an A+. She asks you if you will let her use your paper in her course.

She wants to just retype it and put her name on it. How likely are you to do the following things in this situation? a. Would you let Rhonda use your paper? b. Would you let Rhonda use your paper in exchange for sexual favors? c. Would you ask Rhonda to come to your apartment to discuss the matter?

Scenario 8

Imagine that you are the editor for a major publishing company. It is your job to read new manuscripts of novels and decide whether they

are worthy of publication. You receive literally hundreds of manuscripts per week from aspiring novelists. Most of them are screened

by your subordinates and thrown in the trash. You end up accepting about one in a thousand for publication. One night you go to a

party. There you meet a very attractive woman named Betsy. Betsy tells you that she has written a novel and would like to check into

getting it published. This is her first novel. She is a dental assistant. She asks you to read her novel. How likely are you to do the follow

ing things in this situation?

a. Would you agree to read Betsy’s novel?

b. Would you agree to read Betsy’s novel in exchange for sexual favors?

c. Would you ask Betsy to have dinner with you the next night to discuss your reading her novel?

Scenario 9

Imagine that you are a physician. You go over to the hospital one day to make your rounds visiting your patients. In looking over the

records of one of your patients, you discover that one of the attending nurses on the previous night shift made an error in administer

ing drugs to your patient. She gave the wrong dosage of a

drug. You examine the patient and discover that no harm was actually done.

He seems fine. However, you realize that the ramifications of the error could have been catastrophic under other circumstances. You

pull the files and find out who made the error. It turns out that a new young nurse named Wendy H. was responsible. You have noticed

Wendy in some of your visits to the hospital and have thought of asking her out to dinner. You realize that she could lose her job if you

report this incident. How likely are you to do each of the following things?

a. Would you report Wendy to the hospital administration?

b. Assuming that you fear no reprisals, would you tell Wendy in private that you will not report her if she will have sex with you?

c. Assuming that you fear no reprisals, would you ask Wendy to join you for dinner to discuss the incident?

Scenario 10

Imagine that you are the news director for a local television station. Due to some personnel changes you have to replace the anchor

woman for the evening news. Your policy has always been to promote reporters from within your organization when an anchor woman

vacancy occurs. There are several female reporters from which to choose. All are young, attractive, and apparently qualified for the

job. One reporter, Loretta W., is someone whom you personally find very sexy. You initially hired her, giving her a first break in the TV

news business. How likely are you to do the following things in this situation?

a. Would you give Loretta the job?

b. Assuming that you fear no reprisals in your job, would you offer Loretta the job in exchange for sexual favors?

c. Assuming that you fear no reprisals in your job, would you ask her to meet you after work for dinner to discuss the job?

Note. Scoring the LSH: The key items are respondents' answers to the b item for each scenario. Ratings for these items are simply summed to produce

an overall LSH score.

a The following scale is reproduced after each response option. Exhibit Sexual Harassment Attitudes Questionnaire The purpose of this questionnaire is to examine relationships between instructors and students. You will read two scenarios involving instructors and students. Each will be followed by a set of questions consisting of statements about the scenario you have read. You will be asked to imagine that you or a close woman friend of yours is the student in the situation presented. There are no right or wrong answers, only opinions. If you are unsure about an answer, just indicate the response that best fits your own opinion. Scenario 1 Suppose that you or a close woman friend of yours is attending classes on this campus. After class one day, a professor asks that you come to his office to discuss your grade with him. When you get there he notes that you barely passed the last exam and are in danger of receiving a D for the course. He then tells you at length how much he enjoys having you in the class, leading up to a dinner invitation. He states that if you "get to know each other better" he might be able to work things out so that you can get a better grade. The following are a number of statements about the situation that might help to explain why the above incident occurred. Rate your agreement with each of the following comments. Mark the number on your answer sheet that best describes your feeling. Use the following key: Description The incidence of sexual harassment in educational settings is well documented, yet the psychological dynamics that underlie the perpetuation of sexual harassment are still only partially understood. The Sexual Harassment Attitudes Questionnaire was developed as a research tool to explore psychological factors associated with sexual harassment in educational settings. The questionnaire measures respondents' attitudes regarding (a) responsibility for harassment behaviors, (b) appropriate responses to sexual harassment, and (c) effects of sexual harassment on victims. Respondents first read two scenarios that depict

clear-cut incidents of sexual harassment in a college setting. After each scenario, they indicate to whom they attribute responsibility for the incident. Two questions pertain to victim blame, two to perpetrator blame, and two to no blame. A second set of six questions taps respondents' attitudes about appropriate responses to sexual harassment. Two questions refer to confronting the harassing behavior, two to complying with the harasser, and two to ignoring the harassment. Finally, a set of eight questions measures expectations of the effects of the harassment. Two questions refer to educational effects and six to emotional effects. All questions have 6-point Likert-type scales except for the questions regarding emotional effects, which have 7-point Likert-type scales. Validity Based on responses of 113 female and 111 male college undergraduates, the questionnaire shows evidence of construct validity (Malovich & Stake, 1990). Perpetrator blame scores in this sample were negatively related to victim blame (−.36) and no blame (−.57) scores. Victim blame was positively related to recommendations for compliance (+.47) and expectations for positive educational effects (+.32), and negatively related to recommendations for confrontive action (−.30), expectations for negative emotional effects (−.44), and liberal sex role attitudes (Attitudes Toward Women scores and victim blame: −.22). In contrast, perpetrator blame was positively related to recommendations for confrontive action (+.45), expectations for negative emotional effects (+.54), and liberal sex role attitudes (+.22), and negatively related to recommendations for compliance (−.45) and expectations for positive educational effects (−.37). Reference Malovich, N. J., & Stake, J. E. (1990). Sexual harassment on campus: Individual differences in attitudes and beliefs. Psychology of Women Quarterly, 14, 63–81. Sexual Harassment Attitudes Questionnaire JAYNE E. STAKE 1 AND NATALIE J. MALOVICH, University of Missouri-St. Louis 1 Address correspondence to Jayne Stake, Department of Psychology, University of Missouri-St. Louis, St. Louis, MO 63121; e-mail: jayne_stake@umsl.edu

0 = Strongly disagree

1 = Moderately disagree

2 = Somewhat disagree

3 = Somewhat agree

4 = Moderately agree

5 = Strongly agree

1. The student is probably hoping that getting to know the professor personally will help her get a better grade in the course.

2. The professor probably meant no harm so it should not be taken too seriously.

3. The professor is using his status unfairly to pressure the student into dating him.

4. The professor is responding to normal sexual attraction and cannot really be blamed for his actions in the situation.

5. The professor's actions were unethical and could be harmful to his students.

6. The student is most likely a flirtatious type who enjoys getting special attention from her professors.

The following are a number of statements describing possible ways that you could deal with the situation. Rate your agreement with

each of the following statements. Mark the number on your answer sheet that best describes your feelings. Use the following key:

0 = Strongly disagree

1 = Moderately disagree

2 = Somewhat disagree

3 = Somewhat agree

4 = Moderately agree

5 = Strongly agree

7. Change the subject and try to forget about the conversation.

8. Go to dinner with the professor and talk over the problems you are having in the class.

9. Continue to work hard in the class and avoid any individual conversations with the professor.

10. Tell the professor that you are not interested in a personal relationship, and that this should have nothing to do with your grade in the course.

11. See the professor on a social basis if he is interested as it may help your grade.

12. Go to the department head and tell him/her about the professor's actions.

Below is a set of word pairs that describe how you or a close woman friend might feel about this experience. The two feelings in each

pair are separated by a 7-point scale, with one word on each side on the scale. For each word pair, mark the number on your answer

sheet that is closest to how you think you or your friend might feel.

13. Insulted 0 1 2 3 4 5 6 Flattered

14. Pleased 0 1 2 3 4 5 6 Angry

15. Comfortable 0 1 2 3 4 5 6 Uncomfortable

16. Relaxed 0 1 2 3 4 5 6 Nervous

17. Intimidated 0 1 2 3 4 5 6 Powerful

18. Embarrassed 0 1 2 3 4 5 6 Proud

Scenario 2

Suppose that you or a close woman friend of yours is attending this campus. Through the course of the semester you notice that a

professor in one of your classes frequently seems to be staring at you. When talking with him after class one day about an upcoming

essay exam, he puts his arm around you (or the woman friend) and touches your hair. He then suggests that you come to his offi ce

at the end of the day so that the exam can be discussed further. He adds that if you fail to do so, you will

probably not do as well

on the exam as expected. a

a Questions 19-36 are identical to questions 1-18.

Health

Exhibit

Sexual Health Services Questionnaire

The following questionnaire inquires about the sexual health services your student health center currently offers. If you have any ques

tions please do not hesitate to contact the investigators.

Directions: The items below inquire about your current employment of staff involved with sexual health programs and types of sexual

health services offered by your campus health center. Please mark an “X” next to all that apply.

Employees who deal with student sexual health concerns and/or problems as their primary job responsibility at your health center

include:

Sexuality Program Coordinator ____

Sexuality Educator ____

Physician ____

Physician Assistant ____

Nurse ____

Nurse Practitioner ____

Sexual Assault Nurse Examiner (SANE) ____

Health Educator ____

Psychologist ____

Psychiatrist ____

Social Worker ____

Mental Health Counselor ____

Other (please identify): _____

Employees that deal with student sexual health concerns and/or problems on a regular basis but do not consider sexual health their

primary job responsibility include:

Physician ____

Physician Assistant ____

Nurse ____

Nurse Practitioner ____

Sexual Assault Nurse Examiner (SANE) ____

Health Educator ____

Psychologist ____

Psychiatrist ____

Social Worker ____

Mental Health Counselor ____

Other (please identify): _____

Some health centers house volunteer or paid student peer educators/health advocates. Please mark an “X” next to all of the following

that apply to your college health center.

Do you use student peers . . .

To organize sexuality-related events on campus ____

(e.g., presentations at residence halls/Greek housing)
____

To conduct counseling on relationship issues ____

To conduct sexual health outreach ____

To conduct contraceptive counseling ____

To conduct STD testing counseling ____

To conduct counseling on sexual orientation issues ____

To conduct counseling on other sexuality issues ____

To give away condoms at campus bars/restaurants ____

Other (please identify): _____

Please mark an “X” next to any of the following safer-sex products your health center distributes to students.

Male latex condoms ____

Flavored condoms ____

Non-latex male condoms ____

Specialty condoms ____

(e.g., those above or below average size) ____

Female condoms ____

Sexual lubricants ____

Latex dams (i.e., dental dams) ____

**On average how many condoms does your institution distribute to students per year? (If you do NOT distribute condoms please write

in 0. If you are unsure about how many condoms you distribute please write in 999 for coding purposes)
_____#

Please mark an “X” next to any methods in which your health center distributes condoms (includes both selling and giving away con

doms for free).

At the pharmacy ____

During after-hours ____

Through appointment with health care provider ____

Through educational outreach ____

At campus events ____

At bars and restaurants near campus ____

Please mark an “X” next to any of the following contraceptive methods that are available through your health center.

Oral contraceptive pill ____

Oral contraceptive pill (progestin only) ____

Hormonal transdermal skin patch ____

Hormonal vaginal ring ____

Intrauterine device (IUD) hormonal ____

Intrauterine device (IUD) copper ____

Progestin-only injection ____

Instruction for fertility awareness method (FAM) ____

Emergency contraception pills (ECP) by prescription ____

Emergency contraception pills (ECP) over the counter ____

Diaphragm ____

Cervical cap ____

Hormonal implant ____

Please mark an “X” next to any of the sexually transmitted infections (STIs) that your health center currently offers testing for.

HIV ____

HIV “quick” blood test ____

HIV oral swab test ____

Chlamydia ____

Gonorrhea ____

Hepatitis B ____

Hepatitis A ____

Herpes simplex virus (HSV) ____

Syphilis ____

HPV DNA test for women ____

Trichomonas ____

Please mark an “X” next to any of the following infections
that your health center currently provides a vaccine for.

HPV vaccine ____

Hepatitis B vaccine ____

Please mark an “X” next to any of the following services
that your health center currently provides.

Pap test ____

Bimanual uterine/ovarian exam ____

Colposcopy ____

Please mark an “X” if your health center provides the
service listed below.

Clinical breast exam ____

Please mark an “X” if your health center provides the
service listed below.

Testicular exam ____

Please mark an “X” if your health center provides the
service listed below.

Post-sexual assault exam ____

Please mark an “X” next to any of the following counseling
services that your health center currently provides.

Individual counseling on general sexual health issues
____

Group counseling on general sexual health issues ____

Relationship issues ____

Sexual orientation issues ____

Contraceptive methods ____

Service for survivors of sexual assault ____

Does your health center have a Clinical Laboratory Improvement Amendment (CLIA) certificate? Please mark an "X" next to your

response.

Yes ____

No ____

Unsure ____

Directions: The items below ask about your personal demographics and how long you have been a college health center director.

Please respond by writing in your response or by placing an "X" in the space provided.

Your age: _____

Your race/ethnicity:

Asian _____

Black/African American _____

Caucasian White _____

Hispanic _____

American Indian _____

Other _____

Your gender:

Male _____

Female _____

How many total years have you been the director of a college health center? If you have been the director of more than one health

center, please combine your total years of experience.
_____ years

Your education:

Please mark an “X” next to all of the degrees you have earned

Bachelor’s _____

Master’s _____

PhD _____

MD _____

Other _____

Total number of employees at your health center:
_____

Total student population at your college/university:
_____

What state is your college/university located in?
_____

Directions: The items below are based upon your college/university’s demographics; please respond by placing an “X” in the space provided. Type of Academic Institution Public _____ Private _____ Setting of Your Institution: Urban _____ Small Town _____ Suburban _____ Rural _____

1 Address correspondence to Heather Eastman-Mueller, Student Health Center, 1101 Hospital Drive, Health Promotion Department, University of

Missouri, Columbia, MO 65212; e-mail: eastmanmuellerh@health.missouri.edu

Student Population:

Primarily Residential _____

Primarily Commuter _____

Equal Numbers Residential and Commuter _____

Degrees Awarded at Your Institution (check all that apply)

Associate _____

Baccalaureate _____

Master’s _____

Doctorate _____

Professional (e.g., MD, JD) _____

Other Degrees _____

Does your institution have a medical school?

Yes _____

No _____

Additional Demographic Characteristics (Please check all that apply)

Historically Black College or University _____

Faith-Based Institution _____

All-Male Institution _____

All-Female Institution _____ Thank You for Participating in Our Study!

Address correspondence to [insert return information]:

Sexual Health Survey

HEATHER EASTMAN-MUELLER, 1 DEBORAH CARR, AND STEVE OSTERLIND,

University of Missouri, Columbia

The purpose of the Sexual Health Survey (SHS) is to assess

the Sexual Health Knowledge (SHK), Sexual Health

Attitudes (SHA), and Sexual Health Behaviors (SHB) of

students enrolled in institutes of higher education. The

SHS was designed to assess a comprehensive range of

five sexual health topics, including (a) contraception, (b) pregnancy prevention, (c) sexual health communication, (d) sexual behavior, and (e) sexually transmitted infections (STI) and barriers to obtaining STI testing.

Description

Items generated for this survey were based on an extensive literature review and focus group construct explication performed on priority areas. Content validity was assessed for quality, clarity, and sensitivity to culture and gender by a panel review of five experts from a variety of backgrounds, including a counseling psychologist, a registered nurse, a statistician, an expert on human sexuality, and an expert on sexual violence and lesbian, gay, bisexual, transgender, and queer (LGBTQ) issues. A pilot test study was administered online to 600 randomly sampled university students to further refine the survey instrument. Item analysis reduced the initial number of items from 200 to 127. Items eliminated were based on failure to meet appropriate item discrimination, item difficulty/endorsement, and reliability measures.

Response Mode and Timing

Sexual Health Knowledge (SHK) is assessed using a 6-point Likert-type scale (0 = Strongly Disagree/Very Effective, 5 = Strongly Agree/Very Ineffective) for 24 items that assess basic knowledge of sexually transmitted infection (STI) and pregnancy prevention, effects of alcohol on sexuality, and the impact of STIs among this population. Sexual Health Attitudes (SHA) were assessed using a 6-point Likert-type scale (0 = Very Uncomfortable/Very Unconcerned/Strongly Agree, 5 = Very Comfortable/Very Concerned/Strongly Disagree) across 48 items measuring comfort level in communication with a partner about past

sexual history or contraceptive methods. Other questions

examine level of concern seeking STI testing, perceptions

of peer's sexual activity, belief in rape myths, and commu

nication associated with condom/dental dam procurement.
Sexual Health Behavior (SHB) was assessed using 17

multiple-choice and 16 dichotomous items requesting

age at sexual debut, and sexual activity in last 30 days and

across the lifespan. Other items concerned contraceptive

and alcohol use, number of sexual partners, frequency of
barrier protection use, unintentional pregnancy, and sexual
assault. Demographic information included age, year in
school, sexual orientation, relationship status,
ethnicity, residential arrangements, and membership within
a Greek (fraternity/ sorority) community. The survey takes
approximately 20 minutes to complete. Scoring The scale
can be scored by construct and/or by factor. To obtain a
knowledge score, add all knowledge items, 1–24, for a
possible maximum score of 120. To obtain an attitude
score, sum Items 1 through 10, 17 through 19, 21, 25, and
27 for a maximum score of 80. When scoring factors
independently, larger scores represent a more favorable
attitude toward safer-sex practices and/or abstinence,
increased comfort level with sexual health communication
and barrier methods, and belief in rape myths. For Factor
4, the smaller the score, the less knowledge about latex
barrier effectiveness.

TABLE 1

Items, Factor Loadings, Communality Estimates, Means, and
Standard Deviations for the Four-Factor Solution for Sexual

Health Survey (Rotated)

Item Factor h 2 M SD

Loading

Factor 1: Perceived Sexual Readiness (5 items)

Sex should be reserved for a long-term relationship. .68
.43 1.38 1.52

People should wait until they are married to have sex. .73 .56 2.84 1.73

Sexual intercourse is acceptable in a relationship no .80 .63 2.06 1.67

matter how long the couple has been dating.

Engaging in sexual activity immediately after .83 .70 1.77 1.62

beginning a relationship is ok.

More students on this campus should practice being .69 .53 2.39 1.62

sexually abstinent.

Factor 2: Comfort Sexual Communication (3 items)

Comfort level of asking a partner about their past .71 .52 3.56 1.46

sexual history.

Comfort level asking a partner if she/he has had an .94 .86 3.12 1.66

HIV test.

Comfort level asking a partner if he/she has been tested .92 .85 3.17 1.62

for an STD (excluding HIV).

Factor 3: Comfort with Barrier Methods (3 items)

Comfort level buying a condom or a dental dam. .60 .42 3.48 1.58

Comfort level providing a condom/dental dam if a .96 .58 4.15 1.32

partner did not have one available.

Comfort level of using/asking partner to use a condom .60 .46 4.30 1.18

or dental dam.

Factor 4: Latex Barrier Effectiveness (3 items)

Effectiveness in preventing STDS . . .

. . . wearing (or having a partner wear) a condom. .83 .49 3.92 1.08

. . . wearing a condom containing spermicidal cream. .77 .46 3.76 1.27

. . . using a dental dam during oral sex. .62 .34 3.80 1.14

Factor 5: Belief in Rape Myths (3 items)

A person is more likely to be raped if he/she . . .

. . . feels that he/she owes the person something. .68 .47 1.88 1.43

. . . has sex with multiple partners. .65 .46 2.33 1.57

. . . is in a passive role in a relationship. .71 .52 1.94 1.39

Reliability

To test the internal consistency, a reliability analysis was performed on each subscale and the factor model as a whole. For Factor 1, the subscale named “perceived sexual readi ness,” the Cronbach’s alpha was .88 (k = 5), with all posi tive corrected item-total correlations of .63 and above. For Factor 2, the subscale named “comfort sexual communica tion,” the Cronbach’s alpha was .91 (k = 3), with all positive corrected item-total correlations .71 and above. For Factor 3, the subscale named “comfort with barrier methods” had a Cronbach’s alpha of .79 (k = 3); all positive corrected item-total correlations were .58 and above. For Factor 4,

the subscale named “latex barrier effectiveness” (k = 3), the

Cronbach’s alpha was .79; all positive corrected item-total

correlations were .56 and above. For Factor 5, the subscale

named “belief in rape myths” (k = 3), the Cronbach’s alpha

was .74; all positive corrected item-total correlations were

.55 and above. Finally, for all subscales combined (k = 17),

the Cronbach’s alpha was .79, with corrected item-total

correlations ranging from .23 to .54.

Validity

Principal axis factoring was performed to detect structure

and determine dimensionality of the set of variables. The

Exhibit

Sexual Health Survey (Sample Items)

Knowledge Section

The following questions are intended to access your sexual health knowledge. Please answer each question to the best of your ability

by indicating to what extent you agree or disagree with the following statements. If you feel uncomfortable answering any of the ques

tions you may skip them.

K10) Women can become pregnant the first time they engage in vaginal-penile intercourse.

Strongly Disagree a

Moderately Disagree

Mildly Disagree

Mildly Agree

Moderately Agree

Strongly Agree

For each of the following questions, please indicate the level of effectiveness that each behavior provides in preventing sexually transmit

ted diseases. Select the option that best corresponds with your answer.

K13) Giving and receiving oral sex without any form of barrier protection (condom or dental dam).

Very Effective b

Moderately Effective

Slightly Effective

Slightly Ineffective

Moderately Ineffective

Strongly Ineffective

K15) Wearing (or having a partner wear) a condom that contains spermicidal cream.

K16) Using (or having a partner use) a dental dam or any latex barrier used to help prevent the exchange of fluids, during oral sex. Attitude Section The following questions are intended to access your attitudes towards sexual health topics. Please answer each question to the best of

your ability by selecting one of the following options. If you feel uncomfortable answering any of the questions you may skip them.

To what extent do you feel comfortable or uncomfortable when engaging in the following behaviors? Please indicate your answer for

each behavior by selecting the corresponding option.

A6) Speaking with a partner about using birth control (any method).

Very Comfortable c Moderately Comfortable Slightly Comfortable Slightly Uncomfortable Moderately

Uncomfortable Strongly Uncomfortable A7) Asking a partner about their past sexual history. A10) Engaging in unprotected (no condom or dental dam) sexual activity with a partner. For the following statements, please indicate your level of concern if you were trying to decide whether or not to get tested for a sexu

ally transmitted disease, including HIV (the virus that causes AIDS).

A19) Having unprotected sex (sex without a condom or dental dam) is not worth the risk of contracting a sexually transmitted disease. Behavior Section In this survey, the definition of sexual activity refers to oral, anal, and vaginal sex. This does not include massage, touching, or mutual masturbation. B1) Have you ever had consensual sex (oral, anal, or vaginal)? Yes No B8) In the last 30 DAYS, what type of sex did you have? Check all that apply.

Oral

Anal

Vaginal

Other

B10) If you did NOT use a form of barrier protection such as a condom/dental dam (a latex covering used to prevent the exchange of bodily fluids) in the last 30 DAYS you had sex please indicate the reason. Check all that apply. I just knew my partner was safe. It was a spontaneous, unplanned event. I was under the influence of alcohol or drugs. I did not feel comfortable discussing the matter with my partner. I did not feel I needed to because I was involved in a long-term relationship at the time. I was using another form of birth control. There was not any form of protection method available. The sex was nonconsensual (sex against my will). Other _____ (Must fill in the blank) B15) Which of the following barrier and/or birth control methods do you use most often? Check all that apply.

Condom/dental dams (latex covering used to prevent the exchange of bodily fluids)

Combination hormonal methods (such as birth control pills, Ortho Evra—the Patch, NUVA—intravaginal ring—the Ring).

Depo-Provera (the Shot)

Calendar method (rhythm or having sex only during the “safe” times of the month)

Withdrawal or “pulling out”

Diaphragm

Nothing

Other _____ (Must fill in the blank)

Demographics

D2) Which of the following do you consider yourself?

Male

Female

Transgender

D5) What is your current relationship status?

Single (not in a relationship)

Committed relationship (only dating one person)

Non-committed relationship (casual)

Cohabitating (living together)

Married or partnered

D6) Which of the following commonly used terms best describes you?

Heterosexual

Gay or lesbian

Bisexual

Transgender

Questioning

D7) Where do you currently live?

Campus residence halls

Greek housing

Other university housing

Off-campus housing

Parent’s or guardian’s house

a The responses are repeated for Questions K1 through K11.

b The responses are repeated for Questions K12 through K24.

c The responses are repeated for Questions A1 through A10.
The World Health Organization defines sexual health as the state of physical, emotional, mental, and social well-being related to sexuality, not merely the absence of disease, dysfunction, or infirmity (World Health Organization, 2009). Sexual health has been identified as an important part of each person’s overall wellness and quality of life (Pan American Health Organization & World Health Organization, 2000; World Association of Sexual Health, 2008). Sexual health concerns and problems may generate and/or perpetuate other problems in the individual, family, community, and population at large. In order to be sexually healthy, individuals are encouraged to learn and demonstrate a variety of behaviors (Sexuality Information and Education Council of the United States, 2009). Thus, the Sexual Health Practices Self-Efficacy Scale (SHPSES) was developed to measure respondents’ confidence (self-efficacy) as described as their knowledge, skills, and comfort to carry out 20 different sexual health practices. Bandura proposed the concept of self-efficacy as the conviction or confidence that a person can successfully execute the behavior required to produce a certain outcome (Bandura, 1977, 1982). Selfefficacy is recognized as one of the most important prerequisites for behavior change (Bandura, 1997) and has been prolifically applied to research in diverse areas including smoking cessation, dietary practices, exercise behaviors, alcohol consumption, contraceptive use, and HIV prevention (Strecher, DeVellis, Becker, & Rosenstock, 1986). It has been incorporated into the frameworks of many influential theories, including social cognitive theory, the health belief model, and the transtheoretical model (DiClemente & Peterson, 1994; Glanz, Rimer, & Viswanath, 2008).
Description The Sexual Health Practices Self-Efficacy Scale (SHPSES) consists of 20 items representing a variety of sexual health practices. Respondents indicate their confidence in performing these practices (self-efficacy) on

a scale from 1 (Not at all Confident) to 5 (Extremely Confident). Through the use of factor analysis (see Validity section), six subscales were identified, including self-efficacy in regard to Sexual Relationships (5 items), Sexual Health Care (4 items), Sexual Assault (3 items), Safer Sex (4 items), Sexual Equality/Diversity (3 items), and Abstinence (1 item). SHPSES is appropriate for adolescents to older adults of all backgrounds. Response Mode and Timing Respondents are instructed to indicate how confident they are, at the time they are completing the survey, in carrying out each of 20 different sexual health practices. Confidence is defined as having the knowledge, skills, and comfort necessary to effectively perform the sexual health practice. Respondents use the following scale: 1 = Not at all Confident, 2 = Slightly Confident, 3 = Moderately Confident, 4 = Highly Confident, 5 = Extremely Confident. The term partner refers to whomever the respondent might share his or her sexuality with. The scale takes approximately 5 minutes to complete. Scoring Scores on the SHPSES can range from 20, indicating the least self-efficacy, to 100, indicating the most self-efficacy in performing the variety of sexual health practices. The subscales consist of the following items: Sexual Relationships (7, 8, 12, 13, 14), Sexual Health Care (1, 2, 3, 4), Sexual Assault (15, 16, 17), Safer Sex (5, 9, 10, 11), Sexual Equality/ Diversity (18, 19, 20), and Abstinence (6). Reliability Internal reliability was calculated from 1,200 surveys completed by a convenience sample of undergraduate students attending a major northeastern university from 2004 to 2008. The Cronbach's alpha coefficient for the entire scale was .89 (Koch, 2009). Subscale reliability coefficients were as follows: Sexual Relationships, .82; Sexual Health Care, .81; Sexual Assault, .78; Safer Sex, .71; Sexual Equality/ Diversity, .73. Abstinence was a single item, so no individual alpha coefficient was calculated. Validity Content validity was determined through examination of the sexual health content of 10 major sexuality textbooks and the syllabi of 20 sexuality classes taught at differing colleges and universities throughout the United States. A panel of three sexuality educators/researchers reviewed the initial pool of items for relevance and redundancy. Using the 1,200 surveys collected from undergraduate students, construct validity was examined with a principal component analysis using a varimax rotation with Kaiser 1 Address correspondence to Patricia Barthalow Koch, Professor of Biobehavioral Health, The Pennsylvania State University, 304B Health and Human Development Building East, University Park, PA 16802; e-mail: p3k@psu.edu Sexual Health Practices Self-Effi cacy Scale PATRICIA BARTHALOW

normalization. The rotation converged in six iterations, identifying the following six factors representing sexual health practices self-efficacy: Sexual Relationships (15.4% explained variance), Sexual Health Care (13.4%), Sexual Assault (11.2%), Safer Sex (10.1%), Sexual Equality/ Diversity (10.0%), and Abstinence (5.8%). The SHPSES has been shown to discriminate undergraduate students who have taken sexuality education classes in comparison to students enrolled in nonsexuality or nonhealth-related classes at a major northeastern university (Koch, 2009). Scores from the SHPSES have also been significantly cor related with intentions to practice safer-sex behaviors in the next month and the actual practice of safer sex in the preceding month among a sample of students at a major northeastern community college (Millstein, 2006).

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84, 191–215.

Bandura, A. (1982). Self-efficacy mechanism is human agency. American Psychologist, 37, 121–147.

Bandura, A. (1997). Self-efficacy: The exercise of control. New York: W. H. Freeman. DiClemente, R. J., & Peterson, J. L. (1994). Preventing AIDS: Theories and methods of behavioral interventions. New York: Springer. Glanz, K., Rimer, B. K., & Viswanath, K. (2008). Health behavior and health education: Theory, research, and practice (4th ed.). San Francisco, CA: Jossey-Bass. Koch, P. B. (2009, June). Promoting positive sexual health practices for university students: What works? Presentation at the World Congress for Sexual Health, Gothenburg, Sweden. Millstein, S. (2006). The effects of a human sexuality course on

students’ confidence to engage in healthy sexual practices. Unpublished doctoral dissertation, Widener University, Philadelphia. Pan American Health Organization & World Health Organization. (2000). Promotion of sexual health: Recommendations for action. Retrieved June 22, 2009, from http://new.paho.org/hq/index.php?option=com_content&task=view&id=847&Itemid=1047 Sexuality Information and Education Council of the United States. (2009). Position statements. Retrieved June 22, 2009, from http://www.siecus. org/index.cfm?pageId=494 Strecher, V. J., DeVellis, B. M., Becker, M. H., & Rosenstock, I. M. (1986). The role of self-efficacy in achieving health behavior change. Health Education Quarterly, 13(1), 73-92. World Association of Sexual Health. (2008). Sexual health for the millennium. Retrieved June 22, 2009, from http://www.worldsexology. org World Health Organization. (2009). Working definition of sexual health. Retrieved June 22, 2009, from

Exhibit

Sexual Health Practices Self-Efficacy Scale

Please indicate how confident you are, at this point in time, in carrying out the following sexual health practices if you needed to. Think of

confidence as having the knowledge, skills, and comfort necessary to effectively do these things. The term “partner” refers to whomever

you might choose to share your sexuality with. Use the following scale for your answers:

1 = Not at all Confident

2 = Slightly Confident

3 = Moderately Confident

4 = Highly Confident

5 = Extremely Confident

How confident are you with:

1. Performing breast or testicular self-exams

1 2 3 4 5

2. Getting tested for a sexually transmitted infection (STI)

1 2 3 4 5

3. Getting an HIV test

1 2 3 4 5

4. Talking with a health care worker about a sexual health issue like an STI

1 2 3 4 5

5. Making thoughtful, good decisions about your sexual behaviors

1 2 3 4 5 6. Practicing sexual abstinence 1 2 3 4 5 7. Establishing a fulfilling sexual relationship 1 2 3 4 5 8. Talking with a (prospective) sexual partner about your sexual histories 1 2 3 4 5 9. Using a condom 1 2 3 4 5 10. Using another form of birth control other than a condom 1 2 3 4 5 11. Negotiating with a sexual partner to practice safer sex 1 2 3 4 5 12. Talking with a sexual partner about a sexual health issue, like an STI 1 2 3 4 5 13. Talking with a sexual partner about a relationship issue 1 2 3 4 5 14. Dealing with a sexual functioning difficulty (like difficulty achieving orgasm or ejaculating too quickly 1 2 3 4 5 15. Preventing a sexual assault situation from occurring 1 2 3 4 5 16. Dealing with a sexual assault if it occurs to you 1 2 3 4 5 17. Helping a friend who has been sexually assaulted 1 2 3 4 5 18. Eliminating sexual double standards (based on gender) in your life 1 2 3 4 5 19. Eliminating gender stereotyping from your life 1 2 3 4 5 20. Accepting diversity in sexual orientation (heterosexuality, homosexuality, bisexuality) 1 2 3 4 5

The Pediatric Penile Perception Score (PPPS) is designed

to assess both the penile self-perception of children and

adolescents with hypospadias and the surgical outcome of

hypospadias repair. The PPPS allows a direct comparison

between children's and pediatric urologists' appraisal of penile appearance.

Description

The PPPS was developed and evaluated in a cross-sectional study on the psychosexual development and health related quality of life of children and adolescents with hypospadias (Schönbucher, Landolt, Gobet, & Weber, 2008a, 2008b; Weber, Schönbucher, Landolt, & Gobet, 2008) because no instrument was available to objectively assess the surgical outcome and self-perception after hypospadias repair. Psychological interviews were conducted with 65 children and adolescents between the ages of 6 and 17 years who underwent surgery for hypospadias at the University Children's Hospital Zurich (Switzerland). They were asked to express their satisfaction with the following aspects of surgical outcome and penile appearance on a 4-point Likert-type scale that ranges from Very Dissatisfied to Very Satisfied: position and shape of meatus, shape of the glans, shape of penile skin, and general penile appearance. In addition, patients with hypospadias were offered a physical examination by a pediatric urologist, during which standardized photographs of the penis in four standardized views were taken, namely oblique, lateral, anteroposterior with the penis held against the abdominal wall, and anteroposterior

with the penis held up straight (see Weber et al., 2008).

Examinations were consented to by 56 boys.

The photographs were sent to six pediatric urologists for

blind analysis, four of whom were not affiliated with the

University Children's Hospital Zurich. They were asked

to evaluate the standardized photographs according to the

same criteria and scale as the children. To assess the sta

bility of the instrument, in the set of 56 charts, 10 were

included twice. Reliability was high (interclass correlation

coefficient (ICC): .75–.88). Thus, the scores of the six pedi

atric urologists could be averaged to obtain an objective

assessment of the quality of surgical outcome. For a more

detailed description of the development of the instrument,

see Weber et al. (2008). Response Mode and Timing Younger children's penile perception should be assessed in an interview. Alternatively, adolescents can fill in a questionnaire. (See the Exhibit for interview and questionnaire instructions.) Urologists can objectively rate the surgical outcome either from photographs or in vivo. Appraisal of the results with photographs allows evaluation by noninvolved urologists and avoids the bias that occurs when judging one's own results. The use of the questionnaire by urologists is easy and self-explanatory. The application of the PPPS takes between 5 and 10 minutes for children and 2 minutes for urologists. Scoring Each item of the PPPS is scored as follows: Very Satisfied = 3, Satisfied = 2, Dissatisfied = 1, Very Dissatisfied = 0. The four items are then added to a total score, ranging from 0 to 12. Reliability The PPPS showed an excellent internal consistency for the children's penile self-perception (α = .81), as well as for the pediatric urologists' assessment of the surgical outcome (α = .84). Interrater reliability (ICC: .75–.88) and stability of the pediatric urologists' assessment (rs between the 1st and 2nd assessment: .59–.83) were high both for the four single

items and for the PPPS total score. Validity Validity was not examined. Other Information We recommend that the surgical outcome be assessed by an independent pediatric urologist who was not involved in the surgical treatment of the child, because it is assumed that pediatric urologists' assessment of their own surgical results may be distorted in the direction of a more positive judgment (Weber et al., 2008). We further suppose that the PPPS might also be a reliable

1 Address correspondence to Verena Schönbucher, Child and Woman Abuse Studies Unit, Department of Applied Social Sciences, London Metropolitan

University, Ladbroke House, 62–66 Highbury Grove, London N5 2AD, United Kingdom; e-mail: verena.schoenbucher@kispi.unizh.ch or v.schonbucher@

londonmet.ac.uk

Pediatric Penile Perception Score

VERENA SCHÖNBUCHER, 1 MARKUS A. LANDOLT, RITA GOBET, AND DANIEL M. WEBER,

Herpes

Herpes Attitude Scale

KATHERINE BRUCE, 1 University of North Carolina at Wilmington

J UDITH MCLAUGHLIN, University of Georgia

1 Address correspondence to Katherine Bruce, Department of Psychology, UNC Wilmington, Wilmington, NC 28403; e-mail: bruce@uncw.edu Exhibit Herpes Attitude Scale Instructions: For each of the following 40 statements, please note on the answer sheet whether you agree or disagree with the statements. Use the following scale: SA: Strongly Agree With the Statement A: Agree With the Statement N: Neither Agree nor Disagree With the Statement D: Disagree With the Statement SD: Strongly Disagree With the Statement Each statement is numbered. Be sure to match the statement's number with the number on the answer sheet. Please respond to all items on the questionnaire. There are NO right or wrong answers. 1. The thought of genital herpes is disgusting. 2. I would not feel dirty if I got genital herpes. 3. Genital herpes is not as scary as most people believe. 4. There are a lot of diseases that are worse than genital herpes. 5. People give genital herpes to others for revenge. 6. I could cope with having genital herpes. 7. If I had a roommate with genital herpes, I would move out. 8. Only bad people catch genital herpes. 9. I feel comfortable around friends who have genital herpes. 10. You can tell that someone has genital herpes just by looking at them. 11. I am pretty sure that I could handle having genital herpes if I caught it. 12. Having genital herpes is really no worse than having cold sores. 13. People who have genital herpes are looked down on. 14. I do not like to use public restrooms because I might catch genital herpes there. 15. I could remain calm if I found out that I had gotten genital herpes. 16. A person who has genital herpes got what s/he deserves. 17. If I had genital herpes, I would tell a potential sex partner. 18. There is more to a person who has genital herpes than the fact that s/he has genital herpes. 19. I would not avoid a friend if I found out that s/he had genital herpes. 20. I would consider marrying someone who has genital herpes. 21. People who have genital herpes should be treated the same as anyone else. 22. I would feel self-conscious if I got genital herpes. 23. If I found out that my sexual partner had genital herpes, I would never speak to him/her again. 24. The "new sexual leprosy" is an inappropriate term for genital

herpes. 25. Catching genital herpes would not be the worst thing that could happen to me. 26. I would not be ashamed if I got genital herpes. 27. People who have genital herpes are worth getting to know. 28. Genital herpes is a manageable disease. 29. I think that people who have genital herpes are too sexually active. 30. If I caught genital herpes, I would consider suicide. 31. People who have genital herpes should never have sex again. 32. I would be embarrassed to tell anyone if I had genital herpes. 33. Only unclean people catch genital herpes. 34. If I got genital herpes, no one would want to marry me. 35. If I got genital herpes, I would not want to have children. 36. Everyone would know if I got genital herpes. 37. People who have genital herpes are promiscuous. 38. I could discuss genital herpes with my parents. 39. If I asked a friend a question about genital herpes, s/he would think that I had genital herpes. 40. I would date a person known to have genital herpes.

1 Address correspondence to Katherine Bruce, Department of Psychology, UNC Wilmington, Wilmington, NC 28403; e-mail: bruce@uncw.edu

The Herpes Knowledge Scale (HKS) assesses general

knowledge about genital herpes. Subject areas include

cause, symptoms, treatment, contagion, recurrences, prev

alence, complications, myths, and the relationship between

oral and genital herpes. People who have high knowledge

about these areas can be discriminated from those who

have low knowledge.

Description

This scale is a 54-item true-false test with response

options labeled True, False, and Don’t Know. The items

were selected from an initial pool of 64 rationally field

derived statements about herpes. They were judged for

readability by five undergraduate students and for their

relevance and importance for inclusion in the scale by a

panel of five expert judges. The judges agreed on 57 of the original items for inclusion. The scale was administered to 150 undergraduate students in introductory psychology courses, and an item analysis was conducted to identify the statements that could best discriminate high and low scorers. Fifty-four items had statistically significant item total correlations ($p < .0007$). These items were arranged in random order, and the scale was tested for reliability. This scale was designed to measure college students' knowledge about herpes, but it could be used for other populations.

Response Mode and Timing

Respondents circle or blacken one response option for each item on a separately labeled answer sheet. Most respon

Herpes Knowledge Scale

KATHERINE BRUCE, 1 University of North Carolina at Wilmington

J UDITH MCLAUGHLIN, University of Georgia

Exhibit

Herpes Knowledge Scale

Instructions: For each of the following 54 statements, please note on the answer sheet whether you think the statement is true or false.

If you do not have any idea whether or not the statement is true or false, please note that you don't know. Use the following code for

your responses:

T: The statement is true

F: The statement is false

DK: I don’t know whether the statement is true or false

Each statement is numbered. Be sure to match the statement’s number with the number on the answer sheet. Please respond to all

statements on the questionnaire.

1. The length and severity of genital herpes outbreaks vary from person to person.

2. Genital herpes is caused by a virus.

3. Genital herpes was discovered five years ago.

4. Genital herpes recurrences can be triggered by menstruation (in females) or sexual intercourse.

5. Every person who has a primary (first) outbreak of genital herpes will have recurrence within the next year.

6. Genital herpes makes males infertile (sterile).

7. Between recurrences, the genital herpes virus lies dormant (inactive) in the nerve cells.

8. Herpes Type 1 cannot occur on the genitals.

9. A person having recurrences of genital herpes often experiences prodromal (early warning) sensations.

10. Years may pass between genital herpes recurrences.

11. Every sore on the genitals is herpes.

12. Once a genital herpes sore has healed, the person will never develop another herpes sore.

13. A person who gets cold sores on the mouth is immune to genital herpes.

14. Genital herpes usually looks like blisters on the genitals.

15. Prodromal (early warning) sensations of genital herpes recurrences include tingling or itching in the area where

the genital herpes sores usually appear.

16. If a person has sexual intercourse with someone who has genital herpes, s/he will definitely get genital herpes too.

17. Several hundred people are expected to catch genital herpes from toilet seats this year.

18. A woman who has genital herpes will become sterile because of the herpes infection.

19. People who wear contact lenses and have oral (mouth) herpes should avoid putting the lenses in their mouths because the herpes infection could spread to their eyes.

20. A person with genital herpes is instructed to keep the sore area clean and dry.

21. Genital herpes leads to death.

22. There is a cure for genital herpes at present.

23. Genital herpes recurrences do not typically become less frequent over time.

24. A person who has genital herpes often has more psychological complications than physical complications.

25. When a person has an active outbreak of genital herpes, it is advisable not to have sexual intercourse.

26. People who have genital herpes can sometimes predict when they will have a recurrence.

27. A woman who has genital herpes should have a Pap smear at least once a year.

28. Genital herpes can be contagious even if the herpes sore has a scab on it.

29. First episodes of genital herpes infection are usually more severe than the recurrences.

30. A person who has genital herpes is immune to oral (mouth) herpes.

31. Between recurrences, the genital herpes virus lies dormant (inactive) near the spinal cord.

32. Stress can often trigger a genital herpes recurrence.

33. Herpes can be fatal to a newborn if s/he contracts the infection.

34. Genital herpes can often be detected by the use of a Pap smear.

35. After a person is exposed to genital herpes, s/he will often show symptoms in 2-20 days.

36. Anxiety can trigger a genital herpes recurrence.

37. Condoms offer 100% protection from catching genital herpes.

38. A genital herpes infection usually leads to syphilis.

39. A woman who had genital herpes must have a Caesarean section if she has a baby.

40. Most people have been exposed to oral herpes at one time or another.

41. A woman with genital herpes can deliver a baby through her vagina if she doesn't have an active herpes infection at the time of delivery.

42. If both parents have genital herpes, their children will be born with herpes.

43. A woman who has genital herpes can never have a baby.

44. Genital herpes is not contagious.

45. L-lysine is a cure for genital herpes.

46. Genital herpes may be associated with cancer of the cervix.

47. Contraceptive foam has been proven to kill genital herpes in humans.

48. In a primary (first) case of genital herpes, the person may feel like s/he has the flu.

49. Oral herpes is contagious.

50. The best way to treat genital herpes sores is to keep them moist.

51. Acyclovir (also called Zovirax or Valtrex), an anti-viral drug, can cure genital herpes.

52. A person with genital herpes is not contagious during the prodromal (early warning) stage.

53. Genital herpes is not prevalent (common) on college campuses.

54. Oral herpes cannot be transferred to the genitals during oral-genital sex.

The Genital Herpes Perceived Severity Scales (GHPSS; Mirotznik, 1991) measure attitudes about contracting this sexually transmitted disease. The scales were developed to test the speculations, frequently reported as facts in the media, that (a) single, sexually active, and consequently at-risk young adults had become highly anxious about infection with the herpes virus; and (b) as a result of this heightened concern, those at risk had dramatically altered their dating behaviors. Although several researchers had addressed these issues (Aral, Cates, & Jenkins, 1985; Simkins & Eberhage, 1984; Simkins & Kushner, 1986), they used measures that suffered from important limitations, including vague conceptualizations and operationalizations in terms of a single questionnaire item. Single-item measures tend to be less reliable and, as such, have the untoward effect of attenuating associations with other measures. Another limitation concerned the use of dichotomous response options. Dichotomous response options fail to capture the variability of reactions to geni

tal herpes. Finally, little evidence was presented regarding these measures' psychometric properties. (See Mirotznik, 1991, for a detailed discussion of these limitations.)

The primary theoretical orientation guiding the con ceptualization of the GHPSS was the Health Belief Model (HBM; Janz & Becker, 1984). In the HBM it is hypoth esized that people are likely to take steps to avoid a par ticular disease if they perceive that disease as personally threatening. A major component of perceived threat is the degree to which a disease is thought to be severe. Perceived severity, in turn, has been defined not just in terms of a disease's medical/clinical consequences but also its social and psychological effects. Accordingly, the GHPSS were constructed to measure the degree to which people believe that contracting genital herpes would lead to the latter type

of consequences.

Description

Three scales were developed de novo. Each scale was hypothesized to measure a particular social or psychologi cal consequence of infection. To enhance content and face validity, all items were constructed with the help of two clinicians, a sex therapist and a psychologist, both with expertise in treating people with genital herpes.

The Fear Scale measures whether subjects are frightened

about contracting this disease by determining the degree to

which they endorse seven items that characterize herpes

and those who contract it in highly negative, stigmatizing terms. Each item has a 6-point Likert-type response format ranging from (1) strongly disagree to (6) strongly agree. The Family Impediment Scale measures the degree to which respondents believe that contracting genital herpes would be a hinderance in establishing a family. It consists of one overall question asking respondents to rate how difficult it would be for a single person with genital herpes to experience each of five family life-course events. Each item has a 6-point Likert-type response format ranging from (1) not difficult at all to (6) very difficult. The Emotional Response Scale assesses possible emotional reactions to infection with genital herpes. The scale lists seven emotions. For each emotion, respondents indicate on a 4-point Likert-type format whether they would (1) not react with the emotion or (4) strongly experience the emotion. Response Mode and Timing For the items for each scale, respondents can circle on the questionnaire the number of the response option that best corresponds to their attitude, or they can mark the number on separate machine-scoreable answer sheets. The three scales take approximately 5 minutes to complete. Scoring Items within each scale and between scales are keyed in the same direction with higher scores indicating that respondents perceive herpes to be more severe. For each scale, a total score is calculated by first summing the response number for all answered items and then dividing by the number of answered items. The resulting mean score has the beneficial properties of having the same range as the individual items and also of adjusting for any missing items. Reliability To assess the psychometric properties of the GHPSS and the consistency of those properties across varied populations, the scales were initially administered to two convenience samples: 998 college and graduate students, and 178 residents of a therapeutic community for alcohol and drug rehabilitation (Mirotznik, 1991). Subsequently, the questionnaire was administered to an additional sample of 439 college students. Each sample was subdivided into those who were single, sexually active and thereby at risk of infection and those not at risk. For each of the resulting six

1 Address correspondence to Jerrold Mirotznik, Office of the Associate Provost, Brooklyn College, 2900 Bedford Avenue, Brooklyn, NY 11210; e-mail:

jmirotznik@brooklyn.cuny.edu

Genital Herpes Perceived Severity Scales

The Meharry Questionnaire: The Measurement of

Attitudes Toward AIDS-Related Issues

FREDERICK A. ERNST, 1 RUPERT A. FRANCIS, JOYCE PERKINS, Centre for Addiction

and Mental Health

Q UINTESSA BRITTON-WILLIAMS, AND AJAIPAL S. KANG, Meharry Medical College

1 Address correspondence to Frederick A. Ernst, Department of Psychology and Anthropology, University of Texas–Pan American, 1201 West University

Drive, Edinburg, TX 78541-2999; e-mail: fernst@utpa.edu

Exhibit

The Meharry Questionnaire: The Measurement of Attitudes Toward AIDS-Related

Issues

Please circle the number which reflects the amount of your agreement or disagreement with each statement.

1. AIDS will never be a threat to the rural areas of the U.S.A.

0 1 2 3 4 5 a

Strongly Disagree Strongly
Agree

2. AIDS is the result of God’s punishment (“Divine Retribution”).

3. Most of the AIDS patients in the 1990s will have to be treated by family doctors.

4. AIDS will help the society by decreasing the number of homosexuals (gay people).

5. I have made changes in my personal habits to prevent being infected by the AIDS virus.

6. Sterilized needles should be made available to needle-using drug abusers to prevent the spread of AIDS.

7. All pregnant women should be required to have their blood tested for the AIDS virus.

8. It is easier to catch the AIDS virus than the experts are leading us to believe.

9. The AIDS epidemic is a fulfillment of biblical prophecy.

10. AIDS will help the society by decreasing the number of drug abusers.

11. People with AIDS have gotten what they deserve.

12. In the 1990s, a large increase in health care manpower will be required because of AIDS.

13. Needle-using drug abusers who get AIDS are not worthy of extensive medical attention.

a This scale follows each of the statements.

1 Address correspondence to Patricia Barthalow Koch, Department of Biobehavioral Health, The Pennsylvania State University, 304B Health and Human

Development Building East, University Park, PA 16802; e-mail: p3k@psu.edu

HIV/AIDS Knowledge and Attitudes Scales for Teachers

PATRICIA BARTHALOW KOCH 1 AND MAUREEN D. SINGER, The Pennsylvania State University

HIV is increasing among children and adolescents in the

United States, with an estimate that at least one-half of all

new infections occur in people younger than 25 years of

age (Centers for Disease Control and Prevention, 2007). It

is predicted that, in the near future, all school professionals

will have contact with at least one student who is infected

or affected by the disease (Landau, Pryor, & Haefli, 1995).

Education about prevention and how best to live with HIV

infected family members, friends, and co-workers, as well

as how to deal with the disease if one is personally infected,

is the key to disarming the devastating health effects of this

disease and the stigma attached to it. Education at each

school level (elementary, intermediate, and high school)

has been recommended so that children can grow up know

ing how to protect themselves. Yet researchers have indi

cated that children and adolescents continue to have many

fears and questions about HIV/AIDS arising from a lack of education and from misunderstanding (Kistner et al., 1997; Steitz & Munn, 1993). Although the majority of states mandate HIV/AIDS education, and teachers indicate their support for it (Brucker & Hall, 1996), the implementation of HIV/AIDS education in the classroom is questionable (di Mauro, 1989–1990). Researchers have shown that teachers at various levels and from various backgrounds may lack basic factual knowledge of the cause, transmission, and prevalence of HIV/AIDS or lack sufficient comfort to teach about this topic (Boscarino & DiClemente, 1996; Dawson, Chunis, Smith, & Carboni, 2001). Thus, the HIV/AIDS Knowledge and Attitudes Scales for Teachers were developed to serve as measurement instruments in determining teachers' level of knowledge and attitudes toward HIV disease, in general, and specific educational issues. These scales can be and have been used with preservice education students, teachers in the field, and

related professionals including school counselors (Costin,

Page, Pietrzak, Kerr, & Symons, 2002; Singer, 1991). The

data can be useful in designing college programs and in-ser

vice workshops to prepare more effective AIDS educators.

Description

The HIV/AIDS Knowledge Scale for Teachers consists of two parts. The first part, General Knowledge, includes 14 true-false items regarding the HIV disease process (e.g., cause, symptoms, diagnosis, effects, treatment) and 4 true false items specific to classroom issues. The second part, Likelihood of Transmission, contains 17 possible modes of HIV transmission. Thus, the entire knowledge scale con tains 35 items. The HIV/AIDS Attitudes Scale for Teachers contains 25 items regarding HIV/AIDS, persons with HIV/AIDS, and educational issues. The respondent indicates her or his atti tudes using a 5-point Likert-type scale.

Response Mode and Timing

For the General Knowledge part of the HIV/AIDS Knowledge Scale for Teachers, respondents identify the statements as (1) True, (2) False, or (3) Not Sure. For the Likelihood of Transmission part of the knowledge scale, respondents are given 17 possible modes of HIV transmis sion and asked if transmission through each mode is (1) Very Likely, (2) Somewhat Likely, (3) Somewhat Unlikely, (4) Very Unlikely, (5) Definitely Not Possible, or (6) Don’t Know. The entire scale takes approximately 20 minutes to complete. For the HIV/AIDS Attitudes Scale for Teachers, respon dents indicate, using a Likert-type scale, if they (1) Strongly

Agree, (2) Agree, (3) are Uncertain, (4) Disagree, or (5)

Strongly Disagree with each of the 25 statements. This

scale takes approximately 10 to 15 minutes to complete.

Scoring

The highest possible score on the HIV/AIDS Knowledge

Scale for Teachers is 35. One point is given for every cor

rect answer on the General Knowledge part of the knowl

edge scale, with the highest possible score being 18. Correct

answers are as follows: Definitely True (1) for Items 3, 4,

6, 7, 9, 11, 14, 15, 17, and 18; Definitely False (2) for Items

1, 2, 5, 8, 10, 12, 13, and 16. All Unsure responses are con

sidered incorrect. The highest possible score for the Likelihood of

Transmission part of the knowledge scale is 17, with one

point given for each correct answer. The correct answers

are as follows: Very Likely (1) for Items 27, 30, and 32; Very

Likely or Somewhat Likely (1 or 2) for Items 20, 29, and 34;

Very Unlikely for Items 21, 23, 31, 33, and 35; Definitely

Not Possible for Items 19, 22, 24, 25, 26, and 28. Scores on the HIV/AIDS Attitudes Scale for Teachers

can range from 25 (most unsupportive attitudes) to 125 (most supportive attitudes). A mean score can be calculated, with a mean of 1.00 representing the most unsupportive attitudes and 5.00 indicating the most supportive attitudes toward dealing with HIV disease inside and outside of the classroom. The following items on the scale are reverse scored: 1, 5, 7, 9, 10, 13, 15, 17, 20, 21, 22, 25. Research using these instruments involving 128 elementary education students completing their student

teaching experiences indicated that they had very poor knowledge about HIV disease (M = 18.9), representing a 54% correct response level (Singer, 1991). These student teachers possessed uncertain to slightly positive attitudes toward dealing with HIV disease, with an average score of 87.6 (M = 3.46). The knowledge levels of preservice and in-service school counselors were very similar, with mean scores of 18.9 and 18.5, respectively. The preservice and in-service school counselors reported more positive attitudes, with scores of 97.39 and 97.64 (M = 3.89 and 3.90), respectively. Reliability Reliability for the knowledge and attitudes scales was established using two different methods (Singer, 1991). First, a test-retest of the instruments was conducted with 59 elementary education majors. Pearson product-moment correlations were established for the knowledge scale at .87 and for the attitudes scale at .89. Internal reliability for the knowledge scale, using Kuder-Richardson's statistic, was established using a sample of 128 elementary education student teachers. The reliability for the General Knowledge section was .78 and for the Likelihood of Transmission section was .88, yielding an overall reliability for the entire scale of .89. Cronbach's alpha coefficient was used to establish reliability for the attitude scale at .89. It is recommended that reliability be further tested with groups of education majors, student teachers, and teachers of differing content areas and levels of school (elementary, intermediate, and high school). Validity The HIV/AIDS Knowledge and Attitude Scales for Teachers were constructed adapting items and/or format from the National Health Interview Survey (Hardy, 1989), the Nurses' Attitudes About AIDS Scale (Preston, Young, Koch, & Forti, 1995), and an instrument previously used in a study of preservice elementary education teachers (Ballard, White, & Glascoff, 1990). A panel of three experts in the area of HIV/AIDS disease and education reviewed the items and answers for relevancy and accuracy when the instruments were developed and at 5-year intervals to ensure their continued accuracy and relevancy. A pilot test for content validity was conducted with 10 elementary education majors. It is recommended that construct validity be further tested with groups of education majors, student teachers, and teachers of differing content areas and levels of school.

Ballard, D., White, D., & Glascoff, M. (1990). HIV/AIDS education for

preservice elementary teachers. Journal of School Health, 60, 262-

269.

Boscarino, J. A., & DiClemente, R. J. (1996). AIDS knowledge, teaching

comfort, and support for AIDS education among school teachers: A

statewide study. AIDS Education and Prevention, 8, 267–277.

Brucker, B. W., & Hall, W. H. (1996). Teachers' attitudes toward HIV/

AIDS: An American national assessment. Early Child Development

and Care, 115, 85–98.

Centers for Disease Control and Prevention. (2007). Cases of HIV infec

tion and AIDS in the United States and dependent areas. HIV/AIDS

Surveillance Report, 19, 1–63.

Costin, A. C., Page, B. J., Pietrzak, D. R., Kerr, D. L., & Symons, C. W.

(2002). HIV/AIDS knowledge and beliefs among pre-service and

in-service school counselors. Professional School Counseling, 6(1),

79–86.

Dawson, L. J., Chunis, M. L., Smith, D. M., & Carboni, A. A. (2001).

The role of academic discipline and gender in high school teachers'

AIDS-related knowledge and attitudes. Journal of School Health,

71(1), 3–8.

di Mauro, D. (1989–1990, December/January). Sexuality education 1990: A review of state sexuality and AIDS

education curricula. SIECUS Report, 18(2), 1-9. Hardy, A. M. (1989). AIDS knowledge and attitudes for April-June 1989. Provisional data from the National Health Interview Survey. (Advance Data from Vital and Health Statistics, No. 179.) (DHHS Publication No. PHS 90-1250.) Hyattsville, MD: National Center for Health Statistics. Kistner, J., Eberstein, I. W., Guadagno, D., Sly, D., Sittig, L., Foster, K., et al. (1997). Children's AIDS-related knowledge and attitudes: Variations by grade, race, gender, socioeconomic status, and size of community. AIDS Education and Prevention, 9, 285-298. Landau, S., Pryor, J. B., & Haefli, K. (1995). Pediatric HIV: School-based sequelae and curricular interventions for prevention and social acceptance. School Psychology Review, 24, 213-229. Preston, D. B., Young, E. W., Koch, P. B., & Forti, E. M. (1995). The Nurses' Attitudes About AIDS Scale (NAAS): Development and psychometric analysis. AIDS Education and Prevention, 7, 443-454. Singer, M. D. (1991). Elementary student teachers' knowledge and attitudes of HIV/AIDS and HIV/AIDS education. Unpublished thesis, Pennsylvania State University, University Park, PA. Steitz, J. A., & Munn, J. A. (1993). Adolescents and AIDS: Knowledge and attitude. Adolescence, 28(111), 609-619.

Exhibit

HIV/AIDS Knowledge and Attitudes Scales for Teachers

HIV/AIDS Knowledge Scale for Teachers

Please indicate, to the best of your knowledge, if the following statements are true (1) or false (2) by circling a number from the scale

for your answer. If you are not sure of the correct answer, circle 3.

1 = True 2 = False 3 = Not Sure

1. AIDS is an infectious disease caused by a bacteria. a

2. AIDS breaks down the body's immunity by destroying the B cells in the endocrine system.

3. AIDS can damage the brain.

4. It may be more than 5 years before an HIV-infected person develops AIDS.

5. HIV lives and functions in warm, moist environments for

days outside of the body.

6. Early symptoms of HIV infection include fatigue, fever, weight loss, and swelling of the lymph nodes.

7. A person who has tested negatively on one HIV antibody blood test could still transmit HIV to a sexual partner.

8. The number of HIV-infected persons will be decreasing during the next two years.

9. Two common disorders found in persons with AIDS are pneumocystis carinii pneumonia and Kaposi's sarcoma.

10. Latex condoms are not as effective as "lambskin" or natural membrane condoms in preventing the spread of HIV.

11. Drugs can be used to slow down the rate of reproduction of HIV and lengthen the life of an infected person.

12. It is possible to detect HIV antibodies in the bloodstream immediately after becoming infected.

13. There is a vaccine available in Europe that can protect a person from getting AIDS.

14. There have been no cases of AIDS spread by students to their teachers or classmates through usual daily contact.

15. In recent years, adolescents are among the groups with the largest increase of HIV infection.

16. Less than one-half of the states have mandated that AIDS education be included in their schools' curricula.

17. There is a federal law that protects children with HIV or AIDS from educational discrimination.

18. There is no cure for AIDS at the present time.

To what degree do you think the following are likely to transmit HIV? Please use the numbers from the scale for your answers.

1 = Very Likely 2 = Somewhat Likely 3 = Somewhat Unlikely

4 = Very Unlikely 5 = Definitely Not Possible 6 = Don't Know

19. Working near someone with AIDS.

20. HIV-infected mother to baby during pregnancy/birth.

21. Kissing someone who has AIDS.

22. Eating in a restaurant where the cook has AIDS.

23. Receiving a blood transfusion.

24. Sharing plates, forks, or glasses with someone who has AIDS.

25. Living with a person who has AIDS (without sexual involvement).

26. Donating blood.

27. Sharing needles for drug use with someone who has AIDS.

How likely do you think the following situations are in transmitting HIV? Please use the numbers from the scale for your answers.

1 = Very Likely 2 = Somewhat Likely 3 = Somewhat Unlikely

4 = Very Unlikely 5 = Definitely Not Possible 6 = Don’t Know

28. Mosquito bites.

29. HIV-infected mother to baby through nursing.

30. Receiving anal intercourse from an HIV-infected person without using a condom.

31. Receiving anal intercourse from an HIV-infected person with using a condom.

32. Having sexual intercourse with an HIV-infected person without using a condom.

33. Having sexual intercourse with an HIV-infected person with using a condom.

34. Performing oral sex on an HIV-infected man without using a condom.

35. Performing oral sex on an HIV-infected woman using a dental dam.

HIV/AIDS Attitudes Scale for Teachers

The following statements reflect attitudes about HIV and AIDS. Circle the number that best describes your reactions to each state

ment.

1 = Strongly Agree 2 = Agree 3 = Uncertain 4 = Disagree
5 = Strongly Disagree

1. I believe I have enough information about HIV/AIDS to protect myself in my social life. a

2. I worry about possible casual contact with a person with AIDS.

3. Activities that spread HIV, such as some forms of sexual behavior, should be illegal.

4. I feel uncomfortable when coming in contact with gay men because of the risk that they may have AIDS.

5. I believe I have enough information about HIV/AIDS to protect myself in my future work setting.

6. Persons with AIDS are responsible for getting their illness.

7. Civil rights laws should be enacted/enforced to protect people with AIDS from job and housing discrimination.

8. Male homosexuality is obscene and vulgar.

9. HIV antibody blood test results should be confidential to avoid discrimination against people with positive results.

10. I feel that more time should be spent teaching future teachers about HIV/AIDS in their college courses.

11. I feel disgusted when I consider the state of sinfulness of male homosexuality.

12. I would quit my job before I would work with someone who has AIDS.

13. People should not blame the homosexual community for the spread of AIDS in the U.S.

14. AIDS is a punishment for immoral behavior.

15. I feel secure that I have reduced all risks of personally contracting HIV.

16. I think all children should be tested for HIV before entering school.

17. I believe it is the regular elementary classroom teacher's responsibility to teach AIDS education.

18. In my opinion, parents of all students in the class should be notified if there is a student with HIV or AIDS in the class.

19. I feel that all school personnel who have direct contact with a student with HIV or AIDS should be notified.

20. I think that students with HIV or AIDS should be allowed to fully participate in the day-to-day activities of the regular classroom.

21. I would support including AIDS education in the curriculum in a school where I was teaching.

22. A teacher with HIV or AIDS should be allowed to continue teaching.

23. It scares me to think that I may have a student with HIV or AIDS in my classroom.

24. I believe that teachers should have the right to refuse to have students with HIV or AIDS in their classroom.

25. I feel that I could comfortably answer students' questions about HIV/AIDS.

a The appropriate scale of numbers follows each item in the scale.

Assessment is essential to the evaluation of educational

and other interventions designed to increase knowledge

and encourage the adoption of safer beliefs about prevent

ing HIV/AIDS. We developed and evaluated measures for

adolescents, who were at particularly high risk, owing to

their sexual risk behaviors, for contracting HIV/AIDS and

other sexually transmitted diseases (Whaley, 1999).

Description

Two advisory councils, composed of experts in the area, evaluated a pool of items on the basis of content, accuracy, reading level, and clarity. After revising items, knowledge and beliefs measures were developed, which were revised again based on pilot testing with adolescents. These instruments were then administered to adoles cents involved in research programs with homeless and gay-identified adolescents in New York City (Koopman, Rotheram-Borus, Henderson, Bradley, & Hunter, 1990) and with incarcerated delinquents in Virginia (Canterbury, Clavet, McGarvey, & Koopman, 1998; Chang, Bendel, Koopman, McGarvey, & Canterbury, 2003; Otto-Salaj, Gore-Felton, McGarvey, & Canterbury, 2002). In the research with homeless and gay-identified adolescents, a consecutive series of 450 youths aged 11 to 19 years (M = 16.0, SD = 1.7) were recruited at four homeless shelters and one agency providing social and recreational services to gay identified youths in New York City. Participants included 153 homeless females, 158 homeless males, and 139 gay or bisexual males. Ethnicities were African American (49%), Hispanic/Latino (35%), White (10%), and other (6%). Incarcerated youths were recruited from a juvenile detention facility in Virginia. Youths ranged in age from 12

to 19 years old, with a mean of 15.8. A total of 893 partici

pants were assessed, including 754 male participants and

139 female participants. Participants' ethnic backgrounds

were 55% African American, 39% Caucasian, 3% Native

American, and 3% other.

Since their original development, these measures have

been adapted for other purposes. To ascertain that partici

pants had at least a minimal level of HIV/AIDS knowledge

(Patel, Gutnik, Yoskowitz, O'Sullivan, & Kaufman, 2006; Patel, Yoskowitz, & Kaufman, 2007), a modified, 12-item Knowledge scale was used as a screening instrument of heterosexual undergraduate college students (ages 18 to 24) in New York City. Items from the HIV/AIDS Knowledge and Beliefs measures have been included in research with adult Kenyan males and females (Volk & Koopman, 2001), Indian women (Ananth & Koopman, 2003), and adult women in Botswana (Greig & Koopman, 2003). Response Mode and Timing The HIV/AIDS Knowledge Scale uses true-false response options and also includes a separate Safer Alternatives subscale in which the respondent is asked to identify the safer action of two alternatives. The response format for the Beliefs About Preventing HIV/AIDS instrument is a 4point Likert-type scale for each item (1 = Agree Strongly to 4 = Disagree Strongly). It takes respondents about 20 minutes to complete the HIV/AIDS Knowledge Scale and 15 minutes to complete the Beliefs About Preventing HIV/ AIDS Scale. Scoring For the HIV/AIDS Knowledge Scale, item scores are recoded as correct = 1 or incorrect = 0 and then summed for the total score. In the computation of the Beliefs About Preventing HIV/AIDS scores, 19 items are first reverse scored, as shown in the scoring instructions. Higher Beliefs scores indicate stronger endorsement of beliefs about preventing HIV/AIDS. Reliability and Validity For both measures, the process used in their development contributed to the content validity of the measures (Koopman et al., 1990). Items were generated to ensure content validity across relevant domains. Homeless and Gay-Identifi ed Adolescents Of the original 49 HIV/AIDS Knowledge items, 45 loaded on three factors: Medical/Scientific Knowledge (23 items,

1 Address correspondence to Cheryl Koopman, Department of

Psychiatry and Behavioral Sciences, MC 5718, Stanford University, Stanford, CA 94305

5718; e-mail: koopman@stanford.edu

HIV/AIDS Knowledge and Beliefs Scales for Adolescents

CHERYL KOOPMAN, 1 Stanford University

HELEN REID, University of California, Los Angeles

ELIZABETH MCGARVEY, University of Virginia

A DELAIDA CRUZ CASTILLO, Stanford University

alpha = .71), Myths of HIV Transmission (9 items, alpha = .72), and Knowledge of High-Risk and Prevention Behaviors (13 items, alpha =. 68). For the full 45-item true-false scale, alpha = .85 and test-retest reliability at 1 week was strong (r = .82, p < .0001). For the seven Safer Alternative subscale items, alpha = .69 and test-retest reliability was r = 40, p < .01. Of the Beliefs items, 36 loaded on five factors that generated five corresponding subscales. Internal consistencies for these subscales were calculated: Peer Support for Safe Acts, alpha = .61; Expectation to Prevent Pregnancy, alpha = .72; Perceived Threat, alpha = .81; Self-Control, alpha = .82; and Self-Efficacy, alpha = .90. Test-retest reliability of the overall Beliefs measure was r = .49, p < .001. Correlations among the HIV/AIDS Knowledge subscales ranged from .26 to .61 (p < .0001); among the Beliefs subscales, correlations ranged from .37 to .74 (p < .0001

for all). However, the correlations between Knowledge and Beliefs subscales ranged from .00 to .19. Subscales were significantly correlated with age (r = .12 to r = .34), with the exception of Expectation to Prevent Pregnancy. Gay/bisexual males scored highest on every Knowledge subscale. Homeless females scored significantly lower than gay/bisexual males on the Expectation to Prevent Pregnancy subscale. No other significant differences between male homeless, female homeless, and gay/bisexual male youths were found.

Incarcerated Adolescents

In the research with incarcerated adolescents, for the overall Knowledge true-false scale, the alpha equaled .81. The Safer Alternatives subscale was not administered, so it could not be evaluated with this sample. The Beliefs measure demonstrated strong internal consistency for the overall scale when administered to incarcerated adolescents (alpha = .88). The subscales demonstrated marginal to good internal consistencies: Peer Support for Safe Acts (alpha = .56); Perceived Threat (alpha = .58); Expectation to Prevent Pregnancy (alpha = .60); Self-Control (alpha =

Exhibit

HIV/AIDS Knowledge Scale

Directions: Read each of the following statements and decide whether you think the statement is true or false. If you think the statement is

true, mark “T.” If you think the statement is false, mark “F.”

1. AIDS means Acquired Immune Deficiency Syndrome.

2. Most scientists today believe that AIDS is caused by a virus, called HIV (Human Immunodeficiency Virus).

3. Most people who develop AIDS eventually recover.

4. A baby born to a mother with HIV infection can get AIDS.

5. HIV is carried in the blood.

6. Most people who have HIV infection are sick with AIDS.

7. Prostitutes in New York City have a low chance of getting HIV (which can lead to AIDS).

8. HIV (which can lead to AIDS) is carried in men’s cum (semen).

9. The number of men and women infected with HIV will probably be less in the next several years than it is now.

10. AIDS weakens the body’s ability to fight off disease.

11. People have been known to get HIV and develop AIDS from toilet seats.

12. A negative HIV antibody test means that a person probably has AIDS.

13. You can’t get HIV (which can lead to AIDS) if you only have intercourse with one person for the rest of your life.

14. It is a good idea to ask someone about his/her past sexual activities before having sex with them, even though some partners may

lie to you.

15. If the HIV test comes out negative, it means that the person has AIDS.

16. People get other diseases because of AIDS.

17. You can die from AIDS.

18. Men have a higher chance of getting AIDS from having sex with a woman than from having sex with a man.

19. Using a condom will lessen the chance of getting AIDS.

20. People who have AIDS get pneumonia more often than the average person.

21. Women are more likely to get AIDS from having sex with a straight (heterosexual) man than with a bisexual man.

22. It is safe to have intercourse without a condom with a person who shoots drugs as long as you don't shoot drugs.

23. People have been known to get HIV and develop AIDS from a swimming pool used by someone with AIDS.

24. People of any race can get HIV and develop AIDS.

25. People have been known to get HIV and develop AIDS by tongue kissing a person who is infected.

26. Lambskin condoms are better than latex condoms for preventing HIV infection.

27. People usually become very sick with AIDS a few days after being infected with HIV.

28. Getting AIDS depends on whether or not you practice safe sex, not on the group you hang out with.

29. People have been known to get HIV and develop AIDS from insect bites.

30. It is safer not to have sexual intercourse at all than to have sexual intercourse using a condom.

31. You only need one HIV test to come out positive to be sure that you are infected.

32. Pregnant women are safe from getting HIV infection.

33. A vaccine has recently been developed that prevents people from getting HIV infection (which can lead to AIDS).

34. The virus that can lead to AIDS can be passed by an infected person even though that person isn't sick.

35. If you are really healthy, then exercising daily can prevent getting HIV (which can lead to AIDS).

36. If the person you are now having sex with has been tested and does not have HIV infection, it means that you are not infected.

37. People have been known to get HIV and develop AIDS by eating at a restaurant where a worker has AIDS.

38. When using condoms, it is better to use one with a spermicide like Nonoxynol-9.

39. You can get HIV and eventually AIDS through an open cut or wound.

40. You are safe from AIDS if you have oral sex (with mouth to penis or mouth to vagina) without a condom.

41. If you get a “false positive” result on your HIV antibody test, it means you are infected.

42. Anal (rear end) sex without a condom is one of the safer sexual practices.

43. You can get HIV and eventually AIDS by donating blood.

44. Using drugs like marijuana, alcohol, cocaine, and crack makes it more likely that you may have unsafe sex.

45. You can get HIV (which can lead to AIDS) by getting tested for it.

Safer Alternatives

Directions: For each pair of choices below, show which you think is safer by marking your choice (either A or B) on your answer sheet. If

you do not know, take a guess.

Which is safer?

1. A) Giving blood.

B) Getting a blood transfusion.

2. A) Working in the same office with someone who has AIDS or HIV.

B) Contact with HIV or the AIDS virus through an open cut or sore.

3. A) Heterosexual vaginal intercourse with a woman who has AIDS.

B) Anal intercourse with a man who has AIDS.

4. A) Using a needle just used by a person with HIV.

B) A man having unprotected vaginal intercourse with a woman who has AIDS.

5. A) Having sexual intercourse with a person who shoots drugs.

B) Spending time in the same house or room with a person who has AIDS.

6. A) Homosexual anal intercourse with someone who has AIDS.

B) Receiving a blood transfusion.

7. A) Unprotected sexual intercourse with a lesbian.

B) Unprotected sexual intercourse with a bisexual man.

Note. True/False answer key: 1-T, 2-T, 3-F, 4-T, 5-T, 6-F, 7-F, 8-T, 9-F, 10-T, 11-F, 12-F,13-F, 14-T, 15-F, 16-T, 17-T, 18-F, 19-T, 20-T, 21-F, 22-F, 23-F,

24-T, 25-F, 26-F, 27-F, 28-T, 29-F, 30-T, 31-F, 32-F, 33-F, 34-T, 35-F, 36-F, 37-F, 38-F, 39-T, 40-F, 41-F, 42-F, 43-F, 44-T, 45-F. Subscales: Medical/Scientific

Knowledge (1, 2, 3, 4, 5, 6, 8, 9, 10, 12, 15, 16, 17, 20, 26, 31, 33, 34, 35, 36, 38, 39, 41); Myths of HIV Transmission (11, 23, 25, 27, 29, 32, 37, 43, 45);

Knowledge of High Risk/Prevention Behaviors (7, 13, 14, 18, 19, 21, 22, 24, 28, 30, 40, 42, 44). Safer Alternatives answer key: 1-A, 2-A, 3-A, 4-B, 5-B,

6-B, 7-A.

Beliefs About Preventing HIV/AIDS

Directions: Read each statement carefully. Then show your agreement or disagreement with each statement by marking 1, 2, 3, or 4.

Mark:

1 if you agree strongly

2 if you agree somewhat

3 if you disagree somewhat

4 if you disagree strongly

1. I would feel uncomfortable buying condoms.

2. I would be too embarrassed to carry a condom around with me, even if I kept it hidden.

3. It doesn't bother me if others make fun of me because I believe in having safe sex.

4. If my partner won't use (or let me use) a condom, I won't have sex.

5. My friends have changed the way they have sex because of the AIDS epidemic.

6. I will have safe sex even if people make fun of me for it.

7. AIDS is a health scare that I take very seriously.

8. There is a good chance I will get AIDS during the next five years.

9. If I ask to use condoms, it might make my partner not want to have sex with me.

10. A person who gets AIDS has a good chance of being cured.

11. I plan on being very careful about who I have sex with.

12. My friends practice safe sex.

13. I have no control over my sexual urges.

14. My friends feel that it is too much trouble to use condoms.

15. I have a high chance of getting AIDS because of my past history.

16. My partner will know I really care about him/her if I ask to use condoms.

17. I don’t know how to use a condom.

18. AIDS is the scariest disease I know.

19. If I was going to have sex with someone and they made fun of me for wanting to have safe sex, I would probably give in.

20. There is still time for me to protect myself against AIDS.

21. Trying to have safe sex gets in the way of having fun.

22. I feel almost sure that I will get AIDS.

23. I know how to have safe sex.

24. Using condoms would be a sexual “turn-off” for me.

25. I am not doing anything now that is sexually unsafe.

26. In the future I will always be able to practice safe sex.

27. Before I decide to have intercourse, I will make sure we have a condom.

28. Once I get sexually excited, I lose all control over what happens.

29. Most of my friends think that practicing safe sex can lower the spread of AIDS.

30. If I ask to use a condom, it will look like I don’t trust my partner.

31. Carrying condoms with me every day is a habit I can keep.

32. I am too young to take care of a baby right now.

33. Not getting pregnant (or not getting a girl pregnant) is very important to me.

34. I will not bother with birth control when I have intercourse with a member of the opposite sex.

35. In the future, whenever I have sexual intercourse with a member of the opposite sex, I plan to make sure we are

using birth control.

36. If I wanted to have sex with a member of the opposite sex, and did not have protection, I would go ahead and have intercourse anyway.

Note. Reverse scored: 3, 4, 5, 6, 7, 11, 12, 16, 18, 20, 23, 25, 26, 27, 29, 31, 32, 33, 35. Subscales: Perceived Threat (7, 8, 10, 15, 18, 22); Self-Control (9,

13, 19, 21, 24, 28, 30, 36); Self-Efficacy (1, 2, 3, 4, 6, 11, 16, 17, 20, 23, 25, 26, 27, 31); Peer Support for Safe Acts (5, 12, 14, 29); Expectation to Prevent

Pregnancy (32, 33, 34, 35, 36).

The HIV/AIDS attitudes scale for Hispanics was adapted

from the attitudes survey used by the Centers for Disease

Control and Prevention (Dawson, 1990) and the Nurse's

Attitudes about AIDS Scale (Preston, Young, Koch, &

Forti, 1995).

Description

The scale includes 26 items to measure attitudes about HIV

and people who may be infected, sexual behaviors and safer

sexual practices, and discussion and learning about AIDS.

Response Mode and Timing

Participants respond according to how they feel about each

item using a 5-point Likert scale from Strongly Agree (1) to

Strongly Disagree (5).

Scoring

A mean score is calculated for the scale, with 1 representing

negative attitudes to 5 representing positive attitudes. The

following items are reverse scored: 1, 5, 8, 9, 10, 12, 13,

15,

16, 20, 21, 23, 25, and 26.

Reliability

Reliability analysis was conducted on the scale using a

1 Address correspondence to Raffy R. Luquis, School of Behavioral Sciences and Education, W331 Olmsted, Penn State Harrisburg, 777 West Harrisburg

Pike, Middletown PA 17057; e-mail: rluquis@psu.edu

Attitudes About HIV/AIDS for Hispanic College

Students

RAFFY R. LUQUIS, 1 Penn State Harrisburg

P ATRICIA BARTHALOW KOCH, The Pennsylvania State University

Exhibit

Attitudes About HIV/AIDS for Hispanic College Students

Attitudes About HIV/AIDS

The following statements reflect attitudes about HIV and AIDS. Circle the number that best describes your feeling about each

statement.

Scale: 1 = Strongly Agree, 2 = Agree, 3 = Uncertain, 4 = Disagree, 5 = Strongly Disagree

1. I believe I have enough information about HIV/AIDS to protect myself.

2. I believe women should not have sexual intercourse before marriage.

3. Activities that spread HIV/AIDS, such as some forms of sexual behaviors, should be illegal.

4. I feel uncomfortable when coming in contact with gay men because of the risk that they may have HIV/AIDS.

5. Civil rights laws should be enacted/enforced to protect

people with HIV/AIDS from job and housing discrimination.

6. Male homosexuality is obscene and vulgar.

7. I believe men should not have sexual intercourse before marriage.

8. HIV test results should be confidential to avoid discrimination against people with positive results.

9. I feel that more time should be spent teaching students about HIV/AIDS in my college courses.

10. People should not blame the homosexual community for the spread of HIV/AIDS in the U.S.

11. AIDS is a punishment for immoral behavior.

12. I feel secure that I have reduced all risk of personally contracting HIV.

13. It would not bother me to attend class with a person with HIV/AIDS.

14. Anyone who has had more than one sexual partner is promiscuous.

15. I could comfortably discuss HIV/AIDS with a friend.

16. I would not avoid a friend if she/he had HIV/AIDS.

17. If I discovered that my roommate had HIV/AIDS, I would move out.

18. I do not believe in using condoms.

19. I could not discuss HIV/AIDS with my parents.

20. I would date a person with HIV/AIDS.

21. I would feel comfortable discussing HIV/AIDS in a course.

22. I would not engage in sexual intercourse before marriage.

23. I would feel comfortable asking a new partner about his/her sexual history.

24. I would use HIV/AIDS as an excuse to avoid any sexual

relationships.

25. I would limit myself to one sexual partner.

26. I would use a condom every time I had sex.

Actitudes Acerca del VIH/SIDA

Las siguientes oraciones reflejan actitudes acerca del VIH/SIDA. Circule el numero qua mejor describe tu reacción a cada oración.

Escala: 1 = Muy de Acuerdo, 2 = De Acuerdo, 3 = Inseguro, 4 = En Desacuerdo, 5 = Muy en Desacuerdo

1. Creo tener suficiente información acerca del VIH/SIDA para protegerme.

2. Creo que las mujeres no deberían tener relaciones sexuales antes de casarse.

3. Actividades que trasmiten el VIH/SIDA, tal como algunos comportamientos sexuales, deberían ser ilegales.

4. Me siento incomodo cuando estoy en contacto con hombres homosexuales por miedo de que puedan tener VIH/SIDA.

5. Leyes de Derechos Civiles deben ser promulgadas e impuestas para proteger personas con HIV/SIDA de discriminación de trabajo y casa.

6. La homosexualidad masculina es vulgar y obscena.

7. Creo que los hombres no deberían tener relaciones sexuales antes de casarse.

8. Resultados de la prueba de sangre para el VIH deben ser confidenciales para prevenir discriminación en contra de personas con resultados positivos.

9. Siento que deberían dedicar más tiempo a la enseñanza sobre el VIH/SIDA en mis clases de universidad.

10. La comunidad homosexual no debe ser culpada por la transmisión del VIH/SIDA en los Estados Unidos.

11. El SIDA es un castigo por comportamiento inmoral.

12. Creo haber reducido todos los riesgos que me exponen al VIH/SIDA.

13. No me importaría ir a clases con una persona con VIH/SIDA.

14. Cualquier persona que haya tenido más de un compañero sexual es promiscuo.

15. Podría hablar abiertamente del VIH/SIDA con un amigo.

16. Yo no me alejaría de un amigo si él/ella tuviera VIH/SIDA.

17. Si yo descubriera que mi compañero de apartamento tuviera el VIH/SIDA, yo me mudaría a otro lugar.

18. Yo no estoy de acuerdo con en el uso de condones.

19. Yo no podría hablar el tema del VIH/SIDA con mis padres.

20. Yo saldría con una persona que tuviera VIH/SIDA.

21. Me sentiría cómodo hablando del tema del VIH/SIDA en clase.

22. Me abstendría de relaciones sexuales antes del matrimonio.

23. Me sentiría cómodo al preguntar a mi compañero acerca de su vida sexual pasada.

24. Usaría el VIH/SIDA como excusa para no tener relaciones sexuales.

25. Me limitaría a un solo compañero en mi relación sexual.

26. Siempre que tenga sexo usare un condón.

The Nurses' Attitudes About HIV/AIDS Scale (NAAS) is

a paper-and-pencil test designed to assess nurses' attitudes

about people living with HIV/AIDS (PLWHAs; homo

sexuals, intravenous drug users, and women), nursing care

concerns, and societal/professional concerns. It is a 1997

revision of the original NAAS (Preston, Young, Koch, &

Forti, 1995).

Suggested applications of the NAAS are: (a) as a descrip

tive tool to investigate HIV/AIDS-related attitudes in a

variety of nursing populations, (b) as a means of describing

models of nursing practice behavior related to PLWHAs,

(c) as a means of predicting practice outcomes related to

care of PLWHAs in varying nursing populations—specifi

cally the use of Standard Precautions, (d) as a needs assess

ment for educational programming related to HIV/AIDS,

and (e) as an evaluative tool to assess attitude change as

the result of educational programming. In addition, adap

tion of the NAAS for use with other health care providers,

that is, health educators, social workers, and physicians, is

recommended.

Description

The scale comprises 45 items pertaining to Homosexuality

(12 items), Women with HIV (4 items), IV Drug Abusers

(9 items), Nursing Care Concerns (8 items), and Social/

Professional Issues (12 items). The scale should be admin

istered in its entirety and not as a series of subscales.

We suggest that the items be randomly ordered to avoid

response bias. Response Mode and Timing Respondents indicate their degree of agreement/disagreement with the statements on a scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). The scale requires approximately 20 minutes to complete. Scoring For the Homosexuality items, reverse score Items 2, 7, 11, and 12. For the items on Women with HIV, reverse score Items 2 and 3. For the items pertaining to IV Drug Abusers, reverse score Items 3, 4,

5, and 7. For the Nursing Care Concerns, reverse score Items 1, 2, 6, 7, and 8. For the Social/Professional Issues, reverse score Items 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12. After adding all scores, possible scores range from 45 to 225, with higher scores indicating greater tolerance toward or favorable attitudes about HIV/AIDS. Reliability Cronbach's alpha for the Homosexuality items is .95, for the Women items, α = .64, for the IV Drug Abusers subscale, α = .75, for the Nursing Care Concerns, α = .80, and for the Social/Professional Issues, α = .82. Reference Preston, D. B., Young, E. W., Koch, P. B., & Forti, E. M. (1995). The Nurses' Attitudes About AIDS Scale (NAAS): Development and psychometric analysis. AIDS Education and Prevention, 7, 443–454.

1 Address correspondence to Deborah Bray Preston, Professor Emerita, The Pennsylvania State University, 3296 Shellers Bend, Unit 144, State College,

PA 16801; e-mail: dqp@psu.edu

Nurses' Attitudes About HIV/AIDS Scale—Version 2

DEBORAH BRAY PRESTON, 1 The Pennsylvania State University

ELAINE WILSON YOUNG, Massachusetts General Hospital Institute of Health Professions

PATRICIA BARTHALOW KOCH, The Pennsylvania State University

E STHER M. FORTI, Medical University of South Carolina

Exhibit

Nurses' Attitudes About HIV/AIDS Scale—Version 2

The following are some statements regarding opinions about HIV/AIDS and PWAs. There may be no "right" or "wrong" response.

Place the number from the scale that best represents your reaction in the space provided.

1 Strongly Agree 4 Disagree

2 Agree 5 Strongly Disagree

3 Neither Agree nor Disagree

Homosexuality:

1. Homosexual men should be given social equality. 1. _____

2. Male homosexuality is obscene and vulgar. 2. _____

3. The homosexual civil rights movement is positive for society. 3. _____

4. The love between two males is the same as heterosexual love. 4. _____

5. Homosexual men are a viable part of our society. 5. _____

6. I would be comfortable knowing that my clergy was a homosexual man. 6. _____

7. I feel disgusted when I consider the state of sinfulness of male homosexuality. 7. _____

8. I feel comfortable when I think that male homosexuality is a natural human occurrence. 8. _____

9. I feel confident that homosexual men are just as emotionally healthy as heterosexual men. 9. _____

10. I would feel comfortable if I learned that my son's teacher was a homosexual man. 10. _____

11. Male homosexuality should be considered immoral. 11. _____

12. I feel revolted when I think of two men engaged in private sexual behaviors with each other. 12. _____

Women:

1. Women with HIV ought to have equal access to health care services. 1. _____

2. I feel disgusted when I think of an HIV-infected woman. 2. _____

3. A woman with HIV deserves what she gets. 3. _____

4. I would feel comfortable giving nursing care to an HIV positive woman. 4. _____

IV Drug Abusers:

1. The government should provide free syringes to IV drug abusers. 1. _____

2. IV drug abusers are victims of society. 2. _____

3. I feel disgusted when I consider the immorality of IV drug abuse. 3. _____

4. IV drug abusers ought to be locked up. 4. _____

5. People who contract HIV through IV drug abuse should not be entitled to free medical care. 5. _____

6. People who shoot drugs cannot help themselves. 6. _____

7. I feel upset around IV drug abusers. 7. _____

8. IV drug abusers are mistreated in our society. 8. _____

9. I would feel comfortable giving nursing care to an IV drug abuser. 9. _____

Nursing Care Concerns:

1. I feel worried about the possibility of acquiring AIDS from patients. 1. _____

2. I am bothered that I might not be able to prevent myself from contracting AIDS. 2. _____

3. It is comforting to know that there isn't much difference in caring for AIDS patients than caring for other

terminally ill persons. 3. _____

4. I have enough information to protect myself against AIDS in my workplace. 4. _____

5. I worry about possible casual contact with a person with AIDS. 5. _____

6. I am fearful of caring for persons with AIDS because there is no cure. 6. _____

7. Nurses need to know the HIV antibody status of patients they are caring for. 7. _____

8. I am not bothered about possibly caring for an infant who was born HIV positive. 8. _____

Social/Professional Concerns:

1. Nurses who are HIV positive should be prevented from participating in direct patient care. 1. _____

2. Persons with AIDS are not dangerous to other people with whom they come in casual contact. 2. _____

3. I think the homosexual community has brought the problem of AIDS upon itself. 3. _____

4. I feel angry about possibly caring for a person with AIDS who contracted the disease through high-risk

sexual behaviors. 4. _____

5. There is too much money spent on AIDS research. 5. _____

6. Persons with AIDS should be quarantined. 6. _____

7. Pregnant nurses should be excused from caring for persons with AIDS. 7. _____

8. Civil rights laws should be enacted to protect people with AIDS from job and housing discrimination. 8. _____

9. Activities that spread AIDS, such as some forms of sexual behaviors, should be outlawed. 9. _____

10. It distresses me to think that so many nursing procedures have to be changed or modified as a result of AIDS. 10. _____

11. Nurses should be allowed to refuse to care for a person with AIDS. 11. _____

12. Public school officials should not be required to accept an AIDS child into classes. 12. _____

The purpose of the AIDS Attitude Scale (AAS) is to mea

sure attitudes about AIDS and people who have AIDS or

HIV infection. The scale can be used to discriminate people

who are more empathetic or tolerant toward people who have HIV infection from those who are less tolerant or empathetic. Subject areas on the AAS include fears related to contagion and casual contact, moral issues, and topics related to legal and social welfare issues.

Description

This scale is a 54-item Likert scale (5 points) with response options labeled Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree. The items on the scale were selected from an initial pool of 94 items written by undergraduate students in health education and nursing classes, or derived from literature review and interviews with experts knowledgeable about AIDS. They were reviewed for readability by five different undergraduate and graduate students and for acceptability for inclusion on the scale by a panel of four expert judges. The judges agreed on 67 of the original items for inclusion in the scale.

The scale was administered to 164 undergraduate students in health education courses, and an item analysis was conducted to identify the statements that could best discriminate high and low scorers. Fifty-four items had statistically significant item-total correlations ($p < .001$). These items were arranged in random order, and the scale was tested for reliability. This scale was designed to measure college

students' attitudes about AIDS, but could be used for other

populations.

Response Mode and Timing

Respondents circle or blacken one response option for each

item on a separate answer sheet. Most respondents com

plete the scale within 15 minutes.

Scoring

The 25 tolerant items (2, 3, 5, 6, 9, 12, 14, 15, 19, 21, 22,

23, 24, 26, 28, 31, 32, 34, 36, 38, 41, 46, 51, 52, and 53)

are scored such that Strongly Agree has a value of 5, Agree

a value of 4, and so forth. For the intolerant items (1, 4, 7,

8, 10, 11, 13, 16, 17, 18, 20, 25, 27, 29, 30, 33, 35, 37, 39,

40, 42, 43, 44, 45, 47, 48, 49, 50, 54), reverse scoring is

1 Jacque Shrum is deceased.

2 Address correspondence to Katherine Bruce, Department of Psychology, UNC Wilmington, Wilmington, NC 28403; e-mail: bruce@uncw.edu

AIDS Attitude Scale

JACQUE SHRUM, 1 NORMA TURNER, AND KATHERINE BRUCE, 2

University of North Carolina at Wilmington

Bruce, K., & Moineau, S. (1991). A comparison of sexually transmitted

disease clinic patients and undergraduates: Implications for AIDS pre

vention and education. Health Values, 15, 5–12.

Bruce, K., Pilgrim, C., and Spivey, R. (1994). Assessing the impact of

Magic Johnson's HIV positive announcement on a university campus.

Journal of Sex Education and Therapy, 20, 264-276.

Bruce, K., Shrum, J., Trefethen, C., & Slovik, L. (1990). Students' attitudes about AIDS, homosexuality, and condoms. AIDS Behavior and Prevention, 2, 220-234. Bruce, K. E., & Reid, B. C. (1998). Assessing the construct validity of the AIDS Attitude Scale. AIDS Education and Prevention, 10, 75-89. Bruce, K. E., & Walker, L. J. (2001). College students' attitudes about AIDS: 1986 to 2000. AIDS Education and Prevention, 13, 428-437. Shrum, J., Turner, N., & Bruce, K. (1989). Development of an instrument to measure attitudes towards AIDS. AIDS Education and Prevention, 1, 222-230.

Exhibit

AIDS Attitude Scale

For each of the following statements, please note whether you agree or disagree with the statement. There are no correct answers,

only your opinions. Use the following scale:

SA: Strongly Agree With the Statement

A: Agree With the Statement

N: Neither Agree nor Disagree With the Statement

D: Disagree With the Statement

SD: Strongly Disagree With the Statement

1. Limiting the spread of AIDS is more important than trying to protect the rights of people with AIDS.

2. Support groups for people with HIV (Human Immunodeficiency Virus) infection would be very helpful to them.

3. I would consider marrying someone with HIV infection.

4. I would quit my job before I would work with someone who

has AIDS.

5. People should not be afraid of catching HIV from casual contact, like hugging or shaking hands.

6. I would like to feel at ease around people with AIDS.

7. People who receive positive results from the HIV blood tests should not be allowed to get married.

8. I would prefer not to be around homosexuals for fear of catching AIDS.

9. Being around someone with AIDS would not put my health in danger.

10. Only disgusting people get HIV infection.

11. I think that people with HIV infection got what they deserved.

12. People with AIDS should not avoid being around other people.

13. People should avoid going to the dentist because they might catch HIV from dental instruments.

14. The thought of being around someone with AIDS does not bother me.

15. People with HIV infection should not be prohibited from working in public places.

16. I would not want to be in the same room with someone who I knew had AIDS.

17. The “gay plague” is an appropriate way to describe AIDS.

18. People who give HIV to others should face criminal charges.

19. People should not be afraid to donate blood because of AIDS.

20. A list of people who have HIV infection should be available to anyone.

21. I would date a person with AIDS.

22. People should not blame the homosexual community for

the spread of HIV infection in the United States.

23. No one deserves to have a disease like HIV infection.

24. It would not bother me to attend class with someone who has AIDS.

25. An employer should have the right to fire an employee with HIV infection regardless of the type of work s/he does.

26. I would allow my children to play with children of someone known to have AIDS.

27. People get AIDS by performing unnatural sex acts.

28. People with HIV should not be looked down upon by others.

29. I could tell by looking at someone if s/he had AIDS.

30. It is embarrassing to have so many people with HIV infection in our society.

31. Health care workers should not refuse to care for people with HIV infection regardless of their personal feelings about the dis

ease.

32. Children who have AIDS should not be prohibited from going to schools or day care centers.

33. Children who have AIDS probably have a homosexual parent.

34. HIV blood test results should be confidential to avoid discrimination against people with positive results.

AIDS Discussion Strategy Scale

WILLIAM E. SNELL, JR., 1 Southeast Missouri State University

1 Address all correspondence to William E. Snell, Jr., Department of Psychology, Southeast Missouri State University, One University Plaza, Cape

Girardeau, Missouri 6370l; e-mail: wesnell@semo.edu

In order to gain insight into the nature of how people discuss sexual topics, such as AIDS, with a potential sex partner, Snell and Finney (1990) developed the AIDS Discussion Strategy Scale (ADSS), an objective self-report instrument designed to measure the types of interpersonal discussion strategies that women and men use if they want to discuss AIDS with an intimate partner. The ADSS was found to have subscales involving the use of six specific types of discussion tactics: rational strategies, defined as straight forward, reasonable attempts to discuss AIDS in a forthright manner with an intimate partner; manipulative strategies, defined as deceptive and indirect efforts to persuade an intimate partner to engage in conversation about AIDS; withdrawal strategies, defined as attempts to actually avoid any extended interpersonal contact with an intimate partner until this individual agrees to a discussion about AIDS; charm strategies, defined as acting in pleasant and charming ways toward an intimate partner in order to promote a discussion about AIDS; subtlety strategies, defined as involving the use of hinting and subtle suggestions in order to elicit a conversation about AIDS; and persistence strategies, defined as persistent and continuous attempts to try to influence an intimate partner to discuss AIDS. Description The ADSS consists of 72 items. Subjects respond to the 72 items on

the ADSS using a 5-point Likert-type scale: -2 = definitely would not do this, -1 = might not do this, 0 = not sure whether I would do this, 1 = might do this, and 2 = would definitely do this. To determine whether the 72 items on the ADSS would form independent clusters of items, a principal components factor analysis with varimax rotation was conducted. Six factors with eigenvalues greater than 1 were extracted. Those items that loaded on unique factors (coefficients greater than .30) were used to construct six subscales for the ADSS. The number of items on the respective subscales were as follows: Rational (26 items), Manipulation (20 items), Withdrawal (4 items), Charm (5 items), Subtlety (3 items), and Persistence (4 items). Response Mode and Timing Respondents indicate their response on a computer scan sheet by darkening in a response from A to E for each item. The questionnaire usually requires about 45 minutes to complete.

35. HIV infection is a punishment for immoral behavior.

36. I would not be afraid to take care of a family member with AIDS.

37. If I discovered that my roommate had AIDS, I would move out.

38. I would contribute money to an HIV infection research project if I were making a charitable contribution.

39. The best way to get rid of HIV infection is to get rid of homosexuality.

40. Churches should take a strong stand against drug abuse and homosexuality to prevent the spread of AIDS.

41. Insurance companies should not be allowed to cancel insurance policies for AIDS-related reasons.

42. Money being spent on HIV infection research should be spent instead on diseases that affect innocent people.

43. A person who gives HIV to someone else should be legally liable for any medical expenses.

44. The spread of AIDS in the United States is proof that homosexual behavior should be illegal.

45. A list of people who have HIV infection should be kept by the government.

46. I could comfortably discuss AIDS with others.

47. People with AIDS are not worth getting to know.

48. I have no sympathy for homosexuals who get HIV infection.

49. Parents who transmit HIV to their children should be prosecuted as child abusers.

50. People with AIDS should be sent to sanitariums to protect others from AIDS.

51. People would not be so afraid of AIDS if they knew more about the disease.

52. Hospitals and nursing homes should not refuse to admit patients with HIV infection.

53. I would not avoid a friend if s/he had AIDS.

54. The spread of HIV in our society illustrates how immoral the United States has become.

Scoring

The labels and items for the ADSS subscales are Rational

(Items 2, 4, 8, 9, 11, 12, 14, 16, 17, 18, 21, 23, 25, 28, 29, 31,

32, 35, 37, 43, 49, 53, 55, 61, 65, 67); Manipulation (Items 5,

6, 13, 20, 22, 24, 27, 38, 40, 42, 44, 45, 48, 52, 54, 57, 58, 69,

70, 72); Withdrawal (Items 39, 51, 56, 63); Charm (Items 9,

36, 60, 64, 66); Subtlety (Items 3, 10, 50); and Persistence

(Items 7, 41, 46, 47). The ADSS items are coded so that A =

-2, B = -1, C = 0, D = +1, and E = +2 (no items are reverse

coded). Then, the items on each subscale are averaged so

that higher scores indicate a greater likelihood of using this

type of AIDS-related discussion strategy.

Reliability

Reliability analyses were conducted on each subscale using Cronbach's alpha measure of interitem consistency. In two investigations reported by Snell and Finney (1990), all six subscales were found to have more than adequate internal consistency: Rational (.96, .96), Manipulation (.93, .92), Withdrawal (.83, 85), Charm (.81, .82), Subtlety (.74, .66), and Persistence (.81, .80).

Validity

Gender comparisons on the ADSS (Snell & Finney, 1990) indicate that females reported they would be more likely than males to use rational approaches to discuss AIDS with an intimate partner; that females were less likely than males to report that they would use manipulative tactics to persuade an intimate partner to discuss the topic of AIDS; and that females reported that they would be less likely than males to use charm to persuade an intimate partner to talk about AIDS. Although no other gender effects were found, it is informative to note that both males and females reported that they would use subtlety in trying to discuss AIDS with an intimate partner. By contrast, both males and females indicated that they would be less likely to use withdrawal tactics to elicit a discussion on AIDS with a close partner. Correlations between the ADSS and the Stereotypes About AIDS Scale (Snell & Finney, 1990) indicated that people's use of AIDS-related discussion strategies were associated with their privately held

stereotypes about AIDS. Also, people's willingness to use a variety of strategies to discuss the topics of AIDS with an intimate partner was associated with their own personal sexual dispositions, sexual attitudes, and sexual behaviors. Moreover, the pattern of findings indicated both some similar as well as some unique gender-related findings. For both males and females, the use of manipulative AIDS-related discussion strategies was directly related to their sexual traits (i.e., sexual depression and sexual preoccupation), their sexual attitudes (i.e., manipulative and casual sexual attitudes), and their sexual behaviors (i.e., an exchange orientation to sexual relations). Other gender similarities showed that both men and women who held sexually manipulative attitudes endorsed the use of charm as a tactic for discussing AIDS with a potential sexual partner; and both men and women whose orientation toward their sexual relations was based on mutual caring and concern reported that they would use persistence as a strategy for discussing AIDS with a potential sex partner. Although there was considerable similarity in the way that men's and women's sexual dispositions, attitudes, and behaviors impacted their use of AIDS-related discussion strategies, other findings were more gender specific. For example, women with greater sexual esteem were more likely to report that they would use rational strategies and were less likely to use manipulation and charm as avenues for discussing AIDS. Among males, by contrast, sexual esteem was associated with less willingness to use charm to elicit a conversation about AIDS with a partner. Reference Snell, W. E., Jr., & Finney, P. D. (1990). Interpersonal strategies associated with the discussion of AIDS. Annals of Sex Research, 3, 425–451.

Exhibit

The AIDS Discussion Strategy Scale

Instructions: Suppose you wanted to talk to a potential or current sexual partner about AIDS. The following statements concern the

types of things you might do if you wanted to discuss the topic of AIDS (Acquired Immune Deficiency Syndrome) with a sexual partner

(either a current sexual partner or a future sexual partner). More specifically, we are interested in whether you would use each of the

behaviors listed below. To provide your responses, use the following scale: A = Definitely would not do this. B = Might not do this. C = Not sure whether I would do this. D = Might do this. E = Would definitely do this.

Remember: Be sure to respond to each and every statement; leave no blanks.

1. My partner and I would compromise about the aspects of the topic of AIDS we'd discuss.

2. I would try to reason with my partner to influence him/her to discuss AIDS.

3. I would drop hints about wanting to discuss the topic of AIDS.

4. I would simply tell my partner that I wanted to discuss AIDS with him/her.

5. I would put on a sweet face to induce my partner to discuss AIDS-related issues.

6. I would try to get my partner to discuss AIDS by doing some fast talking.

7. I would continually attempt to discuss the issue of AIDS.

8. I would try to discuss AIDS with my partner.

9. I would explain the reason that it's important for us to discuss AIDS.

10. I would subtly bring up the topic of AIDS.

11. I would state in a matter-of-fact way that I wanted to talk about AIDS.

12. I would try to look sincere to make the person more willing to talk about AIDS.

13. I would persuade my partner to discuss AIDS by telling some small white lies.

14. I would try to discuss the topic of AIDS, despite any obstacles from my partner.

15. I would try to negotiate what AIDS-related topics we'd be willing to discuss.

16. I would argue in a logical way that it’s important for us to discuss AIDS.

17. I would make suggestions that we discuss AIDS.

18. I would simply ask to discuss AIDS with my partner.

19. I would try to put my partner in a good mood before trying to talk about AIDS.

20. I would use deception to get my partner to talk about AIDS.

21. I would talk with my partner about AIDS even if s/he didn’t want to.

22. I would tell my sexual partner that I’d do something special if s/he’d discuss AIDS with me.

23. I would explain the reason why I want to discuss AIDS.

24. I would try to make my partner think that s/he wanted to talk about AIDS.

25. I would tell my partner it’s in his/her best interest to discuss the issue of AIDS.

26. I would get mad if my partner didn’t want to discuss the topic of AIDS.

27. I would make my partner believe that s/he would be doing me a favor by discussing AIDS.

28. I would try to persuade my partner to discuss AIDS related issues.

29. I would try to discuss the topic by convincing my partner that it’s really important.

30. I would make my partner realize that I have a legitimate right to demand we talk about AIDS.

31. I would try to make my partner feel like discussing topics related to AIDS.

32. I would demand to discuss aspects of our relationship that deal with AIDS.

33. I would try to make my partner feel bad or guilty if s/he didn’t discuss AIDS with me.

34. I would moralize about the topic of AIDS.

35. I would talk my partner into discussing issues dealing with AIDS.

36. I would give my partner a big hug to put her/him in a good mood to discuss AIDS.

37. I would tell my partner that it's important for us to discuss AIDS.

38. I would con my partner into discussing things about AIDS.

39. I would tell my partner that we couldn't have sex until we discussed AIDS.

40. I would try to manipulate my partner into a discussion on AIDS.

41. I would keep bugging my partner to discuss the topic of AIDS.

42. I would use flattery to persuade my partner to discuss AIDS.

43. I would tell my partner I want to talk about AIDS.

44. I would pout or threaten to cry if I didn't get my way in discussing AIDS.

45. I would promise sexual rewards if we first discussed AIDS.

46. I would repeatedly remind my partner that I want to discuss AIDS.

47. I would keep trying to discuss AIDS issues with my partner.

48. I would become especially affectionate so my partner would agree to discuss AIDS issues.

49. I would insist that my partner and I discuss AIDS.

50. I would drop subtle hints that I want to talk about AIDS.

51. I would refrain from sexual contact until we discussed

AIDS.

52. I would try to use coercion or blackmail to make my partner discuss AIDS.

53. I would try my hardest to make my partner discuss AIDS.

54. I would blow up in anger if s/he would not discuss the issue of AIDS.

55. I would state my need to discuss AIDS with my partner.

56. I would withhold affection and act cold until s/he discusses the topic of AIDS with me.

57. I would tell my partner that unless we discussed AIDS, I would never talk with him/her again.

58. I would get angry and demand that s/he talk about AIDS with me.

59. I would give up if my partner refused to discuss any AIDS-related issues.

60. I would appeal to my partner's love/affection for me as a basis for our discussing AIDS.

61. I would ask my partner if s/he wanted to discuss AIDS.

62. I would argue until my partner agreed to discuss the topic of AIDS with me.

63. I would refuse to interact further with my partner unless we first discussed AIDS.

64. I would act nice so that my partner could not refuse to discuss AIDS with me.

65. I would convince my partner that we need to discuss AIDS.

66. I would be especially sweet, charming, and pleasant before bringing up the subject of AIDS.

67. I would tell my partner we are close enough to discuss AIDS.

68. I would loudly voice my desire to discuss the topic of AIDS.

69. I would pretend to be an expert about AIDS.

70. I would plead or beg my partner to talk about the disease AIDS.

71. I would get someone else to help persuade my partner to discuss AIDS.

72. I would tell my partner I have a lot of knowledge about the topic of AIDS.

Multidimensional AIDS Anxiety Questionnaire

WILLIAM E. SNELL, JR. 1 AND PHILLIP D. FINNEY, Southeast Missouri State University

1 Address correspondence to William E. Snell, Jr., Department of Psychology, Southeast Missouri State University, One University Plaza, Cape Gi

rardeau, MO 63701; e-mail: wesnwll@semo.edu

Although considerable medical attention has been recently focused on AIDS, relatively little is known about the amount and nature of anxiety that this disease may be fostering in segments of society. To better understand the public's reaction to AIDS, a multidimensional self-report measure of anxiety experienced about AIDS was devel oped, the Multidimensional AIDS Anxiety Questionnaire (MAAQ; Finney & Snell, 1989; Snell & Finney, 1996). Factor analysis indicated that the MAAQ items correspond to five concepts concerned with AIDS anxiety: (a) AIDS related anxiety manifested as physiological arousal, (b) AIDS-related anxiety manifested as fear, (c) AIDS-related anxiety manifested as cognitive worry, (d) AIDS-related anxiety manifested as sexual inhibition, and (e) AIDS-anx

iety manifested as discussion inhibition.

Description

The MAAQ consists of 50 items. In responding to the

MAAQ, individuals are asked to indicate how character

istic each statement is of them. A 5-point Likert-type scale

is used to collect data on the subjects' responses, with each

item being scored from 0 to 4: not at all characteristic of me

(A), slightly characteristic of me (B), somewhat character

istic of me (C), moderately characteristic of me (D), and

very characteristic of me (E). In order to create subscale

scores, the items on each subscale are averaged. Higher scores thus correspond to greater amounts of each respective type of AIDS-related anxiety. Response Mode and Timing Individuals are asked to record their responses to the MAAQ on a computer scan sheet by darkening in a response from A to E for each MAAQ item. Alternatively, one could prepare the MAAQ so that respondents write directly on the instrument itself. The questionnaire usually takes between 20 and 25 minutes to complete. Scoring The MAAQ consists of five subscales designed to measure several aspects of anxiety about AIDS. (The items on the sixth subscale are indicated here also, although the eigenvalue from the factor analysis for this subscale was less than 1. Although this sixth subscale appears to be psychometrically weak, we anticipate that it will gain more prominence in future research.) The labels for these subscales are (with a listing of the items on each subscale) Physiological Arousal (Items 13, 14, 23, 27, 28, 29, 31, 33, 34, 38, 39, 43, 44, 46, 47, 48); Fear of AIDS (Items 5, 6, 10, 15, 16, and 21); Sexual Inhibition (Items 18, 30, 35, 37, 40, 42); Cognitive Worry (Items 1, 3, 4, 8, and 9); Discussion Inhibition (Items 2, 7, 12, 19, and 24); and Anxiety About AIDS Exposure

(Items 20, 49, 50). The MAAQ items are scored so that A =

0, B = 1, C = 2, D = 3, and E = 4. Next, they are averaged for

each subscale so that higher scores correspond to greater amounts of anxiety about AIDS (score range for each sub scale = 0 to 4).

Reliability

Internal consistency coefficients for the MAAQ were reported by Finney and Snell (1989). All five scales had high internal consistency, with Cronbach alphas ranging from a low of .85 to a high of .94. Test-retest reliability coefficients for the Physiological Arousal (.65), Fear of AIDS (.78), and Sexual Inhibition (.63) subscales of the MAAQ were quite high; the coefficients for the Cognitive Worry (.40) and Discussion Inhibition (.40) subscales were somewhat lower.

Validity

To determine whether the 50 MAAQ items would cluster into unique groups, a principal components factor analy sis with varimax rotation was conducted. There were five factors with eigenvalues greater than 1. Factor 1 had an eigenvalue of 17.00 (accounting for 34% of the variance) and consisted of 16 items concerned with signs of general physiological arousal about AIDS. Factor 2 had an eigen value of 4.43 (accounting for 8.9% of the variance) and consisted of six items reflecting a stronger fear of AIDS. Factor 3 consisted of six statements concerned specifically with sexual inhibition resulting from AIDS (eigenvalue

= 2.24; 4.5% percent of the variance). The five items that

characterized Factor 4 concerned cognitive worry about

AIDS (eigenvalue = 1.23; 2.5% of the variance). Factor 5

consisted of five items concerned with discussion inhibi

tion about AIDS (eigenvalue = 1.16; 2.3% of the variance).

As anticipated, physiological (the arousal and fear factors),

Exhibit

The Multidimensional AIDS Anxiety Questionnaire

Instructions: The items listed below refer to feelings and reactions that people may experience about the disease AIDS (Acquired Immune

Deficiency Syndrome). As such, there are no right or wrong answers, only the individual reactions that people have. We are interested

in how typical these feelings and behaviors are of you. To provide your responses, use the following scale to indicate how characteristic

the following statements are for you. A = Not at all characteristic of me. B = Slightly characteristic of me. C = Somewhat characteristic of me. D = Moderately characteristic of me. E = Very characteristic of me.

Note: Remember to respond to all items, even if you are not completely sure. Also, please be honest in responding to these state

ments.

1. Thinking about AIDS makes me feel anxious.

2. I sometimes find it hard to discuss issues dealing with AIDS.

3. I feel tense when I think about the threat of AIDS.

4. I feel quite anxious about the epidemic of AIDS.

5. I feel scared about AIDS when I think about sexual relationships.

6. I’m afraid of getting AIDS.

7. I have trouble talking about AIDS with an intimate partner.

8. I feel flustered when I realize the threat of AIDS.

9. The disease AIDS makes me feel nervous and anxious.

10. I feel scared when I think about catching AIDS from a sexual partner.

11. I’m not worried about getting AIDS.

12. I would feel shy discussing AIDS with an intimate partner.

13. My heart beats fast with anxiety when I think about AIDS.

14. I feel anxious when I talk about AIDS with people.

15. Because of AIDS, I feel nervous about initiating sexual relations.

16. All these discussions of AIDS leaves me feeling a bit alarmed.

17. I would not find it hard to discuss AIDS with an intimate partner.

18. AIDS makes me feel jittery about having sex with someone.

19. I feel uncomfortable when discussing AIDS.

20. I sometimes worry that one of my past sexual partners may have had AIDS.

21. Thinking about catching AIDS leaves me feeling concerned.

22. I would not hesitate to ask a former sex partner about AIDS-related concerns.

23. The issue of AIDS is a very stressful experience for me.

24. I feel nervous when I discuss AIDS with another person.

25. The threat of getting AIDS makes me feel uneasy about sex.

26. I worry about what I should do about AIDS.

27. Anxiety about AIDS is beginning to affect my personal relationships.

28. In general, the media attention on AIDS makes me feel restless.

29. I have feelings of worry when I think about AIDS.

30. Were I to have sexual relations, I would worry about getting AIDS.

31. All this recent media attention about AIDS leaves me feeling on edge.

32. AIDS does not influence my willingness to engage in sexual relationships.

33. When I think about AIDS, I feel tense.

34. I am more anxious than most people are about the disease AIDS.

35. If I were to have sex with someone, I would worry about AIDS.

36. I'm pretty indifferent to the idea of catching AIDS.

37. I would hesitate to involve myself in a sexual relationship because of AIDS.

38. When talking about AIDS with someone, I feel jumpy and high-strung.

39. I become really frightened when I think about the threat of AIDS.

40. The fear of AIDS makes me feel nervous about engaging in sex.

41. The increased chances of being infected with AIDS leaves me feeling troubled.

42. Because of AIDS, I feel too nervous to start a new

sexual relationship.

43. The spread of AIDS is causing me to feel quite a bit of stress.

44. I worry that AIDS may directly influence my life.

45. I had a better attitude towards sex before the AIDS epidemic.

46. I get pretty upset when I think about the possibility of catching AIDS.

47. The discussion of AIDS makes me feel uncomfortable.

48. All this talk about AIDS has left me feeling strained and tense.

49. I'm concerned that I might be carrying the AIDS virus.

50. I feel nervous when I think that a past sexual partner could have given me AIDS

Stereotypes About AIDS Scale

WILLIAM E. SNELL, JR., 1 PHILLIP D. FINNEY, AND LISA J. GODWIN, Southeast Missouri

State University

The spread of AIDS (i.e., Acquired Immune Deficiency

Syndrome) poses such a severe threat to society that a

variety of stereotypes have proliferated about this disease.

Snell, Finney, and Godwin (1991) conducted an investi

gation to examine several stereotypes about AIDS. More

specifically, they developed and provided preliminary vali

dation of the psychometric properties of the Stereotypes

About AIDS Scale (SAAS), a multidimensional measure

of stereotypes about AIDS. The selection of the particular

stereotypes about AIDS measured by the SAAS was based

on a literature review about AIDS stereotypes. Four categories of AIDS-related stereotypes (with multiple subscales in each category) are measured by the SAAS: (a) global stereotypic beliefs about AIDS, (b) personal attitudes about AIDS, (c) medical issues about AIDS, and (d) sexual issues about AIDS. The items in Section A of the SAAS (Global Stereotypes about AIDS) form four separate subscales concerned with stereotypes about the need for AIDS-related education, AIDS-related confidentiality, the transmission of AIDS, and AIDS is caused by homosexuality. The items in Section B of the SAAS (Personal Attitudes About AIDS) form five separate subscales concerned with stereotypes about the desire to avoid those afflicted with AIDS, AIDS is not perceived as self-relevant, a closed-minded approach to AIDS, the issue of AIDS is being exaggerated, and the notion that AIDS is a moral punishment. The items in Section C of the SAAS (Medical Issues about AIDS) form four separate subscales concerned with stereotypes about the belief that AIDS is a threat to medical staff, protecting the U.S. blood supply system from AIDS, a cure for AIDS, and AIDS testing should be conducted. The items in Section D of the SAAS (Sexual Issues about AIDS) form two separate subscales concerned with stereotypes about the relationship between AIDS and sexual activity and the prevention of AIDS through the use of condoms.

Description

The SAAS consists of four sections. Section A has 30 items,

Section B has 35 items, Section C has 30 items, and Section

D has 20 items. In responding to the SAAS, individuals

are asked to indicate how much they agree versus disagree

with each statement, using a 5-point Likert format: agree

(+2), slightly agree (+1), neither agree nor disagree (0),

slightly disagree (-1), and disagree (-2). In order to create

subscale scores, the items on each subscale are averaged.

Higher positive (negative) scores correspond to greater agreement (disagreement) with the stereotypes measured by the SAAS. Response Mode and Timing People respond to the SAAS by using a computer scan sheet to darken a response (either A, B, C, D, or E) for each item. The entire questionnaire (i.e., all four sections) usually takes about 35-45 minutes to complete. Scoring The SAAS consists of 15 separate subscales. Several SAAS items are reversed-scored (A8, A20, A21, C2, C12, and D4) before the subscales are computed. The four subscales for Section A are the need for AIDS-related education (A4, A6, A12, A18, A20, A22, A24, A28, A30), AIDS-related confidentiality (A2, A3, A8, A9, A14, A21, A26, A27), the transmission of AIDS (A5, A11, A15, A17, A23, A29), and AIDS is caused by homosexuality (A1, A7, A13, A19, A25). The five subscales for Section B are the desire to avoid those afflicted with AIDS (B1, B22, B23, B24, B34, B35), AIDS was not perceived as self-relevant (B5, B6, B7, B8), a closed-minded approach to AIDS (B13, B16, B17), the issue of AIDS is being exaggerated (B3, B10, B25, B29), and the notion that AIDS is a moral punishment (B9, B32, B33). The four subscales for Section C are the belief that AIDS is a threat to medical staff (C3, C4, C6, C11, C12, C18), protecting the U.S. blood supply system from AIDS (C2, C5, C7, C17, C25, C27), cure for AIDS (C9, C10, C23), and AIDS testing should be conducted (C13, C14). The two subscales for Section D are the relationship between AIDS and sexual activity (D1, D2, D4 to D12, D13) and the prevention of AIDS through the use of condoms (D3, D10, D17, D18, D19). Reliability Snell, Finney, and Godwin (1991) found that for Section A (Stereotypic Beliefs About AIDS) of the SAAS,

the reliabilities ranged from a low of .75 to a high of .85; for Section B (Personal Attitudes About AIDS) of the SAAS, the reliabilities ranged from a low of .72 to a high of .87; for Section C (Medical Issues Related to AIDS) of the SAAS, the reliabilities ranged from a low of .64 to a high of .83; and for Section D (Sexuality and AIDS) of the SAAS, the Cronbach alphas were .86 and .78, respectively.

1 Address correspondence to William E. Snell, Jr., Department of Psychology, Southeast Missouri State University, One University Plaza, Cape Gi

rardeau, MO 63701; e-mail: wesnwll@semo.edu

Validity

Snell et al. (1991) reported that those individuals who endorsed a wide range of "negative," inaccurate stereo types about AIDS, as measured by their responses to SAAS, reported greater AIDS-related anxiety. In particular, people who believed that AIDS was not relevant to them, who were closed-minded about AIDS, and who believed that the media was exaggerating the issue of AIDS indi cated that they felt sufficient AIDS anxiety to inhibit their sexual activity. Additionally, it was found that those who believed in the importance of AIDS education reported that they would be more likely to use direct, rational strategies to start a conversation about AIDS with a potential sexual partner. One other set of findings reported by Snell et al. dealt with the issue of men's and women's stereotypic reac tions to AIDS. It was found that both males and females were supportive of greater educational efforts about AIDS, although, interestingly enough, they also were somewhat

supportive of widespread mandatory testing for AIDS. In addition, other evidence indicated a consistent pattern of gender differences in men's and women's stereotypic beliefs about AIDS, with the findings generally suggesting that women expressed more positive and less prejudicial AIDS-related attitudes than did males. Snell et al. also found that females' endorsement of several socially undesirable stereotypes about women was predictive of their agreement (and disagreement) with a number of prejudicial (and nonprejudicial) stereotypes about AIDS and AIDSafflicted individuals, as measured by the SAAS. Females who held a set of disparaging beliefs about women (e.g., that women are more passive, vulnerable, and moral than men; that women are sexually passive and sexual teases) reported adhering to a variety of stigmatizing beliefs and attitudes about AIDS, as measured by the SAAS. Reference Snell, W. E., Jr., Finney, P. D., & Godwin, L. J. (1991). Stereotypes about AIDS. Contemporary Social Psychology, 15, 18-38.

Exhibit

The Stereotypes about AIDS Scale

AIDS - Section A

Instructions: The items listed below refer to people's beliefs about the topic of AIDS (Acquired Immune Deficiency Syndrome). We

are interested in whether you agree or disagree with these statements. As such, there are no right or wrong answers, only your own

individual opinions. To indicate your reactions to these statements, use the following scale: A = Agree B = Slightly agree C = Neither agree nor disagree D = Slightly disagree E = Disagree

Remember: There are no right or wrong responses; only your opinions. Be sure to respond to each and every statement; leave no

blanks.

1. Homosexuality is the cause of AIDS.

2. People with AIDS don't really have a right to confidentiality about their disease.

3. People ought to notify their employees if they contract AIDS.

4. Not enough money is being spent on AIDS-related research.

5. AIDS can be transmitted by being in the same room with an AIDS patient.

6. People need education to learn how to avoid getting the virus AIDS.

7. If it weren't for homosexuals, we wouldn't have the disease AIDS.

8. AIDS victims have a right to privacy about their lives and lifestyles.

9. Businesses should have the right to fire people if they have AIDS.

10. The cost of medical care for AIDS patients should be paid by the government.

11. AIDS can be transmitted by shaking hands with an AIDS patient.

12. AIDS education is an appropriate task for schools to perform.

13. The sexual promiscuity of homosexuals is the reason why AIDS exists.

14. The government should be able to test anyone for AIDS.

15. A person can get AIDS from fellow workers at a job.

16. The government is not doing enough to fight AIDS.

17. AIDS can be transmitted by sharing eating utensils with an AIDS patient.

18. Sexual education about AIDS is necessary at school.

19. AIDS is really a punishment sent from God for the sinful acts of homosexuality.

20. AIDS infected children should be kept out of public school.

21. Having a co-worker with AIDS would not bother me.

22. AIDS is a serious national problem that deserves government attention.

23. AIDS can be transmitted by kissing an individual with AIDS.

24. It is important that students learn about AIDS in their classes.

25. AIDS is God's way of getting rid of homosexuals.

26. Identifying those people with AIDS should be a high priority.

27. Employees have a right to know if any of their co-workers have AIDS.

28. The Federal government ought to fund education on AIDS.

29. People can catch AIDS by giving CPR to an individual with AIDS.

30. Children need instruction about AIDS in their school curriculum.

AIDS - Section B

Instructions: The items listed below refer to people's beliefs about the topic of AIDS (Acquired Immune Deficiency Syndrome). We

are interested in whether you agree or disagree with these statements. As such, there are no right or wrong answers, only your own

individual opinions. To indicate your reactions to these statements, use the following scale: A = Agree B = Slightly agree C = Neither agree nor disagree D = Slightly disagree E = Disagree

Remember: There are no right or wrong responses; only your opinions. Be sure to respond to each and every statement; leave no

blanks.

1. I don't want to talk or interact with anyone with AIDS.

2. We have a social obligation to help those with AIDS.

3. People who describe AIDS as an epidemic are exaggerating its true nature.

4. As always, science will eventually find a cure for AIDS.

5. AIDS is really not my problem; it's somebody else's.

6. AIDS is not my problem.

7. AIDS is not a threat to me.

8. The AIDS crisis is really removed from me.

9. People who die from AIDS are being punished for their past wrongs.

10. People are blowing the issue of AIDS way out of proportion.

11. People should test themselves for AIDS.

12. People who get AIDS can blame only themselves.

13. Only people from California have been affected by AIDS.

14. Part of the problem with AIDS is that people don't talk about it.

15. The AIDS epidemic will soon be a financial burden on the U.S. economy.

16. You can't teach young children about AIDS.

17. Men and women don't really need to discuss AIDS with each other.

18. AIDS has become a significant problem in prison populations.

19. A cure for AIDS is inevitable.

20. AIDS is easy to get.

21. AIDS may eventually bankrupt the U.S. health care system.

22. People with AIDS should not be allowed to work in public schools.

23. People with AIDS should not be allowed to handle food in restaurants.

24. People with AIDS should not be allowed to work with patients in hospitals.

25. AIDS is not as big a problem as the media suggests.

26. I am not the kind of person who is likely to get AIDS.

27. I am less likely than most people to get AIDS.

28. I'd rather get any other disease than AIDS.

29. I've heard enough about AIDS, and I don't want to hear any more about it.

30. Living in San Francisco would increase anyone's chances of getting AIDS.

31. If a free blood test was available to see if you have the AIDS virus, I would take it.

32. AIDS is God's punishment for immorality.

33. AIDS patients offend me morally.

34. If I knew someone with AIDS, it would be hard for me to continue that relationship.

35. Children with AIDS should not be allowed to attend public schools.

AIDS - Section C

Instructions: The items listed below refer to people's beliefs about the topic of AIDS (Acquired Immune Deficiency Syndrome). We

are interested in whether you agree or disagree with these statements. As such, there are no right or wrong answers, only your own

individual opinions. To indicate your reactions to these statements, use the following scale: A = Agree B = Slightly agree C = Neither agree nor disagree D = Slightly disagree E = Disagree

Remember: There are no right or wrong responses; only your

opinions. Be sure to respond to each and every statement; leave no

blanks.

1. The family of AIDS victims ought to have the right to participate in medical decisions.

2. People with AIDS should not be admitted to medical hospitals.

3. Doctors can catch AIDS if they treat patients with this disease.

4. AIDS patients will contaminate medical staff and other hospital patients.

5. It’s important to maintain a safe blood banking system, because of AIDS.

6. Health care workers can catch AIDS in medical situations.

7. Medicine has a test to identify whether a person has AIDS.

8. The medical test for AIDS will not always identify a recently-infected person.

9. There’s a vaccine that prevents the spread of AIDS.

10. There are effective medical treatments for those with AIDS.

11. Doctors and nurses are at risk for catching AIDS from infected patients.

12. No medical assistance person has ever caught AIDS from a patient.

13. AIDS blood tests should be administered to everyone in hospitals.

14. Hospitals should have the right to test all patients for AIDS.

15. A doctor with AIDS should not be allowed to treat patients.

16. A hospital worker should not be required to work with AIDS patients.

17. AIDS patients have as much right to quality medical care as anyone else.

18. AIDS makes a medical job a high-risk occupation.

19. Dealing with AIDS patients is different from dealing with other types of patients.

20. The high cost of treating AIDS patients is unfair to other people in need of care.

21. Working with AIDS patients can be a rewarding experience for medical personnel.

22. Hospital personnel should go out of their way to be helpful to a patient with AIDS.

23. People with AIDS can be cured if they seek medical attention.

24. To get AIDS, a person must have intimate sexual or blood contact with an AIDS carrier.

25. The disease AIDS can be transmitted by the exchange of blood (or blood products).

26. AIDS has been identified in hemophiliacs (people who bleed easily).

27. AIDS has been linked to blood transfusion.

28. AIDS is probably in most of the nation’s blood supply.

29. A blood test can identify testing for AIDS.

30. People get AIDS from blood transfusion.

AIDS – Section D

Instructions: The items listed below refer to people’s beliefs about the topic of AIDS (Acquired Immune Deficiency Syndrome). We

are interested in whether you agree or disagree with these statements. As such, there are no right or wrong answers, only your own

individual opinions. To indicate your reactions to these statements, use the following scale: A = Agree B = Slightly

agree C = Neither agree nor disagree D = Slightly disagree
E = Disagree

Remember: There are no right or wrong responses; only your opinions. Be sure to respond to each and every statement; leave no

blanks.

1. AIDS is a serious challenge to the notion of recreational sex.

2. Because of AIDS, everyone has a responsibility to practice healthful sexual behaviors.

3. Condoms offer protection against the spread of AIDS.

4. AIDS cannot be transmitted by heterosexual (male-female) sexual activity.

5. People catch AIDS from their sexual partners.

6. The more sexual partners people have, the greater their chance of acquiring AIDS.

7. AIDS is associated with multiple anonymous sexual contacts.

8. AIDS is transmitted by intimate sexual contact.

9. People can contract AIDS even though they have had sex with only one person.

10. Condoms are a safe shield against AIDS.

11. AIDS is essentially a sexually transmitted disease.

12. People can contract AIDS from sexual contact with a single infected person.

13. Any sexually active people can get AIDS.

14. People get AIDS from sex.

15. People don’t engage in sex very much nowadays because of AIDS.

16. AIDS is transmitted primarily through sexual relations.

17. Proper use of condoms can reduce the risk of catching

AIDS.

18. The use of condoms can prevent the spread of AIDS.

19. Heterosexuals who use condoms can lessen their risk for getting AIDS.

20. People who have “one-night stands” will probably catch AIDS.

Alternate Forms of HIV Prevention Attitude Scales for Teenagers

MOHAMMAD R. TORABI AND WILLIAM L. YARBER, 1 Indiana University

1 Address correspondence to William L. Yarber, Department of Applied Health Science, Indiana University, HPER Building, Bloomington, IN 47405;

e-mail: yarber@indiana.edu

The lack of valid devices for measuring attitudes toward HIV prevention for adolescents has remained an obstacle to HIV/AIDS education evaluation. Many national authority groups, such as the National Research Council (Coyle, Boruch, & Turner, 1989), have recognized the importance of construction of reliable survey questionnaires in evaluating HIV prevention programs. In addition to knowledge and behavioral outcomes, it is imperative to determine attitude status and how it changes in health education settings. Research indicates that attitudes are best described as multidimensional, having the three components of cognitive (belief), affective (feeling), and conative (intention to act; Ajzen & Fishbein, 1980; Kothandapani, 1971; Ostrom, 1969). This model has been successfully applied in measurement of attitudes toward alcohol among teenagers (Torabi & Veenker, 1986), prevention of cancer for college students (Torabi & Seffrin, 1986), and sexually transmitted diseases (Yarber, Torabi, & Veenker, 1989). In testing

situations, especially for test-retest design, there is a need for parallel, equivalent, or alternate forms of tests. Tests are considered to be parallel whenever their information functions are identical (Timminga, 1990).

For most of educational evaluation using pretest/posttest design, the use of alternate forms is preferred over single forms. Our purpose was to develop alternate, attitude scale forms, using the three-component model, to measure adolescents' attitudes toward HIV and prevention of HIV infection.

Description

A large pool of Likert-type items was generated, guided by a table of specifications using a three-component attitude theory and conceptual areas related to HIV and HIV preven tion. A preliminary scale with 50 items was prepared and reviewed by a jury of experts. The jurors provided feedback regarding clarity and content validity. Following revision, the preliminary scale was administered to 210 Midwestern high school students. After extensive item analyses, two comparable forms with 15 maximally discriminatory items were identified. These alternate forms were simultaneously administered to a representative sample of 600 teenagers in a Midwestern high school. Data were subjected to various techniques of item analysis, factor analysis, and reliability estimation.

The item analysis results provided strong evidence of

internal consistency and comparability. The item correla

tion coefficients were positive and statistically
significant

for both forms. Additionally, the normative data regarding

means, the standard deviations of item scores, and the total

scale scores for the two forms were comparable.

Response Mode and Timing

Respondents indicate whether they strongly agree, agree,

undecided, disagree, or strongly disagree to each state

ment. It takes about 10 minutes to complete the scale.

Scoring

The minimum and maximum possible points for each form

are 15 and 75 points, with higher scores indicating more

positive attitudes toward HIV and HIV prevention.

Scoring for Form A. For Items 7, 8, 11, 13, 15, strongly

agree = 5 points, agree = 4, undecided = 3; disagree = 2,

strongly disagree = 1. For the remaining items, strongly

agree = 1, agree = 2, undecided = 3, disagree = 4, strongly

disagree = 5.

Scoring for Form B. For Items 1, 3, 8, 9, 10, 11, 12, 13,

14, 15, strongly agree = 5, agree = 4, undecided = 3, dis

agree = 2, strongly disagree = 1. For the remaining items,

strongly agree = 1, agree = 2, undecided = 3, disagree = 4,

Exhibit

Alternate Forms of HIV Prevention Attitude Scales for
Teenagers

Form A

Directions: Please read each statement carefully. Record your immediate reaction to the statement by blackening the proper oval on the answer

sheet. There is no right or wrong answer for each statement, so mark your own response. Use the below key:

KEY: A = Strongly agree

B = Agree

C = Undecided

D = Disagree

E = Strongly disagree

Example: Doing something to prevent getting HIV is the responsibility of each person.

A B C D E

1. I would feel very uncomfortable being around someone with HIV.

2. I feel that HIV is a punishment for immoral behavior.

3. If I were having sex, it would be insulting if my partner insisted we use a condom.

4. I dislike the idea of limiting sex to just one partner to avoid HIV infection.

5. I would dislike asking a possible sex partner to get the HIV antibody test.

6. It would be dangerous to permit a student with HIV to attend school.

7. It is easy to use the prevention methods that reduce one’s chance of getting HIV.

8. It is important to talk to a sex partner about HIV prevention before having sex.

9. I believe that sharing IV drug needles has nothing to do with HIV.

10. HIV education in schools is a waste of time.

11. I would be supportive of a person with HIV.

12. Even if a sex partner insisted, I would not use a condom.

13. I intend to talk about HIV prevention with a partner if we were to have sex.

14. I intend not to use drugs so I can avoid HIV.

15. I will use condoms when having sex if I'm not sure if my partner has HIV.

Form B

Directions: Please read each statement carefully. Record your immediate reaction to the statement by blackening the proper oval on the answer

sheet. There is no right or wrong answer for each statement, so mark your own response. Use the below key:

KEY: A = Strongly agree

B = Agree

C = Undecided

D = Disagree

E = Strongly disagree

Example: Doing something to prevent getting HIV is the responsibility of each person.

A B C D E

1. I am certain that I could be supportive of a friend with HIV.

2. I feel that people with HIV got what they deserve.

3. I am comfortable with the idea of using condoms for sex.

4. I would dislike the idea of limiting sex to just one partner to avoid HIV infection.

5. It would be embarrassing to get the HIV antibody test.

6. It is meant for some people to get HIV.

7. Using condoms to avoid HIV is too much trouble.

8. I believe that AIDS is a preventable disease.

9. The chance of getting HIV makes using IV drugs stupid.

10. People can influence their friends to practice safe behavior.

11. I would shake hands with a person having HIV.

12. I will avoid sex if there is a slight chance that the partner might have HIV.

13. If I were to have sex I would insist that a condom be used.

14. If I used IV drugs, I would not share the needles.

15. I intend to share HIV facts with my friends.

Sexual Health Knowledge Questionnaire

for HIV+ MSM

PETER A. VANABLE, 1 JENNIFER L. BROWN, MICHAEL P. CAREY, AND REBECCA A. BOSTWICK,

Syracuse University

Most conceptual models of sexual risk behavior identify knowledge about HIV and STDs as an important determinant of risk behavior (e.g., Fisher & Fisher, 1992). Moreover, effective interventions to reduce risks for contracting HIV include modules that focus on improving HIV related knowledge as part of broader strategy to motivate behavior change (e.g., Johnson, Carey, Marsh, Levin, & Scott-Sheldon, 2003). Although a few validated measures of HIV- and STD-related knowledge exist for use in primary

prevention contexts (e.g., Carey & Schroder, 2002), there are no published measures to assess knowledge of specific relevance to sexual risk reduction for persons living with HIV. In this report, we describe reliability and validity data for the Sexual Health Knowledge Questionnaire (SHKQ) for HIV+ men who have sex with men (MSM), a measure developed to assess prevention-related knowledge pertinent to risk reduction among HIV+ MSM. Interventions to promote knowledge of health risks associated with sexual behavior among HIV+ MSM are an important public health priority (Vanable & Carey, 2006).

The SHKQ was developed as part of a program of research to evaluate a sexual risk reduction intervention for HIV+ MSM (Vanable et al., 2009). Knowledge domains assessed by the SHKQ correspond to core knowledge modules that were included in our sexual risk reduction curriculum. Reliability and validity information for the SHKQ are derived from baseline and 3-month follow-up data collected among HIV+ MSM who participated in our pilot intervention trial (Vanable, Carey, Brown, Bostwick, & Blair, 2008).

Description

The SHKQ consists of 18 true-false questions that assess prevention-related knowledge relevant to risk reduction

among HIV+ MSM. The SHKQ focuses on health risks associated with sexual behavior rather than knowledge about medical aspects of HIV. In particular, items assess knowledge regarding the impact of STD co-infections on HIV infectivity and disease progression, health risks related to unprotected sex involving two HIV+ partners, the relationship of HIV viral load to infectivity, differences in HIV transmission risks associated with being the recep tive or insertive partner for anal sex, and STD and HIV transmission risk associated with oral sex. The measure also includes items that assess knowledge of specific STDs that can affect the health of HIV+ MSM. Response Mode and Timing For each item, respondents are asked to indicate whether the statement is True or False. If they are unsure whether the statement is true or false, respondents are instructed to select Don't Know, rather than guessing. The scale takes approximately 5 minutes to complete. Scoring For each item, responses are coded to indicate whether the respondent provided a correct or incorrect answer. Correct responses are assigned a value of one, whereas selection of an incorrect response or Don't Know is assigned a value of zero. For the following items, true is the correct response: 1, 2, 3, 4, 6, 9, 11, 13, 15, 17, 18. False is the correct response for these items: 5, 7, 8, 10, 12, 14, 16. A total score is calculated by summing the number of correct responses across the 18 items. Higher scores indicate greater sexual health knowledge. Reliability and Validity African American (26%) and White (63%) HIV+ MSM were recruited from an infectious disease clinic in upstate New York to participate in the sexual risk reduction program (N = 80). Participants' ages ranged between 22 and 62 (M age = 40.6, SD = 8.0). Participants had been infected with HIV for 9.0 years, on average (SD = 5.6). Participants were randomly assigned to an immediate intervention condition (n = 40) or a time-delayed intervention control condition (n = 40). Test-Retest Reliability Test-retest reliability data for the SHKQ were obtained using baseline and 3-month follow-up data among participants in the delayed intervention control condition. A total of 35

respondents in the delayed intervention condition completed the SHKQ both at baseline and at a 3-month follow-up. Test-retest reliability for SHKQ for this subsample was .78, $p < .001$. Based on established benchmarks

1 Address correspondence to Peter A. Vanable, Department of Psychology & Center for Health and Behavior, Syracuse University, 430 Huntington Hall,

Syracuse, NY 13244; e-mail: pvanable@syr.edu

(Cicchetti, 1994), our findings provide evidence of moder

ate to excellent test-retest agreement.

Validity

To provide evidence of convergent validity, the correlation

between participants' SHKQ scores and responses to five

items assessing medical knowledge related to HIV (e.g.,

"A low CD4 count indicates that an HIV+ person has mini

mal damage to the immune system") and five items assess

ing attitudes toward condom use (Sacco, Levine, Reed, &

Thompson, 1991) was calculated. SHKQ scores were posi

tively correlated with higher levels of medical knowledge

related to HIV ($r = .34$, $p < .005$) and positively associated

with having more favorable attitudes toward condom use (r

$= .24$, $p < .05$). SHKQ scores also correlated positively with

participants' education level ($r = .23$, $p < .05$). We conducted analyses to determine whether the SHKQ

was sensitive to changes in knowledge following participa

tion in a two-session group intervention to promote sexual

risk reduction among HIV+ MSM. Our results demonstrated

that knowledge scores improved from baseline ($M = 9.3$,

SD = 3.3) to follow-up (M = 10.7, SD = 2.4) among partici

pants in the immediate intervention condition who attended

at least one intervention workshop, whereas knowledge

showed no improvement from baseline to 3-month follow

up among participants in the delayed intervention condi

tion, F (1, 63) = 9.0, p < .005. To examine whether there

was a similar pattern of results for the
delayed-intervention

participants after receiving the intervention, we conducted

paired t-tests evaluating change from the pre-intervention

assessment to the 3-month follow-up. Delayed-interven

tion participants reported greater HIV transmission knowl

edge at the 3-month assessment (M = 12.0, SD = 2.1) than

before receiving the intervention (M = 10.1, SD = 2.4), t

Exhibit

Sexual Health Knowledge Scale

Directions: For each statement, please tell us whether the
statement is “True” or “False.” If you do not know the
answer, please do not

guess; please say “Don’t Know.”

1. Having an undetectable viral load reduces the risk of
transmitting HIV. True False Don’t Know

2. Having another STD makes it easier for an HIV+ person to
give HIV to an

HIV-negative partner. True False Don’t Know

3. Infection with another STD can speed up HIV disease
progression for a person

who is HIV+. True False Don’t Know

4. Human Papillomavirus (HPV) sometimes leads to rectal cancer in gay men. True False Don’t Know

5. Having an undetectable viral load eliminates the chance that a person with HIV will infect

a sexual partner. True False Don’t Know

6. Among gay men, Hepatitis A is transmitted through rimming (oral-anal contact). True False Don’t Know

7. Doctors have now proven that reinfection with another strain of HIV worsens the health

of an HIV+ person. True False Don’t Know

8. Unlike HIV, most other viral STDs can be cured. True False Don’t Know

9. A person can get an STD through oral sex. True False Don’t Know

10. An HIV+ person is less likely to transmit HIV to a sexual partner if he is the insertive

partner (top) than if he is the receptive partner (bottom). True False Don’t Know

11. Transmission of drug- resistant HIV to HIV-negative sexual partners is more common

than transmission of drug- resistant HIV to HIV+ partners. True False Don’t Know

12. If you’’re HIV positive, infections like gonorrhea and chlamydia in your penis can decrease

the amount of HIV in your semen. True False Don’t Know

13. Syphilis is a bacterial STD. True False Don’t Know

14. It is a good idea to use Vaseline or baby oil with latex condoms. True False Don’t Know

15. Gonorrhea can be found in the throat. True False Don’t Know

16. For two HIV+ partners, STDs are less of a concern than contracting drug- resistant HIV. True False Don’t Know

17. HIV can be transmitted through oral sex, but the risks are much lower than for anal or

vaginal sex. True False Don’t Know

18. An HIV+ person who has sex with another HIV+ person should still use a condom to

avoid new health problems. True False Don’t Know

Adolescent AIDS Knowledge Scale

GREGORY D. ZIMET, 1 Indiana University School of Medicine

1 Address correspondence to Gregory D. Zimet, Indiana University School of Medicine, Section of Adolescent Medicine, 410 West 10th Street, HS 1001,

Indianapolis, IN 46202; e-mail: gzimet@iupui.edu

The Adolescent AIDS Knowledge Scale (AAKS) was

developed as part of a comprehensive questionnaire to

evaluate adolescents’ knowledge, beliefs, and attitudes

about acquired immunodeficiency syndrome (AIDS;

Zimet et al., 1989). The knowledge scale was developed

with two principal issues in mind. First, we wanted to

ensure that the scale covered relevant material. To accom

plish this goal, item content was derived from a 1988 infor

mational brochure distributed to every household by the

U.S. Government (Centers for Disease Control, 1988). As a

result, the scale addresses multiple AIDS-related domains,

including modes of transmission, high-risk behaviors, mor

tality, the existence of a cure, prevention of transmission,

and the appearance of persons with AIDS (PWAs).

A second issue considered during scale development

was that most existing AIDS knowledge scales confounded knowledge (i.e., awareness of scientific facts about AIDS) with beliefs. It seemed likely that a person might “know” the facts according to experts, but not believe them. In considering the design of AIDS education interventions, it appeared particularly important to assess AIDS aware ness/knowledge separately from AIDS beliefs. To address this issue, each item on the AAKS was constructed to begin with the phrase “Do most experts say . . .?” A separate but parallel AIDS Beliefs scale was developed to evaluate the extent to which adolescents believed what experts were saying. Description The AAKS has 22 items. Each item takes the form of a question (e.g., “Do most experts say you can get AIDS by giving blood?”). Transmission-related items cover true modes of transmission (e.g., sharing needles), low- or no-risk behaviors (e.g., sharing a glass of water), behaviors that increase risk of transmission (e.g., prostitution), and transmission of human immunodeficiency virus (HIV) without clinical AIDS. Two protection items address effective (i.e., condom use) and ineffective (i.e., eating healthy foods) protective behaviors. Finally, single items cover such topics as the mortality associated with AIDS, whether there is a cure for AIDS, and whether it is possible to determine if someone has AIDS by looking at him or her. Response Mode and Timing To each question, respondents are asked to circle yes, no, or don’t know. Response times vary, but typically the scale requires less than 5 minutes to complete. Scoring A correct response receives a score of 1. An incorrect answer or a don’t know response each receives a score of 0. For the following items, no is the correct response: 1, 3, 4, 5, 9, 11, 13, 15, 17, and 19. For the following items, yes is the correct response: 2, 6, 7, 8, 10, 12, 14, 16, 18, 20, 21,

and 22. The total score for the scale, which is calculated by

summing across items, can range from 0 to 22.

Reliability

An AIDS-knowledge scale such as this one represents

multiple content areas, not a single construct. Therefore,

standard measures of internal reliability that assess overall

internal consistency (e.g., Cronbach's coefficient alpha or

Kuder-Richardson formula 20) are inappropriate (Anastasi,

1982; Zimet, 1992b). A more useful approach involves a

specialized form of Spearman-Brown split-half reliability

in which items from one half are matched for content with

items from the other half (Zimet, 1992b). Given that the

AAKS was not designed with this approach to reliability

in mind, it is not possible to match all items perfectly (e.g.,

only one item addresses mortality associated with AIDS).

Nonetheless, in a sample of 721 junior and senior high

school students, the Spearman-Brown matched-item split

half method resulted in a coefficient of .82, indicating good

internal reliability (Zimet, 1992b).

Validity

The content validity of the scale was established through

the use of the U.S. government brochure on AIDS to

guide item selection (Centers for Disease Control, 1988).

Furthermore, in addressing major AIDS-related domains

(i.e., HIV transmission, protection, mortality, appearance,

etc.), the scale demonstrates good face validity. Support for the construct validity of the AAKS is dem

onstrated by expected relationships with other variables.

For example, it may be expected that older students have

more accurate knowledge about AIDS than younger stu

dents. For the AAKS, analysis of variance indicated a linear

increase in scores across grade level among 617 7th to 12th

graders, $F(5, 611) = 8.8$, $p < .0001$ (Zimet, DiClemente, et

Exhibit

Adolescent AIDS Knowledge Scale

Instructions: Experts on AIDS have talked about the spread and prevention of AIDS. Please circle your answer for each question.

1. Do most experts say there's a high chance of getting AIDS by kissing someone on the mouth

who has AIDS? Yes No Don't Know

2. Do most experts say AIDS can be spread by sharing a needle with a drug user who has AIDS? Yes No Don't Know

3. Do most experts say you can get AIDS by giving blood? Yes No Don't Know

4. Do most experts say there's a high chance that AIDS can be spread by sharing a glass of water

with someone who has AIDS? Yes No Don't Know

5. Do most experts say there's a high chance you can get AIDS from a toilet seat? Yes No Don't Know

6. Do most experts say AIDS can be spread if a man has sex with a woman who has AIDS? Yes No Don't Know

7. Do most experts say AIDS can be spread if a man has sex

with another man who has AIDS? Yes No Don't Know

8. Do most experts say a pregnant woman with AIDS can give AIDS to her unborn baby? Yes No Don't Know

Homophobia

Exhibit

Modern Homonegativity Scale

Scale Items

MHS-G

1. Gay men have all the rights they need.*

2. Gay men have become far too confrontational in their demand for equal rights.*

3. Gay men should stop shoving their lifestyle down other people's throats.*

4. Gay men seem to focus on the ways in which they differ from heterosexuals, and ignore the ways in which they are similar.*

5. Gay men who are "out of the closet" should be admired for their courage.* [R]

6. Many gay men use their sexual orientation so that they can obtain special rights and privileges.*

7. Gay men no longer need to protest for equal rights.*

8. In today's tough economic times, Canadians' tax dollars shouldn't be used to support gay men's organizations.*

9. The notion of universities providing degrees in gay and lesbian studies is ridiculous.

10. Gay men should stop complaining about the way they are treated in society, and simply get on with their lives.

11. Celebrations such as "Gay Pride Day" are ridiculous because they assume that an individual's sexual orientation should constitute a source of pride.

12. If gay men want to be treated like everyone else, then they need to stop making such a fuss about their sexuality/culture.

MHS-L

1. The notion of universities providing degrees in gay and

lesbian studies is ridiculous.*

2. Celebrations such as “Gay Pride Day” are ridiculous because they assume that an individual’s sexual orientation should constitute a source of pride.*

3. Lesbian women should stop shoving their lifestyle down other people’s throats.*

4. Lesbian women seem to focus on the ways in which they differ from heterosexuals, and ignore the ways in which they are the same.*

5. Many lesbian women use their sexual orientation so that they can obtain special rights and privileges.*

6. Lesbian women have become far too confrontational in their demand for equal rights.*

7. Lesbian women who are “out of the closet” should be admired for their courage.* [R]

8. In today’s tough economic times, Canadians’ tax dollars shouldn’t be used to support lesbian organizations.*

9. If lesbians want to be treated like everyone else, then they need to stop making such a fuss about their sexuality/culture.*

10. Lesbian women should stop complaining about the way they are treated in society, and simply get on with their lives.*

11. Lesbian women no longer need to protest for equal rights.

12. Lesbian women have all the rights they need.

Note. [R] = Item requires reverse scoring. If using the invariant items only, standardized scores are recommended (total MHS-L score divided by 10 and

total MHS-G score divided by 8).

*Items identified as invariant between Canadian and American samples of university students (M. A. Morrison et al., 2009).

Index of Homophobia (Index of Attitudes

Toward Homosexuals)

WENDELL A. RICKETTS AND WALTER W. HUDSON, 1, 2 WALMYR Publishing Co.

The Index of Homophobia (IHP) is a short-form scale designed to measure homophobic versus nonhomophobic attitudes (the fear of being in close quarters with homo sexuals).

Description

The IHP contains 25 category-partition (Likert-type) items, some of which are worded negatively to partially offset the potential for response-set bias. Each item is scored on a relative frequency scale as shown in the scoring key of the instrument. Obtained scores range from 0 to 100 where higher scores indicate greater degrees of homophobia. The IHP has a cutting score of 50, such that scores above that value indicate the presence of an increasingly homophobic attitude toward human sexual expression, whereas scores below that value indicate the presence of an increasing non homophobic orientation. A score of 0 represents the most nonhomophobic position, and a score of 100 represents the most homophobic position. The IHP can be used with all English-speaking populations aged 12 or older. The readability statistics for the IHP are Flesch Reading Ease: 68, Gunning’s Fog Index: 10, Flesch-Kincaid Grade Level: 7.

Response Mode and Timing

The IHP is normally completed in 5 –7 minutes.

Scoring

Items 3, 4, 6, 9, 10, 12, 13, 14, 15, 17, 19, 21, and 24 must

first be reverse-scored by subtracting the item response

from K+1 where K is the number of response categories

in the scoring key. After making all appropriate item rever

sals, compute the total score as S = (ΣX i –N)(100) / [(K-1)N]

where X is an item response, i is item, K is the number of

response categories, and N is the number of properly com

pleted items. Total scores remain valid in the face of missing

values (omitted items) provided the respondent completes

at least 80% of the items. The effect of the scoring formula

1 Walter W. Hudson, 1934–1999.

2 Address correspondence to WALMYR Publishing Co., P.O. Box 12217, Tallahassee, FL 32317-2217; e-mail: walmyr@walmyr.com S A M P L E

Exhibit

Index of Attitudes Toward Homosexuals (IAH)

Name: _____

Today’s Date: _____

This questionnaire is designed to measure the way you feel about working or associating with homosexuals. It is not a test, so there

are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as

follows.

1 = Strongly agree

2 = Agree

3 = Neither agree nor disagree

4 = Disagree

5 = Strongly disagree

1. _____ I would feel comfortable working closely with a male homosexual.

2. _____ I would enjoy attending social functions at which homosexuals were present.

3. _____ I would feel uncomfortable if I learned that my neighbor was homosexual.

4. _____ If a member of my sex made a sexual advance toward me I would feel angry.

5. _____ I would feel comfortable knowing that I was attractive to members of my sex.

6. _____ I would feel uncomfortable being seen in a gay bar.

7. _____ I would feel comfortable if a member of my sex made an advance toward me.

8. _____ I would be comfortable if I found myself attracted to a member of my sex.

9. _____ I would feel disappointed if I learned that my child was homosexual.

10. _____ I would feel nervous being in a group of homosexuals.

11. _____ I would feel comfortable knowing that my clergyman was homosexual.

12. _____ I would be upset if learned that my brother or sister was homosexual.

13. _____ I would feel that I had failed as a parent if I learned that my child was gay.

14. _____ If I saw two men holding hands in public I would

feel disgusted.

15. _____ If a member of my sex made an advance toward me I would be offended.

16. _____ I would feel comfortable if I learned that my daughter's teacher was a lesbian.

17. _____ I would feel uncomfortable if I learned that my spuse or partner was attracted to members of his or her sex.

18. _____ I would feel at ease talking with a homosexual person at a party.

19. _____ I would feel uncomfortable if I learned that my boss was homosexual.

20. _____ It would not bother me to walk through a predominantly gay section of town.

21. _____ It would disturb me to find out that my doctor was homosexual.

22. _____ I would feel comfortable if I learned that my best friend of my sex was homosexual.

23. _____ If a member of my sex made an advance toward me I would feel flattered.

24. _____ I would feel uncomfortable knowing that my son's male teacher was homosexual.

25. _____ I would feel comfortable working closely with a female homosexual.

Copyright © 1990, Wendell A. Ricketts & Walter W. Hudson
IIlegal to Photocopy or Otherwise Reproduce

Note. 3, 4, 6, 9, 10, 12, 13, 14, 15, 17, 19, 21 and 24 are reverse scored.

Homophobic Behavior of Students Scale

PAUL VAN DE VEN, 1 LAUREL BORNHOLT, AND MICHAEL BAILEY,
University of Sydney

The Homophobic Behavior of Students Scale (HBSS; Van

de Ven, Bornholt, & Bailey, 1993, 1996) was developed to

measure students' behavioral intentions toward gay males and lesbians, in the context of teaching about homosexuality. The HBSS complements existing cognitive and affective measures of homophobia, thereby giving researchers of antigay and antilesbian prejudice an efficient strategy to measure the much neglected, though highly important, behavioral dimension of homophobic responses (Van de Ven, 1994a). Previous assessments of homophobic behavior have relied on highly contrived experimental manipulations which are unsuitable for everyday classroom use and, with their reliance on naive participants, cannot be used in the repeated measures designs of behavior change studies. The HBSS has the advantages of being practical and plausible, and of being a measure of personal commitment to action which can be assessed on multiple occasions. The HBSS can be treated as an individual-differences measure of homophobic behavioral intentions or as a dependent variable when evaluating the impact on behavioral intentions of homophobia reduction strategies (see Van de Ven, 1994b, 1995a, 1995b).

Description

The HBSS consists of 10 items arranged in a 5-point Likert-type format to rate strength of intention from 1 (definitely false) to 5 (definitely true). The first six items

are designed to measure, across classroom and social situ
ations, the extent to which students associated willingly or
avoided contact with gay males and lesbians. These items
were construed as a measure of social distance aspects of
behavior. The remaining items were selected to measure
additional and related aspects of behavior expressed as
willingness to act in support of gay and lesbian rights.
Separate analyses of the responses of 97 undergradu
ate students (26 males; 71 females) and 40 high school
students (24 males; 16 females) suggested that the items
contributed to a single factor of behavioral intentions. The
HBSS is appropriate to use with both high school and col
lege populations. A posttest version of the HBSS is cre
ated by changing the instructions minimally as specified

in the Exhibit. Response Mode and Timing Students circle the number from 1 to 5 that corresponds with their willingness to participate in each activity. The HBSS takes approximately 3 minutes to complete. Scoring A combination of positive and negative items is used to control for potential response set bias. The positively phrased items (i.e., Items 1, 2, 4, 6, 7, 9, & 10) have their scoring reversed in the analysis so that higher scores, following convention, indicate more negative behavioral intentions toward homosexuals. Computed HBSS scores, which can range from 0 (least homophobic) to 100 (most homophobic), are determined by using the equation: HBSS computed score = (HBSS summed raw score −10) ✖ 2.5. Reliability For the sample of 97 undergraduate students, Cronbach's alpha was .81, M = 37.65; SD = 19.94. For the sample of 40 high school students, Cronbach's alpha was .86, M = 65.25; SD = 24.29 (Van de Ven et al., 1993, 1996). Validity As expected, Van de Ven et al. (1993, 1996) found that the computed score of the HBSS was significantly correlated with Homophobic Cognition, r = .78, as measured by the Modified Attitudes Toward Homosexuality Scale (Price, 1982). Also in line with

expectations, homophobic behavioral intentions were significantly correlated with both Homophobic Anger, r = .66, and Homophobic Guilt, r = .38, and significantly negatively correlated with Warmth Toward Homosexuals, r = −.56, as measured by the Affective Reactions to Homosexuality Scale (Van de Ven, 1994a; Van de Ven et al., 1993, 1996; after Ernulf & Innala, 1987). To assess the predictive validity of the HBSS, the 40 high school students were given the opportunity to participate in each of the 10 activities of the HBSS (Van de Ven et al., 1993, 1996). As expected, the group of participants for each activity had a lower HBSS mean than the corresponding

1 Address correspondence to Paul Van de Ven, 11 John St, Ashfi eld NSW 2131, Australia; e-mail: p.vandeven@bigpond

group that abstained from participation. Group means were

significantly different at the .005 alpha level (for a family

wise error rate of .05) for six of the HBSS activities.

Other Information

If the HBSS is used by researchers, notification to the

first author of the use and the results obtained would be

appreciated.

This scale was developed while the authors were at

the School of Educational Psychology, Measurement and

Technology, University of Sydney. Laurel Bornholt is now

at Charles Darwin University.

Ernulf, K. E., & Innala, S. M. (1987). The relationship between affec

tive and cognition components of homophobic reaction. Archives of

Sexual Behavior, 16, 501–509. Price, J. H. (1982). High school students' attitudes toward homosexuality. Journal of School Health, 52, 469–474. Van de Ven, P. (1994a). Challenging homophobia in schools. Unpublished doctoral thesis, University of Sydney. Van de Ven, P. (1994b).

Comparisons among homophobic reactions of undergraduates, high school students, and young offenders. The Journal of Sex Research, 31, 117–124. Van de Ven, P. (1995a). Effects on high school students of a teaching module for reducing homophobia. Basic and Applied Social Psychology, 17, 153–172. Van de Ven, P. (1995b). Effects on young offenders of two teaching modules for reducing homophobia. Journal of Applied Social Psychology, 25, 632–649. Van de Ven, P., Bornholt, L., & Bailey, M. (1993, November). Homophobic attitudes and behaviours: Telling which teaching strategies make a difference. Paper presented at the Annual Conference of the Australian Association for Research in Education, Freemantle, Western Australia. Van de Ven, P., Bornholt, L., & Bailey, M. (1996). Measuring cognitive, affective, and behavioral components of homophobic reaction. Archives of Sexual Behavior, 25, 155–179.

Exhibit

Homophobic Behavior of Students Scale

Instructions: As part of the unit of work (Posttest version: As part of the follow-up to the unit of work) on lesbian and gay issues, it may

be possible to organize some additional activities and guest speakers. So that these can be planned, please indicate in which of the fol

lowing activities, if any, you would participate. Circle the number that comes closest to representing your willingness to participate.

Please do not leave any statements unanswered.

1. I would speak in a small class group with a gay person or lesbian about homosexual issues.

Definitely false 1 2 3 4 5 Definitely true a

2. I would speak individually, in class, with a gay person or lesbian about homosexual issues.

3. I would NOT like to have a gay person or lesbian address the class about homosexual issues.

4. I would take the opportunity to talk in an informal lunch-time meeting with a group of four lesbians or gay males.

5. I would NOT attend a lunch-time barbecue at which four gay males or lesbians were present.

6. I would watch a video in class in which a lesbian or gay person is featured.

7. I would sign my name to a petition asking the government to do more to stop violence against gay men and lesbians.

8. I would NOT sign my name to a petition asking the government to make sure gays and lesbians have equal rights with everybody else.

9. I would sign my name to a petition asking the government to allow lesbian and gay couples to officially register their marriage or partnership.

10. I would sign my name to a petition asking the government to allow lesbian and gay couples to adopt children.

a The scale is repeated after each item.

Internalized Homophobia Scale

GLENN J. WAGNER, 1 New York State Psychiatric Institute

The Internalized Homophobia Scale was developed for

use with gay men and is intended to measure the extent to

which negative attitudes and beliefs about homosexuality

are internalized and integrated into one’s self-image and

identity as gay. The significance of measuring internalized

homophobia is its negative impact on the mental health of

gay and lesbian individuals as it is often associated with guilt,

shame, depression, and feelings of worthlessness. Several

clinical reports documenting the effects and dynamics of

internalized homophobia have been published, but research

studies in which internalized homophobia has been sys

tematically measured have been confined (by and large) to studies of gay men with Human Immunodeficiency Virus (HIV). In research conducted by our group, and others, we have found that internalized homophobia is associated with demoralization, depression, and general psychological dis tress, as well as low self-esteem and avoidant coping.

Description

The Internalized Homophobia Scale consists of 20 items, 9 of which are from the Nungesser Homosexual Attitudes Inventory (Nungesser, 1983), with the other 11 items devel oped by the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute. A principal compo nents factor analysis with a varimax rotation was performed on a sample of 142 gay men who completed the IHS and a 22-item scale of demoralization (Dohrenwend, Shrout, Egri, & Mendelsohn, 1987), and the 7-item depression subscale of the Brief Symptom Inventory (Derogatis & Melisaratos, 1983). Using all items a two-factor solution resulted, with all but one (Item 4) of the IHS items loading on Factor 1. All of the items from the depression scale loaded on Factor 2, as did 17 of the items from the demoralization scale. None of the items from the three factors loaded on discrepant factors (Wagner, Brondolo, & Rabkin, 1996).

Response Mode and Timing

Each item is scored on a 5-point Liker-type scale with 1 =

strongly disagree and 5 = strongly agree, and each response

represents the degree to which the respondent endorses the

statement or item. The scale requires approximately 5 min

utes to complete.

Scoring

There are 10 items that are positively keyed and 10 that

1 Address correspondence to Glenn J. Wagner, RAND Corporation, 1776 Main St., Santa Monica, CA 90407; e-mail: gwagner@rand.org

1 Address correspondence to Stacy Weibley; e-mail: sweibley@msn.com

Exhibit

Internalized Homophobia Scale

Instructions: The following are some statements that individuals can make about being gay. Please read each one carefully and decide

the extent to which you agree with the statement, then circle the number that best reflects how much you agree or disagree with the

statement.

Response format: 1 Strongly Disagree

2 Disagree

3 Neutral

4 Agree

5 Strongly Agree

1. Male homosexuality is a natural expression of sexuality in human males.

2. I wish I were heterosexual.

3. When I am sexually attracted to another gay man, I do not mind if someone else knows how I feel.

4. Most problems that homosexuals have come from their status as an oppressed minority, not from their homosexuality per se.

5. Life as a homosexual is not as fulfilling as life as a heterosexual.

6. I am glad to be gay.

7. Whenever I think a lot about being gay, I feel critical about myself.

8. I am confident that my homosexuality does not make me inferior.

9. Whenever I think a lot about being gay, I feel depressed.

10. If it were possible, I would accept the opportunity to be completely heterosexual.

11. I wish I could become more sexually attracted to women.

12. If there were a pill that could change my sexual orientation, I would take it.

13. I would not give up being gay even if I could.

14. Homosexuality is deviant.

15. It would not bother me if I had children who were gay.

16. Being gay is a satisfactory and acceptable way of life for me.

17. If I were heterosexual, I would probably be happier.

18. Most gay people end up lonely and isolated.

19. For the most part, I do not care who knows I am gay.

20. I have no regrets about being gay.

Self-Identifi ed Lesbian Internalized Homophobia Scale

STACY WEIBLEY 1 AND MICHELLE HINDIN, Johns Hopkins

University

The Self-Identified Lesbian Internalized Homophobia Scale (SLIHS) was developed to gain a greater understanding of internalized homophobia in the lives of women who identify as lesbian and to address significant gaps in the literature regarding this topic. It has been hypothesized that internalized homophobia is linked to the elevated rates of mental health and substance abuse issues experienced by gay, lesbian, bisexual, and transgender (GLBT) individuals, including the disproportionately high rates of suicide among GLBT youth. However, although previous research suggests internalized homophobia is a statistically significant and distinct factor in the lives of gay men (Meyer, 1995), there is a dearth of research regarding this issue among other GLBT groups, including lesbians. Of the few existing empirical studies regarding internalized homophobia among lesbians, many rely on questions developed to measure this construct among gay men rather than those that appropriately address lesbian culture (Radonsky & Borders, 1995). Other studies are limited owing to a lack of theoretical support, small sample size, or additional methodological issues (DiPlacido, 1998; Peterson & Gerrity, 2006). Although there are several published scales that assess internalized homophobia among men, only one scale addresses women (Szymanski & Chung, 2001). However, this scale was validated using a sample that included a significant number (approximately 30%) of participants who did not identify as lesbian and was biased in terms of education level, and it includes

questions that confound internalized homophobia with other psychological issues or personality traits.

Description

The SLIHS is a self-administered survey that is completed by women who self-identify as lesbian. The instrument includes four subscales, Visibility, Connectedness, Self Acceptance, and Judgment, and a total of 30 closed-ended questions.

Response Mode and Timing

This two-page self-administered survey takes approxi mately 3 minutes to complete. The response has been very high: Over 95% completed the survey.

Scoring

Overall and subscale scores can be calculated. Possible overall scores range from 30 to 120 (with higher numbers representing greater internalized homophobia), whereas subscale scores range from 7 to 28 for Visibility (Items 1 –7) and Connectedness (Items 8–14), 5 to 20 for Self Acceptance (Items 15–19), and 11 to 44 for Judgment (Items 20–30). The Likert-type scale response categories and associated points for about half of the items are the fol lowing: Strongly Agree = 1, Agree = 2, Disagree = 3, and

Exhibit

Self-Identified Lesbian Internalized Homophobia Scale

Strongly Agree Disagree Strongly

Agree Disagree

I am comfortable being “out.”

I am “out” to my boss/employer.

I am “out” to my co-workers.

I am “out” to my parents.

I feel comfortable discussing homosexuality in a public setting.

When discussing your partner, it is all right to use gender neutral pronouns to make

heterosexual people more comfortable. [R]

Homophobia Scale

LESTER W. WRIGHT, JR., 1 HENRY E. ADAMS, 2 AND JEFFREY BERNAT, University of Georgia

1 Address correspondence to Lester W. Wright, Jr., Department of Psychology, Western Michigan University, Kalamazoo, MI 49008; e-mail:

lester.wright@wmich.edu

2 Henry E. Adams died October 16, 2000.

When/if I am in a relationship, I feel comfortable talking about my lesbian partner.

I feel comfortable about the idea of another woman making an advance toward me.

I feel comfortable at lesbian-centered events or places.

I feel comfortable in social situations with other lesbians.

I have stopped myself from coming out because no heterosexuals are truly accepting. [R]

I have very little in common with other lesbians. [R]

It is important for me to be part of the lesbian community.

It is important to have people in my life who know I am a

lesbian.

I am comfortable being a lesbian.

I feel comfortable thinking about my homosexuality.

I sometimes feel disappointed in myself for being a lesbian. [R]

I sometimes feel embarrassed to be a lesbian. [R]

I would prefer to be heterosexual. [R]

Being a lesbian is all right when you are young, but I worry how people will perceive me

as an older lesbian. [R]

Children should be taught that being gay or lesbian is normal.

I find myself making negative comments about other lesbians. [R]

I sometimes think heterosexual people’s judgments of lesbians are, at least in part,

justified. [R]

I think of lesbians as sexually predatory. [R]

I wish other lesbians would not flaunt their lesbianism. [R]

It is understandable that people judge lesbians who do not dress or act “straight.” [R]

It is understandable that some people believe that lesbians are not worthy of the same

treatment as other women. [R]

Lesbians should try to look as non-offensive as possible. [R]

Lesbians who have a very masculine appearance make me uncomfortable. [R]

Most lesbians grow out of their lifestyles. [R]

Note. [R] = reverse-scored items.

The Homophobia Scale (HS) was developed to assess the cognitive, affective, and behavioral components of homophobia.

Description

The HS consists of 25 statements to which respondents answer on a 5-point Likert scale of 1 (Strongly Agree) to 5 (Strongly Disagree). The majority of the homophobia scales currently in use measure attitudes toward gay and lesbian individuals and what has been referred to as homonegativity, but do not capture the entire construct of homophobia. The inclusion of items that assess social avoidance and aggressive acting, in addition to the attitudinal items found on many homophobia measures, differentiates the HS from other scales. The participants for the development and validation studies (N = 321 for the initial field trial and N = 122 for test-retest reliability) were students from a large midwestern university. Their average age was 22.38 (SD = 4.12).

The mean total score for the scale based on 145 participants was 32.04 (SD = 19.76). The mean score for the male participants (n = 47) was 41.38 (SD = 19.32). The mean score for the female participants (n = 98) was 27.56 (SD = 18.44).

It is recommended that users of the scale conduct statistics on their samples to determine cut scores for high and low responding. The scale contains three factors that accounted for 68.69% of the scale's variance. The first factor, Behavioral/ Negative Affect, accounted for 40.88% of the scale's variance and contained 10 items that assess primarily negative affect and avoidance behaviors. The mean score for Factor

1 = 10.79 (SD = 8.22). The second factor, Affect/Behavioral Aggressive, accounted for 23.05% of the scale's variance and contained 10 items that assess primarily aggressive behavior and negative affect. The mean score for Factor 2 = 14.28 (SD = 12.51). The third factor, Cognitive Negativism, accounted for 4.77% of the scale's variance and contained five items that assess negative attitudes and cognitions. The mean score for Factor 3 = 7.10 (SD = 4.84).

Response Mode and Timing

Respondents can indicate their level of agreement or dis agreement with the statements by circling the number on the Likert scale that most closely matches their thoughts, feelings, or behavior. The scale can be completed in approx imately 5 to 7 minutes.

Scoring

A total score and three subscale scores can be calculated for the scale.

1. Reverse score the following items: 1, 2, 4, 5, 6, 9, 12, 13, 14, 15, 17, 19, 21, 23, 24, 25 (to reverse score the items 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1). Use these reverse scores to calculate total score and factor subscale scores.

Exhibit

Homophobia Scale

This questionnaire is designed to measure your thoughts, feelings, and behaviors with regard to homosexuality. It is not a test, so there

are no right or wrong answers. Answer each item by circling the number after each question as follows:

1 Strongly Agree

2 Agree

3 Neither Agree nor Disagree

4 Disagree

5 Strongly Disagree

1. Gay people make me nervous.

1 2 3 4 5

2. Gay people deserve what they get.

1 2 3 4 5

3. Homosexuality is acceptable to me.

1 2 3 4 5

4. If I discovered a friend was gay I would end the friendship.

1 2 3 4 5

5. I think homosexual people should not work with children.

1 2 3 4 5

6. I make derogatory remarks about gay people.

1 2 3 4 5

7. I enjoy the company of gay people.

1 2 3 4 5

8. Marriage between homosexual individuals is acceptable.

1 2 3 4 5

9. I make derogatory remarks like “faggot” or “queer” to people I suspect are gay.

1 2 3 4 5

10. It does not matter to me whether my friends are gay or straight.

1 2 3 4 5

11. It would not upset me if I learned that a close friend was homosexual.

1 2 3 4 5

12. Homosexuality is immoral.

1 2 3 4 5

13. I tease and make jokes about gay people.

1 2 3 4 5

14. I feel that you cannot trust a person who is homosexual.

1 2 3 4 5

15. I fear homosexual persons will make sexual advances towards me.

1 2 3 4 5

16. Organizations which promote gay rights are necessary.

1 2 3 4 5

17. I have damaged property of gay persons, such as “keying” their cars.

1 2 3 4 5

18. I would feel comfortable having a gay roommate.

1 2 3 4 5

19. I would hit a homosexual for coming on to me.

1 2 3 4 5

20. Homosexual behavior should not be against the law.

1 2 3 4 5

21. I avoid gay individuals.

1 2 3 4 5

22. It does not bother me to see two homosexual people together in public.

1 2 3 4 5

23. When I see a gay person I think, “What a waste.”

1 2 3 4 5

24. When I meet someone I try to find out if he/she is gay.

1 2 3 4 5

25. I have rocky relationships with people that I suspect are gay.

1 2 3 4 5

Homosexualities (also see Attraction)

Exhibit

Gay Identity Questionnaire

Directions: Please read each of the following statements carefully and then circle whether you feel the statements are true (T) or false (F)

for you at this point in time. A statement is circled as true if the entire statement is true, otherwise it is circled as false.

True False

1. I probably am sexually attracted equally to men and women. (Stage 2) T F

2. I live a homosexual lifestyle at home, while at work/school I do not want others to know about my lifestyle.

(Stage 4) T F

3. My homosexuality is a valid private identity, that I do not want made public. (Stage 4) T F

4. I have feelings I would label as homosexual. (validity check item) T F

5. I have little desire to be around most heterosexuals. (Stage 5) T F

6. I doubt that I am homosexual, but still am confused about who I am sexually. (Stage 1) T F

7. I do not want most heterosexuals to know that I am definitely homosexual. (Stage 4) T F

8. I am very proud to be gay and make it known to everyone around me. (Stage 5) T F

9. I don’t have much contact with heterosexuals and can’t say that I miss it. (Stage 5) T F

10. I generally feel comfortable being the only gay person in a group of heterosexuals. (Stage 6) T F

11. I’m probably homosexual, even though I maintain a

heterosexual image in both my personal and public life. (Stage 3) T F

12. I have disclosed to 1 or 2 people (very few) that I have homosexual feelings, although I'm not sure I'm homosexual.

(Stage 2) T F

13. I am not as angry about treatment of gays because even though I've told everyone about my gayness, they have

responded well. (Stage 6) T F

14. I am definitely homosexual but I do not share that knowledge with most people. (Stage 4) T F

15. I don't mind if homosexuals know that I have homosexual thoughts and feelings, but I don't want others to know.

(Stage 3) T F

16. More than likely I'm homosexual, although I'm not positive about it yet. (Stage 3) T F

17. I don't act like most homosexuals do, so I doubt that I'm homosexual. (Stage 1) T F

18. I'm probably homosexual, but I'm not sure yet. (Stage 3) T F

19. I am openly gay and fully integrated into heterosexual society. (Stage 6) T F

20. I don't think that I'm homosexual. (Stage 1) T F

21. I don't feel as if I am heterosexual or homosexual. (Stage 2) T F

22. I have thoughts I would label as homosexual. (validity check item) T F

23. I don't want people to know that I may be homosexual, although I'm not sure if I am homosexual or not. (Stage 2) T F

24. I may be homosexual and I am upset at the thought of it. (Stage 2) T F

25. The topic of homosexuality does not relate to me

personally. (Stage 1) T F

26. I frequently confront people about their irrational, homophobic (fear of homosexuality) feelings. (Stage 5) T F

27. Getting in touch with homosexuals is something I feel I need to do, even though I'm not sure I want to. (Stage 3) T F

28. I have homosexual thoughts and feelings but I doubt that I'm homosexual. (Stage 1) T F

29. I dread having to deal with the fact that I may be homosexual. (Stage 2) T F

30. I am proud and open with everyone about being gay, but it isn't the major focus of my life. (Stage 6) T F

31. I probably am heterosexual or non-sexual. (Stage 1) T F

32. I am experimenting with my same sex, because I don't know what my sexual preference is. (Stage 2) T F

33. I feel accepted by homosexual friends and acquaintances, even though I'm not sure I'm homosexual. (Stage 3) T F

34. I frequently express to others, anger over heterosexuals' oppression of me and other gays. (Stage 5) T F

35. I have not told most of the people at work that I am definitely homosexual. (Stage 4) T F

36. I accept but would not say I am proud of the fact that I am definitely homosexual. (Stage 4) T F

37. I cannot imagine sharing my homosexual feelings with anyone. (Stage 1) T F

38. Most heterosexuals are not credible sources of help for me. (Stage 5) T F

39. I am openly gay around heterosexuals. (Stage 6) T F

40. I engage in sexual behavior I would label as homosexual. (validity check item) T F

41. I am not about to stay hidden as gay for anyone. (Stage 5) T F

42. I tolerate rather than accept my homosexual thoughts and feelings. (Stage 3) T F

43. My heterosexual friends, family, and associates think of me as a person who happens to be gay, rather than as a gay person. (Stage 6) T F

44. Even though I am definitely homosexual, I have not told my family. (Stage 4) T F

45. I am openly gay with everyone, but it doesn't make me feel all that different from heterosexuals. (Stage 6) T F

Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale

FRANK R. DILLON, Florida International University

ROGER L. WORTHINGTON, 1 University of Missouri

1 Address correspondence to Roger L. Worthington, 217 Jesse Hall, University of Missouri, Columbia, MO 65211; e-mail: WorthingtonR@missouri.edu

Recent scholars have conceptualized attitudes toward lesbian, gay, and bisexual (LGB) individuals as multidimensional and wide-ranging (Worthington, Savoy, Dillon, & Vernaglia, 2002). There are two concurrent yet divergent trends in the United States with respect to attitudes toward LGB individuals. Although Yang (2000) has reported data that suggest a gradual trend over the past 25 years toward more positive attitudes among the general population, there also has been a corresponding increase in highly publicized violence (Cloud, 2008) and a mixture of outcomes in a variety of judicial and legislative legal battles over LGB civil rights issues. Furthermore, as LGB individuals become

more visible in the mainstream of United States culture, knowledge of LGB history, symbols, and community is likely to evidence corresponding increases. Therefore, as attitudes toward LGB individuals reflect widening com plexities in society, it is critical that scientific measurement provides increasing precision of range and dimensionality. The Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale (LGB-KAS) measures respondents' attitudes and knowledge levels regarding LGB individuals. The multidimensional and wide-ranging factors assessed by the LGBKAS include (a) Internalized Affirmativeness: a willingness to engage in proactive social activism for LGB issues and internalized sense of comfort with same-sex attractions, (b) Civil Rights Attitudes: beliefs about the civil rights of LGB individuals with respect to marriage, child rearing, health care, and insurance benefits, (c) Knowledge: basic knowledge about the history, symbols, and organizations related to the LGB community, (d) Religious Conflict: conflictual beliefs and ambivalent homonegativity with respect to LGB individuals, often of a religious nature, and (e) Hate: attitudes about avoidance, self-consciousness, hatred, and violence toward LGB individuals.

Description

The LGB-KAS consists of 28 items. Each item represents an attitude or fact concerning LGB individuals or issues. Higher factor scores are indicative of a stronger endorse ment of beliefs (or a higher level of knowledge) concern ing each of the five factors (Internalized Affirmativeness, Civil Rights Attitudes, Knowledge, Religious Conflict, and Hate). The scale is intended for self-identifying heterosex ual respondents.

The development and validation of the LGB-KAS included four studies (Worthington, Dillon, & Becker

Schutte, 2005). In Study 1, item development procedures and an exploratory factor analysis of an initial item pool were conducted. Discriminant validity estimates also were examined (described in Validity section). A review of (a) measures of homophobia, racism, and sexism, (b) literature examining attitudes toward LGB individuals, and (c) the Worthington et al. (2002) model of sexual identity yielded 211 initial items. Pilot studies decreased the item pool to 32 items. The remaining items reflected the following dimensions: violent homonegativity (e.g., “I sometimes feel violent toward gay men/lesbian women/bisexual individuals”); homophobic intolerance (e.g., “Same-sex marriage just does not make sense to me”); negatively ambivalent attitudes (e.g., “I do not care what LGB individuals do as long as they do not draw attention to themselves”); indifference (e.g., “I have never given much thought to my beliefs about lesbian, gay, or bisexual people”); positively ambivalent attitudes (e.g., “I’m not sure what to say or do when someone makes an anti-LGB joke or statement”); affirmative or supportive attitudes (e.g., “It is important to teach children positive attitudes about LGB people”); and specific attitudes toward lesbians or gay men or bisexual persons (e.g., “Lesbian women [Gay men] should be allowed to adopt children”; “Gay men [Lesbian women] deserve the

hatred they receive"). In addition, 28 items were developed to expand the range of items included in the measure. These new items reflected more contemporary issues related to civil rights (e.g., "Hospitals should acknowledge same-sex partners equally to any other next of kin"), items intended to reflect differential negativity toward lesbians versus gay men versus bisexual individuals (e.g., ["Lesbian/Gay/Bisexual] individuals should not be allowed to work with children"), and issues of religiosity (e.g., "I keep my religious views to myself in order to accept LGB people"). These items also were intended to reflect the present literature on attitudes and offer the foundation for multiple forms of the LGB-KAS to independently examine attitudes and knowledge regarding gay men or lesbians or bisexual men and women. An exploratory factor analysis (EFA) using principal axis factor extraction was performed on the remaining 60 items of the LGB-KAS. A five-factor solution using an oblique rotation yielded the most interpretable solution.

In Study 2, the factor stability of the initial EFA solution was established via confirmatory factor analyses, and construct validity estimates were obtained (described in the Validity section). Study 3 provided the test-retest reliability estimates of the instrument (described in the Reliability section) and evidence of convergent validity (described in the Validity section). In Study 4, another indication of construct validity of the LGB-KAS was investigated, that is, the sensitivity of the LGB-KAS to change across sexual orientation identities (described in the Validity section). Response Mode and Timing

Participants respond to each item using a 6-point Likerttype scale ranging from 1 (Very Uncharacteristic of Me or My Views) to 6 (Very Characteristic of Me or My Views). It typically takes a participant approximately 10 minutes to complete the LGB-KAS. Scoring LGB-KAS subscale scores are obtained by summing all items within each of the five subscales and dividing by the number of items on the subscales receiving responses (i.e., items with missing data are not scored or included in the averaging). There are no reverse-scored items. Reliability The LGB-KAS subscales have evidenced adequate internal consistency (Cronbach's α > .70) in past studies (Worthington et al., 2005). Test-retest reliability estimates indicated LGB-KAS subscale scores as highly stable over a 2- week time period (Worthington et al., 2005). Validity Discriminant validity was evidenced by an absence of relations between the total scale and subscales and a measure of impression management (Worthington et al., 2005). Construct validity was supported through (a) exploratory and confirmatory factor analyses, (b) correlations between LGB-KAS subscales and social dominance orientation and sexual identity exploration, and (c) findings indicating differences between heterosexual and LGB individuals on all five subscales (Worthington et al., 2005). Convergent validity for subscales was supported by correlations with measures of attitudes toward bisexuality, as well as lesbian women and gay men (Worthington et al., 2005). More recently, Worthington & Reynolds (2009) have demonstrated that the LGB-KAS can be administered to LGB individuals to obtain information about internalized homonegativity. Other Information Ann M. Becker-Schutte was one of the original authors of the scale.

Exhibit

Lesbian, Gay, and Bisexual Knowledge and Attitudes Scale

Instructions: Please use the scale below to respond to the following items. Circle the number that indicates the extent to which each

statement is characteristic or uncharacteristic of you or your views. Please try to respond to every item.

1 2 3 4 5 6

Very Very

Uncharacteristic Characteristic

of Me or My of Me or My

Views Views

Note: LGB = Lesbian, Gay, or Bisexual.

Please consider the ENTIRE statement when making your rating, as some statements contain two parts.

1. I feel qualified to educate others about how to be affirmative regarding LGB issues. a

1 2 3 4 5 6

2. I have conflicting attitudes or beliefs about LGB people.

3. I can accept LGB people even though I condemn their behavior.

4. It is important to me to avoid LGB individuals.

5. I could educate others about the history and symbolism behind the “pink triangle.”

6. I have close friends who are LGB.

7. I have difficulty reconciling my religious views with my interest in being accepting of LGB people.

8. I would be unsure what to do or say if I met someone who is openly lesbian, gay, or bisexual.

9. Hearing about a hate crime against an LGB person would not bother me.

10. I am knowledgeable about the significance of the Stonewall Riot to the Gay Liberation Movement.

11. I think marriage should be legal for same-sex couples.

12. I keep my religious views to myself in order to accept LGB people.

13. I conceal my negative views toward LGB people when I am with someone who doesn’t share my views.

14. I sometimes think about being violent toward LGB people.

15. Feeling attracted to another person of the same sex would not make me uncomfortable.

16. I am familiar with the work of the National Gay and Lesbian Task Force.

17. I would display a symbol of gay pride (pink triangle, rainbow, etc.) to show my support of the LBG community.

18. I would feel self-conscious greeting a known LGB person in a public place.

19. I have had sexual fantasies about members of my same sex.

20. I am knowledgeable about the history and mission of the PFLAG organization.

21. I would attend a demonstration to promote LGB civil rights.

22. I try not to let my negative beliefs about LGB people harm my relationships with the lesbian, gay, or bisexual individuals I know.

23. Hospitals should acknowledge same-sex partners equally to any other next of kin.

24. LGB people deserve the hatred they receive.

25. It is important to teach children positive attitudes toward LGB people.

26. I conceal my positive attitudes toward LGB people when I am with someone who is homophobic.

27. Health benefits should be available equally to same-sex partners as to any other couple.

28. It is wrong for courts to make child custody decisions based on a parent's sexual orientation.

Cloud, J. (2008, February 18). Prosecuting the gay teen murder. Time, 172. Retrieved September 26, 2008, from http://www.time.com/time/nation/article/0,8599,1714214,00.html

Worthington, R. L., Dillon, F. R., & Becker-Schutte, A. M. (2005). Development, reliability, and validity of the LGB Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH). Journal of Counseling Psychology, 52, 104-118.

Worthington, R. L., & Reynolds, A. L. (2009). Within group differences in sexual orientation and identity. Journal of Counseling Psychology, 56, 44–55. Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. The Counseling Psychologist, 30, 496–531. Yang, A. (2000). From wrong to rights: Public opinions on gay and lesbian Americans' move toward equality. Washington, DC: National Gay and Lesbian Task Force Institute.

Sexual Correlates of Female Homosexual Experience

ERICH GOODE, 1 State University of New York at Stony Brook

1 Address correspondence to Erich Goode, 3 Washington Square Village, Apartment 3B, New York, NY 10012; e-mail: egoode2001@aol.com

Scoring:

Hate = 4, 24, 8, 14, 9, 18

Knowledge = 20, 10, 16, 5, 1

Civil Rights = 27, 23, 11, 28, 25

Religious Conflict = 26, 12, 22, 7, 3, 13, 2

Internalized Affirmativeness = 19, 15, 17, 6, 21

There are no reverse-scored items. Subscale scores are obtained by averaging ratings on items receiving a response for each participant.

Thus, if Item 19 is not rated by a specific respondent, only the remaining four items on the Internalized Affirmativeness subscale are used

to obtain the average, and so on. This method ensures comparable scores when there are missing data.

a The 6-point rating scale follows each of the items.

Goode and Haber (1977) investigated whether and to what

extent college women who have engaged in homosexual

behavior have had different sexual experiences than those

who have not engaged in such behavior. Hence, setting aside the direction of causality, whether the respondent engaged in versus did not engage in homosexual or lesbian experiences was taken as the “independent” variable. We used a questionnaire that consisted of 66 questions about a wide variety and range of sexual behaviors and experi ences. These included age of first heterosexual intercourse, total number of sexual partners, sex partners with whom the respondent was not in love, experiences with fellatio and heterosexual cunnilingus, types of sexual experiences with a woman, age of the respondent when she first engaged in homosexual experience, whether she engaged in masturba tion and how often, and so on. We took the answers to these 66 questions as the “dependent” variables.

Description

We distributed the questionnaire/instrument during the spring of 1975 to all the female residents of several dormi tories at the State University of New York at Stony Brook; the questionnaires were delivered on a door-to-door basis. When completed, residents sealed them in an envelope; we picked them up a week later. The response rate for the initial wave was just under 50%; the total response rate following the third and final wave was 64%, which is con sidered good for this type of survey. The sample N was 160. We consider the findings from this survey exploratory rather than definitive. Because the respondents were

college students, their average age was between 19 and 20; no respondent was older than 23. Among our respondents, 86% had engaged in heterosexual intercourse at least once in their lives; only 16 respondents (10%) had engaged in at least one form of homosexual experience we asked about at least once, and 9 out of the 16 had never achieved an orgasm in this fashion. We found that the homosexually experienced women had engaged in a wider range of heterosexual experiences, and with a substantially larger number of partners, than was true of the homosexually naive women. For instance, the modal number of men the women with homosexual experience had engaged in intercourse with was 2, the median was 5, and the mean was 7.4; for those without homosexual experience, these figures were 1, 2, and 3.6, respectively. The median age at first heterosexual intercourse for the homosexually experienced was 16.7, with a mode of 15 and a median of 16; for the homosexually inexperienced, the figures were 18.3, 17, and 17, respectively. Women with homosexual experience were more likely to have experienced or engaged in fellatio, heterosexual cunnilingus, loveless sex, regular self-masturbation, and fantasy during heterosexual intercourse. Women without homosexual experience were more likely to enjoy fellatio and rank heterosexual intercourse as the source of their most pleasurable orgasm. Attainment of orgasm in heterosexual sex (at all) was slightly more likely among homosexually experienced women, but always or almost always attaining orgasm during heterosexual intercourse was slightly less likely. In short, homosexually experienced women appeared to

be more heterosexually experienced as well, at least at this

stage of their lives. We speculated that this category includes

a “mixed bag”: young women who are sexual “adventur

ers,” experimenting with a variety of sexual experiences,

most of whom will go on to become exclusively hetero

sexual; those who will decide to have a bisexual lifestyle;

and those who will come to regard themselves as lesbians.

Members of the last of these categories will, in all likeli

hood, abandon heterosexuality activity later in their lives.

Possible indicators of the last of these categories include

the following: nonenjoyment of fellatio; the predominance

of loveless heterosexual sex; mention of homosexual sex

as the source of their most pleasurable sexual activity; and

mention of women in sexual fantasies.

Response Mode and Timing

The questions were framed in the form of a forced-choice

checklist or a question requesting that the respondent write

out a specific answer, often a number. Most respondents needed between 30 and 60 minutes to complete the questionnaire. Scoring No scoring is required (see below). Reliability and Validity Because the study for which the instrument was developed (Goode & Haber, 1977) was descriptive and exploratory and not explanatory and definitive, we did not conduct tests of reliability, validity, and significance. We used simple percentage differences—as determined by magnitude—to determine the differences between our two categories of respondents. Reference Goode, E., & Haber, L. (1977). Sexual correlates of homosexual experience: An exploratory study of college women. The Journal of Sex Research, 13, 12–21.

Exhibit

Sexual Correlates of Female Homosexual Experience: Sexual Experience

Questionnaire/Instrument

Instructions: The intent of this study is to find out what and how women feel about their own sexuality. These questions are designed as

a means of understanding what women experience in their sexual relationships and activities. It is my belief that we, as women, have been letting one another down by allowing men to define out sexuality for us. The time has

come for us to speak candidly and frankly about our sexual lives. Only in this way can we know the nature of our collective experi

ences. It will not be easy to shed the beliefs we were taught and expected to accept pertaining to our sexuality, but it is something we must

do for ourselves and for each other. Several hundred questionnaires will be distributed to a sample of women on the Stony Brook campus. All returned questions will remain

confidential. There is no need to write your name on this questionnaire. Please answer all questions honestly, completely, and seriously. Your cooperation is very much appreciated. Thank you! a

1. Have you ever engaged in sexual intercourse with a man or a boy? (Please check one) Yes ____ No ____

(If no, skip to Question 2; if yes, proceed to Question 1a)

1a. Please write the age when you first engaged in sexual intercourse with a man or boy ____

1b. Please write in the total number of men or boys with whom you have engaged in sexual intercourse ____

1c. Have you ever engaged in sexual intercourse with a man or boy you were not in love with? Yes ____ No ____

1d. If yes to Question 1c, how did you usually feel right after engaging in sexual intercourse when you were not in love? (Please check the alternative that comes closest to your feeling)

Negative (sad, depressed, guilty, etc.) ____

Positive (It was what I wanted to do at the time) ____

Neutral (it didn't bother me) ____

It depended on the man; I felt different with different men ____

It depended on my mood at the time____

Other (please explain)
_____

1e. About what proportion of the time do you generally achieve orgasm during intercourse with a man? (Please check the appropriate category)

Never ____

Rarely (less than 10% of the time) ____

Occasionally (less than a quarter of the time but more than 10% of the time) ____

About half the time, more or less ____

Usually ____

Always or almost always ____

1f. Please estimate the total number of times that you have had intercourse with any boy or man. (Please write in the number)

___

2. Have you ever engaged in fellatio with a boy or man (oral stimulation of a man's penis) whether or not it led to his orgasm?

Yes ____ No ____

2a. Could you estimate the number of times that you have engaged in fellatio, with any boy or man _____

2b. About what proportion of this number did your oral stimulation of a boy or a man's penis lead to his orgasm? Please estimate

about what percentage of the time this happened) _____

2c. With how many boys or men have you engaged in fellatio when it did not lead to his orgasm? _____

2d. With how many men have you engaged in fellatio when it did lead to his orgasm? _____

2e. How old were you when you first engaged in fellatio with a boy or man? _____

2f. How old were you when you first engaged in fellatio when it led to his orgasm? _____

2g. Do you usually enjoy fellating a man? Yes ____ No ____

2h. Do you usually fellate a man spontaneously, or does the man usually request you to do it?

Usually spontaneously ____

At first, I was asked; later, it's usually been spontaneous
____

It depends on how much I like the man ____

I usually have to be asked to do it ____

There's no particular pattern to it ____

It's some other way (please explain)
_____

3. Has a man ever engaged in cunnilingus (oral stimulation of the woman's genitals) with you? Yes ____ No ____

If no, have you ever wanted a man to engage in cunnilingus with you? Yes _____ No ____; if yes, how often has this happened and

with how many men? _____; If yes, a man has engaged in cunnilingus with you, could you please estimate the total number

of times that this has taken place? _____

(If no, a man has not engaged in cunnilingus with you, please skip to Question 4; if at least one has, please continue with Question

3a)

3a. About what proportion of the time would you say you have achieved orgasm during cunnilingus with a man? (Please check the

appropriate category):

Never ____

Rarely (less than 10 % of the time) ____

Occasionally (less than a quarter of the time but more than 10% of the time) ____

About half the time, more or less ____

Usually ____

Always or almost always ____

3b. If you achieved orgasm during cunnilingus with a man less than half the time, why do you think this is so?

(Please explain) _____

3c. If a man engages in cunnilingus with you, do you usually ask him to do it or does he usually do it without you having to ask

him?

I always have to ask ____

I usually have to ask ____

It depends on the man ____

It happens both ways about half the time ____

The man usually does it without my asking ____

The man always does it without my asking ____

3d. How many men have performed cunnilingus with you? ____

3e. How old were you when a man first performed cunnilingus with you? ____

3f. How old were you when a man first performed cunnilingus with you when it led to your orgasm? _____

3g. Have you ever been afraid to ask a man to perform cunnilingus with you because you thought he wouldn't like it?

Yes ____ No ____

3h. If yes, about how many times has that taken place? (Please estimate the number of times) _____

3i. If yes, with how many men have you been afraid to ask? (Please estimate the number of men) _____

4. Have you ever engaged in any of the following sexual experiences with another woman?

Nude hugging and kissing and caressing without genital

contact? Yes ____ No ____

Cunnilingus? Yes ____ No____

Mutual pubic rubbing? Yes ____ No ____

Manual genital contact? Yes ____ No ____

(If you have not engaged in any of these activities, please skip to Question 5; if you have, please proceed with Question 4a)

If you have engaged in any other sexual experiences with another woman, what were they?

(Please explain) _____

4a. Could you estimate the total number of times that you have had sexual experiences with another woman asked about in Question 4—caressing, cunnilingus, pubic rubbing, and manual genital contact? (Please write in the total number) ____

4b. About what proportion of the time have you engaged in the following activities when you have engaged in sexual experiences with another woman? (Please write in the percentage)

Nude hugging, kissing, and caressing, without genital contact _____%

Cunnilingus _____%

Mutual pubic rubbing _____%

Manual genital contact _____%

4c. How old were you when you had any of these sexual experiences with another woman? ____

4d. With how many women have you engaged in any of these experiences? _____

4e. Have you ever engaged in any of these sexual experiences with a woman, with a man present? Yes ____ No ____

4f. If so, how often has this happened? _____

4g. About what proportion of the time that you had a sexual

experience with another woman did you achieve orgasm?

Never ____ Rarely_____ Occasionally _____ About half the time _____

Usually ____ Always or almost always _____

5. Have you ever masturbated yourself? Yes ____ No ____

(If no, skip to Question 6; if yes, proceed with Question 5a)

5a. How old were you when you first masturbated yourself? _____

5b. How old were you when you first masturbated yourself to orgasm? _____

5c. How frequently would you say you have masturbated yourself per month in the past year? _____

5d. About what proportion of the time would you say that you achieved orgasm when you masturbated yourself?

Never ____ Rarely ____ Occasionally ____

5e. Do you feel that masturbation is a substitute for having orgasms during sex with another person, or do you think that it is an enjoyable activity in itself? A substitute ____ Enjoyable in itself ____ Something else (Please explain) _____

6. Are some of your orgasms significantly more enjoyable than others, or are they equally enjoyable?

Some are far more enjoyable than others _____

They are about equally enjoyable _____

I have never had an orgasm _____

Something else (Please explain) _____

6a. If some of your orgasms are far more pleasurable than others, what do you think makes them this way?

(Please explain) _____

6b. Which of the following activities gives you the most

pleasurable orgasm? Which one the least? Please rank all of the following activities in terms of how pleasurable your orgasms have been when you engaged in each one:

Intercourse with a man ____

Cunnilingus with a man ____

Masturbating yourself ____

A man masturbating me ____

Sexual experience with another woman ____

My orgasms are about equally enjoyable ____

I have orgasms only one way ____

I have never had an orgasm ____

Something else (Please explain) _____

7. If you fail to achieve an orgasm with a man during intercourse, are you usually:

Extremely disappointed and frustrated _____

Somewhat disappointed and frustrated _____

Indifferent; if it happens, it happens, if it doesn't, it doesn't _____

I usually feel some other way (Please explain)
_____

8. How do you know you are having an orgasm? What are the signs? What happens to your body or mind that tells you that you are having an orgasm? (Please explain)
_____

9. Are there any sexual activities that you have not participated in but you would like to try? Yes ____ No _____

If yes, what are they? (Write it/them out)
_____

10. When you've been in bed with another person, have there been times when you would have liked to engage in a certain activity but

didn’t because you were afraid to ask your partner? Yes ____ No _____

If yes, what were they? (Please explain) _____

11. When you have been in bed with someone for the first time, have you ever felt reluctant to take off your clothes, or to have your

partner take off your clothes, because you were afraid the other person might not like your body? Yes ____ No_____

12. About how many orgasms per week do you feel is ideal for yourself? _____

13. In the best of all possible worlds, how often would you engage in sexual activity each week? _____

14. Do you fantasize during sex, any form of sex? Yes ____ No____

15. When you have sex, any form of sex, and have an orgasm, do you feel that one orgasm is satisfying for the next few hours, or do

you feel that you would like to have more than one?

One is usually satisfying ____

I usually would like to have more than one ____

It depends ____ (If it depends, what does it depend on? _____)

Something else (Please explain) _____

I rarely or never have orgasms ____

16. If you could have things more or less exactly the way you wanted sexually, what would they be like? How would you change your

life? What would your sex life be like? _____

17. What is your age? _____

18. What is your grandparents' religion?
_____

19. How religious would you say you are?

Very religious _____

Somewhat religious ____

Not very religious ____

I'm not religious at all ____

20. Father's education: _____ Mother's education: _____

21. Race: Black _____ White_____ Asian _____ Latino _____

Other (Please write in your race if it is Other)
_____

22. How influential do you feel your parents are now in your life? (Check one)

Very influential now _____

Somewhat influential now _____

Not very influential now _____

Not at all influential now _____

23. Have you ever smoked marijuana? Yes ____ No ____

24. During the past six months or so, how often would you estimate that you have smoked marijuana?

Not at all ____

Less than monthly ____

More than monthly but less than weekly ____

About once a week ____

Several times a week ____

Daily or so ____

More than once a day _____

25. Are there any questions that we should have asked in this questionnaire but didn't?

a The original introductory instructions were written by Goode's collaborator, Lynn Haber.

Attitudes Toward Lesbians and Gay Men Scale

GREGORY M. HEREK 1 AND KEVIN A. MCLEMORE, University of California at Davis

The Attitudes Toward Lesbians and Gay Men (ATLG) Scale is a brief measure of heterosexuals' attitudes toward gay men and lesbians. The original scale consisted of 20 different statements, 10 about gay men (ATG subscale) and 10 about lesbians (ATL subscale), to which respondents indicated their level of agreement or disagreement. Shorter versions have subsequently been developed, consisting of ATG and ATL subscales with parallel versions of 3, 4, or 5 items. These shorter versions have been found to be highly correlated with the original, longer subscales (e.g., rs > .95 between 5-item versions of the ATG and ATL and their 10-item counterparts), and their use is now recommended instead of the original subscales.

Response Mode and Timing

The ATLG can be self-administered (presented on paper or on a computer) or administered orally (as in a telephone survey). When presented visually, scale items are typically accompanied by a 5-, 7-, or 9-point Likert-type scale with anchor points of Strongly Disagree and Strongly Agree.

When administered orally during telephone or face-to face interviews, four response options are usually offered (Strongly Disagree, Disagree Somewhat, Agree Somewhat, Strongly Agree), and respondents are allowed to volunteer a middle response (e.g., “Neither Agree nor Disagree”). Completion time is roughly 30–60 seconds per item.

Scoring

Scoring is accomplished by assigning numerical values to the response options (e.g., for a 7-point response format, 1 = Strongly Disagree, 7 = Strongly Agree) and summing across items for each subscale. Some items are reverse scored as indicated below. For ease of interpretation, the sum of item values can be divided by the total number of items to yield a score that matches the response scale metric. The possible range of scores depends on the response scale used. Scores on the original ATL and ATG subscales, which are based on responses to differently worded items, were not directly comparable. Researchers wishing to compare respondents’ attitudes toward gay men with their attitudes toward lesbians were advised to use parallel forms of one subscale (usually the ATG items). The use of such paral lel forms (with each item presented once in reference to gay men and once in reference to lesbians) is now recom mended for all ATLG scale users, as shown in the Exhibit. Reliability and Validity The ATLG subscales have high levels of internal consistency. When self-administered, α > .85 with most college student samples and α > .80 with

most nonstudent adult samples. For telephone surveys with oral administration to adult samples, α > .80 for 5-item versions and α > .70 for 3-item versions. Test-retest reliability (rs > .80) has been demonstrated with alternate forms (Herek, 1988, 1994). Scores on the ATLG subscales are reliably correlated with other theoretically relevant constructs (e.g., Herek, 1994, 2009; Herek & Capitanio, 1996, 1999a). Higher scores are associated with high religiosity, lack of interpersonal contact with gay men and lesbians, adherence to traditional gender-role attitudes, belief in a traditional family ideology, and endorsement of policies that discriminate against sexual minorities. In addition, ATG scores are reliably correlated with AIDS-related stigma. The ATLG's discriminant validity also has been established. Members of lesbian and gay organizations scored at the extreme positive end of the range, and nonstudent adults who publicly supported a gay rights ballot measure scored significantly lower on the ATLG than did community residents who publicly opposed the initiative (Herek, 1988, 1994). Administration in Other Languages and Outside the United States Although the ATLG was originally developed for administration to English-speaking heterosexual adults in the United States, it has also been used in research conducted in England (Hegarty, 2002) and Canada (Mohipp & Morry, 2004), and translated versions have been administered in the Netherlands (Meerendonk, Eisinga, & Felling, 2003), Singapore (Detenber et al., 2007), Brazil (DeSouza, Solberg, & Elder, 2007), Chile (Cardenas & Barrientos, 2008; Nierman, Thompson, Bryan, & Mahaffey, 2007), and Turkey (Gelbal & Duyan, 2006). In addition, a Spanish-language version was created for a study of California adults of Mexican descent (Herek & Gonzalez-Rivera, 2006). In these studies, scale reliability has been consistently acceptable (typically, α > .80), and the patterns of correlations between ATLG scores and theoretically related constructs have been similar to those obtained with U.S. Englishspeaking samples.

1 Address correspondence to Gregory Herek, Department of Psychology, University of California, Davis, CA 95616-8686; e-mail through

http://psychology.ucdavis.edu/Herek/

Other Information

Item order effects have been observed among heterosexual

males in telephone surveys, which may indicate a gender linked pattern in heterosexuals' attitudes (Herek, 2002; Herek & Capitanio, 1999b). For more information about the ATLG's development and usage, see Herek (1994, 2009). Researchers need not obtain the author's permission to use the ATLG in not-for-profit research that is consis tent with the American Psychological Association's Ethical Principles of Psychologists.

Cardenas, M., & Barrientos, J. (2008). The Attitudes Toward Lesbians and Gay Men Scale (ATLG): Adaptation and testing the reliability and validity in Chile. The Journal of Sex Research, 45, 140–149.

DeSouza, E., Solberg, J., & Elder, C. (2007). A cross-cultural perspective on judgments of woman-to-woman sexual harassment: Does sexual orientation matter? Sex Roles, 56, 457–471.

Detenber, B., Cenite, M., Ku, M., Ong, C., Tong, H., & Yeow, M. (2007). Singaporeans' attitudes toward lesbians and gay men and their toler ance of media portrayals of homosexuality. International Journal of Public Opinion Research, 19, 367–379.

Gelbal, S., & Duyan, V. (2006). Attitudes of university students toward lesbians and gay men in Turkey. Sex Roles, 55, 573–579.

Hegarty, P. (2002). "It's not a choice, it's the way we're built": Symbolic

beliefs about sexual orientation in the US and Britain. Journal of

Community and Applied Social Psychology, 12, 153-166.

Herek, G. M. (1988). Heterosexuals' attitudes toward lesbians and gay

men: Correlates and gender differences. The Journal of Sex Research,

25, 451-477. Herek, G. M. (1994). Assessing heterosexuals' attitudes toward lesbians and gay men: A review of empirical research with the ATLG scale. In B. Greene & G. M. Herek (Eds.), Lesbian and gay psychology: Theory, research, and clinical applications (pp. 206-228). Thousand Oaks, CA: Sage. Herek, G. M. (2002). Gender gaps in public opinion about lesbians and gay men. Public Opinion Quarterly, 66, 40-66. Herek, G. M. (2009). Sexual stigma and sexual prejudice in the United States: A conceptual framework. In D. A. Hope (Ed.), Contemporary perspectives on lesbian, gay and bisexual identities: The 54th Nebraska Symposium on Motivation (pp. 65-111). New York: Springer. Herek, G. M., & Capitanio, J. (1996). "Some of my best friends": Intergroup contact, concealable stigma, and heterosexuals' attitudes toward gay men and lesbians. Personality and Social Psychology Bulletin, 22, 412-424. Herek, G. M., & Capitanio, J. (1999a). AIDS stigma and sexual prejudice. American Behavioral Scientist, 42, 1130-1147. Herek, G. M., & Capitanio, J. (1999b). Sex differences in how heterosexuals think about lesbians and gay men: Evidence from survey context effects. The Journal of Sex Research, 36, 348-360. Herek, G. M., & Gonzalez-Rivera, M. (2006). Attitudes toward homosexuality among U.S. residents of Mexican descent. The Journal of Sex Research, 43, 122-135. Meerendonk, B. van de, Eisinga, R., & Felling, A. (2003). Application of Herek's Attitudes Toward Lesbians and Gay Men Scale in the Netherlands. Psychological Reports, 93, 265-275. Mohipp, C., & Morry, M. (2004). The relationship of symbolic beliefs and prior contact to heterosexuals' attitudes toward gay men and lesbian women. Canadian Journal of Behavioural Science, 36, 36-44. Nierman, A. J., Thompson, S., Bryan, A., & Mahaffey, A. (2007). Gender role beliefs and attitudes toward lesbians and gay men in Chile and the U.S. Sex Roles, 57, 61-67.

Exhibit

Attitudes Toward Lesbians and Gay Men Scale, Revised 5-Item Version

Attitudes Toward Gay Men (ATG-R-S5) Subscale

1. Sex between two men is just plain wrong. *

2. I think male homosexuals are disgusting. *

3. Male homosexuality is a natural expression of sexuality in men. * (Reverse scored)

4. Male homosexuality is a perversion.

5. Male homosexuality is merely a different kind of lifestyle that should not be condemned. (Reverse scored)

Attitudes Toward Lesbians (ATL-R-S5) Subscale

1. Sex between two women is just plain wrong. *

2. I think female homosexuals (lesbians) are disgusting. *

3. Female homosexuality is a natural expression of sexuality in women. * (Reverse scored)

4. Female homosexuality is a perversion.

5. Female homosexuality is merely a different kind of lifestyle that should not be condemned. (Reverse scored)

* This item is included in the 3-item version (ATLG-R) of the subscale.

Attitudes Toward Lesbians and Gay Men Scale: Spanish-Language Version

Attitudes Toward Gay Men (ATG)

1. Las relaciones sexuales entre dos hombres simplemente están mal. [Sex between two men is just plain wrong.]

2. Yo pienso que los hombres homosexuales son repugnantes. [I think that male homosexuals are disgusting.]

3. La homosexualidad masculina es una expresión natural de la sexualidad del hombre. [Male homosexuality is a natural expression of sexuality in men.]

4. La homosexualidad masculina es una perversión. [Male

homosexuality is a perversion.]

Attitudes Toward Lesbians (ATL)

1. Las relaciones sexuales entre dos mujeres simplemente están mal. [Sex between two women is just plain wrong.]

2. Yo pienso que las lesbianas son repugnantes. [I think that lesbians are disgusting.]

3. La homosexualidad femenina es una expresión natural de la sexualidad de la mujer. [Female homosexuality is a natural expression of sexuality in women.]

4. La homosexualidad femenina es una perversión. [Female homosexuality is a perversion.]

Note. The Spanish-language version was adapted for use by Herek and Gonzales-Rivera (2006).

Component Measure of Attitudes Toward

Homosexuality

MARY E. KITE, 1 Ball State University

1 Address correspondence to Mary E. Kite, Department of Psychological Science, Ball State University, Muncie, IN 47306; e-mail: mkite@bsu.edu

Researchers have demonstrated that attitudes toward gay

men and lesbians are multidimensional and that, to fully

understand antigay prejudice, these different aspects of

people’s attitudes and perceptions should be considered (see

Kite & Whitley, 1996; LaMar & Kite, 1998). Because atti

tudes toward homosexuality can serve different functions for

different people (Herek, 1986), antigay prejudice can best be

understood by considering these differing perspectives. One

attitude component reflects the general belief that homo

sexuality violates traditional values, for example, whereas

another component reflects the possibility that people fear contact with gays and lesbians in general or sexual advances from a same-sex other specifically. These attitudes are separate from the stereotypic beliefs people hold about gay men and women and from people's tendency to support or deny gay men and lesbians' civil rights.

Description

To construct this measure, established measures of attitudes toward homosexuality, summarized in Beere (1990), were reviewed. Initially, 174 items were selected that conceptually represented five components of attitudes toward homosexuality: Civil Rights, Condemnation/Tolerance, Contact, Morality, and Stereotypes. These items were categorized by component, and overlapping items were eliminated. For those categories not well represented by previous measures, new items were written. A sample of 270 college students completed the measure, and their responses were analyzed using a varimax factor analysis. Results revealed five factors that accounted for 56.8% of the variance. Most parallel items for lesbians and gay men loaded on the same factor; the exception was that the gay male and lesbian contact items emerged as separate factors. Contrary to expectations, civil rights did not emerge as a separate factor. Rather, those items loaded on the Condemnation/Tolerance factor, thereby resulting in four final components. The final measure consists of 91 items assessing attitudes toward gay men and lesbians. Of these, 42 items address attitudes toward gay men and 42 parallel items address attitudes toward lesbians. An additional seven items refer to homosexuality or same-sex interactions (and do not vary by sex of target). Number of items per subscale and Cronbach's alpha, based on LaMar and Kite (1998), are as

follows: Gay Male Condemnation/Tolerance (11 items; alpha = .92); Lesbian Condemnation/Tolerance (11 items; alpha = .89); Gay Male Morality (10 items; alpha = .92); Lesbian Morality (10 items; alpha = .93); Neutral Morality (3 items; alpha = .80); Gay Male Contact (14 items; alpha = .96); Lesbian Contact (14 items; alpha = .95); Neutral Contact (4 items; alpha = .75); Gay Male Stereotypes (7 items; alpha = .78); Lesbian Stereotypes (7 items; alpha = .75). This measure was developed using a college student sample; however, it can be used with any population.
Response Mode and Timing Participants evaluate these items using a 5-point Likert scale ranging from 1, Strongly Agree, to 5, Strongly

TABLE 1

Correlations Among Subscales of Component Measure of Attitudes Toward Homosexuality

	Gay Condemnation-Tolerance	Lesbian Condemnation-Tolerance	Gay Morality	Lesbian Morality	Gay Contact	Lesbian Contact	Neutral Contact	Gay Stereotypes	Lesbian Stereotypes
Gay Condemnation-Tolerance	.90	.83	.75	.83	.55	.46	.62	.61	
Lesbian Condemnation-Tolerance	.79	.79	.78	.67	.50	.62	.63		
Gay Morality	.91	.85	.64	.58	.63	.61			
Lesbian Morality	.76	.75	.59	.62	.63				
Gay Contact	.61	.67	.60	.56					
Lesbian Contact	.63	.54	.54						
Neutral Contact	.42	.42							
Gay Stereotypes	.79								
N	263	264	264	264	263	263	264	264	264

Note. All correlations are significant at $p < .001$.
Reprinted from LaMar and Kite (1998), Table 2, with

permission from Taylor & Francis.

Disagree. It is recommended that the item order be ran domized and parallel items not appear contiguously on the measure. At administration, items from the four factors can be intermixed. However, each factor can be used as a stand alone instrument to assess a specific component of attitudes toward homosexuality. The instrument takes approximately 15 minutes to complete.

Scoring

Subscales are created for each of the 10 factors by first reverse scoring items that are worded negatively. Items that are reverse scored are marked on the instrument (see the Exhibit). Subscale scores are then created by averaging participants' ratings on the items. LaMar and Kite (1998) reported correlations among the subscales. Correlations between the gay male and lesbian versions of the sub scales are high for Condemnation/Tolerance (r = .90) and Morality (r = .91) and smaller for Contact and Stereotype (see Table 1).

Reliability

Information concerning the internal consistency of the sub scales is presented in the description of the development of the scale (see above). Additional information is provided in Table 1. Test-retest reliability of the measure has not been established.

Validity

To establish validity of the factors, LaMar and Kite (1998) compared mean subscale scores for each target sex for male and female respondents. Results showed that men evaluated gay men more negatively than they evaluated lesbians on both the Condemnation/Tolerance and the Morality subscales. On these two subscales, women respondents evaluated gay men and lesbians similarly. For the Contact subscale, men rated contact with gay men more negatively

Herek, G. M. (1986). The instrumentality of attitudes: Toward a neofunctional theory. Journal of Social Issues, 42(2), 99–114.

Kite, M. E., & Whitley, B. E., Jr. (1996). Sex differences in attitudes toward homosexual persons, behavior, and civil rights. Personality and Social Psychology Bulletin, 22, 336–353.

LaMar, L., & Kite, M. E. (1998). Sex differences in attitudes toward gay men and lesbians: A multi-dimensional perspective. The Journal of Sex Research, 35, 189–196.

Pratto, F., Sidanius, J., Stallworth, L. M., & Malle, B. F. (1994). Social dominance orientation: A personality variable predicting social and political attitudes. Journal of Personality and Social Psychology, 67, 741–763. Spence, J. T., & Hahn, E. D. (1997). The Attitudes Toward Women Scale and attitude change in college students. Psychology of Women Quarterly, 21, 17–34. Whitley, B. E., Jr. (1999). Right-wing authoritarianism, social dominance orientation, and prejudice. Journal of Personality and Social Psychology, 77, 126–134. Wilkinson, W. W. (2006). Exploring heterosexual women’s anti-lesbian attitudes. Journal of Homosexuality, 51(2), 139–155. Wilkinson, W. W. (2008). Threatening the patriarchy: Testing an explanatory paradigm of anti-lesbian attitudes. Sex Roles, 59, 512–520.

Exhibit

Component Measure of Attitudes Toward Homosexuality

Record your responses to each item using the following scale:

1 2 3 4 5

Strongly Agree Strongly Disagree

Condemnation/Tolerance

1. Apartment complexes should not accept lesbians (gay men) as renters.

2. Lesbians (gay men) should be required to register with the police department where they live.

3. Lesbians (gay men) should not be allowed to hold responsible positions.

4. Job discrimination against lesbians (gay men) is wrong.*

5. Lesbians (gay men) are a danger to young people.

6. Lesbians (gay men) are more likely to commit deviant acts such as child molestation, rape, voyeurism (peeping Toms) than are heterosexuals.

7. Lesbians (gay men) dislike members of the opposite sex.

8. Finding out an artist was a gay man (lesbian) would have no effect on my appreciation of his (her) work.*

9. Lesbians (gay men) should be allowed to serve in the military.*

10. Lesbians (gay men) should not be discriminated against because of their sexual preference.*

11. Lesbians (gay men) should not be allowed to work with children.

Gay Male/Lesbian Social Norms/Morality

1. The increasing acceptance of gay men (lesbians) in our society is aiding in the deterioration of morals.

2. Gay men (lesbians) endanger the institution of the family.

3. Many gay men (lesbians) are very moral and ethical people.*

4. Gay male (lesbian) couples should be able to adopt children the same as heterosexual couples.*

5. The idea of marriages between gay men (lesbians) seems ridiculous to me.

6. State laws regulating private, consenting behavior between gay men (lesbians) should be loosened.*

7. Gay men (lesbians) just can't fit into our society.

8. Gay men (lesbians) do need psychological treatment.

9. Gay men (lesbians) are a viable part of our society.*

10. Homosexual behavior between two men (women) is just plain wrong.

Neutral Morality

1. Homosexuality, as far as I am concerned, is not sinful.*

2. Homosexuality is a perversion.

3. I find the thought of homosexual acts disgusting.

Gay Male/Lesbian Contact

1. I enjoy the company of gay men (lesbians).*

2. It would be upsetting to me to find out I was alone with a gay man (lesbian).

3. I avoid gay men (lesbians) whenever possible.

4. I would feel nervous being in a group of gay men (lesbians).

5. I think gay men (lesbians) are disgusting.

6. I would enjoy attending social functions at which gay men (lesbians) were present.*

7. Bars that cater solely to gay men (lesbians) should be placed in a specific and known part of town.

8. I would feel comfortable working closely with a gay man (lesbian).*

9. If a gay man (lesbian) approached me in a public restroom, I would be disgusted.

10. I would not want a gay man (lesbian) to live in the house next to mine.

11. Two gay men (lesbians) holding hands or displaying affection in public is revolting.

12. I would be nervous if a gay man (lesbian) sat next to me on a bus.

13. I would decline membership in an organization if I found out it had gay male (lesbian) members.

14. If I knew someone was a gay male (lesbian), I would go ahead and form a friendship with that individual.*

Neutral Contact

1. If a member of my sex made advances toward me, I would feel angry.

2. I would feel comfortable knowing I was attractive to members of my sex.*

3. I would be comfortable if I found myself attracted to a member of my sex.*

4. I would feel uncomfortable if a member of my sex made an advance toward me.

Gay Male/Lesbian Stereotypes

1. Lesbians (gay men) prefer to take roles (passive or aggressive) in their sexual behavior.

2. The love between two lesbians (gay men) is quite different from the love between two persons of the opposite sex.

3. Lesbians (gay men) have weaker sex drives than heterosexuals.

4. A lesbian's (gay man's) mother is probably very domineering.

5. Most lesbians (gay men) have a life of one-night stands.

6. Most lesbians (gay men) like to dress in opposite-sex

clothing.

7. Most lesbians (gay men) have identifiable masculine (feminine) characteristics.

*Items reverse scored.

Gay Peer Crowds Questionnaire

BETTY S. LAI, 1 University of Miami

B RIAN L. B. WILLOUGHBY, Massachusetts General Hospital and Harvard Medical School

NATHAN D. DOTY, Children’s Hospital of Philadelphia

NEENA M. MALIK, University of Miami Miller School of Medicine

1 Address correspondence to Betty Lai, Department of Psychology, University of Miami, P. O. Box 249229, Coral Gables, FL 33124; e-mail:

bettylai10@gmail.com

The Gay Peer Crowds Questionnaire (GPCQ) assesses

self-identified gay men’s affiliations with distinct sub

groups that may exist within the larger gay community.

Peer crowds of interest include Activist, Artsy, Bear, Circuit

Partier, Drag Queen, Goth, Granola, Leather Men, Muscle

Boy, Professional, Suburban, and Twink. Men are asked to

give their opinions on whether these crowds exist, rate their

identification with each crowd, and indicate their primary

affiliation. Additional information, such as the reputation

and attractiveness of each crowd, is also assessed. Description The GPCQ is a 23-item self-report measure. The format of the GPCQ is based upon the Peer Crowds Questionnaire, a measure of adolescents’ peer crowd affiliations (La Greca, Prinstein, & Fetter, 2001; Mackey

& La Greca, 2006). To examine the existence of gay peer crowds, respondents are provided with descriptions of 12 key peer crowds and asked whether they believe that each group exists. For example, men are asked, “Is there a group of gay men who are boyish-looking, with a slim or athletic figure and little

body hair (‘Bois/Twinks’)?” Response options include

Yes, No, and Unsure. Respondents are also asked to pro

vide other common names for each crowd and asked to list

other adult gay peer crowds in an open-ended format (i.e.,

“What other adult gay peer crowds may exist?”). To examine the degree of identification with gay peer

crowds, respondents are then asked to rate the degree to

which they identify with 12 peer crowds on a 5-point Likert

type scale (1 = Not at all, 5 = Very Much). In addition, par

ticipants are asked, “Which one of these groups, if any, do

you identify with?” Participants are also asked how other

groups view the individual’s peer crowd on a 5-point Likert

scale (1 = Very Disliked, 5 = Very Liked), whether others

who are not in the group are able to identify the group (Yes

or No), and whether there are symbols, behaviors, or val

ues associated with the group (Yes or No). Affiliation with

gay peer crowds is measured through five questions related

to perception of peer crowds, and close social network

ties to peer crowds (e.g., “Which group does your closest

gay male friend (not including your partner) belong to?”

“Which group are you most attracted to?” “Which group

does your relationship partner belong to?”). Several steps were involved in developing the GPCQ.

First, a preliminary list of gay subcommunities was gen
erated from the limited empirical data available in this
area (i.e., Clausell & Fiske, 2005; Peacock, Eyre, Quinn,
& Kegeles, 2001). Next, this list was given to an informal
focus group of gay men and to researchers who are experts
in the area of psychological research and sexuality. Each
person commented on the list by providing written descrip
tions of the peer crowds, listing other crowds that may
exist, and providing general feedback. Descriptions from
the focus group and researchers were combined with defi
nitions provided by Peacock et al. (2001) to create the
final
list of gay peer crowds with their descriptions.

Response Mode and Timing

Respondents are provided with a copy of the GPCQ and
asked to read instructions carefully. For each question,
respondents should check the box corresponding with
their answer. The GPCQ was developed specifically for
self-identified gay men. A full administration of the GPCQ
takes approximately 10 minutes.

Scoring

Items on the GPCQ should be examined individually; that
is, no summary scores need to be calculated. Some of the
items are categorical in nature, whereas others (i.e., Items
14 and 16) are continuous, ranging from 1 (Not at all; Very

Disliked) to 5 (Very Much; Very Liked).

Validity

The GPCQ has been implemented and examined in a large

empirical investigation (Willoughby, Lai, Doty, Mackey, &

Malik, 2008). In this initial study, 340 self-identified adult

Exhibit

Gay Peer Crowds Questionnaire

Certain groups or “peer crowds” of gay men may exist in the United States or Canada. We’d like to ask you about whether or not you

believe these different groups exist.

Section I. Existence of Peer Crowds Please check the box indicating your answer.

Yes No Unsure

1. Is there a group of gay men who are interested in political and social issues and promote/protest certain ☐ ☐ ☐

views and policies (“Activists”)?

What might be other names for gay men who are “Activists”?
_____

2. Is there a group of gay men who are hairy (e.g., beards) and have husky builds (“Bears”)? ☐ ☐ ☐

What might be other names for gay men who are “Bears”?
_____

3. Is there a group of gay men who are very interested in arts, such as writing, poetry, galleries, and/or ☐ ☐ ☐

theatre performances (“Artsy”)?

What might be other names for gay men who are “Artsy”?
_____

4. Is there a group of gay men who rebel against the norm

(in clothing or ideas, for example), or attempt not [illegible]

to conform to social ideals (“Goths/Alternatives”)?

What might be other names for gay men who are “Goths/Alternatives”? _____

5. Is there a group of gay men who follow the club scene and go to circuit parties (“Circuit Partiers”)? [illegible]

What might be other names for gay men who are “Circuit Partiers”? _____

6. Is there a group of gay men who live in suburban areas, enjoy the comfort of home, and shy away from [illegible]

the gay social scene (“Suburbans”)?

What might be other names for gay men who are “Suburbans”? _____

7. Is there a group of gay men who spend a lot of time working out and like to maintain a muscular physique [illegible]

(“Muscle Boys”)?

What might be other names for gay men who are “Muscle Boys”? _____

8. Is there a group of gay men who are well educated, have white-collar jobs, and/or lead wealthy lifestyles [illegible]

(“Professionals”)?

What might be other names for gay men who are “Professionals”? _____

9. Is there a group of gay men who wear leather or uniforms for social activities (“Leather Men”)? [illegible]

What might be other names for gay men who are “Leather Men”? _____

10. Is there a group of gay men who dress up and/or perform as women (“Drag Queens”)? [illegible]

What might be other names for gay men who are “Drag Queens”? _____

11. Is there a group of gay men who are concerned about the environment and nature, liberal in political ☐ ☐ ☐

beliefs, and/or vegetarian, vegan, or have other dietary restrictions (“Granola”)?

What might be other names for gay men who are “Granola”? _____

12. Is there a group of gay men who are boyish-looking, with a slim or athletic figure and little body hair ☐ ☐ ☐

(“Bois/Twinks”)?

What might be other names for gay men who are “Bois/Twinks”? _____

13. What other adult gay peer crowds may exist? (please list) _____

Section II. Self-Identification Please check the box indicating your answer.

14. How much do you identify with the: Not at All Somewhat Very Much

1 2 3 4 5

Activists ☐ ☐ ☐ ☐ ☐

Bears ☐ ☐ ☐ ☐ ☐

Artsy ☐ ☐ ☐ ☐ ☐

Goths/Alternatives ☐ ☐ ☐ ☐ ☐

Circuit Partiers ☐ ☐ ☐ ☐ ☐

Suburbans ☐ ☐ ☐ ☐ ☐

Muscle Boys ☐ ☐ ☐ ☐ ☐

Professionals ☐ ☐ ☐ ☐ ☐

Leather Men ☐ ☐ ☐ ☐ ☐

Drag Queens ☐ ☐ ☐ ☐ ☐

Granolas ☐ ☐ ☐ ☐ ☐

Bois/Twinks □ □ □ □ □

15. Which one of these groups, if any, do you identify with? (Select one that fits you best)

Activists □

Bears □

Artsy □

Goths/Alternatives □

Circuit Partiers □

Suburbans □

Muscle Boys □

Professionals □

Leather Men □

Drag Queens □

Granolas □

Twinks □

None/Average □

Very Moderately Neutral Moderately Very

Disliked Disliked Liked Liked

16. How is your group treated by most other gay men? (Select one) □ □ □ □ □

17. Can your group be identified by other gay men who are not part of your group? Yes □ No □

18. Does your group have symbols (e.g., certain clothes), behaviors (e.g., hanging out at similar places), or

values (e.g., believe in same things)? Yes □ No □

Section III. Group Affiliation Please select one group for each column.

19. Which one of 20. Which one of 21. Which group does 22.

Which 23. Which group

these groups, if these groups your closest gay male group
are does your

any, would you would your friends friend (not including
you most relationship

most like to be say you are most your partner) attracted
to? partner

a part of? similar to? belong to? belong to?

Activists □ □ □ □ □

Bears □ □ □ □ □

Artsy □ □ □ □ □

Goths/Alternatives □ □ □ □ □

Circuit Partiers □ □ □ □ □

Suburbans □ □ □ □ □

Muscle Boys □ □ □ □ □

Professionals □ □ □ □ □

Leather Men □ □ □ □ □

Drag Queens □ □ □ □ □

Granolas □ □ □ □ □

Twinks □ □ □ □ □

None/Average □ □ □ □ □

Power Sharing in Lesbian Partnerships

JEAN M. LYNCH, 1 Miami University

M ARY ELLEN REILLY, University of Rhode Island

The instrument was developed to determine egalitarianism

in lesbian partnerships as a function of similarity in
social

status variables. Specifically, it investigates whether cou
ples who are similar in age, income, occupation, education,
and financial assets tend to characterize their relationships
as equal in a variety of areas. Previous researchers have
typically investigated one partner's perception of power
in the relationship (e.g., Blood & Wolfe, 1960; Peplau et
al., 1982). Our instrument is designed to assess similarities
and differences in each partner's assets so that it can be
determined whether differences in these demographic vari
ables are related to social status. Additionally, our instru
ment allows a determination of whether type of couple
(i.e., equal, unequal but in agreement about who has more
power, and couples with differing perceptions about power
sharing) is related to social status variables.

Description

The power sharing instrument consists of demographic
items, such as respondent's age as of the last birthday,
income, educational attainment, occupation and occupa
tional classification, and several items which assess the
respondent's assets. A number of items also investigate
financial sharing by partners, such as whether the cou
ple are cosignatories on saving and checking accounts,
and whether the partner is a sole or partial beneficiary.
Respondents also indicate how financial contributions in

the household are divided, such as whether the respondent

or her partner pays, or whether equal or proportional pay

ments are made for a variety of household needs.

The remainder of the questionnaire measures egali

tarianism in a variety of areas. Specifically, these items

refer to responsibility for household chores and financial

decision making. Three items query respondents regard

ing sexual equality in terms of initiation, decisions about

the frequency of sex, and sexual satisfaction. As above,

1 Address correspondence to Jean M. Lynch, Department of Sociology and Anthropology, Miami University, Oxford, OH 45056; e-mail:

lynchjm@muohio.edu.

Exhibit

Power Sharing in Lesbian Relationships

This questionnaire is the main source of data for a study of lesbian relationships. It should only take a few minutes to complete.

Your replies will be completely anonymous since there are no identifying marks on the questionnaire. Please do not sign the question

naire. It is important that each partner fills out her questionnaire separately and places it in one of the blank envelopes. Both should be

returned to me together in the stamped, addressed envelope provided. Since I am studying couples, this is essential. Thank you very

much for your time and cooperation.

1. What is your age as of your last birthday? _____ years.

2. What is your income (as reported on all W-2 forms)?
_____

3. Which of the following best describes your highest level of educational attainment?

( ) Completed grammar school

( ) Completed high school

( ) Some college or technical school

( ) Completed college

( ) Master's degree

( ) Ph.D., M.D., Ed.D., J.D.L.

( ) Other, please describe _____

4. What is your occupation? _____

5. Which of the following would you use to describe your occupation?

( ) Homemaker

( ) Professional

( ) Manager or Administrator

( ) Sales worker

( ) Clerical

( ) Craftsworker

( ) Farm worker

( ) Machinist or Transportation Worker

( ) Laborer

( ) Service worker

( ) Private household worker

( ) Other

6. What is the current worth of your personal financial assets? (stocks, bonds, property, cars, savings and checking accounts). Please estimate:

( ) $0

( ) $1,001–$9,999

( ) $10,000–$19,999

( ) $20,000–$34,999

( ) $35,000–$49,999

( ) $50,000–$74,999

( ) $75,000–$100,000 or more

7. Which of the following are currently held by you? Check all that apply.

A ( ) Savings accounts in my name only

B. ( ) Checking accounts in my name only

C. ( ) Investments in my name only

D. ( ) Joint savings accounts

E. ( ) Joint checking accounts

F. ( ) Investments in my name and someone else’s

8. If you checked A, B, or C in Question 7 above, are the account(s) or investment(s) arranged so that your partner could manage your personal finances in the event that you were unable to do so?

( ) Yes

( ) No

9. If you checked C, E, or F in Question 7 above, is the other name on the account(s) or investment(s):

Partner Relative Some other person, not related

Checking ( ) ( ) ( )

Savings ( ) ( ) ( )

Investments ( ) ( ) ( )

10. If you have a will, is your partner named as:

( ) A beneficiary of all of your estate

( ) A beneficiary of part of your estate

( ) Not mentioned in your will

( ) I do not have a will

11. If you have life insurance, who is your beneficiary?

( ) Partner

( ) Relative

( ) Some other person, not related

( ) Both partner and relative

( ) I do not have any insurance

12. If you are currently renting, and have a lease, whose name is it in?

( ) My name

( ) My partner’s name

( ) Both of our names

( ) Someone else’s name

( ) No lease

13. If you own your own home, whose name is on the mortgage title or title to the house?

( ) My name

( ) My partner’s name

( ) My partner and I are tenants in common

( ) My partner and I are joint tenants

14. If you currently own a car, who paid (or is paying) for it?

( ) I

( ) My partner

( ) Both own it equally

( ) Each has her own car which she owns

( ) Other, please explain _____

15. In our current residence, household furnishings are:

( ) Predominantly mine

( ) Predominantly hers

( ) Each person owns approximately half of the furnishings

( ) Ours jointly

16. In your household, how are contributions to the following arranged:

My partner We split bills based We split Included in Does

I pay pays on our ability to pay bills equally the rent not apply

A. Mortgage payments ( ) ( ) ( ) ( ) ( ) ( )

B. Property taxes ( ) ( ) ( ) ( ) ( ) ( )

C. Rent payments ( ) ( ) ( ) ( ) ( ) ( )

D. Insurance (house or apartment) ( ) ( ) ( ) ( ) ( ) ( )

E. Heating bills ( ) ( ) ( ) ( ) ( ) ( )

F. Electric bills ( ) ( ) ( ) ( ) ( ) ( )

G. Telephone bills ( ) ( ) ( ) ( ) ( ) ( )

H. Groceries ( ) ( ) ( ) ( ) ( ) ( )

I. Household repairs ( ) ( ) ( ) ( ) ( ) ( )

17. Reviewing the items in Question 16 above, how would you describe your overall contributions to these household expenses?

( ) I contribute more

( ) My partner contributes more

( ) We contribute according to our ability to pay

( ) We contribute equally

18. How long have you and your partner been living together? ____ years

19. When you and your partner first began living together, whose residence did you use?

( ) Mine

( ) Partner’s

( ) A new residence chosen by us

20. Our current residence is:

( ) Mine, where I lived before meeting my partner

( ) Hers, where she lived before meeting me

( ) Ours, since we met

21. Do you have children?

( ) Yes

( ) No (Please skip to Question 25)

22. How many children do you have?

_____ Girls

_____ Boys

23. Where are the children presently living? Please describe _____

24. Who is financially responsible for the support of the children?

( ) I am primarily responsible for their support

( ) Father is primarily responsible for their support

( ) Father and I support them equally

( ) Father, partner and I support them

( ) Partner and I support them equally

( ) Partner is primarily responsible for their support

( ) Other. Please describe
_____

25. For the following items, please indicate who has the major responsibility for the following chores:

Always I Usually I Partner and I Usually Always Does not apply or

exactly equal partner partner done by hired person

A. Cooking ( ) ( ) ( ) ( ) ( ) ( )

B. Laundry ( ) ( ) ( ) ( ) ( ) ( )

C. Dishwashing and cleaning up ( ) ( ) ( ) ( ) ( ) ( )

D. Household repairs ( ) ( ) ( ) ( ) ( ) ( )

E. Dusting and vacuuming ( ) ( ) ( ) ( ) ( ) ( )

F. Housecleaning (windows, floors, cleaning

drapes) ( ) ( ) ( ) ( ) ( ) ( )

G. Child care ( ) ( ) ( ) ( ) ( ) ( )

H. Payment of bills ( ) ( ) ( ) ( ) ( ) ( )

I. Bathroom cleaning ( ) ( ) ( ) ( ) ( ) ( )

J. Outdoor maintenance (e.g., washing windows,

cleaning gutters, painting) ( ) ( ) ( ) ( ) ( ) ( )

K. Lawn care ( ) ( ) ( ) ( ) ( ) ( )

L. Gardening (flowers and vegetables) ( ) ( ) ( ) ( ) ( ) ( )

M. Car repairs ( ) ( ) ( ) ( ) ( ) ( )

N. Decorating ( ) ( ) ( ) ( ) ( ) ( )

26. Who do you think is more involved in your relationship—your partner or you?

_____ Partner is much more involved

_____ Partner is somewhat more involved

_____ We are involved to exactly the same degree

_____ I am somewhat more involved

_____ I am much more involved

27. Who do you think has revealed more about herself to the other—your partner or you?

_____ Partner has revealed much more

_____ Partner has revealed somewhat more

_____ We have revealed exactly the same amount

_____ I have revealed somewhat more

_____ I have revealed much more

28. Who do you think has more of a say about what you and your partner do together—your partner or you?

_____ Partner has much more say

_____ Partner has somewhat more say

_____ We have exactly the same amount of say

_____ I have somewhat more say

_____ I have much more say

29. Who do you think is more satisfied in the relationship—your partner or you?

_____ Partner is much more satisfied

_____ Partner is somewhat more satisfied

_____ We are exactly equally satisfied

_____ I am somewhat more satisfied

_____ I am much more satisfied

30. Who do you think is more committed to the relationship—your partner or you?

_____ Partner is much more committed

_____ Partner is somewhat more committed

_____ We are committed to exactly the same degree

_____ I am somewhat more committed

_____ I am much more committed

31. Who do you think should have more of a say about what you and your partner do together—your partner or you?

_____ Partner should have much more say

_____ Partner should have somewhat more say

_____ We should have exactly equal say

_____ I should have somewhat more say

_____ I should have much more say

32. If my partner and I disagreed on political issues or candidates,

_____ Partner would definitely change her opinion

_____ Partner would probably change her opinion

_____ Neither of us would change our opinion

_____ I would probably change my opinion

_____ I would definitely change my opinion

33. When my partner and I argue,

_____ Partner always gives in first

_____ Partner usually gives in first

_____ Sometimes she gives in first, sometimes I give in first

_____ I usually give in first

_____ I always give in first

34. If my partner expressed dislike for a friend of mine,

_____ I would definitely reevaluate my opinion of the friend

_____ I would probably reevaluate my opinion of my friend

_____ Neither of us would change our opinion

_____ I would probably not reevaluate my opinion of the friend

_____ I would definitely not reevaluate my opinion of the friend

35. If your partner were offered an attractive job opportunity in another city, how likely is it that you would move with your partner?

_____ I would definitely move with my partner

_____ I would probably move with my partner

_____ Uncertain if I would move or not

_____ I would probably not move with my partner

_____ I would definitely not move with my partner

36. If you were offered an attractive job opportunity in another city, how likely is it that your partner would move with you?

_____ My partner would definitely move with me

_____ My partner would probably move with me

_____ Uncertain if my partner would move with me

_____ My partner would probably not move with me

_____ My partner would definitely not move with me

37. Who do you think takes more of the initiative in your sexual relationship?

_____ My partner takes much more of the initiative

_____ My partner takes somewhat more of the initiative

_____ We both initiate sex to exactly the same degree

_____ I take somewhat more of the initiative

_____ I take much more of the initiative

38. Who do you think makes more of the decisions about the frequency of sex?

_____ My partner makes much more of the decisions

_____ My partner makes somewhat more of the decisions

_____ We make mutual decisions

_____ I make somewhat more of the decisions

_____ I make much more of the decisions

39. Who do you think is more sexually satisfied in your relationship?

_____ My partner is much more satisfied

_____ My partner is somewhat more satisfied

_____ We are both satisfied to exactly the same degree

_____ I am somewhat more satisfied

_____ I am much more satisfied

40. For the following, please check the appropriate responses:

Partner Partner more Partner and I Usually I Always I Does not apply;

always than I exactly equal has never been

an issue

Who usually makes the final decision about:

A. What car to get ( ) ( ) ( ) ( ) ( ) ( )

B. Whether or not to buy life insurance ( ) ( ) ( ) ( ) ( ) ( )

C. How much money to spend per week on food ( ) ( ) ( ) ( ) ( ) ( )

D. Where to go on vacation ( ) ( ) ( ) ( ) ( ) ( )

E. What restaurants to frequent ( ) ( ) ( ) ( ) ( ) ( )

F. How to spend leisure time ( ) ( ) ( ) ( ) ( ) ( )

G. Which friends to spend time with ( ) ( ) ( ) ( ) ( ) ( )

H. Where to go on holidays ( ) ( ) ( ) ( ) ( ) ( )

I. What house or apartment to take ( ) ( ) ( ) ( ) ( ) ( )

41. Do any of the following know that you are a lesbian?

Your mother _____ Your father _____ Brothers _____ Sisters _____ Other relatives _____

Neighbors _____ Friends _____ Colleagues at work _____

42. How many friends are aware of your relationship?

All _____ Most _____ Half _____ A few _____ None _____

43. Do you and your partner participate in any lesbian organizations?

_____ Yes

_____ No

44. How often do you see your family?

Weekly _____ Monthly _____ Several times a year _____ Never _____

Identifi cation and Involvement With the Gay

Community Scale

PETER A. VANABLE, 1 DAVID J. MCKIRNAN, AND JOSEPH P. STOKES,

University of Illinois at Chicago

The Identification and Involvement with the Gay Community Scale (IGCS) is designed to measure involvement with and perceived closeness to the gay community among men who have sex with men. Although bisexually and homosexually active men are often considered to be part of the same homogeneous group, there are substantial individual differences in the extent to which these men perceive themselves to be part of a larger gay community and in the degree to which they self-identify as gay (Stokes, McKirnan, & Burzette, 1993; Vanable, McKirnan, Stokes, Taywaditep, & Burzette, 1993). The IGCS was developed to characterize these individual differences. The scale was initially developed as part of a larger research program designed to identify both individual and community level variables associated with HIV risk behavior among a heterogenous group of bisexually active men (see McKirnan, Stokes, Doll, & Burzette, 1995, for a description). Thus, although the construct tapped by this scale may be equally relevant to women who have sex with women, reliability and validity data have been gathered only for men.

Description

The scale consists of a eight self-report items. Four items require respondents to rate how much their degree of agreement with attitude statements regarding the importance of self-identifying as gay and associating with a gay commu

nity. Response options range from completely disagree (1) to completely agree (5). In previous testing of this instrument, these four questions were embedded within a larger set of questions assessing attitudes toward sexuality and AIDS. Three items tap the frequency with which respondents read a gay or lesbian newspaper, attend gay or lesbian organizational activities, and frequent gay bars. The final item assesses the overall number of gay friends in the respondent's social network.

An earlier version of this scale, focussing only on behavioral indices of involvement in the gay community, was described by Stokes et al. (1993). The present version, which includes subjective ratings of identification with the gay community, was initially tested using a face-to face interview format in which responses were elicited by trained interviewers. In a more recent study (McKirnan & Vanable, 1995), the scale was administered using a self report format, yielding similar psychometric properties. Response Mode and Timing Respondents are instructed to circle the response that most accurately describes their personal attitudes and experiences. The scale requires 2 to 3 minutes to complete. Scoring Prior to computing scale scores, responses to questions 5 through 8 should be converted to numeric values (A = 1, B = 2, C = 3, D = 4, E = 5). Final scale scores are obtained by computing a mean across the eight items. Item 4 must be reverse coded. Higher scores indicate more identification and involvement with the gay community. Reliability Reliability and validity data come from a large, diverse sample of bisexual and gay men living in the metropolitan Chicago area (N = 750). African-American (51%) and White (49%) respondents between the ages of 18 and 30 were recruited on the basis of specific sexual behavior criteria. During

the first phase of the research, interviews were conducted with men reporting that they had both male and female partners within the past 3 years (n = 536). The remaining 214 men were recruited on the basis of having only male sexual partners in past 3 years. For the complete sample, 43% of respondents self-identified as bisexual, 48% self-identified as gay, and 7% self-identified as being straight (2% refused to provide a label). The Cronbach alpha for the complete sample was .78. A subgroup of respondents (n = 218) completed a 1-year follow-up interview. Test-retest reliability for this subsample was .74. Validity In the sample described above, scores on the IGCS were positively correlated with 7-point Kinsey ratings of sexual orientation (r = .58, p <.0001) such that people with stronger involvement and identification with the gay community tended to rate themselves as more homosexual in orientation. Similarly, scores on the IGCS reliably differentiated between men who variously described their sexual orientation as either gay, bisexual, or straight (Ms = 3.09, 2.38, & 1.51); F(2, 733) = 159.0, p <.0001. In addition, men showing greater identification with the gay community were more “out” to others about their same-sex activity, were

1 Address correspondence to Peter A. Vanable, Department of Psychology & Center for Health and Behavior, Syracuse University, 430 Huntington Hall,

Syracuse, NY 13244; e-mail: pvanable@syr.edu

less self-homophobic, reported that their friends were more

ented toward using gay bars as a social resource, rs = .53,

–.35, .56, .47, ps <.0001. Similar construct validity data are

reported by Stokes et al. (1993), using an earlier version of

this scale. Of greater theoretical interest are data linking scores

on the IGCS to differences in sexual behavior with men

and women, and specific practices that place homosexu

ally active men at increased risk for HIV infection. In our

sample, we found that rates of sexual behavior with men

and women were directly related to differences in identifi
cation and involvement with the gay community, with high
scorers on the IGCS reporting more overall sexual behavior
with men and low scorers reporting more sexual behavior
with women in the past 6 months (McKirnan, Vanable, &
Stokes, 1995). In comparison to men who were less iden
tified with the gay community, high scorers on the IGCS
were more likely to report having had unprotected anal
contact with another man. However, when the sample was
restricted to only those men who had any anal sex with men
in the past 6 months, these differences were eliminated.
These data suggest that men showing greater identification
and involvement with the gay community are at increased
risk for HIV as a direct function of their being more likely
to have anal sex with men at all (for a discussion of related
findings, see McKirnan, Stokes, Vanable, Burzette, &
Doll., 1993; Vanable et al., 1993). A reversal in this pat
tern occurs for behaviors with women, with lower scores

Exhibit

Identification and Involvement With the Gay Community Scale

Directions: This questionnaire concerns some of your general attitudes and experiences. For each question, circle the response that is
most accurate for you personally. Answer the questions quickly, giving your first “gut reactions.”

Do not Strongly

agree at all agree

(1) It is very important to me that at least some of my friends are bisexual or gay. 1 2 3 4 5

(2) Being gay makes me feel part of a community. 1 2 3 4 5

(3) Being attracted to men is important to my sense of who I am. 1 2 3 4 5

(4) I feel very distant from the gay community. 1 2 3 4 5

For questions 5-7, please think in terms of the last six months or so.

(5) How often do you read a gay or lesbian oriented paper or magazine, such as the Advocate or other local gay/bisexual papers?

A = Never C = Several times a month E = Several times a week or daily

B = Once a month or less D = About once a week

(6) How often do you attend any gay or lesbian organizational activities, such as meetings, fund-raisers, political activities, etc.?

A = Never C = Several times a month E = Several times a week or daily

B = Once a month or less D = About once a week

(7) How often do you go to a gay bar?

A = Never C = Several times a month E = Several times a week or daily

B = Once a month or less D = About once a week

(8) About how many gay men would you call personal friends (as opposed to casual acquaintances)?

A = None C = 2 gay friends E = 5 or more gay friends

B = 1 gay friend D = 3 or 4 gay friends

Perceived Parental Reactions Scale

BRIAN L. B. WILLOUGHBY, 1 Department of Psychiatry, Massachusetts General Hospital

and Harvard Medical School

N ATHAN D. DOTY, Department of Psychology, Children's Hospital of Philadelphia

ELLEN B. BRAATEN, Department of Psychiatry, Massachusetts General Hospital and

Harvard Medical School

N EENA M. MALIK, Department of Pediatrics, University of Miami Miller School of Medicine

The Perceived Parental Reactions Scale (PPRS) assesses

gay, lesbian, and bisexual (LGB) individuals' perceptions

of their parents' initial reactions to their coming out. It

evaluates eight theoretical dimensions of perceived paren

tal reactions, including negative shock, denial, anger, bar

gaining, depression, acceptance, general homophobia, and

parent-focused concerns.

Description

The PPRS is a 32-item scale wherein self-identified LGB

individuals are asked to rate their mother's or father's initial

reactions to their coming out. Maternal and paternal reac

tions are rated on separate versions of the scale, which are

are required to think back to the week their mother or father

found out about their sexual orientation and indicate agree

ment or disagreement with several possible reactions (e.g.,

cried tears of sadness) using a 5-point Likert scale. The

PPRS was developed on the basis of Weinberg's (1972) love versus conventionality theory and Savin-Williams' (2001) initial reactions model.

The scale was initially developed to assess nine theoreti cal dimensions of parents' initial reactions to coming out, including negative shock, denial, anger, bargaining, depres sion, acceptance, general homophobia, parent-focused concerns, and child-focused concerns. Four items assess each dimension. Items assessing the child-focused dimen sion were later removed based on the results of the initial scale development study. Child-focused items were writ ten to address parental responses of concern for their child (e.g., "My mother was worried about my chances of find ing a relationship partner"), which were initially conceptu alized as positive reactions from parents. However, these items did not correlate with the PPRS total as expected and lowered overall reliability estimates (i.e., alpha) in both the mother and the father versions of the scale. The result, therefore, was a 32-item scale assessing eight theoretical dimensions of perceived parental reactions.

Response Mode and Timing

During administration, individuals are provided with cop ies of the mother and father versions of the PPRS, asked to read the instructions carefully, and asked to respond to each item by circling a number on a Likert scale. Respondents should complete the PPRS only if (a) they have directly disclosed their sexual orientation to a parent or (b) they have had direct discussion with a parent about

their sexuality following the parent's discovery of their sexual orientation through other means (e.g., parent discovered gay material on the Internet, read a diary, or was told by someone else). It takes approximately 15 minutes to complete both the mother and the father versions of the PPRS. Scoring Before calculating the scale total, Items 1, 5, 8, and 10 are reverse scored. The PPRS total score is obtained by summing all items, with possible scores ranging from 32 to 160. Higher scores represent more negative perceived reactions from parents. Items assessing the various theoretical domains are as follows: negative shock (Items 13, 18, 23, 28), denial (Items 14, 19, 24, 29), anger (Items 15, 20, 25, 30), bargaining (Items 16, 21, 25, 31), depression (Items 17, 22, 26, 32), acceptance (Items 1, 5, 8, 10), general homophobia (Items 3, 6, 9, 11), and parent-focused concerns (Items 2, 4, 7, 12). Despite these various theoretical domains, the scale should be used as a whole, because factor analyses have not yet supported the use of individual domain scores as discrete subscales. Reliability The reliability of the PPRS has been examined in two independent empirical investigations. In the initial development study (Willoughby, Malik, & Lindahl, 2006), the PPRS was administered to 72 gay men (ages 18 to 26) recruited from LGB community- and university-based organizations. Participants were ethnically diverse (39% Hispanic, 39% White-Anglo European, 10% Caribbean/ African American, 12% Mixed/Other). The majority of participants had completed some college or a bachelor's degree (83%), whereas others reported high school (15%) or elementary school (1%) as their highest level of education. Of the 72 respondents, 70 were out to their mothers and 45 were out to their fathers. Means and standard

1 Address correspondence to Brian Willoughby, Learning and Emotional Assessment Program, Department of Psychiatry, Massachusetts General Hospital,

151 Merrimac Street, Fifth Floor, Boston MA 02114; e-mail: brianwilloughby@gmail.com

deviations for the PPRS total score were as follows: mother

version M = 90.16, SD = 35.21; father version M = 86.87,

SD = 31.73. In this study, all items on both the mother and

the father versions of the PPRS showed item-total correla

tions of .40 or above and demonstrated good internal con

sistencies (mother version [n = 70], α = .97; father version [n = 45], α = .97). Using a subset of participants, both versions of the PPRS showed good test-retest reliability after a 14-day interval (mother version [n = 19], r = .97; father version [n = 12], r = .95). The mother version of the PPRS was administered as part of a larger protocol examining the family and peer relationships of LGB young people. Participants included 81 young men (69%) and women (31%), who identified as gay, lesbian, bisexual, or queer. Ages ranged from 14 to 25 (M = 19.70, SD = 1.76), and the sample included young people from diverse ethnic backgrounds (54% White-Anglo European, 20% Hispanic/Latino, 14% African/Caribbean American, 6% Asian, and 6% Mixed/Other). Participants were recruited from LGB social and college groups, as well as via study advertisements and friend referrals. Of the 81 young people, 65 were out to their mother. In this sample, the mean of the PPRS total score was 89.64 (SD = 34.37). Similar to the development study, all items showed item total correlations of .39 and above. Internal consistency was also adequate (n = 65), α = .97.

Validity

Initial evidence supports the construct validity of the PPRS. First, as reported by Willoughby et al. (2006),

Exhibit

Perceived Parental Reactions Scale—Mother Version

Instructions: Think only about your mother when filling out this questionnaire.

Think back to the week when your mother first became aware of your sexual orientation. Read the following statements and indicate

how much you agree or disagree with each statement by circling a number. Remember, there are no correct or incorrect answers.

These are your opinions.

Strongly Disagree Disagree Neutral Agree Strongly Agree a

1 2 3 4 5

The week when I told my mother I was gay/lesbian/bisexual (or when she found out I was gay/lesbian/bisexual) she:

1. supported me

2. was worried about what her friends and other parents would think of her

3. had the attitude that homosexual people should not work with children

4. was concerned about what the family might think of her

5. was proud of me

6. believed that marriage between homosexual individuals was unacceptable

7. was concerned about the potential that she wouldn’t get grandchildren from me

8. realized I was still “me,” even though I was gay/lesbian/bisexual

Identity (also see Attraction, Experience, Gender Identification, and Homosexualities)

Dillon, F. R., Worthington, R. L., Soth-McNett, A. M., & Schwartz, S. J. (2008). Gender and sexual identity based predictors of lesbian, gay, and bisexual affirmative counseling self-efficacy. Professional Psychology: Research and Practice, 39, 353–360.

Fassinger, R. E., & Miller, B. A. (1996). Validation of an inclusive model of sexual minority identity formation on a sample of gay men. Journal of Homosexuality, 32, 53–78. Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1953). Sexual behavior in the human female. Philadelphia: W. B. Saunders. Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. (1948). Sexual behavior in the human male. Philadelphia: W. B. Saunders. Klein, F. (1993). The bisexual option (2nd ed.). New York: Haworth Press. Marcia, J. E. (1966). Development and validation of ego identity status. Journal of Personality and Social Psychology, 5, 551–558. McCarn, S. R., & Fassinger, R. E. (1996). Revisioning sexual minority identity formation: A new model of lesbian identity and its implications for counseling and research. The Counseling Psychologist, 24, 508–534. Worthington, R. L., Dillon, F. R., & Becker-Schutte, A. M. (2005). Development, reliability and validity of the LGB Knowledge and Attitudes Scale for Heterosexuals (LGB-KASH). Journal of Counseling Psychology, 52, 104–118. Worthington, R. L., Navarro, R. L., Savoy, H. B., & Hampton, D. (2008). Development, reliability and validity of the measure of sexual identity exploration and commitment (MoSIEC). Developmental Psychology, 44, 22–33. Worthington, R. L., & Reynolds, A. L. (2009). Within group differences in sexual orientation and identity. Journal of Counseling Psychology, 56, 44–55. Worthington, R. L., Savoy, H., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and group identity [Monograph]. The Counseling Psychologist, 30, 496–531.

Exhibit

Measure of Sexual Identity Exploration and Commitment

Please read the following definitions before completing the survey items:

Sexual needs are defined as an internal, subjective experience of instinct, desire, appetite, biological

necessity, impulses, interest,

and/or libido with respect to sex.

Sexual values are defined as moral evaluations, judgments and/or standards about what is appropriate, acceptable, desirable, and

innate sexual behavior.

Sexual activities are defined as any behavior that a person might engage in relating to or based on sexual attraction, sexual arousal,

sexual gratification, or reproduction (e.g., fantasy to holding hands to kissing to sexual intercourse).

Modes of sexual expression are defined as any form of communication (verbal or nonverbal) or direct and indirect signals that a

person might use to convey her or his sexuality (e.g., flirting, eye contact, touching, vocal quality, compliments, suggestive body move

ments or postures).

Sexual orientation is defined as an enduring emotional, romantic, sexual, or affectional attraction to other persons that ranges from

exclusive heterosexuality to exclusive homosexuality and includes various forms of bisexuality.

Please use the following scale to respond to Items 1–22.

1 2 3 4 5 6

Very Uncharacteristic of Me Very Characteristic of Me

1. My sexual orientation is clear to me. a

1 2 3 4 5 6

2. I went through a period in my life when I was trying to determine my sexual needs.

3. I am actively trying to learn more about my own sexual needs.

4. My sexual values are consistent with all of the other aspects of my sexuality.

5. I am open to experiment with new types of sexual activities in the future.

6. I am actively trying new ways to express myself sexually.

Ideology (also see Attitudes, and Knowledge)

Exhibit

Sexual Ideology Instrument

Directions: Put your answers on side 1, beginning with question 1. For each of the statements, indicate whether you strongly agree (SA)

= 1, agree (A) = 2, are undecided (U) = 3, disagree (D) = 4, or strongly disagree (SD) = 5.

SA A U D SD

1 2 3 4 5

Remember: (1) Be sure that the number of the statement you are reading corresponds to the number you are marking on the answer sheet.

(2) Mark only one response for each statement.

(3) Respond the way you really feel, which may or may not be in agreement with the majority of public opinion.

_____ 1. I am in favor of laws that promote gender equality.

_____ 2. Women who emphasize sexual pleasure in their lives overlook life's more important pursuits.

_____ 3. Sexual emotions are strong but manageable by most males.

_____ 4. A mature man and woman should get their greatest sexual pleasure from intercourse rather than from some other sexual activity.

_____ 5. Having a physical attraction to someone would be sufficient for me to enjoy sex with that person.

_____ 6. A preschool child is likely to suffer if the mother works.

_____ 7. It is acceptable for a 16-17 year old unmarried male to have sexual intercourse.

_____ 8. Masturbation is an acceptable activity for males.

_____ 9. I would feel very guilty if I had sexual relations with someone I did NOT love.

_____ 10. I would be very upset if my spouse had had many previous sexual relationships.

_____ 11. I hope that the family, social, and career roles of men and women become more alike.

_____ 12. Since many men seem to be unable to control their sex drive, it is important for women to be in control of theirs.

_____ 13. I do NOT respect women who appear in pornographic films or magazines.

_____ 14. Homosexuals should NOT be teaching school. It is too risky to allow the possibility of such a teacher taking advantage of or influencing the sexual orientation of even one student.

_____ 15. I approve of a man having premarital sex with someone he likes but is NOT in love with.

_____ 16. If a woman really loves her husband, she will want to include the vow “to obey” her husband in the marriage ceremony.

_____ 17. Women degrade themselves when they show obvious sexual interest in a man they are NOT in love with.

_____ 18. Men can have affairs that do NOT disrupt their life style.

_____ 19. The primary goal of sexual activity between men and women should be intercourse.

_____ 20. A successful and satisfying sex partnership CANNOT be established unless the sex partners are quite willing to be sexually faithful to one another.

_____ 21. It would be difficult for me to enjoy sex with someone I did NOT love.

_____ 22. Orgasm resulting from manual genital stimulation by the sex partner can be as satisfying as intercourse.

_____ 23. Women can have affairs without significant emotional involvement.

_____ 24. It is more important for a wife to help her husband's career than to have one herself.

_____ 25. I approve of a woman having extramarital sex WITH her husband's consent.

_____ 26. Pornography influences men to commit sexual crimes including rape.

_____ 27. Men are generally more interested in sex than women.

_____ 28. If women yield to their sexual feelings, these feelings will probably disrupt and dominate their lives in destructive ways.

_____ 29. The Supreme Court ruling making abortions legal should be reversed.

_____ 30. I approve of a man having premarital sex with someone he is strongly attracted to but knows only casually.

_____ 31. Group sex (sex involving more than two people) is an acceptable sexual activity for men and women.

_____ 32. John is married to Ann. John is strongly attracted to, but not in love with Mary. I approve of John and Mary having sexual relations.

_____ 33. Extramarital sex is always wrong.

_____ 34. Sexuality is a very powerful force and females should do all they can to control it in their lives.

_____ 35. It is acceptable for a 16-17 year old unmarried female to have sexual intercourse.

_____ 36. I approve of a man having extra-marital sex WITHOUT his wife's consent.

_____ 37. I would NOT object to my spouse having had a couple of previous sexual relationships.

_____ 38. I can accept and do NOT condemn homosexual activities for females.

_____ 39. Sexual emotions are strong but manageable by most females.

_____ 40. I approve of a woman having premarital sex with someone she likes but is NOT in love with.

_____ 41. A man CANNOT have a satisfactory and satisfying sex life without being in love with his sex partner.

_____ 42. Sexual intercourse with someone other than the regular sex partner can bring about an improvement in the sexual relationship of the established pair.

_____ 43. It would be best for our society if there were about an equal number of men and women in all high-level positions of government, business and education.

_____ 44. To advocate an emphasis on sexual pleasure is to forget that the major purpose of sexual relations is procreation.

_____ 45. The innate differences in men and women's strengths and weaknesses are the major source of satisfaction in male-female relationships.

_____ 46. I approve of a man having extra marital sex WITH his wife's consent.

_____ 47. I enjoy looking at the pictures of nude men and women that appear in "Playgirl" and "Playboy" type magazines.

_____ 48. Oral or mouth-genital sex is a good substitute for intercourse.

_____ 49. Masturbation is an acceptable activity for females.

_____ 50. I approve of a woman having premarital sex with someone she is strongly attracted to but knows only casually.

_____ 51. It is much better for everyone involved if the man is the achiever outside the home and the woman takes care of the home and family.

_____ 52. Men can have affairs without significant emotional involvement.

_____ 53. If men yield to their sexual feelings, these feelings will probably disrupt and dominate their lives in destructive ways.

_____ 54. The decision about an abortion should be left up to a woman and her doctor.

_____ 55. A woman cannot have a satisfactory and satisfying sex life without being in love with her sex partner.

_____ 56. Having intercourse is the best way to end sex.

_____ 57. Anal intercourse is a good substitute for vaginal intercourse.

_____ 58. Ann is married to John. Ann is strongly attracted to, but not in love with Jim. I approve of Ann and Jim having sexual relations.

_____ 59. Non-violent pornography is harmless to our society.

_____ 60. Sexuality is a very powerful force and males should do all they can to control it in their lives.

_____ 61. Men and women have different sexual needs that are based on differences in male and female anatomy and hormones.

_____ 62. Basically, I simply love sex and would enjoy making love to many different people.

_____ 63. It is a mistake to allow oral sex to become as important as intercourse in one's sex life.

_____ 64. A working mother can establish just as warm and secure a relationship with her children as a mother who is NOT employed.

_____ 65. Men who emphasize sexual pleasure in their lives overlook life's more important pursuits.

_____ 66. Sexual intercourse does NOT have to be the major focus of positive and pleasurable sexual activity for men and women.

_____ 67. I can accept and do NOT condemn homosexual activities for males.

_____ 68. Sexual intercourse is often best when enjoyed for its own sake, rather than for the purpose of expressing love.

_____ 69. I approve of a woman having extramarital sex WITHOUT her husband's consent.

_____ 70. Where abortions are legal, the father should have the right to veto the abortion.

_____ 71. Casual sexual intercourse with a variety of sex partners can be as satisfying and satisfactory as intercourse that is limited to an established sex partnership.

_____ 72. Women can have affairs that do NOT disrupt their lifestyle.

Sexual Rights Instrument

ILSA L. LOTTES, 1 University of Maryland, Baltimore County

The purpose of the Sexual Rights Instrument is to assess the 11 sexual rights formulated and adopted by the World Association of Sexology (WAS; WAS, 1999) and listed in Table 1. The Sexual Rights Instrument can be used to assess all 11 sexual rights of WAS or a subset. The construction and psychometric properties of this instrument were originally discussed by Lottes and Adkins (2003).

Description

The Sexual Rights Instrument contains 94 Likert items where the response options to each item are one of five choices: (a) Strongly Agree, (b) Agree, (c) Neither Agree nor Disagree, (d) Disagree, and (e) Strongly Disagree. The 94 items are ordered in the questionnaire so that items assessing one sexual right are not all listed consecutively but rather placed throughout with measures of other rights. Each of the 11 sexual rights of WAS is assessed by a single

scale except for the right to sexual equity, and for that right

there are separate scales corresponding to groups of the

population that are known for their lack of sexual equity.

Thus, for the right to sexual equity there are five scales: one

for each of the following groups: Poor People, Gays and Lesbians, Handicapped People, Adolescents, and Elderly People. One of the fundamental principles of human rights, in general, and sexual rights, in particular, is their interconnectivity. Violation of one right often implies violation of another. Thus, it is not possible to assess multiple sexual rights using mutually exclusive items in all scales. From both theoretical and content perspectives, items could apply to more than one scale. For example, although the sexual health professionals who formulated the right to comprehensive sex education intended for this right to mean that sexuality information should be provided to people throughout their lifetime, these same professionals acknowledge that adolescence is a critical period when youth need to acquire sexual knowledge. Thus, items of the scale assessing the right to sexual equity for adolescents overlap with the items of the scale assessing the right to comprehensive sex education. The Sexual Rights Instrument was administered to two samples of college students in the northeastern United States. Sample 1 included students from a human sexuality class and students who were not taking the human sexuality class but who were recruited by students in that class.

1 Address correspondence to Ilsa L. Lottes, University of Maryland, Baltimore County, Department of Sociology and Anthropology, 1000 Hilltop Circle,

Baltimore, MD 21250; e-mail: lottes@umbc.edu

TABLE 1

Sexual Rights Formulated by the World Association of Sexology

The right to sexual freedom—Sexual freedom encompasses the possibility for individuals to express their full sexual potential. However, this excludes all

forms of sexual coercion, exploitation and abuse at any time and situations in life.

The right to sexual autonomy, sexual integrity, and safety of the sexual body—This right involves the ability to make autonomous decisions about one's

sexual life within a context of one's own personal and social ethics. It also encompasses control and enjoyment of our own bodies free from torture,

mutilation, and violence of any sort.

The right to sexual privacy—This involves the right for individual decisions and behaviors about intimacy as long as they do not intrude on the sexual

rights of others.

The right to sexual equity—This refers to freedom from all forms of discrimination regardless of sex, gender, sexual orientation, age, race, social class,

religion, or physical and emotional disability.

The right to sexual pleasure—Sexual pleasure, including autoeroticism, is a source of physical, psychological, intellectual, and spiritual well-being.

The right to emotional sexual expression—Sexual expression is more than erotic pleasure or sexual acts. Individuals have a right to express their sexuality

through communications, touch, emotional expression, and love.

The right to sexually associate freely—This means the possibility to marry or not, to divorce, and to establish other types of responsible sexual associa

tions.

The right to make free and responsible reproductive choices—This encompasses the right to decide whether or not to have children, the number and spac

ing of children, and the right to full access to the means of fertility regulation.

The right to sexual information based upon scientific

inquiry—This right implies that sexual information should be generated through the process of

unencumbered and yet scientifically ethical inquiry, and disseminated in appropriate ways at all societal levels.

The right to comprehensive sexuality education—This is a lifelong process from birth throughout the lifecycle and should involve all social institutions.

The right to sexual health care—Sexual health care should be available for prevention and treatment of all sexual concerns, problems, and disorders.

Students responded to the survey on their own time. This

was part of a project that was enthusiastically supported

by students in the human sexuality class. The final number

of usable questionnaires was 388. This sample was 41%

male and 59% female with a mean age of 26.5. The data

collection method for Sample 2 was similar except that

the class recruiting other students was a research methods

class. Members of this class were later involved in analyz

ing the responses to the Sexual Rights Instrument. This

sample included 175 students of whom 38% were male and

62% female. The mean age of this sample was 28.6. In gen

eral, the Sexual Rights Instrument would be appropriate to

administer to adult samples. Most of the Sexual Rights Instrument's items were con

structed by Lottes and Adkins (2003), with 19 items taken

from previously published scales. The final list of items

was sent to a sexuality researcher with expertise in sexual

rights. Two items were revised according to this research

er's suggestions. A list of the item numbers corresponding

to each scale can be found in Table 2, which identifies the

items that were reverse scored and the reference for the

items used from previously constructed scales.

Response Mode and Timing

Two response modes are possible. If machine-scored sheets

that can be scanned and then transferred to a dataset readable

by a statistical data analysis program are used, respondents shade in the circle of the number indicating their agreement/ disagreement with each item. If machine-scored sheets are not used, then the numbers 1 through 5 need to be included next to each item, and respondents should be instructed to circle the number indicating their agreement/disagreement with each item. The Sexual Rights Instrument requires an average of 40 minutes to complete. Scoring To determine the score for each scale, add the responses (coded 1 through 5) to the individual items of each scale. The reverse-scored items are indicated in Table 2, and these items need to be recoded before summing the responses to each item in a scale. For all scales, the higher the score, the more a respondent supports sexual rights. Reliability The reliability of each scale was estimated by computing Cronbach's alpha. Table 2 lists the 15 sexual rights scales with their reliabilities. Validity The construct validity of the 15 scales was supported by examining (a) correlations of the scales with measures of conservative political views, religiosity, support for femi

TABLE 2

Reliability and Item Numbers of the Scales of the Sexual Rights Instrument for Sample 1 (Sample 2)

Right	Number of Items	Cronbach's Alpha	Item Numbers in Scale
Sexual freedom	4	.72 (.65)	1*, 16*, 42, 60*
Sexual autonomy and safety	13	.84 (.79)	10*, 15, 21, 24*, 28*, 29*, 34*, 35*, 36*, 43*, 61*, 72*, 84*

Sexual privacy 9 .71 (.57) 1*, 2, 11, 16*, 22, 53, 60*, 62, 78

Sexual equity

Poor people 5 .77 (.81) 26*, 27*, 41*, 73*, 94

Gays and lesbians 13 .93 (.92) 3, 5*, 8*, 11, 15, 23*, 47*, 61*, 63, 68, 75, 83, 92

Handicapped people 5 .75 (.75) 9, 67, 70*, 81*, 93*

Adolescents 15 .87 (.83) 10*, 19*, 22, 28*, 35*, 36*, 40*, 51*, 52*, 57*, 62, 72*, 76*, 84*, 89*

Elderly people 6 .74 (.72) 37, 45*, 54, 74*, 78, 86*

Sexual pleasure 9 .83 (.82) 4*, 14*, 56, 64, 65*, 69, 79*, 87, 88*

Emotional sexual expression 7 .64 (.67) 13*, 23*, 45, 46, 50*, 55*, 91*

Sexually associate freely 11 .83 (.72) 1*, 5*, 8*, 12, 16*, 25*, 30*, 31, 39, 47, 60

Responsible reproductive choices 18 .90 (.85) 6, 17*, 19*, 26*, 32*, 40*, 51*, 52*, 62, 71, 76*, 80, 82*, 85*, 86*, 90*, 92, 94

Information based on scientific inquiry 10 .82 (.79) 6, 17*, 19*, 33*, 38, 44*, 57*, 58*, 66, 77*

Comprehensive 27 .91 (.90) 6, 7*, 8*, 10*, 17*, 18,

sexuality education 19*, 24*, 28*, 33*, 35*, 36, 38, 40*, 44*, 48, 52*, 57*, 58*, 66, 70*, 72*, 74*,

76*, 81*, 83, 89*

Sexual health care 11 .86 (.86) 20*, 26*, 27*, 43*, 47*, 49, 58*, 59, 72*, 77*, 94

Note. Rights are from the World Association of Sexology (1999). Item codes range from 1 to 5, with a higher score indicating greater support for the sexual right. Items 1, 16,

38, 48, 67, and 68 are from the Sexuality Attitudes Scale in either their original or slightly revised forms (Hudson,

Murphy, & Nurius, 1983). Item 61 is a slightly revised item

from the Homophobic Behavior of Students Scale (Van de Ven, Bornholt, & Bailey, 1998). Item 72 is a slightly revised item from the Sexuality Education Feature/Program

Outcome Inventory (Klein, 1998). Item 62 is a slightly revised item from the Attitudes Toward Sexuality Scale (Fisher & Hall, 1998). Items 33, 76, 84, and 89 are taken from the

Family Life Sex Education Goal Questionnaire in either their original or slightly revised forms (Godin, Frank, & Jacobson, 1998). Items 45, 50, and 78 are all slightly revised

items from the Aging Sexual Knowledge and Attitudes Scale (White, 1998). Items 71, 80, and 90 are all from the Abortion Attitude Scale in either their original or slightly

revised forms (Berne, 1998).

*Indicates item is reverse scored.

nist causes, and personal value of sex and (b) differences

between scale means for those who had only heterosexual

sex partners and those who had at least one same-sex part

ner. Nearly all the correlations and mean differences were

highly significant, supporting predictions that more sup

port for sexual rights is given by less conservative and less

religious people, people with more rather than less feminist

views, people who place a high value on sex in their per

sonal lives, and people who have had at least one same-sex

partner.

Berne, L. (1998) Abortion Attitude Scale. In C. M. Davis, W. L. Yarber, R.

Bauserman, G. Schreer, & S. L. Davis (Eds.), Handbook of

sexuality

related measures (pp. 1–2). Thousand Oaks, CA: Sage.

Fisher, T., & Hall, R. (1998). Attitudes Toward Sexuality Scale. In C. M.

Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L. Davis (Eds.),

Handbook of sexuality-related measures (pp. 32–33). Thousand Oaks,

CA: Sage.

Godin, S., Frank, S., & Jacobson, S. (1998). Family Life Sex Education Goal Questionnaire. In C. M. Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L. Davis (Eds.), Handbook of sexuality-related measures (pp. 203–205). Thousand Oaks, CA: Sage. Hudson, W., Murphy, G., & Nurius, P. (1983). A short-form scale to measure liberal vs. conservative orientations toward human sexual expression. The Journal of Sex Research, 19, 258–272. Klein, D. (1998). The Sexuality Education Program Feature/Program Outcome Inventory. In C. M. Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L. Davis (Eds.), Handbook of sexuality-related measures (pp. 206–208). Thousand Oaks, CA: Sage. Lottes, I., & Adkins, C. (2003). The construction and psychometric properties of an instrument to assess support for sexual rights. The Journal of Sex Research, 40, 286–295. Van de Ven, P., Bornholt, L., & Bailey, M. (1998). Homophobic Behavior of Students Scale. In C. M. Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L. Davis (Eds.), Handbook of sexuality-related measures (pp. 369–370). Thousand Oaks, CA: Sage. White, C. (1998). Aging Sexual Knowledge and Attitudes Scale. In C. M. Davis, W. L. Yarber, R. Bauserman, G. Schreer, & S. L. Davis (Eds.), Handbook of sexuality-related measures (pp. 66–69). Thousand Oaks, CA: Sage. World Association of Sexology. (1999). Declaration of sexual rights. Retrieved May 5, 2001, from http://www.worldsexology.org/about_sexualrights.html

Exhibit

Sexual Rights Instrument

Directions: Circle the response that best corresponds to your view about each statement using the following choices:

Strongly Agree Agree Neither Agree nor Disagree Disagree Strongly Disagree

SA A N D SD

1. There should be no laws prohibiting sexual acts between consenting adults. SA A N D SD

2. Candidates for public office should be willing to disclose their sexual histories to the public. SA A N D SD

3. The federal government has done enough already to eliminate discrimination against gay men. SA A N D SD

4. A pleasurable sex life is very important to the vast majority of men’s overall sense of well-being. SA A N D SD

5. Homosexual couples should have the same legal rights as married couples. SA A N D SD

6. Women do NOT need to be educated about the most up to date means of fertility regulation/

contraception. SA A N D SD

7. It is a responsibility of the media, including TV and the Internet, to inform people about scientific

research relating to contraception/birth control. SA A N D SD

8. Sex education courses in public high schools should discuss issues related to sexual orientation. SA A N D SD

9. It is unreasonable to try to provide ways for physically handicapped people to enjoy their sexuality. SA A N D SD

10. High school students should be taught negotiating skills enabling them to avoid unwanted sexual

activities. SA A N D SD

11. It is still important to investigate the sexual orientation (that is, finding out if they are gay, lesbian, or

bisexual) of those people working in any branch of the armed forces. SA A N D SD

12. Laws should make it financially difficult for married

couples with children to get divorced. SA A N D SD

13. It is perfectly normal to have sexual fantasies. SA A N D SD

14. A pleasurable sex life is very important to the vast majority of women's overall sense of well- being. SA A N D SD

15. National policy has successfully protected lesbians from discrimination. SA A N D SD

16. What two consenting adults do together sexually is their business. SA A N D SD

17. Men should be educated about the most up-to-date means of fertility regulation/contraception. SA A N D SD

18. It is NOT the obligation of the media to inform the public about the harmful effects and treatment of

sexually transmitted diseases. SA A N D SD

19. Teenagers should be given up-to-date information on how to avoid becoming a parent before they are

ready. SA A N D SD

20. Health insurance companies should routinely cover the majority of costs to treat the most common

and curable sexually transmitted diseases. SA A N D SD

21. It is acceptable to put pressure on someone to participate in a sexual activity that was initially refused. SA A N D SD

22. Health care professionals should have to get parental consent before treating an adolescent (<18) for a

sexually transmitted disease. SA A N D SD

23. It should be acceptable for gay men to hold hands in public. SA A N D SD

24. The media, including TV and the Internet, should take a major role in educating people about the harmful

effects of sexual abuse on its victims. SA A N D SD

25. It should be socially acceptable for two people to live together without being married. SA A N D SD

26. Low-income women should be given financial assistance for the purchase of contraception. SA A N D SD

27. There should be a place where uninsured people with low incomes can get immediate treatment for

curable sexually transmitted diseases. SA A N D SD

28. Young children (<12) need to be taught ways to help them minimize their risk of being sexually abused. SA A N D SD

29. It is wrong to psychologically pressure someone to engage in sexual activity. SA A N D SD

30. Laws giving cohabiting couples the same legal opportunities as married couples, with respect to health

insurance, need to be enacted. SA A N D SD

31. If a non-married couple conceives a child, they should get married. SA A N D SD

32. Safe and legal abortions should be available to all women, before the 4th month of pregnancy. SA A N D SD

33. Sex education courses in high school should help adolescents understand how different ethnic and

cultural groups vary in sexual beliefs and behaviors. SA A N D SD

34. Affordable health services should be available to help victims recovering from sexual abuse. SA A N D SD

35. Public high schools should provide programs to try to eliminate forms of non-consensual sexual activity. SA A N D SD

36. The media should provide examples demonstrating to young people how to say ‘No’ to unwanted

sexual activity. SA A N D SD

37. Sexual activity for senior citizens should be discouraged. SA A N D SD

38. Sex education should be restricted to the home. SA A N D SD

39. It is much too easy to get a divorce in the United States. SA A N D SD

40. Teenage girls should be educated in high school about how sexually transmitted diseases influence their

ability to get pregnant. SA A N D SD

41. Policies in the United States should enable health providers to offer all people affordable diagnosis and

treatment of sexually transmitted diseases. SA A N D SD

42. I approve of state laws which make anal sex illegal. SA A N D SD

43. A person should be able to stop a sexual interaction at any point, no matter how far that sexual

interaction has gone. SA A N D SD

44. Sexuality instructors should have training in the health, social, cultural, and biological aspects of sexuality. SA A N D SD

45. Sexual activity is often psychologically beneficial for older (>65) people. SA A N D SD

46. For most people, emotional expression is of little value to their long-term sexual relationships. SA A N D SD

47. The union of homosexual couples deserves some form of public recognition. SA A N D SD

48. Sex education should only be given to people ready for marriage. SA A N D SD

49. The government already contributes enough for the health care of its citizens. SA A N D SD

50. Sexual activity is typically a lifelong need. SA A N D SD

51. It should be easy for teenagers to get contraceptives. SA A N D SD

52. Teenage girls should be educated in high school about

the harmful effects of a mother’s sexually

transmitted disease or her drug use on her baby. SA A N D SD

53. The media should be able to report on the sexuality of any person. SA A N D SD

54. Nursing homes should restrict the sexual activities of their residents. SA A N D SD

55. Sexual intimacy provides a way for many people to express their love for their partner. SA A N D SD

56. Self-masturbation as an adult is juvenile and immature. SA A N D SD

57. Teenagers should be taught ways to reduce their risk for getting a sexually transmitted disease. SA A N D SD

58. Physicians should be educated on how illnesses and their treatments affect a patient’s sexual response. SA A N D SD

59. The government should NOT help small businesses provide health insurance for their employees. SA A N D SD

60. It is wrong to investigate the sexual activities of two consenting adults. SA A N D SD

61. I would sign my name to a petition asking the government to protect gay men from physical violence. SA A N D SD

62. Parents should be informed if their children (<18) have been to a health professional to obtain a

contraceptive device. SA A N D SD

63. Heterosexual men have more positive characteristics than gay men. SA A N D SD

64. Women who emphasize sexual pleasure in their lives overlook life’s more important pursuits. SA A N D SD

65. Self-masturbation in childhood can help a person develop a natural and healthy attitude toward sex. SA A N D SD

66. It is the duty of parents and NOT the schools to provide sex education for their children. SA A N D SD

67. Physically handicapped people should NOT have sex. SA A N D SD

68. Too much social approval has been given to gay men. SA A N D SD

69. Self-masturbation by a person who is married is NOT healthy. SA A N D SD

70. Sexuality courses should be provided for those who are disabled. SA A N D SD

71. Abortion is wrong, no matter what the circumstances are. SA A N D SD

72. Sex education courses in high school should help adolescents express their desire NOT to be involved

sexually if they do NOT wish to be. SA A N D SD

73. The government should provide more financial assistance to hospitals and doctors to help cover the

cost of the health care of poor people. SA A N D SD

74. Care takers of the aged should be educated about the sexual needs of their patients. SA A N D SD

75. Homosexual men are treated justly in our society. SA A N D SD

76. Sex education courses in high school should help adolescents use protection (condom/birth control) if

they plan to have intercourse. SA A N D SD

77. Physicians should communicate to patients how illnesses and their treatments affect sexual response. SA A N D SD

78. Nursing homes have no obligation to provide privacy for residents who wish to express their sexuality,

either alone or with their partner. SA A N D SD

79. Self-masturbation in private should be considered a normal and healthy activity for adolescents. SA A N D SD

80. The Supreme Court should make abortion illegal in the United States. SA A N D SD

81. Care takers of the disabled should be educated about the sexual needs of their patients. SA A N D SD

82. I believe contraceptive use is a responsibility for both men and women. SA A N D SD

83. Heterosexual women have more positive characteristics than lesbians. SA A N D SD

84. Sex education courses in high school should help adolescents deal with the negative aspects of peer

pressure. SA A N D SD

85. Artificial insemination should be available to lesbians. SA A N D SD

86. Nursing homes should provide condoms for their residents. SA A N D SD

87. Men who emphasize sexual pleasure in their lives overlook life's more important pursuits. SA A N D SD

88. Adults who self-masturbate in private should be considered normal and healthy. SA A N D SD

89. Adolescents in high school should be taught skills to reduce guilt and fear about sexual issues. SA A N D SD

90. The final decision to have an abortion should be up to the pregnant woman. SA A N D SD

91. Sexual relationships provide an important and fulfilling part of life for most people. SA A N D SD

92. Gay men should NOT be able to adopt children. SA A N D SD

93. Institutions for the physically disabled should provide privacy to allow residents to engage in sexual

activities. SA A N D SD

94. The government does NOT need to provide family planning services to low-income women. SA A N D SD

Sexual Polarity Scale

DONALD L. MOSHER 1 AND JAMES SULLIVAN, University of

Connecticut

1 Address correspondence Donald L. Mosher, 648 Ternberry Forest Drive, The Villages, FL 32162; e-mail: dlmosher@aol.com

Sexual polarity is defined as a sexual ideology (a) consisting of a more or less organized set of ideas about sexuality that orders information about the ideals and aspirations in a sexual world view; (b) polarizing into a left-wing (naturalist) and a right-wing (jehovanist) set of ideas; and (c) serving as a script, often shared by a community of believers, to interpret, to predict, to explain, to evaluate, or to control past, present, and future sexual scenes. The concepts of jehovanist and naturalist, introduced by Davis (1983), suggested the content of the items. Jehovanists believe that sex is dirty and aside from moderate intensity— marital coitus—threatens the dissolution of the individual's self and the destruction of the social order. Naturalists are modernists who place sex into a nonsacred, biological context of natural behavior that occurs commonly in humans across cultures and in other species of animals. The Sexual Polarity Scale (SPS), in addition, contains selected items from Tomkins' (1965) Polarity Scale (TPS).

Tomkins (1965) defined ideology as "any organized set of ideas about which humans are most passionate and for which there is no evidence and about which they are least certain" (p. 78). The left-wing of the polarity, called humanist, is rooted in the view, introduced by Protagoras, of man as the measure of all things. The right-wing of the polarity, called

normative, is anchored to the Platonic conception of Ideas and Essences as the realm of reality and value. Humanists, who view people as basically good, view science as promoting human realization, government as promoting social welfare, and socialization as requiring unconditional love, sympathy, and play. Normatives, who view people as basically bad, view science as establishing truth, government as preserving law and order, and socialization as requiring conditional love to promote respect for rules and authority.

Description

The SPS consists of 30 forced-choice items measuring the sexual polarity of jehovanist or the naturalist ideology and 30 selected forced-choice items from the TPS measuring the polarity in world-views of the normative or humanist ideology. The 60 items are randomly mixed. Thus, the scale measures a relative preference for a left-wing world-view (humanist ideology) and a left-wing sexual ideology (naturalist) or a right-wing world-view (normative ideology) and a right-wing sexual ideology (jehovanist).

Response Mode and Timing

Respondents can circle the letter of the preferred alternative in each pair or respond on a machine-scoreable answer sheet. Approximately 13 minutes is required for completion.

Scoring

Alternatives assigned to the jehovanist ideology are scored

1, and naturalist alternatives are scored 0. The jehovanist

item numbers and letters for that choice are: 1a, 4b, 8a, 9b,

10b, 11a, 14a, 15b, 16b, 17b, 19b, 20a, 22b, 23b, 25b, 27b,

28b, 29a, 30b, 35a, 36a, 37b, 39b, 40a, 41b, 43b, 44a, 46b,

51b, and 52a. Alternatives assigned to the normative ideology are

scored 1, and humanist alternatives are scored 0. The nor

Exhibit

Sexual Polarity Scale

Instructions: An ideology is an organized set of ideas that offers a world view. An ideology can be concerned with theories of value, educa

tion, science, sex, or socialization. These are just a few examples. A sexual ideology is an organized set of ideas about sex reflecting the

ideas and aspirations of the individual, society, and culture. In the 60 items that follow, polar or contrasting ideas are presented. Your

task is to select the item in each pair which is closest to your personal point of view. If you prefer alternative (a) circle letter (a); if you

prefer alternative (b) circle letter (b). Although your cooperation is appreciated, you are, of course, free not to answer any item.

1. a) Pornography is disgusting.

b) So-called pornography can be enjoyable.

2. a) The most important aspect of science is that it enables man to realize himself by gaining understanding and control of the world around him.

b) The most important aspect of science is that it enables

man to separate the true from the false, the right from the wrong, reality from fantasy.

3. a) To assume that most people are well-meaning brings out the best in others.

b) To assume that most people are well-meaning is asking for trouble.

4. a) Abandoning yourself to pleasure helps to produce orgasmic response.

b) Sexual abandonment endangers the person's ability to control his or her own body.

5. a) No government should sanction legalized gambling. Ultimately this will undermine the very foundations of authority.

b) Legalized gambling is at worst innocuous. At best it lends spice and zest to life.

6. a) What children demand should be of little consequence to their parents.

b) What children demand, parents should take seriously and try to satisfy.

7. a) The most important thing in the world is to know yourself and be yourself.

b) The most important thing in the world is to try to live up to the highest standards.

8. a) The sin of fornication can be a worse crime than murder.

b) It is better to make love than to fight.

9. a) Homosexual teachers have no necessary affect on children's personality sexual orientation.

b) Homosexual teachers can corrupt a young mind.

10. a) Sexual fantasy is a way for a person to increase their erotic pleasure through the

use of imagination.

b) Too much thinking about sex is a sign of an impure mind

that will be easy prey to sexual temptation.

11. a) Sex undermines the distinction between humans and animals, making people more bestial.

b) Sex affirms the essential similarity of all of nature's creatures.

12. a) Juvenile delinquency is simply a reflection of the basic evil in human beings. It

has always existed in the past and it always will.

b) Juvenile delinquency is due to factors we do not understand. When we do understand these we will be able to prevent it in the future.

13. a) When man faces death he learns how basically insignificant he is.

b) When man faces death he learns who he really is and how much he loved life.

14. a) Pornography pollutes the senses, the self, and the society.

b) Erotica arouses the senses, frees the self, and purges false prudery from society.

15. a) The child molester deserves society's help, treatment, and rehabilitation.

b) The child molester should receive their just deserts-punishment.

16. a) Scientific knowledge provides the best guide to leading a satisfying sex life.

b) The Bible and religious leaders provide the best guide to leading a moral sex life.

17. a) Pornography is protected by the freedom of speech clause in the First Amendment.

b) Pornography should not be protected by the First Amendment because it creates a clear and present danger to society.

18. a) The important thing in science is to be right and make as few errors as possible.

b) The important thing in science is to strike out into the unknown-right or wrong.

19. a) Sexually explicit materials can be used in the classroom to educate young people about the facts of human sexuality.

b) The danger of sex education in the classroom is that it will corrupt the minds of young people who are open to immoral influences.

20. a) Nudity at public beaches endangers the well-being of the young.

b) Nudity at public beaches can lead to an appreciation of the human body as part of nature.

21. a) Great achievements require first of all great imagination.

b) Great achievements require first of all severe self-discipline.

22. a) Engaging in a single homosexual act does not necessarily mean the person has, or will adopt, an identity as a homosexual.

b) Engaging in a single homosexual act identifies a person as homosexual.

23. a) Although child pornography is distasteful, its influence is overrated.

b) If child pornography is permitted in any form, civilization, as we know it, is doomed.

24. a) If human beings were really honest with each other, there would be a lot more antipathy and enmity in the world.

b) If human beings were really honest with each other, there would be a lot more sympathy and friendship in the world.

25. a) Leaders in the public eye have no special moral obligations-they are fallible like all humans.

b) Sexual morality is necessary in our clergy, government officials, and teachers to uphold the standards of society.

26. a) The beauty of theorizing is that it has made it possible to invent things which otherwise never would have existed.

b) The trouble with theorizing is that it leads people away from the facts and substitutes opinion for truth.

27. a) Sometimes abortion is the best choice available to a young, unmarried woman.

b) Abortion is immoral because it takes a human life.

28. a) Sex education in the schools, including teaching about contraception, is the most effective way to reduce teenage pregnancies.

b) Sex education in the schools threatens to undermine the authority of the family and the morality of the community.

29. a) People should wash their hands and genitals after engaging in sexual relations.

b) Washing after sex destroys the relaxed mood that is created since it implies that sex is dirty.

30. a) The loss of control during sexual intercourse heightens orgasmic and interpersonal fulfillment.

b) Sexual intercourse and orgasm resemble having an epileptic fit, lacking the gracefulness and beauty of more refined social interaction.

31. a) Imagination leads people into self-deception and delusions.

b) Imagination frees people from the dull routines of life.

32. a) Thinking is responsible for all discovery and invention.

b) Thinking keeps people on the straight and narrow.

33. a) Observing the world accurately enables human beings to separate reality from imagination.

b) Observing the world accurately provides a human being with constant excitement and novelty.

34. a) Some people can only be changed by humiliating them.

b) No one has the right to humiliate another person.

35. a) Sex is so powerful that it alters your moral character, making you more like your partner.

b) Sex has no more power to alter personality or character than any other form of social interaction.

36. a) The wages of sexual sin is death.

b) The wages of sexual guilt is sexual inhibition.

37. a) Marital sex can remain exciting if the couple is imaginative and uninhibited.

b) Marriage is a good remedy for sexual temptation.

38. a) Those who err should be forgiven.

b) Those who err should be corrected.

39. a) Consenting sex is a worthwhile moral end.

b) Too often, sex leads people to relate to one another as means rather than as ends.

40. a) Oral and anal sex are more depraved than sexual intercourse.

b) Oral and anal sex are as morally acceptable as intercourse as long as the couple agrees.

b) There are natural and unnatural positions for men and women to use during sexual intercourse.

42. a) Whenever a person has difficulty in deciding which of two things to do he should do that which will give him the greatest satisfaction. In the long run that will be the right choice.

b) Whenever a person has difficulty in deciding which of two things to do he should do what he ought to do, whether it gives him satisfaction or not.

43. a) All of sex is natural, without necessarily having any cosmic or religious significance.

b) Marital sex, and only marital sex, is sacred-to be regarded with wonder.

44. a) Human sex was set apart forever from animal sex by the divine act that created the human soul.

b) Human sex is similar, biologically and behaviorally, to sex in primates like the apes.

45. a) Anger should be directed against the oppressors of mankind.

b) Anger should be directed against those revolutionaries who undermine law and order.

46. a) Masturbation is a normal sexual behavior that has produced needless worries.

b) At best, masturbation must be controlled; at worst, it is a sinful waste of human seed.

Initiative/Initiation

Exhibit

Sexually Assertive Behavior Scale

This portion of the questionnaire is an attempt to discover some of the behavior that you employ in your sexual activities. Sexual contact

is defined as fondling, kissing, petting, or intercourse. There are no right or wrong answers to the questions. Please answer as honestly

as you can.

1. How many times have you had sexual contact (fondling, kissing, petting, or intercourse) with a man when you both wanted to?

2. How many times have you initiated sexual contact (fondling, kissing, petting, or intercourse) with a man?

3. In initiating sexual contact with a man, how many times have you overestimated the level of sexual activity he desired to have with you?

4. How many times have you attempted to have sexual contact with a man because you were so sexually aroused you did not want to stop?

5. How many times have you attempted to have sexual contact with a man by getting him sexually aroused?

6. How many times have you attempted to have sexual contact (fondling, kissing, petting, or intercourse) with a man by threatening to end your relationship?

7. How many times have you attempted to have sexual contact with a man by saying things that you didn’t mean?

8. How many times have you attempted to have sexual contact with a man by pressuring him with verbal arguments?

9. How many times have you attempted to have sexual contact with a man in order to make another man jealous?

10. How many times have you attempted to have sexual contact with a man in order to get even with or hurt another man?

11. How many times have you attempted to have sexual contact with a man in order to end a relationship with another man?

12. How many times have you attempted to have sexual contact with a man in a position of power or authority over you (boss, teacher, or supervisor) in order to better your situation or gain something?

13. How many times have you attempted to have sexual contact with a man because you were angry at him?

14. How many times have you attempted to have sexual contact with a man to retaliate for something he did to you?

15. How many times have you attempted to have sexual contact (fondling, kissing, petting, or intercourse) with a man to gain power or control over him?

16. How many times have you attempted to have sexual contact with a man while his judgment was impaired by drugs or alcohol?

17. How many times have you attempted to have sexual contact with a man by taking advantage of a compromising position he was in (being where he did not belong or breaking some rule)?

18. How many times have you attempted to have sexual contact with a man by threatening to use some degree of physical force (holding him down, hitting him, etc.)?

19. How many times have you attempted to have sexual contact with a man by using some degree of physical force?

Kinsey, A., Pomeroy W., & Martin, C. (1948). Sexual behavior in the human male. Philadelphia: Saunders.

Koss, M., & Gidycz, C. (1985). Sexual Experiences Survey: Reliability and validity. Journal of Consulting and Clinical Psychology, 53, 422-423. Koss, M., & Oros, C. (1982). Sexual Experiences Survey: A research instrument investigating sexual aggression and victimization. Journal of Consulting and Clinical Psychology, 50, 455-457.

Intimacy (see Satisfaction)

Depth of Sexual Involvement Scale

MARITA P. MCCABE 1 AND JOHN K. COLLINS, Macquarie University

1 Address correspondence to Marita P. McCabe, School of Psychology, Deakin University, 221 Burwood Highway, Burwood, Victoria, Australia 3125;

e-mail: marita.mccabe@deakin.edu.au

and future concepts (pp. 181–195). Chicago: Year Book Medical

Publishers.

Guttman, L. (1944). A basis for scaling qualitative ideas. American

Sociological Review, 9, 139–150.

Luckey, E., & Nass, G. A. (1969). A comparison of sexual attitudes and

behavior in an international sample. Journal of Marriage and the

Family, 31, 364–379.

McCabe, M. P. (1982). The influence of sex and sex role on the dating atti

tudes and behavior of Australian youth. Journal of Adolescent Health

Care, 3, 54–62. McCabe, M. P., & Collins, J. K. (1981). Dating desires and experiences: A new approach to an old question. Australian Journal of Sex, Marriage and the Family, 2, 165–173. McCabe, M. P., & Collins, J. K. (1983). The sexual and affectional attitudes and experiences of Australian adolescents during dating: The effects of age, church attendance, type of school and socioeconomic class. Archives of Sexual Behavior, 12, 525–539. McCabe, M. P., & Collins, J. K. (1984). Measurement of depth of desired and experienced sexual involvement at different stages of dating. The Journal of Sex Research, 20, 377–390.

Exhibit

Depth of Sexual Involvement Scale

The following instructions accompany the scale, depending upon the purpose for which it is used.

Desire on First Date

This task is to determine what you would like at different stages in the dating relationship.

Indicate which of the following you would like on the FIRST DATE (i.e., the first time you go out with a new dating partner to whom you

are attracted).

Circle the response which is applicable.

Behavior on First Date

Instructions as above, but “would like” is replaced by “have never experienced.”

Desires After Several Dates

Instructions as for Desires on First Date but “ FIRST DATE” is replaced by “SEVERAL DATES” with the definition of this stage of dating

given earlier in this paper.

Behavior After Several Dates

Instructions as for Behavior on First Date but “ FIRST DATE” is replaced by “SEVERAL DATES” with the definition of this stage of dating

given earlier in this paper.

Desires When Going Steady

Instructions as for Desires on First Date but “ FIRST DATE” is replaced by “when GOING STEADY” with the definition of this stage of

dating given earlier in this paper.

Behavior When Going Steady

Instructions as for Behavior on First Date but “ FIRST DATE” is replaced by “when GOING STEADY” with the definition of this stage of

dating given earlier in this paper.

Scale of Sexual Activities

1. Hand holding: holding hands or locking arms, generally while walking.

2. Light kissing: casual goodnight kiss on the lips.

3. Necking: close body contact, with hugging and prolonged kissing.

4. Light breast petting: caress of the girl’s breasts outside the clothing.

5. Heavy breast petting: fondling or kissing of the girl’s breasts under the clothing.

6. Light genital petting of the female: touching genital area of the girl, outside the clothing.

7. Heavy genital petting of female: touching genital area of the girl, under the clothing.

8. Manual stimulation of male genitals.

9. Oral stimulation of female genitals.

10. Oral stimulation of male genitals.

11. Petting of each other’s genitals resulting in orgasm for one or both partners.

12. Intercourse.

DONALD L. MOSHER, 1 University of Connecticut

In Mosher’s (1980) sexual involvement theory, orgasmic

response is potentiated by effective sexual stimulation that

is subjectively experienced as pleasurable: (a) sensory

signals, (b) the discrete affects of interest-excitement and

enjoyment-joy, and (c) the cognitive interpretation and

evaluation of sensory and affective pleasure as ordered by rules contained in facilitating sexual scripts. Effective sexual stimulation is a joint function of the optimal density of physical sexual stimulation and depth of involvement in the sexual episode. The optimal density of physical stimulation is a function of scripted rules for ordering information about the intensity times duration of sexual touching. Involvement is defined as a latent or theoretical construct consisting of a complex of interacting psychological processes that motivate and define the state of absorption in the sexual episode. The involvement complex consists of (a) the affects of interest-excitement and enjoyment-joy, (b) affect-cognition blends of anticipatory excitement and sexual pleasure with the sexual goal, image, and plan (i.e., the sexual motive) for the episode, and (c) the facilitating sexual scripts of involvement potential and path preference and potential involvement. Involvement is manifested as a state of absorption in the inherently acceptable affective scene of the sexual episode. To be involved or absorbed means the person is fully attending to or totally engrossed in the possibilities of the sexual image and plan and the unfolding actualities or expressive action, subject experience, and interpersonal engagement emergent in the present moment of the sexual episode. Depth of involvement in

the sexual episode is a function of a deepening involvement

within three (so far identified) general paths, or families of

plans, that are distinguished conceptually as (a) the path

of involvement in sexual role enactment, (b) the path of

involvement in sexual trance, and (c) the path of involve

ment with the sex partner. A path is defined as a general sexual script contain

ing (a) the ordered set of rules for generating, predicting,

interpreting, controlling, and evaluating a related family of

sexual scenes and (b) its associated affect. The potential

ity for deep involvement in a particular sexual scene is a

function of (a) involvement potential; (b) multiple, highly

feedback from auxiliary information about the goodness

of-fit of the unfolding incidents and events to the sexual

1 Address correspondence to Donald L. Mosher, 648 Ternberry Forest Drive, The Villages, FL 32162; e-mail: dlmosher@aol.com

25, 30, 32, 34, 37, 41, 45, 48, 51, 53, 57, 58, 63, 64, 67, 71,

73, 76, 79, 82, 87, and 88. An individual might have one,

two, three, or no highly valued paths as defined by scores

above 120 for a particular path. If each partner of a couple

has completed the inventory independently, then indices of

compatibility of involving path preference can be scored.

A score for Compatible Role Path is a count of the 30

items keyed above on which both members of the cou

ple rated the same item as 5, 6, or 7 (i.e., it was true of them both). A score for Compatible Trance Path is a similar count of the 30 items keyed in that path which both members of the couple endorsed as true for them; likewise, a count is made for Compatible Partner Path. A sum of these three scores yields an index of Potential for Compatible Involvement.

Reliability

Cronbach alpha coefficients were computed on a sample of 100 sexually experienced adult men and women for Involvement Potential, alpha = .93; Preference for Role Path, alpha = .92; Preference for Trance Path, alpha = .86; and Preference for Partner Path, alpha = .91.

Validity

Sirkin (1985) found that 76 college men scored significantly higher on the Path of Role Enactment, M = 100.01, than 62 college women, M = 87.52, $t(136) = 2.72$, $p < .01$. For the women in the sample, Involvement Potential, Trance Path Preference, and Role Path Preference were significantly correlated (Mdn $r(60) = .43$) with self-reports of sexual behavior, sexual pleasure, and sexual fantasy. Partner Path

Exhibit

consists of 90 items arranged into 30 triplets. Each set of three items is related to some aspect of a sexual episode between two

partners. You are to respond to each of the 90 items as honestly as you can by rating your response on a 7-point

scale where 0

means not at all true of (for) me, and 6 means extremely true of (for) me. Ratings of 1 through 5 represent ratings of disagreement/

agreement that are intermediate between not at all true and extremely true. The items are arranged in sets of three to permit you to

compare the intensity of agreement/disagreement among the set since they all relate to the same feature of the sexual situation.

This limited comparison is often useful since people frequently most or least prefer one item in each set. In some instances it is

possible that all items in a set may be not at all true or extremely true for you. Most often, there will be a gradation in preference. You

may prefer or believe some items to be more characteristically true of you than others, and you may not prefer some items which

are much less true for you than others. Rate each of the 90 items from 0 to 6 as you keep in mind the value of comparing items within

the triplets.

Sexual metaphors

1. Sex is artful and dramatic play.

2. Sex is union.

3. Sex is trance.

Mood

4. My favorite mood for enjoying sex is like a tranquil meditative state or the relaxation that you might get from a massage or marijuana.

5. When I’m feeling that “All the world’s a stage, and all the people are sex players,” then I know I want to get it on.

6. When my heart is bursting with love, I know our sex will be bursting with loving pleasure.

Settings

7. I like to have sex in a romantic context in which my partner and I are feeling loving toward one another.

8. I could enjoy having sex in a setting close to nature (e.g., on a mountain top or by the ocean), if I knew that we were totally alone and sure of privacy.

9. I would enjoy having sex in a dramatic setting, like in an oriental harem or an elegant New Orleans brothel.

Sexual techniques

10. Regardless of contemporary views on sexual variety, for me nothing will replace my favorite position for coitus of being face to face with the one I love.

11. I enjoy having sexual intercourse in a wide variety of positions.

12. I prefer slow and rhythmic movement that permits me to really sense the shades and nuances of pleasure that can exist during sexual intercourse.

Sexual metaphors

13. Sex is a drama that begins with attraction, develops a plot filled with intrigue, mystery, and sex play, and ends in tumultuous climax worthy of an audience’s applause.

14. Sex is a trip into your own sensory nerves and erotic images.

15. I consider sex to be the organ of love.

Mood

16. The most important aspect of my mood when I get into sex is that I be physically relaxed and mentally receptive.

17. To really want sex my mood must be one of really loving my partner.

18. I love serious sex play when I’m in a playful mood.

Settings

19. I believe that I would feel very excited by having secret sex in a semi-public place.

20. I like a setting for having sex that ensures total privacy.

21. I enjoy having sex in a place that has special meanings for me and my partner.

Sexual techniques

22. Ideally, all sexual techniques begin and build from kissing the face and lips.

23. I pride myself in being quite accomplished in the techniques of oral sex.

24. The most important thing about sexual technique is pacing and repetition that permits you and your partner to become absorbed into the sex.

Sexual style

25. My sexual style is affectionate and loving.

26. My sexual style is as varied as my mood suggests and my fantasies can create.

27. I concentrate on my inward sensations and experience during sex.

Ideal partner

28. Sexual skill and a flair for experimenting make an ideal sex partner.

29. An ideal sex partner flows with your mood and the situation rather than trying to dictate just how sex is to be done.

30. My ideal sex partner is my ideal love object.

Sex talk

31. If I talk during sex it’s liable to be to say something like “oh, that feels so good, oh more, mmmh good, etc.”

32. Most of all during sex I like to hear and say “I love you.”

33. I really get off when my partner is urging, begging, or directing me by saying, for example, “fuck me, fuck me, fuck me!”

Sex fantasies

34. Sometimes I imagine that my partner through his/her sexual participation is pledging his/her love to me for life.

35. I can enjoy a wide range of sexual fantasies that create novelty in partners, activities, and settings.

36. I like to use my imagination to increase my absorption into the sensory experience of sex.

Sexual techniques

37. My sexual style concentrates on mutual pleasuring to bond us closer together.

38. Sexual variety is the spice of a love life.

39. When I have truly good sex I care less about what and how we are doing it sexually than I do about what I am sensing, feeling, and

experiencing as a consequence.

Sexual style

40. For me the sexual experience is truly entrancing, and you would never know how intensely I am experiencing the sex by just looking

at me.

41. In my sexual style I try to blend the romantic with the erotic to offer a full rich gift of sexual love.

42. I like to play different sexual roles and scripts that act out fantasies while having sex.

Ideal partner

43. I expect my sexual partner to help create and sustain an ambiance of sensual pleasure.

44. I like a partner who moans and writhes and is carried

away by his/her passion.

45. I expect my sex partner to be truly sexually considerate and loving.

Sex talk

46. I can enjoy lusty sex talk that uses erotic language for erotic acts.

47. During sex I like little talk and more sensual friction.

48. Sex talk should be love talk.

Sex fantasies

49. I have several fantastic sex fantasies with dramatic and exciting plots that help turn me on during ordinary sex.

50. I may imagine how I look or how my own and my partner's sex organs look, etc. during sex to enhance my erotic

pleasure.

51. Sometimes I imagine my partner is telling me how much he/she loves me during our lovemaking in ways that exceed the limits of

mere words.

Ideal sex

52. Truly good sex for me usually entails a wide variety of sex practices and coital positions.

53. Good sex is the physical expression through sexual union of an interpersonal loving union.

54. Good sex for me is characterized by an intense involvement into the sensual and sexual sensation of the moment.

Music

55. Music to have sex by should have dramatic changes in rhythm, tempo, and volume while building to a lively crescendo.

56. Music to have sex by should be soft, low, and

repetitive to form a rhythmic background that facilitates the flow without setting a

pace to be followed.

57. Music to have sex by should be lyrical, romantic, and poetic in tone to match the partner's loving mood.

Orgasms

58. I most enjoy orgasms in which I seem to flow into my partner and lose myself in our union.

59. I love it when sex moves me to uninhibited self-expression that leaves me with no sense of control of my sounds, movements, and orgasm.

60. I most enjoy orgasms in which I experience sensations that are so intense that I actually lose consciousness or at least waking consciousness fades in the face of the culminative sensations and experience.

Ideal partner

61. An ideal sex partner knows exactly what I like and want now.

62. I enjoy a partner who is open to playing different roles so that we can create a novel and dramatic sexual script.

63. If a person cannot look me in the eye before, during and after sex, I suspect the attraction is to my body and not to me.

Sex fantasies

64. Most of my fantasies during sex are really memories of past shared moments in which we felt especially close and loving.

65. Sometimes I experience visual and auditory images that accompany the sensual sensory experience during sex.

66. Sometimes I imagine that I could enjoy sex on a stage surrounded by an admiring audience.

Ideal sex

67. The best sex for me is loving sex.

68. The best sex occurs when sexual expression becomes so ecstatic that it becomes nonvolitional and I lose all sense of conscious control.

69. When I'm having the best sex, my sex organs become alive and their sensations demand and direct the action.

Orgasms

70. I love it when my orgasms are nearly convulsive and I involuntarily scream in pleasure, and grab, and/or bite, or scratch.

71. To orgasm, I must be secure in my love for and from my partner.

72. During orgasms my awareness is flooded with intense sensations.

Emotions

73. Love is the predominant emotion in my sexual experience.

74. Excitement is the predominant emotion in my sexual experience.

75. Enjoyment is the predominant emotion in my sexual experience.

Meanings of sex

76. Sex is the merger of two into a unity of physical and spiritual love.

77. The meaning of sex is that it permits me to set aside my daily existence and to be transported into an underworld of sensations.

78. Sex when most meaningful is a cathartic drama that requires mastery and artful performance of one's sexual identity.

Sex fantasies

79. I sometimes imagine that my partner and I have been selected to symbolize the essence of love in a religious-like, sexual-spiritual ritual.

80. I can enjoy imagining that I am an amazingly successful

porno film star and sex symbol in our culture.

81. I rarely have a sex fantasy with a plot; usually I only have a series of nonconnected, visual, sexual images of, for example, sex organs.

Ideal sex

82. The best sex occurs when I enter into a loving warm union with my partner, when we become two in one.

83. Sexual ecstasy is my criterion of good sex.

84. Good sex is total absorption into the sexual experience.

Orgasms

85. The moment of orgasm is a moment of total surrender to intense sensations.

86. The best orgasm is like an involuntary dramatic shock that overwhelms yet releases my sexual tension.

87. Orgasms are a unique moment of fusion in which my soul cries out its love through my body, and my longing for my partner is fulfilled.

Jealousy

Exhibit

Anticipated Sexual Jealousy Scale

How would you feel if your partner were to engage in the following behavior with another man/woman?

1. Flirting 2. Sexual intercourse a

a. extremely pleased 3. Light petting

b. very pleased 4. A long-term sexual relationship

c. fairly pleased 5. Falling in love

d. somewhat pleased

e. neutral

f. somewhat bothered

g. fairly bothered

h. very bothered

i. extremely bothered

a The nine response options are repeated for each item.

Knowledge (also see Adolescents)

TABLE 1

A Description of the Subscales, Areas, and Range of Scores

for the Sexual Knowledge, Experience, Feelings, and Needs

Scale (SexKen, SexKen-ID, SexKen-PD, SexKen-C)

Number Range

Subscale Area of Items of Scores

Friendship (23 items) Knowledge: 1 0–2

Experience: 13 5–22

Feelings: 4 4–20

Needs: 5 5–25

Dating and Intimacy (16 items) Knowledge: 2 0–4

Experience: 4 3–9

Feelings: 6 4–11

Needs: 4 4–20

Marriage (16 items) Knowledge: 2 0–4

Experience: 0 —

Feelings: 13 6–10

Needs: 1 1–5

Body Part Identification (21 items) Knowledge: 21 0–42

Experience: 0 —

Feelings: 0 —

Needs: 0 —

Sex and Sex Education (16 items) Knowledge: 1 0–2

Experience: 7 6–27

Feelings: 5 5–25

Needs: 3 3–15

Menstruation (16 items) Knowledge: 11 0–22

Experience: 2 2–4

Feelings: 2 2–10

Needs: 1 1–5

Sexual Interaction (52 items) Knowledge: 21 0–42

Experience: 15 8–31

Feelings: 14 8–31

Needs: 2 2–10

Contraception (19 items) Knowledge: 9 0–18

Experience: 8 4–11

Feelings: 1 1–5

Needs: 1 1–5

Pregnancy, Abortion and Knowledge: 15 0–30

Childbirth (24 items) Experience: 3 —

Feelings: 4 4–20

Needs: 2 2–10

Sexually Transmitted Diseases Knowledge: 11 0–22

(19 items) Experience: 2 1–2

Feelings: 4 4–20

Needs: 2 2–10

Masturbation (16 items) Knowledge: 3 0–6

Experience: 6 4–20

Feelings: 6 5–25

Needs: 1 1–5

Homosexuality (10 items) Knowledge: 1 0–2

Experience: 1 1–5

Feelings: 6 4–20

Needs: 2 2–10

Locus of Control

TABLE 1

Normative Data for Dyadic Sexual Regulation Scale NABS a Study (Wave 2)

N Mean SD Range Mdn Alpha

National Sample 1,022 15.62 2.83 15.0 16.0 .59

High Risk Cities 3,598 15.37 2.86 15.0 15.0 .57

Ethnicity

White

National Sample 747 15.75 2.75 15.0 16.0 .61

High Risk Cities 1,565 15.62 2.68 15.0 16.0 .61

Black

National Sample 162 15.23 2.99 14.0 15.0 .47

High Risk Cities 1,181 15.18 3.06 15.0 15.0 .52

Hispanic

National Sample 90 15.45 3.03 14.0 15.6 .61

High Risk Cities 764 14.98 3.20 15.0 15.0 .60

Gender

Male

National Sample 410 15.37 2.65 14.0 15.0 .86

High Risk Cities 1,553 15.24 2.77 15.0 15.0 .56

Female

National Sample 612 15.85 2.98 15.0 16.0 .61

High Risk Cities 2,043 15.53 2.94 15.0 16.0 .58

Education

< 12 years

National Sample 82 14.74 2.89 12.0 15.0 .38

High Risk Cities 483 14.76 3.12 15.0 15.0 .53

= 12 years

National Sample 273 15.75 2.93 13.0 16.0 .59

High Risk Cities 807 15.41 2.96 15.0 16.0 .54

> 12 years

National Sample 668 15.71 2.76 15.0 16.0 .59

High Risk Cities 2,308 15.54 2.72 15.0 16.0 .58 AMEN b Study

Total 954 15.08 3.01 15.0 15.0 .58

Ethnicity

White 418 15.14 2.88 13.0 15.0 .63

Black 238 15.0 13.24 15.0 15.0 .53

Hispanic 229 14.98 3.08 15.0 15.0 .55

Gender

Male 410 15.22 2.74 15.0 15.0 .52

Female 544 14.98 3.20 15.0 15.0 .61

Education

< 12 years 109 15.44 3.30 13.0 16.0 .57

= 12 year 213 14.64 3.21 15.0 15.0 .54

> 12 years 626 15.26 2.86 14.0 15.0 .59

Note. Because weights for probability of selection are used, all frequencies may not

sum to equal total frequencies.

a National AIDS Behavior Study.

b AIDS in Multi-Ethnic Neighborhoods.

3 For further details on sample construction and weighting of the AMEN cohort study, see Catania Coates, Stall, et al. (1992).

Love

Exhibit

Juvenile Love Scale (Forms A and B)

Instructions for both scale forms: We are trying to find out how children feel when they love somebody in a very special way. Some children

think about a special person a lot, get very excited about him or her, and want to get very, very close. Sometimes we call this a “crush.”

Please list on the lines that follow the name of the eight people you have loved or liked most in your life:

Name Male or female

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

6. _____ _____

7. _____ _____

8. _____ _____

Now draw a circle around the name of the person you’d feel most excited about seeing right now or used to get excited about seeing if

that person isn’t around anymore. Do not choose mother, father, or brother or sister. If you aren’t excited about him/her right now, try

to remember how you felt when you did feel the most excited. If you don’t think you have ever felt very excited, try to answer anyway,

remembering how you did feel.

Each question is followed by a 9-point rating scale. If you

circle the 9, it means you agree very much with what the item says. If you circle

the 1, it means you agree very little with what the item says. Try to circle the number that most closely explains how you do feel.

Juvenile Love Scale (Form A)

1. I feel like things would always be sad and gloomy if I had to live without _____ forever.

2. Did you ever keep thinking about ____ when you wanted to stop and couldn't?

3. I feel happy when I am doing something to make _____ happy.

4. I would rather be with _____ than anybody else.

5. I'd feel bad if I thought _____ liked somebody else better than me.

6. I want to know all I can about _____.

7. I'd like _____ to belong to me in every way.

8. I'd like it a lot if _____ played with me all the time.

9. If I could, when I grow up I'd like to marry (live with) _____.

10. When _____ hugs me my body feels warm all over.

11. I am always thinking about _____.

12. I want _____ to know me, what I am thinking, what scares me, what I am wishing for.

13. I look at _____ a lot to see if he/she likes me.

14. When _____ is around I really want to touch him/her and be touched.

15. When I think _____ might be mad at me, I feel really sad.

Possible answers range from

1 2 3 4 5 6 7 8 9

Agree Very Little Agree Very Much

Juvenile Love Scale (Form B)

1. When _____ is around I laugh and cry more often.

2. I feel like things would always be sad and gloomy if I had to live without _____ forever.

3. Sometimes I feel shaky all over when I see ______.

4. Sometimes I think it is fun just to watch _____ move around.

5. Did you ever keep thinking about ____ when you wanted to stop and couldn't?

6. I feel happy when I am doing something to make _____ happy.

7. I would rather be with _____ than anybody else.

8. I'd feel bad if I thought _____ liked somebody else better than me.

9. No one else could like _____ as much as I do.

10. I want to know all I can about _____.

11. I'd like _____ to belong to me in every way.

12. I will always like _____.

13. I feel all happy inside when _____ looks at me and I look at _____.

14. I'd like it a lot if _____ played with me all the time.

15. If I could, when I grow up I'd like to marry (live with) _____.

16. _____ is the person who can make me feel the happiest.

17. When _____ hugs me my body feels warm all over.

18. I feel all soft and happy inside about _____.

19. I am always thinking about _____.

20. If I were away from _____ for a long time I would be very lonely.

21. Sometimes I can't do my school work because I am thinking about _____.

22. I want _____ to know me, what I am thinking, what scares me, what I am wishing for.

23. Knowing that _____ cares about me makes me feel more like I am OK.

24. I look at _____ a lot to see if he/she likes me.

25. If _____ needed help from me, I'd stop what I was doing, even if it was lots of fun and go help him (her).

26. _____ can make me feel bubbly, like coke.

27. When _____ is around I really want to touch him/her and be touched.

28. Living without _____ would be very, very sad.

29. I want to hug _____ very, very tight.

30. When I think _____ might be mad at me, I feel really sad.

Possible answers range from

1 2 3 4 5 6 7 8 9

Agree Very Little Agree Very Much

Passionate Love Scale

ELAINE HATFIELD, 1 University of Hawaii

SUSAN SPRECHER, Illinois State University

Many classifications and typologies of love exist in the lit

erature, but the most common distinction is between pas

sionate love and companionate love. Hatfield and Walster

(1978) described passionate love as "a state of intense

longing for union with another. Reciprocated love (union

with the other) is associated with fulfillment and ecstasy;

unrequited love (separation) is associated with emptiness,

anxiety, or despair" (p. 9). In 1986, Hatfield and Sprecher published the Passionate

Love Scale (PLS) for the purpose of promoting more

research on this intense type of love. Although a compan

ion scale to measure companionate love was not also devel

oped by this team of researchers, other measures exist in the literature designed to assess this type of love (see, e.g., Grote & Frieze's [1994] Friendship-Based Love Scale). Description The PLS scale was specifically designed to assess the cognitive, emotional, and behavioral components of passionate love. The cognitive components consist of Intrusive thinking; Preoccupation with the partner; Idealization of the other or of the relationship; and Desire to know the other and be known by him/her. Emotional components consist of Attraction to the partner, especially sexual attraction; Positive feelings when things go well; Negative feelings

1 Address correspondence to Elaine Hatfield, 2430 Campus Road, Honolulu, HI 96822; e-mail: elaineh1@aol.com

when things go awry; Longing for reciprocity—passionate

lovers not only love but want to be loved in return; Desire for

complete and permanent union; and Physiological (sexual)

arousal. Finally, behavioral components consist of Actions

aimed at determining the other's feelings; Studying the

other person; Service to the other; and Maintaining physi

cal closeness.

The most common form of the PLS is a 15-item scale

(Form A), but an alternative 15-item version (Form B) is

also available. The two scales can be combined to form a

30-item scale. Although the scale was originally designed using North American young adults in pilot studies, the scale has subsequently been revised to be administered to children and has been translated into many languages and administered to samples in other countries.

Response Mode and Timing

Participants are presented with statements such as “I would feel deep despair if ____ left me” and are asked to indicate how true the statement is of them. Possible responses range from 1 = Not at all True to 9 = Definitely True. (The ____ in each statement refers to the partner.) The scale takes only a few minutes to complete, although often it is embedded in a larger questionnaire with other measures.

Scoring

The total score of the scale can be represented either by the mean of the scores for the items or by the sum of the ratings.

Higher scores indicate greater passionate love. An average score for young adults across the items is approximately 7.

Recently, for a popular press article, Hatfield and Sprecher (2004) provided for readers the following rubric to inter pret their summed scores across 15 items:

- 106–135 points = Wildly, recklessly, in love
- 86–105 points = Passionate but less intense

- 66–85 points = Occasional bursts of passion
- 45–65 points = Tepid, infrequent passion
- 15–44 points = The thrill is gone

Reliability

Hatfield and Sprecher (1986) reported a coefficient alpha

of .91 for the 15-item version and .94 for the 30-item ver

sion. Others have also reported high levels of reliability for

the scale (e.g., Sprecher & Regan, 1998). The PLS appears

to be primarily unidimensional, with one primary factor

emerging from a principal components factoring.

Validity

The scale is uncontaminated by a social desirability bias, as

indicated by a nonsignificant correlation between the PLS

and their scores on the 1964 Crowne and Marlowe Social

Exhibit

Passionate Love Scale

Passionate Love Scale (Form A)

We would like to know how you feel (or once felt) about the person you love, or have loved, most passionately. Some common terms

for passionate love are romantic love, infatuation, love sickness, or obsessive love.

Please think of the person whom you love most passionately right now. If you are not in love, please think of the last person you loved.

If you have never been in love, think of the person you came closest to caring for in that way.

Try to describe the way you felt when your feelings were most intense. Answers range from (1) Not at all True to (9) Definitely True.

Whom are you thinking of?

- Someone I love right now.
- Someone I once loved.
- I have never been in love.

1. I would feel deep despair if _____ left me.

1 2 3 4 5 6 7 8 9 a

Not at all True Definitely True

2. Sometimes I feel I can't control my thoughts; they are obsessively on _____.

3. I feel happy when I am doing something to make _____ happy.

4. I would rather be with _____ than anyone else.

5. I'd get jealous if I thought _____ were falling in love with someone else.

6. I yearn to know all about _____.

7. I want _____ physically, emotionally, mentally.

8. I have an endless appetite for affection from _____.

9. For me, _____ is the perfect romantic partner.

10. I sense my body responding when _____ touches me.

11. _____ always seems to be on my mind.

12. I want _____ to know me—my thoughts, my fears, and my hopes.

13. I eagerly look for signs indicating _____'s desire for me.

14. I possess a powerful attraction for _____.

15. I get extremely depressed when things don’t go right in my relationship with _____.

Total: _______

Results:

- 106–135 points = Wildly, even recklessly, in love
- 86–105 points = Passionate, but less intense
- 66–85 points = Occasional bursts of passion
- 45–65 points = Tepid, infrequent passion
- 15–44 points = The thrill is gone

James, P. (2007). Effects of a communication training component added to an emotionally focused couples therapy. Journal of Marital and Family Therapy, 17, 263–275.

Landis, D., & O’Shea, W. A., III. (2000). Cross-cultural aspects of passionate love: An individual difference analysis. Journal of CrossCultural Psychology, 31, 754–779. Sprecher, S., & Regan, P. C. (1998). Passionate and companionate love in courting and young married couples. Sociological Inquiry, 68, 163–185. Tucker, P., & Aron, A. (1993). Passionate love and marital satisfaction at key transition points in the family life cycle. Journal of Social and Clinical Psychology, 12, 135–147.

Passionate Love Scale (Form B)

We would like to know how you feel (or once felt) about the person you love, or have loved, most passionately. Some common terms

for passionate love are romantic love, infatuation, love sickness, or obsessive love.

Please think of the person whom you love most passionately right now. If you are not in love, please think of the last person you loved.

If you have never been in love, think of the person you came closest to caring for in that way.

Try to describe the way you felt when your feelings were most intense. Answers range from (1) Not at all True to (9) Definitely True.

Whom are you thinking of?

- Someone I love right now.

- Someone I once loved.

- I have never been in love.

1. Since I've been involved with ____, my emotions have been on a roller coaster.

1 2 3 4 5 6 7 8 9 a

Not at all True Definitely True

2. Sometimes my body trembles with excitement at the sight of _____.

3. I take delight in studying the movements and angles of _____'s body.

4. No one else could love _____ like I do.

5. I will love _____ forever.

6. I melt when looking deeply into ____'s eyes.

7. _____ is the person who can make me feel happiest.

8. I feel tender toward _____.

9. If I were separated from ____ for a long time, I would feel intensely lonely.

10. I sometimes find it difficult to concentrate on work because thoughts of _____ occupy my mind.

11. Knowing that _____ cares about me makes me feel complete.

12. If _____ were going through a difficult time, I would put away my own concerns to help him/her out.

13. _____ can make me feel effervescent and bubbly.

14. In the presence of _____, I yearn to touch and be touched.

15. An existence without _____ would be dark and dismal.

Total: _____

Results:

- 106–135 points = Wildly, even recklessly, in love
- 86–105 points = Passionate, but less intense
- 66–85 points = Occasional bursts of passion
- 45–65 points = Tepid, infrequent passion
- 15–44 points = The thrill is gone

a This response scale follows each item.

Bem, S. L. (1981). Bem Sex-Role Inventory professional manual. Palo Alto, CA: Consulting Psychological Press.

Blanchard, R. (1985a). Research methods for the typological study of gender disorders in males. In B. W. Steiner (Ed.), Gender dysphoria: Development, research, management (pp. 227–257). New York: Plenum.

Blanchard, R. (1985b). Typology of male-to-female transsexualism. Archives of Sexual Behavior, 14, 247–261.

Blanchard R., Clemmensen, L. H., & Steiner, B. W. 1985). Social desirability response set and systematic distortion in the self-report of adult male gender patients. Archives of Sexual Behavior, 14, 505–516. Blanchard, R., & Freund, K. (1983). Measuring masculine gender identity in females. Journal of Consulting and Clinical Psychology, 51, 205–214. Blanchard, R., McConkey, J. G., Roper, V., & Steiner, B. W. (1983). Measuring physical aggressiveness in heterosexual, homosexual, and transsexual males. Archives of Sexual Behavior, 12, 511–524. Crowne, D. P., & Marlowe, D. (1964). The approval motive: Studies in evaluative dependence. New York: Wiley. Freund, K., & Blanchard, R. (1983). Is the distant relationship of fathers and homosexual sons related to the sons' erotic preference for male partners, or to the sons' atypical gender identity, or to both? Journal of Homosexuality, 9, 7–25. Freund, K., Langevin, R., Satterberg, J., & Steiner, B. W. (1977). Extension of the Gender Identity Scale for Males. Archives of Sexual Behavior, 6, 507–519. Freund, K., Nagler, E., Langevin, R., Zajac, A., & Steiner, B. W. (1974). Measuring feminine gender identity in homosexual males. Archives of Sexual Behavior, 3, 249–260. Freund, K., Steiner, B. W., & Chan, S. (1982). Two types of cross-gender identity. Archives of Sexual Behavior, 11, 49–63. Freund, K., Scher, H., Chan, S., & Ben-Aron, M. (1982). Experimental analysis of pedophilia. Behavior Research & Therapy, 20, 105–112. Guloien, E. H. (1983). Childhood gender identity and adult erotic orientation in males. Unpublished master's thesis, University of Guelph, Guelph, Ontario. Hooberman, R. E. (1979). Psychological androgyny, feminine gender identity, and self-esteem in homosexual and heterosexual males. The Journal of Sex Research, 15, 306–315. Jackson, D. (1974). Personality research form manual. Goshen, NY: Research Psychologist's Press.

Exhibit 1

Feminine Gender Identity Scale for Males

Part A

1. Between the ages of 6 and 12, did you prefer

a. to play with boys (0)

b. to play with girls (2)

c. didn’t make any difference (0)

d. not to play with other children (1)

e. don’t remember (1)

2. Between the ages of 6 and 12, did you

a. prefer boys’ games and toys (soldiers, football, etc.) (0)

b. prefer girls’ games and toys (dolls, cooking, sewing, etc.) (2)

c. like or dislike both about equally (1)

d. had no opportunity to play games or with toys (1)

3. In childhood, were you very interested in the work of a garage mechanic? Was this

a. prior to age 6 (0)

b. between ages 6 and 12 (0)

c. probably in both periods (0)

d. do not remember that I was very interested in the work of a garage mechanic (1)

4. Between the ages of 6 and 14, which did you like more, romantic stories or adventure stories?

a. liked romantic stories more (2)

b. liked adventure stories more (0)

c. it did not make any difference (1)

5. Between the ages of 6 and 12, did you like to do jobs or chores which are usually done by women?

a. yes (2)

b. no (0)

c. don't remember (1)

6. Between the ages of 13 and 16, did you like to do jobs or chores which are usually done by women?

a. yes (2)

b. no (0)

c. don't remember (1)

7. Between the ages of 6 and 12, were you a leader in boys' games or other activities?

a. more often than other boys (0)

b. less often than other boys (1)

c. about the same, or don't know (0)

d. did not partake in children's games and/or other activities (1)

8. Between the ages of 6 and 12, when you read a story did you imagine that you were

a. the male in the story (cowboy, detective, soldier, explorer, etc.) (0)

b. the female in the story (the girl being saved, etc.) (2)

c. the male sometimes and the female other times (1)

d. neither the male nor the female (1)

e. did not read stories (1)

9. In childhood or at puberty, did you like mechanics magazines? Was this

a. between ages 6 and 12 (0)

b. between ages 12 and 14 (0)

c. probably in both periods (0)

d. do not remember that I liked mechanics magazines (1)

10. Between the ages of 6 and 12, did you wish you had been born a girl instead of a boy

a. often (2)

b. occasionally (1)

c. never (0)

11. Between the ages of 13 and 16, did you wish you had been born a girl instead of a boy

a. often (2)

b. occasionally (1)

c. never (0)

12. Since the age of 17, have you wished you had been born a girl instead of a boy

a. often (2)

b. occasionally (1)

c. never (0)

13. Do you think your appearance is

a. very masculine (0)

b. masculine (0)

c. a little feminine (1)

d. quite feminine (2)

14. In childhood, did you sometimes imagine yourself a well-known sports figure, or did you wish you would become one? Was this

a. prior to age 6 (0)

b. between ages 6 and 12 (0)

c. probably in both periods (0)

d. do not remember such fantasies (1)

15. In childhood fantasies did you sometimes wish you could go hunting big game? Was this

a. prior to age 6 (0)

b. between ages 6 and 12 (0)

c. probably in both periods (0)

d. do not remember such fantasies (1)

16. In childhood fantasies did you sometimes imagine yourself as being a policeman or soldier? Was this

a. prior to age 6 (0)

b. between ages 6 and 12 (0)

c. probably in both periods (0)

d. do not remember that I had such a fantasy (1)

17. In childhood was there ever a period in which you wished you would, when adult, become a dressmaker or dress designer?

a. prior to age 6 (1)

b. between ages 6 and 12 (1)

c. probably in both periods (1)

d. do not remember having this desire (0)

18. In childhood fantasies did you sometimes imagine yourself driving a racing car? Was this

a. prior to age 6 (0)

b. between ages 6 and 12 (0)

c. probably in both periods (0)

d. do not remember having this fantasy (1)

19. In childhood did you ever wish to become a dancer? Was

this

a. prior to age 6 (1)

b. between ages 6 and 12 (1)

c. probably in both periods (1)

d. do not remember having this desire (0)

Part B

20. What kind of sexual contact with a male would you have preferred on the whole, even though you may not have done it?

a. inserting your privates between your partner's upper legs (thighs) (0)

b. putting your privates into your partner's rear end (0)

c. you would have preferred one of those two modes but you cannot decide which one (0)

d. your partner putting his privates between your upper legs (thighs) (1)

e. your partner putting his privates into your rear end (2)

f. you would have preferred one of these two latter modes but you cannot decide which one (1)

g. you would have liked all four modes equally well (1)

h. you would have preferred some other mode of sexual contact (1)

i. had no desire for physical contact with males (exclude subject)

21. What qualities did you like in males to whom you were sexually attracted?

a. strong masculine behavior (2)

b. slightly masculine behavior (1)

c. rather feminine behavior (0)

d. did not feel sexually attracted to males (exclude

subject)

22. Would you have preferred a partner

a. who was willing to have you lead him (0)

b. who was willing to lead you (2)

c. you didn't care (1)

d. did not feel sexually attracted to males (exclude subject)

Part C

23. Between the ages of 6 and 12, did you put on women's underwear or clothing

a. once a month or more, for about a year or more (2)

b. (less often, but) several times a year for about 3 years or more (1)

c. very seldom did this during this period (0)

d. never did this during this period (0)

e. don't remember (0)

24. Between the ages of 13 and 16, did you put on women's underwear or clothing

a. once a month or more, for about a year or more (2)

b. (less often, but) several time a year for about 2 years or more (1)

c. very seldom did this during this period (0)

d. never did this during this period (0)

25. Since the age of 17, did you put on women's underwear or clothing

a. once a month or more, for at least a year (2)

b. (less often, but) several times a year for at least 2 years (1)

c. very seldom did this during this period (0)

d. never did this during this period (0)

26. Have you ever wanted to have an operation to change you physically into a women?

a. yes (2)

b. no (0)

c. unsure (1)

27. If you have ever wished to have a female body rather than a male one, was this

a. mainly to please men but also for your own satisfaction (2)

b. mainly for your own satisfaction but also to please men (2)

c. entirely for your own satisfaction (2)

d. entirely to please men (1)

e. about equally to please men and for your own satisfaction (2)

f. have never wanted to have a female body (0)

28. Have you ever felt like a woman

a. only if you were wearing at least one piece of female underwear or clothing (1)

b. while wearing at least one piece of female underwear or clothing and only occasionally at other times also (1)

c. at all times and for at least 1 year (female clothing or not) (2)

d. never felt like a woman (0)

29. When completely dressed in male clothing (underwear, etc.) would you

a. have a feeling of anxiety because of this (2)

b. have no feeling of anxiety but have another kind of unpleasant feeling because of this (2)

c. have no unpleasant feelings to do with above (0)

Exhibit 2

Androphilia Scale

1. About how old were you when you first made quite strong efforts to see males who were undressed or scantily dressed?

a. younger than 12 (1)

b. between 12 and 16 (1)

c. older than 16 (1)

d. never (0)

2. About how old were you when you first felt sexually attracted to males?

a. younger than 6 (1)

b. between 6 and 11 (1)

c. between 12 and 16 (1)

d. older than 16 (1)

e. never (0)

3. Since what age have you been sexually attracted to males only?

a. younger than 6 (1)

b. between 6 and 11 (1)

c. between 12 and 16 (1)

d. older than 16 (1)

e. never (0)

4. Since the age of 16, have you ever fallen in love with a person of the male sex?

a. yes (1)

b. no (0)

5. How old were you when you first kissed a male because you felt sexually attracted to him?

a. younger than 12 (1)

b. between 12 and 16 (1)

c. older than 16 (1)

d. never (0)

6. Since age 12, how old were you when you first touched the privates of a male to whom you felt sexually attracted?

a. between 12 and 16 (1)

b. older than 16 (1)

c. never (0)

7. What kind of sexual contact with a male would you have preferred on the whole, even though you may not have done it?

a. inserting your privates between your partner's upper legs (thighs) (1)

b. putting your privates into your partner's rear end (1)

c. you would have preferred one of those two modes but you cannot decide which one (1)

d. your partner putting his privates between your upper legs (thighs) (1)

e. your partner putting his privates into your rear end (1)

f. you would have preferred one of those two latter modes but you cannot decide which one (1)

g. you would have liked all four modes equally well (1)

h. you would have preferred some other mode of sexual contact (1)

i. had no desire for physical contact with males (0)

8. What qualities did you like in males to whom you were

sexually attracted?

a. strong masculine behavior (1)

b. slightly masculine behavior (1)

c. rather feminine behavior (1)

d. did not feel sexually attracted to males (0)

9. Would you have preferred

a. male homosexual partners (1)

b. male partners who were not homosexual (1)

c. had no preference (1)

d. did not feel sexually attracted to males (0)

10. Since age 18, how old was the oldest male to whom you could have felt sexually attracted?

a. younger than 6 (1)

b. between 6 and 11 (1)

c. between 12 and 16 (1)

d. between 17 and 19 (1)

e. between 20 and 30 (1)

f. between 31 and 40 (1)

g. between 41 and 50 (1)

h. older than 50 (1)

i. did not feel sexually attracted to males (0)

11. Would you have preferred a partner

a. who was willing to have you lead him (1)

b. who was willing to lead you (1)

c. you didn’t care (1)

d. did not feel sexually attracted to males (0)

12. Since age 16 and up to age 25 (or younger if you are less than 25) how did the preferred age of male partners change as you got older?

a. became gradually younger (1)

b. became gradually older (1)

c. remained about the same (1)

d. never felt attracted to males (0)

13. Since age 16, have you even been equally, or more, attracted sexually by a male age 17 and over than by females at 17-40?

a. yes (1)

b. no (0)

Exhibit 3

Gynephilia Scale

1. Since the age of 17 when you went dancing, was this to

a. mainly meet girls at the dance (1)

b. mainly meet male friends at the dance (0)

c. mainly because you liked dancing itself (0)

d. never went dancing since age 17 (0)

2. How old were you when you first tried (on your own) to see females 13 or older naked or dressing or undressing (including strip

tease, movies or pictures)?

a. younger than 12 (1)

b. between 12 and 16 (1)

c. older than 16 (1)

d. never (0)

3. Since age 13, have you ever fallen in love with or had a

crush on a female who was between the ages of 13-40?

a. yes (1)

b. no (0)

4. Have you ever desired sexual intercourse with a female age 17-40?

a. yes (1)

b. no (0)

5. How do you prefer females age 17-40 to react when you try to come into sexual contact (not necessarily intercourse) with

them?

a. cooperation on the part of the female (1)

b. indifference (1)

c. a little resistance (1)

d. considerable resistance (1)

e. you don’t care (0)

f. do not try to come into sexual contact with females age 17-40 (0)

6. Do you prefer females of age 17-40

a. who have no sexual experience (1)

b. who have had a little experience (1)

c. who have had considerable experience (1)

d. you don’t care how much experience (1)

e. not enough interest in females age 17-40 to know (0)

7. Between 13 and 16, when you first saw females 13 or over in the nude (or dressing or undressing) including strip-tease, movies or

picture, did you feel sexually aroused?

a. very much (1)

b. mildly (1)

c. not at all (0)

d. never saw females 13 or over in the nude, dressing or undressing (including striptease, movies or pictures) (0)

8. When you have a wet dream (reach climax while dreaming), do you always, or almost always, dream of a female age 17-40?

a. yes (1)

b. no (0)

c. don't remember any wet dreams (0)

9. In your sexual fantasies, are females age 17-40 always, or almost always involved?

a. yes (1)

b. no (0)

c. haven't had such fantasies (0)

Exhibit 4

Heterosexual Experience Scale

1. Since age 13, how old were you when you first kissed a female age 13-40 who seemed to be interested in you sexually?

a. between the ages 13-16 (1)

b. between the ages 17-25 (1)

c. 26 or older (1)

d. never after age 12 (0)

2. Since age 13, how old were you when you first petted (beyond kissing) with a female age 13-40 who seemed to be interested in

you sexually?

a. between the ages 13-16 (1)

b. between the ages 17-25 (1)

c. 26 or older (1)

d. never after age 12 (0)

3. Have you ever attempted sexual intercourse with a female age 17-40?

a. yes (1)

b. no, and you are older than 25 (0)

c. no, and you are 25 or younger (0)

4. When did you first have sexual intercourse with a female age 17-40?

a. before age 16 (1)

b. between 16 and 25 (1)

c. 26 or older (1)

d. never, and you are older than 25 (0)

e. never, and you are 25 or younger (0)

5. When did you first get married or begin living common-law?

a. before 30 (1)

b. between 30-40 (1)

c. age 41 or older (1)

d. never married or had common-law relations, and you are older than 30 (0)

e. never, and you are 30 or younger (0)

6. Was there any period of 14 days or less when you had sexual intercourse with a female age 17-40 more than 5 times?

a. yes (1)

b. no, and you are older than 25 (0)

c. no, and you are 25 or younger (0)

Exhibit 5

Fetishism Scale

1. Do you think that certain inanimate objects (velvet, silk, leather, rubber, shoes, female underwear, etc.) have a stronger sexual attraction for you than for most other people?

a. yes (1)

b. no (0)

2. Has the sexual attractiveness of an inanimate (not alive) thing ever increased if it had been worn by, or had been otherwise in contact with

a. a female (1)

b. a male (1)

c. preferably a female but also when in contact or having been in contact with a male (1)

d. preferably a male but also when in contact or having been in contact with a female (1)

e. a female or male person equally (1)

f. contact between a person and a thing never increased its sexual attractiveness (1)

g. do not feel sexually attracted to any inanimate thing (0)

3. Did the sexual attractiveness to you of such a thing ever increase if you wore it or were otherwise in contact with it yourself?

a. yes (1)

b. no (0)

c. have never been sexually attracted to inanimate things (0)

4. Were you ever more strongly sexually attracted by

inanimate things than by females or males?

a. yes (1)

b. no (0)

5. What was the age of persons who most increased the sexual attractiveness for you of a certain inanimate object by their contact with it?

a. 3 years or younger (1)

b. between 4 and 6 years (1)

c. between 6 and 11 years (1)

d. between 12 and 13 years (1)

e. between 14 and 16 years (1)

f. between 17 and 40 years (1)

g. over 60 years (1)

h. contact between a person and a thing never increased its sexual attractiveness (1)

i. have never been sexually attracted to inanimate things (0)

6. Is there more than one kind of inanimate thing which arouses you sexually?

a. yes (1)

b. no (1)

c. have never been sexually attracted to inanimate things (0)

7. Through which of these senses did the thing act most strongly?

a. through the sense of smell (1)

b. through the sense of taste (1)

c. through the sense of sight (1)

d. through the sense of touch (1)

e. through the sense of hearing (1)

f. have never been sexually attracted to inanimate objects (0)

8. At about what age do you remember first having a special interest in an inanimate thing which later aroused you sexually?

a. younger than 2 (1)

b. between 2 and 4 (1)

c. between 5 and 7 (1)

d. between 8 and 10 (1)

e. between 11 and 13 (1)

f. older than 13 (1)

g. have never been sexually attracted to inanimate objects (0)

Exhibit 6

Masochism Scale

1. If you were insulted or humiliated by a person to whom you felt sexually attracted, did this ever increase their attractiveness?

a. yes (1)

b. no (0)

c. unsure (0)

2. Has imagining that you were being humiliated or poorly treated by someone ever excited you sexually?

a. yes (1)

b. no (0)

3. Has imagining that you had been injured by someone to the point of bleeding ever excited you sexually?

a. yes (1)

b. no (0)

4. Has imagining that someone was causing you pain ever aroused you sexually?

a. yes (1)

b. no (0)

5. Has imagining that someone was choking you ever excited you sexually?

a. yes (1)

b. no (0)

6. Has imagining that you have become dirty or soiled ever excited you sexually?

a. yes (1)

b. no (0)

7. Has imagining that your life was being threatened ever excited you sexually?

a. yes (1)

b. no (0)

8. Has imagining that someone was imposing on you heavy physical labor or strain ever excited you sexually?

a. yes (1)

b. no (0)

9. Has imagining a situation in which you were having trouble breathing ever excited you sexually?

a. yes (1)

b. no (0)

10. Has imagining that you were being threatened with a knife or other sharp instrument ever excited you sexually?

a. yes (1)

b. no (0)

11. Has imagining that you are being tied up by somebody ever excited you sexually?

a. yes (1)

b. no (0)

Exhibit 7

Sadism Scale

1. Did you ever like to read stories about or descriptions of torture?

a. yes (1)

b. no (0)

2. Did you usually re-read a description of torture several times?

a. yes (1)

b. no (0)

c. don’t remember (0)

3. Were you

a. very interested in descriptions of torture (1)

b. a little interested (0)

c. not at all interested (0)

d. never read such descriptions (0)

4. Between the ages of 13 and 16, did you find the sight of blood

a. exciting (1)

b. only pleasant (1)

c. unpleasant (0)

d. did not affect you in any way (0)

5. Has beating somebody or imagining that you are doing so ever excited you sexually?

a. yes (1)

b. no (0)

6. Have you ever tried to tie the hands or legs of a person who attracted you sexually?

a. yes (1)

b. no (0)

7. Has cutting or imagining to cut someone's hair ever excited you sexually?

a. yes (1)

b. no (0)

8. Has imagining that you saw someone bleeding ever excited you sexually?

a. yes (1)

b. no (0)

9. Has imagining someone being choked by yourself or somebody else ever excited you sexually?

a. yes (1)

b. no (0)

10. Has imagining yourself or someone else imposing heavy physical labor or strain on somebody ever excited you sexually?

a. yes (1)

b. no (0)

11. Has imagining that someone was being ill-treated in some way by yourself or somebody else ever excited you sexually?

a. yes (1)

b. no (0)

12. Has imagining that you or someone else were causing pain to somebody ever excited you sexually?

a. yes (1)

b. no (0)

13. Has imagining that you or somebody else were threatening someone's life ever excited you sexually?

a. yes (1)

b. no (0)

Stereotypes About Male Sexuality Scale

WILLIAM E. SNELL, JR., 1 Southeast Missouri State University

1 Address all correspondence to William E. Snell, Jr., Department of Psychology, Southeast Missouri State University, One University Plaza, Cape

Girardeau, MO 63701; e-mail: wesnell@semo.edu

14. Has imagining that someone other than yourself was crying painfully ever excited you sexually?

a. yes (1)

b. no (0)

15. Has imagining that someone other than yourself was dying ever excited you sexually?

a. yes (1)

b. no (0)

16. Has imagining that you or someone else were making it difficult for somebody to breathe ever excited you sexually?

a. yes (1)

b. no (0)

17. Has imagining that you or someone else were tying up somebody ever excited you sexually?

a. yes (1)

b. no (0)

18. Has imagining that you or somebody else were threatening someone with a knife or other sharp instrument ever excited you sexu

ally?

a. yes (1)

b. no (0)

19. Has imagining that someone was unconscious or unable to move ever excited you sexually?

a. yes (1)

b. no (0)

20. Has imagining that someone had a very pale and still face ever excited you sexually?

a. yes (1)

b. no (0)

Cognitive approaches to human sexuality have recently

received considerable attention. However, there has been

a paucity of instruments designed to deal with the types of

cognitive beliefs that might influence sexual feelings and

behaviors. Snell and his colleagues attempted to address

this concern through the development and validation of the

Stereotypes About Male Sexuality Scale (SAMSS; Snell,

Belk, & Hawkins, 1986, 1990; Snell, Hawkins, & Belk,

1988). The SAMSS is an objective self-report question

naire that is designed to measure 10 distinctive stereotypic

beliefs about males and their sexuality (cf. Zilbergeld,

1978; Chap. 4): (a) Inexpressiveness, (b) Sex Equals

Performance, (c) Males Orchestrate Sex, (d) Always

Ready for Sex, (e) Touching Leads to Sex, (f) Sex Equals

Intercourse, (g) Sex Requires Erection, (h) Sex Requires

Orgasm, (i) Spontaneous Sex, and (j) Sexually Aware Men.

The 10 subscales on the SAMSS can be used in research as

individual-tendency measures of stereotypes about males

and their sexuality. Description The SAMSS consists of 60 items. Individuals respond to the 60 items on the SAMSS using a 5-point Likert-type scale: agree (+2); slightly agree (+1); neither agree nor disagree (0); slightly disagree (−1); and disagree (−2). Response Mode and Timing Individuals typically indicate their responses on a computer scan sheet by darkening in a response ranging from A (agree) to E (disagree). The questionnaire usually takes about 20–25 minutes to complete. Scoring Individuals respond to the 60 statements on the SAMSS using a 5-point Likert-type scale. The items are recoded so that A = +2, B = +1, C = 0, D = −1, and E = −2, so that the anchors range from agree (+2) to disagree (−2). The items

assigned to each subscale are (a) Inexpressiveness (1, 11,

21, 31, 41, 51); (b) Sex Equals Performance (2, 12, 22,

32, 42, 52); (c) Males Orchestrate Sex (3, 13, 23, 33, 43,

53); (d) Always Ready for Sex (4, 14, 24, 34, 44, 54); (e)

Touching Leads to Sex (5, 15, 25, 35, 45, 55); (f) Sex Equals

Intercourse (6, 16, 26, 36, 46, 56); (g) Sex Requires Erection

(7, 17, 27, 37, 47, 57); (h) Sex Requires Orgasm (8, 18, 28,

38, 48, 58); (i) Spontaneous Sex (9, 19, 29, 39, 49, 59); and

(j) Sexually Aware Men (10, 20, 30, 40, 50, 60). Higher sub

scale scores thus correspond to greater agreement with the 10 cognitive beliefs measured by the SAMSS.

Reliability

The alpha values for these 10 subscales range from a low of .63 to a high of .93 with an average of .80 (Snell et al., 1986).

Validity

Snell et al. (1990) reported the results of two investigations involving the SAMSS. In the first study, the relationship between the SAMSS and two gender-role measures were examined. The results were that the restrictive emotionality aspect of the masculine role was strongly associated with stereotypic beliefs about male sexuality (Doyle, 1989; Gould, 1982; Gross, 1978; Herek, 1987; Mosher & Anderson, 1986; Mosher & Sirkin, 1984). Other gender-role associated with conventional “performance” approaches to male sexuality. In the second investigation, counseling trainees were asked to describe how mentally healthy adult men and women would respond to the SAMSS. The responses of both male and female in-training counselors indicated that they expected mentally healthy males (a) to reject inhibited, control, and constant readiness approaches to the expression of male sexuality and (b) to express greater disagreement toward defining male sexuality only in terms of sexual inter

Exhibit

Stereotypes About Male Sexuality Scale

Instructions: We would like to know something about people’s beliefs about male sexuality. For this reason we are asking you to respond

to a number of items that deal with male sexuality, indicating the extent to which you disagree/agree with the statements. For each of

the items on this page, you will be indicating your answer on the computer-scoreable answer sheet by darkening in the number (or

letter) that corresponds to your response. Your response should be based on the sorts of things that you believe about male sexuality.

Use the following scale to indicate your degree of agreement/disagreement with each item:

A B C D E

Agree Slightly Agree Neither Agree nor Disagree Slightly Disagree Disagree

There are no right or wrong answers. Your choices should be a description of your own personal beliefs.

1. Men should not be held.

2. Most men believe that sex is a performance.

3. Men generally want to be the guiding participant in sexual behavior.

4. Most men are ready for sex at any time.

5. Most men desire physical contact only as a prelude to sex.

6. The ultimate sexual goal in men’s mind is intercourse.

7. Lack of an erection will always spoil sex for a man.

8. From a man’s perspective, good sex usually has an “earthshaking” aspect to it.

9. Men don’t really like to plan their sexual experiences.

10. Most men are sexually well-adjusted.

11. Only a narrow range of emotions should be permitted to men.

12. Men are almost always concerned with their sexual performance.

13. Most men don’t want to assume a passive role in sex.

14. Men usually want sex, regardless of where they are.

15. Among men, touching is simply the first step towards sex.

16. Men are not sexually satisfied with any behavior other than intercourse.

17. Without an erection a man is sexually lost.

18. Quiet, lazy sex is usually not all that satisfying for a man.

19. Men usually like good sex to “just happen.”

20. Most men have healthy attitudes toward sex.

21. A man who is vulnerable is a sissy.

22. In sex, it’s a man’s performance that counts.

23. Sexual activity is easier if the man assumes a leadership role.

24. Men are always ready for sex.

25. A man never really wants “only” a hug or caress.

26. Men want their sexual experiences to end with intercourse.

27. A sexual situation cannot be gratifying for a man unless he “can get it up.”

28. Sexual climax is a necessary part of men’s sexual behavior.

29. Most men yearn for spontaneous sex that requires little conscious effort.

30. In these days of increased openness about sex, most men have become free of past inhibiting ideas about their sexual behavior.

31. A man should be careful to hide his feelings.

32. Men’s sexuality is often goal-orientated in its nature.

33. Sex is a man’s responsibility.

34. Most men come to a sexual situation in a state of constant desire.

35. Men use physical contact as a request for sex.

36. Men believe that every sexual act should include intercourse.

37. Any kind of sexual activity for a man requires an erection.

38. Satisfying sexual activity for a man always includes increasing excitement and passion.

39. A satisfying sexual experience for a man does not really require all that much forethought.

40. Most men have progressive ideas about sex.

41. It is unacceptable for men to reveal their deepest concerns.

42. Men usually think of sex as work.

43. A man is supposed to initiate sexual contact.

44. Men are perpetually ready for sex.

45. Many men are dissatisfied with any bodily contact which is not followed by sexual activity.

46. Many men are only interested in sexual intercourse as a form of sexual stimulation.

47. An erection is considered by almost all men as vital for sex.

48. Men’s sexual desire is often “imperative and driven” in nature.

49. Men consider sex artificial if it is preplanned.

50. In these days of wider availability of accurate information, most men are realistic about their sexual activities.

51. Intense emotional expressiveness should not be discussed by men.

52. Sex is a pressure-filled activity for most men.

53. Men are responsible for choosing sexual positions.

54. Men usually never get enough sex.

55. For men, kissing and touching are merely the preliminaries to sexual activity.

56. During sex, men are always thinking about getting to intercourse.

57. Without an erection, sexual activity for a man will end in misery.

58. Sexual activity must end with an orgasm for a man to feel satisfied.

59. For men, natural sex means “just doing it instinctively.”

Masculinity (see Male Sexuality)

Mosher, D. L. (1979a). The meaning and measurement of guilt. In C. E. Izard (Ed.), Emotions in personality and psychopathology (pp. 105–129). New York: Plenum.

Mosher, D. L. (1979b). Negative attitudes toward masturbation in sex therapy. Journal of Sex & Marital Therapy, 5, 315–333.

Mosher, D. L., & Abramson, P. R. (1977). Subjective sexual arousal to films of masturbation. Journal of Consulting and Clinical Psychology, 45, 796–807. Mosher, D. L., & O'Grady, K. E. (1979). Homosexual threat, negative attitudes toward masturbation, sex guilt, and male's sexual and affective reactions to explicit sexual films. Journal of Consulting and Clinical Psychology, 47, 860–873. Mosher, D. L., & Vonderheide, S. G. (1985). Contributions of sex guilt and masturbation guilt to women's contraceptive attitudes and use. The Journal of Sex Research, 21, 24–39.

Exhibit

Negative Attitudes Toward Masturbation

The following 30 items sample diverse opinions and attitudes about masturbation. Masturbation means stimulating your own genitals to

enjoy the pleasurable sensations or experience orgasm. Answers are to be marked on the separate answer sheet. Marking 1 means the

item is not at all true for you; marking 2 means it is somewhat untrue; marking 3 means you are undecided; marking 4 means it is somewhat

true; marking 5 means it is strongly true for you.

1. People masturbate to escape feelings of tension and anxiety.

2. People who masturbate will not enjoy sexual intercourse as much as those who refrain from masturbation.

3. Masturbation is a private matter which neither harms nor concerns anyone else.

4. Masturbation is a sin against yourself.

5. Masturbation in childhood can help a person develop a natural, healthy attitude toward sex.

6. Masturbation in an adult is juvenile and immature.

7. Masturbation can lead to homosexuality.

8. Excessive masturbation is a needless worry, as it is physically impossible.

9. If you enjoy masturbating too much, you may never learn to relate to the opposite sex.

10. After masturbating, a person feels degraded.

11. Experience with masturbation can potentially help a woman become orgastic in sexual intercourse.

12. I feel guilty about masturbating.

13. Masturbation can be a “friend in need” when there is no “friend in deed.”

14. Masturbation can provide an outlet for sex fantasies without harming anyone else or endangering oneself.

15. Excessive masturbation can lead to problems of impotence in men and frigidity in women.

16. Masturbation is an escape mechanism which prevents a person from developing a mature sexual outlook.

17. Masturbation can provide harmless relief from sexual tension.

18. Playing with your own genitals is disgusting.

19. Excessive masturbation is associated with neurosis, depression, and behavioral problems.

20. Any masturbation is too much.

21. Masturbation is a compulsive, addictive habit which once begun is almost impossible to stop.

22. Masturbation is fun.

23. When I masturbate, I am disgusted with myself.

24. A pattern of frequent masturbation is associated with introversion and withdrawal from social contacts.

25. I would be ashamed to admit publicly that I have masturbated.

26. Excessive masturbation leads to mental dullness and fatigue.

27. Masturbation is a normal sexual outlet.

28. Masturbation is caused by an excessive preoccupation with thoughts about sex.

29. Masturbation can teach you to enjoy the sensuousness of your own body.

30. After I masturbate, I am disgusted with myself for losing control of my body. Attitudes Toward Masturbation Scale CHANTAL D. YOUNG AND CHARLENE L. MUEHLENHARD, 1 University of Kansas The Attitudes Toward Masturbation Scale (ATMS) was developed to measure individuals' complex and often conflicting thoughts and feelings about masturbating (Young & Muehlenhard, 2009). We found two existing scales for measuring attitudes about masturbation: Abramson and Mosher's (1975) Negative Attitudes Toward Masturbation Inventory and Miller and Lief's (1976) Masturbation Attitude Scale. Both are more than 30 years old, both yield only one global score, and both assess respondents' attitudes about masturbation in general rather than about their own masturbation. The purpose of the ATMS is to measure respondents' (a) reasons for wanting (or being tempted) to masturbate, (b) reasons for avoiding (or trying to avoid) masturbating, and (c) positive and negative feelings related to masturbating. Description The ATMS was developed using a multistep process. First, in a pilot study, 236 undergraduate women and men wrote answers to open-ended questions about their attitudes and feelings about masturbation. Second, we compiled their responses and used them to create scale items. We also created scale items reflecting themes identified in prior studies of attitudes toward masturbation (e.g., Clifford, 1978; Elliott & Brantley, 1997). Our preliminary scale included 223 items divided into three sections reflecting reasons for wanting—or being tempted—to masturbate, reasons for avoiding—or trying to avoid—masturbation, and feelings about masturbating. Third, a new sample of 518 undergraduate women and men rated these items on a 7-point scale. We used their responses to divide the items into subscales,

based on factor loadings derived from principal components analysis, Cronbach's alphas, and conceptual considerations (Young & Muehlenhard, 2009). The ATMS consists of 179 items, divided into 28 subscales in three categories. (a) The 13 reasons-forwanting-to-masturbate subscales assess themes such as pleasure, self-exploration and improvement, and mood improvement. Items are rated on a 7-point scale, from 0 (Not a Reason) to 6 (A Very Important Reason). (b) The 10 reasons-for-avoiding-masturbation subscales assess themes such as immorality, lack of desire or interest, and preference for partner sex. The same 7-point scale is used. (c) The 5 feelings-related-to-masturbation subscales assess satisfaction, guilt, anger, anxiety, and indifference. 1 Address correspondence to Charlene Muehlenhard, Department of Psychology, 426 Fraser Hall, University of Kansas, 1415 Jayhawk Blvd, Lawrence, KS 66045-7556; e-mail: charlene@ku.edu Respondents rate the strength of each feeling, using a 7point scale ranging from 0 (Not at all) to 6 (Very Strongly). The scale was developed and tested using samples of college students, but it could be used with other populations. It is designed so that anyone can complete it, regardless of whether they masturbate. Response Mode and Timing The ATMS is a paper-and-pencil questionnaire. It can be completed in about 15 to 30 minutes. Scoring Subscale scores are calculated by averaging the respondent's ratings for the items on the subscale. Subscale scores can range from 0 to 6. For the reasons-for-wanting-to-masturbate subscales and the reasons-for-avoiding-masturbation subscales, higher scores reflect a greater importance of the reason tapped by that subscale. For the feelings-relatedto-masturbation subscales, higher scores reflect greater intensity of feeling. Each subscale score can be used individually to assess the specific content of each subscale. In addition, four composite scores can be calculated: the Wanting Composite (the mean of the 13 reasons-for-wanting-to-masturbate subscales), the Avoiding Composite (the mean of the 10 reasons-for-avoiding-masturbation subscales), the Negative-Feelings Composite (the mean of the Guilt, Anger, Anxiety, and Indifference subscales), and the Positive-Feelings Composite (the Satisfaction subscale score). These composites can be used to assess the respondent's overall positive and negative attitudes toward masturbation. The subscales and items on each are as follows: Reasons-for-Wanting-to-Masturbate Subscales Pleasure: 1, 2, 35, 41, 42, 44, 50, 51, 52 Self-Exploration and Improvement: 11, 13, 17, 23, 39, 54, 55, 56, 63, 68 Mood Improvement: 47, 60, 62, 67 Relaxation and Stress Relief: 6, 7, 16, 40, 46, 58, 61, 64 Avoidance of Partner

Sex: 26, 28, 29, 30, 34, 65 Arousal Decrease: 18, 21, 33, 49, 59, 69 Compulsion: 8, 25, 27, 32, 43 Pleasure of Partner: 15, 66, 70 Adherence to Social Norms: 12, 14, 19, 20, 38, 57

Substitution for Partner Sex: 4, 9, 10, 22, 24, 31

Importance of Fantasy: 36, 37, 48, 72

Feeling Unattractive: 45, 53, 71

Boredom: 3, 5

Reasons-for-Avoiding-Masturbation Subscales

Immorality: 73, 74, 75, 79, 81, 83, 105, 122, 123, 124, 125, 126, 127, 131, 132, 134

No Desire or Interest: 76, 77, 86, 87, 88, 100, 101, 114, 118, 119, 120

Preference for Partner Sex: 90, 103, 104, 107, 110, 128, 129, 133

Fear of Negative Social Evaluation: 84, 91, 93, 95, 102, 121

Sex Negativity: 78, 82, 85, 94, 96, 97

Negative Mood State: 92, 106, 109, 117

Detraction from Partner Sex: 111, 112

In Committed Relationship: 80, 98, 108, 115

Bothered by Thoughts: 116, 130

Self-Control: 89, 99, 113

Feelings-Related-to-Masturbation Subscales

Guilt: 136, 138, 142, 143, 153, 154, 155, 167, 168, 169, 171, 179

Satisfaction: 135, 139, 146, 147, 149, 150, 151, 152, 156, 157, 158, 163, 166, 170, 173, 174, 176, 177, 178

Anger: 159, 160, 161, 165

Anxiety: 144, 145, 148, 162

Indifference: 137, 140, 141, 164, 172, 175

Reliability

Based on a sample of 518 undergraduate women and men (Young & Muehlenhard, 2009), Cronbach's alphas for the subscales ranged from .71 to .97, providing evidence that the subscales have good internal consistency.

Validity

Based on data from 518 undergraduate women and men, Young and Muehlenhard (2009) found numerous signifi cant differences between participants who masturbated and those who did not, even after controlling for gender. Compared with nonmasturbators, masturbators scored significantly higher on 9 of the 13 reasons-for-wanting to-masturbate subscales and the Satisfaction subscale and significantly lower on 5 of the 10 reasons-for-avoiding masturbation subscales and the Guilt, Anger, Anxiety, and Indifference subscales.

Consistent with meta-analytic findings that more men than women masturbate (Oliver & Hyde, 1993; Petersen & Hyde, 2007), there were significant gender differ ences on 18 of the 28 subscales. Men generally reported stronger reasons for wanting to masturbate, weaker rea sons for avoiding masturbation, and stronger positive and weaker negative feelings related to masturbation. When controlling for masturbation status, there were fewer gen

der differences, but some remained: For the reasons-for

37. I get aroused by sexual activities that are not possible in real life, so I fantasize about them during masturbation (e.g., sex with a movie star, sex on a beach, etc.)

38. Because I hear about it from TV, movies, magazines, etc.

39. Masturbating improves my sexual health

40. To help me fall asleep

41. Because it’s fun

42. Because I know exactly how to stimulate myself and maximize my pleasure

43. It’s a habit

44. If I am already sexually aroused (e.g., from watching a movie, reading a magazine)

45. Because I feel like no one is attracted to me

46. If I want to relax

47. If I’m angry

48. If I want to exercise my imagination

49. So that I can focus my concentration on a task after masturbating

50. Because I deserve to experience pleasure

51. If I see someone or something that is arousing

52. If I have an urge to do something sexual

53. Because I’m not comfortable enough with my body to be sexual with someone else

54. To learn how to give myself pleasure

55. To gain more sexual confidence

56. Because it’s good exercise

57. Because my friends masturbate

58. To calm myself down

59. So that I can stop thinking about masturbating

60. If I feel frustrated about something else

61. It makes me feel peaceful

62. It distracts me when I'm feeling down

63. To try a new method (e.g., sex toys, pornography)

64. It's an escape

65. To avoid using another person for sex

66. Because it arouses my partner when he/she knows that I masturbated

67. If I'm in a bad mood

68. To learn how to have better orgasms

69. If I'm already sexually aroused, and I want to decrease my level of sexual arousal

70. Because it arouses my partner when I masturbate in front of him/her

71. If I'm feeling unattractive

72. I enjoy my fantasies during masturbation

Reasons for Avoiding (or for Trying to Avoid) Masturbating

Whether they masturbate or not, people might avoid (or try to avoid) masturbating for many different reasons. Below is a list of pos

sible reasons. Please rate how strong each of the reasons is for you avoiding (or trying to avoid) masturbating, regardless of whether or

not you actually masturbate.

0 1 2 3 4 5 6

Not a A Moderately A Very

Reason Important Important

Reason Reason

For you, how strong are the following reasons for avoiding (or trying to avoid) masturbating?

73. It’s against my religion

74. It’s against my morals or values

75. It’s against my parents’ morals or values

76. I’m just not interested

77. It just doesn’t appeal to me

78. I am uncomfortable with any sexual behavior 79. It would make me feel cheap 80. If I am committed to someone 81. I would feel guilty about it 82. I am anxious about sexual behavior 83. I know I’d regret it 84. I fear it will damage my reputation 85. I feel uncomfortable or embarrassed about my body 86. I think it would be physically uncomfortable 87. It seems weird to me 88. I feel strange doing it 89. I think I should have more self-control 90. If I’m currently sexually satisfied 91. Society says it’s wrong 92. If I’m stressed 93. I’m afraid of someone knowing I masturbate 94. It makes me feel lonely 95. If I’m afraid of being caught 96. It makes me feel sexually inadequate 97. It’s bad for my health 98. If I’m in a committed relationship 99. I like to feel in control of my urges 100. I’m not sure how to masturbate 101. I don’t like how it feels 102. It’s embarrassing to me 103. Because I like intercourse better 104. Because I like any sexual contact with a partner better 105. I feel bad about myself afterwards 106. If I’m depressed 107. Orgasms are better with a partner 108. My partner doesn’t want me to do it 109. If I’m worried about something else 110. If I’ve recently had sex 111. It makes me less able to orgasm during sex 112. It makes me less horny during sex 113. I want to improve my self-discipline 114. It’s boring 115. I feel like I’m cheating on my partner 116. My fantasies during masturbation bother me 117. If I’ve had a bad day 118. It’s a waste of time 119. It seems pointless 120. I don’t find it sexually arousing 121. Other people might find me gross 122. My family is against it 123. My friends are against it 124. It makes me feel empty inside 125. I was raised to believe it’s wrong 126. It makes me feel ashamed 127. It’s disrespectful to

myself 128. If I’m satisfied with the quantity of the sex I’m having 129. If I’m satisfied with the quality of the sex I’m having 130. My sexual thoughts during masturbation bother me 131. Masturbation in an adult is immature 132. It makes me feel like I’m sinning against myself 133. It’s not as good as sex 134. It does not fit with my religious views

Feelings About Masturbation

Check which set of directions applies to you:

_____ If you masturbate: People feel many different things when they masturbate. Below is a list of possible feelings. How strongly, if

at all, do you usually experience these feelings when you masturbate?

_____ If you don’t masturbate: People feel many different things when they masturbate. Below is a list of possible feelings. How

strongly, if at all, do you think you would usually experience these feelings if you did masturbate?

0 1 2 3 4 5 6

Not at all Somewhat Very Strongly

How strongly do you experience this feeling when you masturbate?

OR

How strongly would you experience this feeling if you did masturbate?

135. happy 158. refreshed

136. guilty 159. frustrated

137. empty 160. aggressive

138. pathetic 161. angry

139. healthy 162. nervous

140. indifferent 163. content

141. nothing 164. unemotional

142. strange 165. stressed

143. embarrassed 166. attractive

144. anxious 167. immoral

145. tense 168. remorseful

146. horny 169. disgusted

147. focused 170. thrilled

148. awkward 171. disappointed

149. good 172. detached

150. calm 173. aroused

151. relieved 174. relaxed

152. in control 175. passive

153. ashamed 176. comfortable

154. regretful 177. satisfied

155. degraded 178. invigorated

156. pleased 179. sinful

157. connected to myself

Molestation (see Abuse)

Exhibit

Sexual Narcissism Scale

Item Wording Subscale

If I ruled the world for one day, I would have sex with anyone I choose. Exp

One way to get a person in bed with me is to tell them what they want to hear. Exp

When I want to have sex, I will do whatever it takes. Exp

I could easily convince an unwilling person to have sex with me. Exp

I would be willing to trick a person to get them to have sex with me. Exp

I feel I deserve sexual activity when I am in the mood for it. Ent

I am entitled to sex on a regular basis. Ent

I should be permitted to have sex whenever I want it. Ent

I would be irritated if a dating partner said no to sex. Ent

I expect sexual activity if I go out with someone on an expensive date. Ent

When I sleep with someone, I rarely know what they are thinking or feeling. Emp

It is important for me to know what my sexual partner is feeling when we make love. a Emp

I enjoy sex more when I feel I really know a person. a Emp

The feelings of my sexual partners don’t usually concern me. Emp

I do not usually care how my sexual partner feels after sex. Emp

I am an exceptional sexual partner. Skill

My sexual partners think I am fantastic in bed. Skill

I really know how to please a partner sexually. Skill

I have been very successful in my sexual relationships.
Skill

Others have told me I am very sexually skilled. Skill

Note. Items were randomized for survey administration. Exp
= Sexual Exploitation, Ent = Sexual Entitlement, Emp = Low
Sexual Empathy, Skill = Sexual

Skill.

a Reverse-scored item.

Orgasm (also see Female Sexuality)

1 Address correspondence to Joseph W. Critelli, Department of Psychology, North Texas State University, P.O. Box 13587, Denton, TX 76203-3587;

e-mail: critelli@unt.edu

Weiner, B. (1979). A theory of motivation for some classroom experiences. Journal of Educational Psychology, 71, 3-25.

Weiner, B., & Kukla, A. (1970). An attributional analysis of achievement motivation. Journal of Personality and Social Psychology, 15, 1-20.

Weiner, B., Nierenberg, R., & Goldstein, M. (1976). Social learning (locus of control) versus attributional (causal stability) interpretations of expectancy of success. Journal of Personality, 44, 52-68. Weiner, B., Russell, D., & Lerman, D. (1978). Affective consequences of causal ascriptions. In J. H. Harvey, W. J. Ickes, & R. F. Kidd (Eds.), New directions in attribution research (Vol. 1, pp. 59-90). Hillsdale, NJ: Lawrence Erlbaum. Wong, T. P., & Weiner, B. (1981). Why people ask “why” questions, and the heuristics of attributional search. Journal of Personality and Social Psychology, 40, 650-663.

Exhibit

Causal Attributions for Coital Outcome Scale

I. Complete the following sentence by placing a check mark in front of the ONE CHOICE IN EACH PAIR of choices which you believe is MORE ACCURATE FOR YOU. Please respond to all six choices.

When I have an orgasm during coitus, it is typically because: (Select one answer from each pair.)

1. a) _____ I am typically sexually responsive.

OR

b) _____ I particularly wanted to have an orgasm.

2. a) _____ I particularly wanted to have an orgasm.

OR

b) _____ My partner is a good lover.

3. a) _____ My partner is a good lover.

OR

b) _____ It was a matter of luck.

4. a) _____ It was a matter of luck.

OR

b) _____ I am typically sexually responsive.

5. a) _____ My partner is a good lover

OR

b) _____ I am typically sexually responsive.

6. a) _____ I particularly wanted to have an orgasm.

OR

b) _____ It was a matter of luck.

II. Complete the following sentence by placing a check mark in front of the ONE CHOICE IN EACH PAIR of choices which you believe is MORE ACCURATE FOR YOU. Please respond to all six choices.

When I do not have an orgasm during coitus, it is typically because: (Select one answer from each pair.)

1. a) _____ I am typically sexually unresponsive.

OR

b) _____ I did not particularly want to have an orgasm.

2. a) _____ I did not particularly want to have an orgasm.

OR

b) _____ My partner is not a good lover.

3. a) _____ My partner is not a good lover.

OR

b) _____ It was a matter of luck.

4. a) _____ It was a matter of luck.

OR

b) _____ I am typically sexually unresponsive.

5. a) _____ My partner is not a good lover.

OR

b) _____ I am typically sexually unresponsive.

6. a) _____ I did not particularly want to have an orgasm.

OR

b) _____ It was a matter of luck.

Orgasm Rating Scale

KENNETH MAH, 1 Toronto General Hospital

Y ITZCHAK M. BINIK, McGill University Health Centre

The Orgasm Rating Scale (ORS) employs a multidimen

sional approach to assess and quantify the psychologi

cal experience of orgasm in both men and women. It was

developed to address the lack of a comprehensive, theoreti

cally based self-report measure of orgasm.

Description

The ORS is a 40-item, self-report adjective-rating scale.

Two subscales assess sensory and cognitive-affective

dimensions, reflecting a two-dimensional model of the psy

chological experience of orgasm that has been previously

theorized and/or investigated by others (e.g., Davidson,

1980; Mah & Binik, 2001; Warner, 1981). The sensory

dimension represents the perception of physiological events (e.g., contractile sensations), whereas the cognitive affective dimension represents the subjective evaluations (e.g., intensity, satisfaction) and emotions (e.g., elation, intimacy) associated with orgasm. Each of these dimen sions further encompasses multiple components. The ORS contains 40 adjectives, 28 of which are employed in sub scale scoring. Individuals are asked to rate each adjective on a 0–5 rating scale according to how well it describes their most recent orgasm experience. The ORS was devel oped to describe orgasm experiences attained under two sexual-context conditions: solitary masturbation and sex with a partner.

To create the scale (see Mah & Binik, 2002), an initial pool of 141 adjectives was compiled from the available self-report literature in which individuals had been asked to describe their subjective experience of orgasm. Pilot rat ings of items reduced the pool to a final set of 60 adjectives.

These adjectives were formatted into a preliminary version of the ORS, which was then employed in two cross-sec tional studies of the two-dimensional model of the expe rience of orgasm. Undergraduate and graduate student participants rated the set of adjectives, using the 0–5 rat ing scale, to describe orgasm experiences attained through solitary masturbation and through sex with a partner. When

rating orgasm experienced with a partner, individuals were also asked to indicate from a list of options the particular sexual behavior by which they attained the orgasm (e.g., through intercourse, oral stimulation, manual stimulation, etc.). Exploratory factor analysis of the ratings data resulted in the current reduced pool of 28 adjectives; the remaining 12 adjectives included in the current 40-item version reflect aspects hypothesized to be relevant to the orgasm experience (e.g., intensity, altered state of consciousness) but were not specifically evaluated. Response Mode and Timing The ORS is a self-administered measure and may be used to assess orgasm experiences attained during solitary masturbation or sex with a partner. In both cases, individuals are asked to recall their most recent orgasm experience attained under the specific contextual condition and to rate each adjective, using the 0–5 scale (0 = Does Not Describe It At All, 5 = Describes It Perfectly), according to how well each describes that orgasm experience. The ORS requires approximately 5 to 10 minutes to rate the 40 adjectives. Scoring Only 28 of a total of 40 adjectives are employed in scoring the ORS. The ORS contains two primary subscales reflecting the sensory and cognitive-affective dimensions of orgasm experience. The sensory dimension further encompasses six components that are represented by particular adjectives (listed in brackets after each component): building sensations (building, swelling), flooding sensations (flooding, flowing), flushing sensations (flushing, spreading), shooting sensations (shooting, spurting), throbbing sensations (throbbing, pulsating), and general spasms (shuddering, trembling, quivering). The cognitiveaffective dimension includes four components represented by particular adjectives: emotional intimacy (close, loving, passionate, tender, unifying), ecstasy (ecstatic, elated, euphoric, rapturous), pleasurable satisfaction (pleasurable, satisfying, fulfilling), and relaxation (relaxing, peaceful, soothing). Total scores for each of the 10 components are obtained by summing the ratings of a component’s respective adjectives (e.g., the total score for the building-sensations component is the sum of the ratings for its adjectives, “building” and “swelling”). Total scores

for each of the two-dimensional subscales are obtained by summing the total scores of the components for that dimension (e.g., the total score for the cognitive-affective dimension would be the sum of the total scores for the “emotional-intimacy,” “ecstasy,” “pleasurable-satisfaction,” and “relaxation” components; see Exhibit).

1 Address correspondence to Kenneth Mah, Behavioural Sciences and Health Research Division, Toronto General Hospital, Eaton North, 9EN 220, 200

Elizabeth Street, Toronto, Ontario, Canada M5G 2C4; e-mail: kmah@uhnres.utoronto.ca

Reliability

Internal consistency of the ORS was examined in the initial

and cross-validation studies (Mah & Binik, 2002). Results

in both studies indicated high internal consistency for both

men and women across sexual contexts (Cronbach’s alphas

ranging from .88 to .92).

Validity

The two-dimensional model of the orgasm experience,

comprising the sensory and cognitive-affective dimensions

and their respective components, was evaluated in initial

and cross-validation studies, using the ORS as the corre

sponding measure of the model (Mah & Binik, 2002). Fit of

the model was assessed using confirmatory factor analysis

in both studies. In addition, gender and sexual-context (i.e.,

comparison of orgasm attained through solitary masturba

tion versus sex with a partner) effects on the components

were investigated. Results indicated that the two-dimensional model pro

vided an adequate representation of the orgasm experi

ence in both men and women across both sexual contexts.

The model was superior to an alternative one-dimensional

model, in which all components were loaded onto a single

global dimension of orgasm experience. It was also compa

rable to an alternative three-dimensional model that retained

the sensory dimension but separated the cognitive-affective

into distinct cognitive and affective dimensions. Significant

gender differences were observed in both studies for pri

marily sensory-type components, with women reporting

higher subscale scores than men, but these differences were

generally small. The only consistently large gender differ

ence across both studies involved the shooting-sensations

component, with men reporting higher scores than women.

This was interpreted to reflect the male capacity for ejacula

tion. Similarly, significant sexual-context differences were

observed with several components, but only the difference

involving the emotional-intimacy component appeared

consistent and substantial, with higher scores in the sex

with-partner context. This finding may reflect the impact of

the sex-with-partner context’s inherent psychosexual and

emotional qualities on the orgasm experience. We also examined potential determinants of orgasmic

pleasure and satisfaction as a critical aspect of the subjec

Exhibit

Orgasm Rating Scale

[Instructions for solitary-masturbation context]

Recall to the best of your ability the most recent orgasm you experienced during solitary masturbation. This would include any sexual

activity in which you engaged while alone.

[Instructions for sex-with-partner context]

Recall to the best of your ability the most recent orgasm you experienced during sex with a partner. This would include any sexual

activity with your partner in which you had orgasm while your partner was present.

1. To the best of your memory, how did you have this orgasm with your partner? (circle letter)

a. through intercourse (vaginal/anal/other)

b. through oral stimulation from partner

c. through manual stimulation from partner

d. through manual stimulation from myself

e. other (describe briefly on line below, e.g., clitoral stimulation/vaginal intercourse at same time)

_____

Below is a list of words that might be used to describe the experience of orgasm. Different people may use different words to describe

their personal experience, and so there is no “right” answer. After each word, write the number that best indicates how well that

word describes your most recent orgasm experienced through [indicate sexual context, either solitary masturbation or sex with a

partner].

If you have never had an orgasm in this way, please place an X on this line ____ and rate the words according to how you think orgasm

experienced through [indicate sexual context, either solitary masturbation or sex with a partner] would feel.

To rate each of the words below, use the following scale.

0 1 2 3 4 5

Does Not Describe Describes It

It At All Perfectly

Please rate all of the words; do not skip any

absorbed _____ blissful _____ building _____ close _____ ecstatic _____

elated _____ engulfing _____ euphoric _____ exciting _____ exploding _____

flooding _____ flowing _____ flushing _____ fulfilling _____ hot _____

immersing _____ loving _____ passionate _____ peaceful _____ pleasurable _____

pulsating _____ quivering _____ rapturous _____ relaxing _____ rising _____

satisfying _____ shooting _____ shuddering _____ soothing _____ spreading _____

spurting _____ swelling _____ tender _____ throbbing _____ trembling _____

uncontrolled _____ unifying _____ unreal _____ warm _____ wild _____

Scoring the Orgasm Rating Scale

To obtain total scores for each component: Sum the adjective ratings for that component to obtain a total score (e.g., for total score for the

Building-Sensations component, add up the ratings for the

adjectives listed for that component, “building” and “swelling”).

To obtain total scores for each dimension: Sum the total scores for each component within that dimension to obtain a total score (e.g., for a

total score for the Cognitive-Affective dimension, add up the total scores for the Emotional-Intimacy, Ecstasy, Pleasurable-Satisfaction,

and Relaxation components).

Dimension Component Adjectives

Sensory Building Sensations building + swelling

Flooding Sensations flooding + flowing

Flushing Sensations flushing + spreading

Shooting Sensations shooting + spurting

Throbbing Sensations throbbing + pulsating

General Spasms shuddering + trembling + quivering

Cognitive-Affective Emotional Intimacy close + loving + passionate + tender + unifying

Ecstasy ecstatic + elated + euphoric + rapturous

Pleasurable Satisfaction pleasurable + satisfying + fulfilling

Relaxation relaxing + peaceful + soothing

Female Orgasm Scale

ALEXANDRA MCINTYRE-SMITH AND WILLIAM A. FISHER, 1
University of Western Ontario

This scale assesses the consistency of female orgasm dur

ing partnered sexual activities (e.g., intercourse, oral stim

ulation, self-stimulation with partner present) and overall

satisfaction with orgasm frequency and quality.

Description

The scale comprises seven items. Five items inquire about the frequency of orgasm during different sexual activities: (a) intercourse, (b) intercourse with additional direct clitoral stimulation, (c) hand/manual stimulation of the clitoris and/or genitals by a partner, (d) self-stimulation of the clitoris and/or genitals in the presence of a partner, and (e) oral stimulation. Respondents indicate the percentage of time they experience orgasm on an 11-point scale in 10% increments ranging from 0% to 100%. Respondents are also provided with the option, “Does not apply to me (I do not have sexual interactions involving . . .)” to allow the 0% response option to identify respondents who engage in the type of stimulation described in the item but do not experience orgasm from it. Two other items assess perceived satisfaction with the number and quality of orgasms experienced during sexual activity with a partner. They are rated on a 7-point scale ranging from Very Satisfied to Very Unsatisfied. Scale development followed an iterative process, whereby items were developed and refined over a series of three studies. An initial pool of 17 items was developed and administered to 198 female undergraduate students. Items were subject to individual item analyses and exploratory

factor analyses. Nine items were deleted owing to poor empirical performance or poor conceptual overlap with the construct, and five new items were written. The 13 items were then administered to a second sample of 242 female undergraduate participants, and items were subjected to item analyses and exploratory factor analyses. Six items were deleted and two additional items were written. The nine items were administered to 211 female undergraduate participants, and responses were subjected to item analyses and test-retest reliability analyses. Seven items were retained for the final scale. Decision-making regarding item deletion was based on the following scale-development guidelines (see Netemeyer, Bearden, & Sharma, 2003; Streiner & Norman, 2008): (a) range restriction problems (i.e., more than 50% of the sample endorsed a single response option, low standard deviations), (b) poor inter-item correlations with two or more scale items ($r < .30$), (c) poor corrected item-total correlations ($r < .30$), (d) high cross-loadings on nontarget factors (> .35 or more), (e) low percentage of variance accounted for within items (i.e., poor communalities; < .30), (f) poor item-wording as judged by scale developers, (g) redundancy with other items, (h) poor conceptual overlap (i.e., item was judged to be too dissimilar from other items and/or to poorly reflect the construct). Sampling was conducted with three groups of female undergraduate students, aged 17–49 (M = 18.83–19.24, SD = 2.67–3.38), who were heterosexually active (i.e., they reported having sexual intercourse with a male partner at least twice per month). As this scale was developed based on responses from undergraduate female participants, it is most appropriate for use with this population. Future studies examining the use of this measure with additional populations are needed. Response

Mode and Timing Respondents are provided with the scale and instructions, and are asked to complete the survey on their own, and with as much privacy as possible. Sampling for the purposes of scale development was conducted using the Internet. Paper-and-pencil administration of the scale requires 2 to 5 minutes. No particular time frame was assigned to the scale (i.e., it provides a global overview of a woman's orgasm experience rather than being limited to the past 4 weeks, current partner, etc.). This approach was chosen to allow the scale to be applicable to a broad range of temporal and relationship contexts. If one were interested in limiting the use of the scale to a specific time frame or sexual relationship (e.g., current partner), the scale could be prefaced with additional instructions specifying this constraint. The Female Orgasm Scale was strongly correlated with the Orgasm subscale of the Female Sexual Function Index (Rosen et al., 2000), r = .71, which measures orgasmic function over the past 4 weeks. This provides preliminary support for the consistency of female orgasmic experience as measured by the Female Orgasm Scale, and for tailoring the scale to a specific time frame. Scoring 1. Examine the number of responses marked "Does not apply to me." These responses can be coded either as missing data or as 0, depending on the rationale of the researcher and use of the scale.

1 Address correspondence to Alexandra McIntyre-Smith or William Fisher, Department of Psychology, The University of Western Ontario, London,

Ontario, Canada N6A 5C2; e-mail: amcsmith@gmail.com or fisher@uwo.ca

2. Score Items 1–5 as follows: 0% = 0, 10% = 1, 20% = 2,

. . . 100% = 10.

3. Score Items 6–7 as follows: Very Unsatisfied = 1 . . . Very

Satisfied = 7.

4. Because Items 1–5 are essentially keyed on a 10-point

scale (i.e., there is no conceptual equivalent to the 0%

response option on the 7-point scale for Items 6–7), and

the rest of the items are coded on a 7-point scale, items

should be weighted in the following manner:

a. Multiply Items 1–5 by 7.

b. Multiply Items 6–7 by 10.

5. Calculate the average score or the total score for all items. Higher scores indicate greater orgasm consistency and satisfaction.

6. Calculate subscale scores if desired:

a. Orgasm from Clitoral Stimulation—Items 2–5

b. Satisfaction with Orgasm—Items 6–7

When calculating subscale scores, items do not need to be weighted within a given subscale, because the response options are the same for all items (e.g., Items 2–5 are answered on a 7-point scale).

Reliability

Internal consistency of the Female Orgasm Scale was good in all three studies (α = .84–.86), and for both subscales: Orgasm from Clitoral Stimulation (α = .81–.82) and Satisfaction with Orgasm (α = .72–.90). Corrected item total correlations ranged from r = .41 to .77 for the total scale, and from r = .56 to .81 for the subscales. Inter-item correlations ranged from r =.19 to .61 for the total scale,

Exhibit

Female Orgasm Scale

Instructions: The following questions ask about your sexual experiences (such as sexual activities with a partner). You are asked to rate

each item on the scale provided. Please check off one box per item to indicate your response.

1. How often do you have an orgasm from vaginal penetration only (no direct clitoral stimulation) during intercourse with a partner?

Please indicate what percentage of the time:

□ □ □ □ □ □ □ □ □ □ □

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

OR □ Does not apply to me

(i.e., I do not have sexual interactions involving vaginal penetration only during intercourse with a partner)

2. How often do you have an orgasm from intercourse with a partner that includes both vaginal penetration and direct clitoral stimulation?

Please indicate what percentage of the time:

□ □ □ □ □ □ □ □ □ □ □

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

OR □ Does not apply to me

(i.e., I do not have sexual interactions involving vaginal penetration and simultaneous clitoral stimulation)

3. How often do you have an orgasm from HAND/MANUAL stimulation of your genitals/clitoris by a partner?

Please indicate what percentage of the time:

□ □ □ □ □ □ □ □ □ □ □

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

OR □ Does not apply to me

(i.e., I do not have sexual interactions involving manual stimulation of the genitals/clitoris with a partner)

4. How often do you have an orgasm when you yourself manipulate or rub your own genitals/clitoris when you are with a partner?

Please indicate what percentage of the time:

□ □ □ □ □ □ □ □ □ □ □

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

OR □ Does not apply to me

(i.e., I do not have sexual interactions where I
self-manipulate my own genitals/clitoris when I am with a
partner)

5. How often do you have an orgasm from ORAL stimulation of
your genital/clitoris by a partner?

Please indicate what percentage of the time:

□ □ □ □ □ □ □ □ □ □ □

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

OR □ Does not apply to me

(i.e., I do not have sexual interactions involving oral
stimulation of the genitals/clitoris with a partner)

6. In general, how satisfied . . . unsatisfied are you with
the number of orgasms that you have during sexual activity
with a partner? □ □ □ □ □ □ □

Very Satisfi ed Moderately Slightly Neither Satisfi ed
Slightly Moderately Very

Satisfi ed Satisfi ed nor Unsatisfi ed Unsatisfi ed
Unsatisfi ed Unsatisfi ed

7. In general, how satisfied . . . unsatisfied are you with
the quality or experience of orgasm that you have during
sexual activity with a partner? □ □ □ □
□ □ □

Very Satisfi ed Moderately Slightly Neither Satisfi ed
Slightly Moderately Very

Satisfi ed Satisfi ed nor Unsatisfi ed Unsatisfi ed
Unsatisfi ed Unsatisfi ed

Pedophilia (see Abuse)

Exhibit

Sexual Socialization Instrument

Directions: Below you will see five numbers corresponding to five choices. Choose the response that best describes your degree of agree

ment/disagreement with each statement. Write or shade in only one response for each statement. Because all responses will remain anony

mous you can respond truthfully with no concerns about anyone connecting responses with individuals.

Strongly Agree (1) Agree (2) Undecided (3) Disagree (4) Strongly Disagree (5)

1. My mother would have felt okay about my having sex with many different people.

2. I am uncomfortable around people who spend much of their time talking about their sexual experiences.

3. My father would have felt upset if he'd thought I was having sex with many different people.

4. Among my friends, men who have the most sexual experience are the most highly regarded.

5. My friends disapprove of being involved with someone who was known to be sexually easy.

6. According to my parents, having sexual intercourse is an important part of my becoming an adult.

7. Most of my friends don't approve of having multiple sexual partners.

8. My friends and I enjoy telling each other about our sexual experiences.

9. My parents stress that sex and intimacy should always be linked.

10. Most of my friends believe that you should only have sex in a serious relationship.

11. Among my friends alcohol is used to get someone to sleep with you.

12. My parents would disapprove of my being sexually active. 13. My friends approve of being involved with someone just for sex. 14. My friends brag about their sexual exploits. 15. My friends suggest dates to each other who are known to be sexually easy. 16. My parents encourage me to have sex with many people before I get married. 17. Among my friends, people seldom discuss their sexuality. 18. Among my friends, women who have the most sexual experience are the most highly regarded. 19. My father would have felt okay about my having casual sexual encounters. 20. My mother would only have approved of me having sex in a serious relationship. Reiss Premarital Sexual Permissiveness Scale (Short Form) IRA L. REISS, 1 University of Minnesota This scale measures the level of premarital sexual permissiveness that an individual accepts. The scale allows one to precisely place a respondent on the cumulative, low to high, scale of permissiveness. This newer short form focuses on only the measures of coital permissiveness and consists of just four questions (Reiss, 1989; Schwartz & Reiss, 1995). Description The short-form scale and the original form are Guttman scales (i.e., they produce a ladder from low to high permissiveness; Reiss, 1967, 1989; Schwartz & Reiss, 1995). The original form consisted of a 12-question scale asking about the person’s acceptance of kissing, petting, and intercourse in relationships involving no affection, strong affection, love, or engagement (Hampe & Ruppel, 1974; Reiss, 1964). That scale met all Guttman scaling criteria in both a nationally representative sample and several regional samples. It has been tested in a number of other countries (Huang & Uba, 1992; Sprecher & Hatfield, 1996; Stillerman & Shapiro, 1979). It led to the development of the “Autonomy Theory,” explaining changes in premarital sexuality (Crawford & Popp, 2003; Reiss, 1965, 1967; Weis, 1998; Weis, Rabinowitz, & Ruckstuhl, 1992; Weis & Slosnerick, 1981). I would add here that my use of the term premarital does not involve any assumption that everyone will marry, but rather it indicates that the scale focuses on attitudes toward sexual behavior of young unmarried people. In 1989, I composed a revision consisting of a simple four-item scale that used three of the original coital questions and added a fourth question (Reiss, 1989). The fourth question was added because the old scale lacked a “moderate” affection category. The focus on only coital relationships in this newer short-form scale derived from the fact that our culture had changed from a minority of young people

accepting premarital intercourse to a majority of young people accepting and having premarital intercourse (Reiss, 2006). This short version has been tested both in the United States and in Sweden and found to meet all Guttman scaling requirements (Schwartz & Reiss, 1995). Although this scale focuses on heterosexual penile/ vaginal intercourse, a similar scale measuring the role of affection in same-gender sexual relations could be devised. Doing that could produce some very interesting comparisons. Response Mode and Timing The short form of the Premarital Sexual Permissiveness Scale (PSPS) offers three degrees of agreement and three degrees of disagreement with each question (see Exhibit). Respondents circle the degree of agreement or disagreement they have with each item. The four questions take only a couple of minutes for almost everyone to answer. Scoring Because Guttman scaling has been proven to work on both the old form and this newer short form of the scale, respondents could simply be scored by dichotomizing their answers into agree or disagree and assigning one point for each question to which they agreed. Dichotomizing each question's answers would yield a total permissiveness scale score for each respondent ranging from a low of 0 to a high of 4. But keep the six choices in each question because it does make respondents feel that they can more accurately express their feelings on the questions, and some researchers may want to use all six categories. 1 Address correspondence to Ira L. Reiss, 5932 Medicine Lake Road, Minneapolis, MN 55422; e-mail: irareiss@comcast.net

Reliability

Reliability is indicated in that both the original and the short

form of the scale always met Guttman Scale criteria, such

as the coefficient of reproducibility and the coefficient of

scalability. This held up in the U.S. and other industrialized

countries (Reiss & Miller, 1979; Schwartz & Reiss, 1995;

Walsh, Zey-Ferrell, & Tolone, 1976; Whitbeck, Simons, &

Kao, 1994).

Validity

Construct validity was established by finding the expected differences between parents and college students, Whites and Blacks, and males and females (Crawford & Popp, 2003; Liao & Tu, 2006; Reiss, 1967; Schwartz & Reiss, 1995). In the short form the results fit precisely with what was expected when comparing Swedish and American college students (e.g., Swedish students were much more acceptant of Question 4 than were U.S. students).

Other Information

In the last five decades, the PSPS, in one form or the other, has been widely used. For research today, I would recommend using the newer short form of the scale. It incorporates the theoretical structure of the original scale, and three of its four questions are from the coital part of that scale. It can be compared to earlier results with confidence that it is measuring the same thing as the original. I give my permission to use this scale in any research project, but I would ask that you let me know your results.

Crawford, M., & Popp, D. (2003). Sexual double standards: A review and methodological critique of two decades of research. The Journal of Sex Research, 40, 13–26.

Hampe, G., & Ruppel, H. (1974). The measurement of premarital sexual permissiveness: A comparison of two Guttman scales. Journal of Marriage and the Family, 36, 451–464. Huang, K., & Uba, L. (1992). Premarital sexual behavior among Chinese college students in the U.S.

Archives of Sexual Behavior, 21, 227–240. Liao, P. S., & Tu, S. H. (2006). Examining the scalability of intimacy permissiveness in Taiwan. Social Indicators Research, 76, 207–232. Reiss, I. L. (1964). The scaling of premarital sexual permissiveness. Journal of Marriage and the Family, 26, 188–198. Reiss, I. L. (1965). Social class and premarital sexual permissiveness: A re-examination. American Sociological Review, 29, 747–756. Reiss, I. L. (1967). The social context of premarital sexual permissiveness. New York: Holt, Rinehart & Winston. Reiss, I. L. (1989). Is this my scale? Journal of Marriage and the Family, 51, 1079–1080. Reiss, I. L. (2006). An insider's view of sexual science since Kinsey. Lanham, MD: Rowman & Littlefield. Reiss, I. L., & Miller, B. C. (1979). Heterosexual permissiveness: A theoretical analysis. In W. Burr, R. Hill, I. Nye, & I. L. Reiss (Eds.), Contemporary theories about the family (Vol. 1, pp. 57–100). New York: Free Press. Schwartz, I., & Reiss, I. L. (1995). The scaling of premarital sexual permissiveness revisited. Test results of Reiss's new short-form version. Journal of Sex and Marital Therapy, 21, 78–86. Sprecher, S., & Hatfield, E. (1996). Premarital sexual standards among U.S. college students: Comparison with Russian and Japanese students. Archives of Sexual Behavior, 25, 261–288. Stillerman, E. D., & Shapiro, C. M. (1979). Scaling sex attitudes and behavior in South Africa. Archives of Sexual Behavior, 8, 1–14. Walsh, R. H., Zey-Ferrell, M., & Tolone, W. L. (1976). Selection of reference group, perceived reference group permissiveness, and personal permissiveness attitudes and behavior: A study of two consecutive panels (1967–71; 1970–74). Journal of Marriage and the Family, 38, 495–507. Weis, D. L. (1998). The use of theory in sexuality research. The Journal of Sex Research, 35, 1–9. Weis, D. L., Rabinowitz, B., & Ruckstuhl, M. F. (1992). Individual changes in sexual attitudes and behavior within college level human sexuality courses. The Journal of Sex Research, 29, 43–59. Weis, D. L., & Slosnerick, M. (1981). Attitudes toward sexual and nonsexual extramarital involvements among a sample of college students. Journal of Marriage and the Family, 43, 349–358. Whitbeck, L. B., Simons, R. L., & Kao, M. (1994). The effects of divorced mothers' dating behaviors and sexual attitudes on the sexual attitudes and behaviors of their adolescent children. Journal of Marriage and the Family, 56, 615–621.

Exhibit

Reiss Premarital Sexual Permissiveness Scale (Short Form)

The following four questions concern your personal attitude

regarding premarital sexual intercourse. First decide whether you agree or

disagree with the view expressed; then indicate the level of your agreement or disagreement by circling the answer that best expresses

your view. The six choices below follow each question.

Agree: Strongly Moderately Slightly

Disagree: Strongly Moderately Slightly

1. I believe that premarital sexual intercourse is acceptable if one is in a love relationship.

2. I believe that premarital sexual intercourse is acceptable if one is in a relationship involving strong affection.

3. I believe that premarital sexual intercourse is acceptable if one is in a relationship involving moderate affection.

4. I believe that premarital sexual intercourse is acceptable even if one is in a relationship without much affection.

Note. The wording presented above asks what is acceptable for “one” and that term includes both the respondent and others. If you wished to know

only what the respondent believes is acceptable for her- or himself, then you could change the wording of each question to a more personalized form.

For example change Question 1 to read: “. . . acceptable if I am in a love relationship.” It would be interesting to compare the two different wordings of

this scale to see what differences, if any, would be found. My own testing of this with students found very little difference. Premarital Sexual Permissiveness Scale SUSAN SPRECHER, 1 Illinois State University The Premarital Sexual Permissiveness Scale (PSPS) was developed to assess people’s attitudes about the acceptability of premarital sex at different levels of relational development (Sprecher, McKinney, Walsh, & Anderson, 1988). It was modeled after the Reiss (1964, 1967) Premarital Sexual Permissiveness Scale, but with sexual behaviors and

relationship stages that my colleagues and I believed would more adequately measure variation in sexual permissiveness. Multiple-item scales, such as the PSPS, are more discriminating measures of sexual standards than the single items often found in national studies, such as the one used in the General Social Survey: “If a man and a woman have sex relations before marriage, do you think it is always wrong, almost always wrong, wrong only sometimes, not wrong at all or don’t know.” That is, people may be accepting of premarital sex under some relational conditions (e.g., a serious, committed relationship) but not others (e.g., casual dating), and the PSPS can assess this interesting variation. In addition, multiple versions of the scale can be administered, either with the same participants or with different participants, with each version focusing on a different target in the scale items. This allows the investigator not only to examine a sample’s general sexual permissiveness but also to examine how sexual permissiveness may vary for different targets. The most common comparisons that have been made are standards for self versus standards for others and standards for males versus females (i.e., a double standard). Description The original version (Sprecher et al., 1988) of the PSPS was created containing 15 items that asked about acceptance of three sexual behaviors (heavy petting [touching of genitals], sexual intercourse, and oral-genital sex) for each of five relationship stages (first date, casually dating, seriously dating, pre-engaged, and engaged). Not surprisingly, people were found to be least accepting of premarital sex at the first date stage, and most accepting at the engaged stage. With each increasing relationship stage, more acceptance was expressed. Variation in acceptability was also found among the sexual activities. People were most accepting of heavy petting; and sexual intercourse was viewed as slightly more acceptable than oral-genital sex. In some of my research (Sprecher, 1989) I found that the “pre-engaged stage” (defined further as “seriously discussed the possibility of getting married”) was dropped. In addition, in recent research, I have reduced the scale to only the sexual intercourse items. Response Mode and Timing In our research, the scale items of the PSPS are followed by a 6-point response scale. The response options are Agree Strongly, Agree Moderately, Agree Slightly, Disagree Slightly, Disagree Moderately, Disagree Strongly. Interpretation of results is facilitated by reverse coding the responses so that the higher number indicates greater acceptance. The scale, even if it is administered multiple times, does not take long to complete. The version that includes five items takes 1 to 2 minutes to complete.

Scoring To create a total score presenting degree of sexual permissiveness, a mean of the items is recommended (although a sum is also all right). If multiple versions are included (i.e., a version for self, a version for a male target, a version for a female target), it is recommended that a total score be computed separately for each version. Also, as noted above, it is recommended, for ease of interpretation, that the response options first be reverse scored so that the higher number indicates greater agreement. Reliability The scale has high internal consistency. With unpublished data collected from over 6,000 undergraduate students at a Midwest university, Cronbach's alpha for the 5-item subscale measuring acceptability of sexual intercourse for the self was .82. Validity Construct validity is evidenced by findings of expected differences between male and female participants (e.g., Sprecher, 1989; Sprecher et al., 1988). That is, men are found to be more permissive than women, especially at the stages of first date and casually dating. In addition, in unpublished data, the subscale of acceptability of sexual intercourse for the self was found to be significantly and positively correlated with the sexual attitude items from the Sociosexuality Orientation Inventory (Simpson & Gangestad, 1991).

1 Address correspondence to Susan Sprecher, Dept. of Sociology and Anthropology, Illinois State University, Normal, IL 61790; e-mail:

Sprecher@ilstu.edu

Other Information

If the researcher has the space for only a few items of the

scale, my suggestion is that the three items asking about

acceptability of sexual intercourse for first date, casual dat

ing, and serious dating be selected. The greatest variation

is found for the items asking about first date and casual

dating.

Although the scale has been used primarily to examine

young adults' attitudes about their own and peers' sexual

activity prior to marriage, it could also be used in other

ways, including to assess parents' attitudes about their

adult children's sexual behavior (e.g., "I believe that sexual

intercourse is acceptable for my son when he is casually

dating").

Exhibit

Premarital Sexual Permissiveness Scale

Following are the items for sexual intercourse in reference to the self.

Directions. For each of the following statements, indicate to what extent you agree or disagree with it. These statements concern what

you think is appropriate behavior for you.

Response option: The following response options follow each item.

1 Agree Strongly

2 Agree Moderately

3 Agree Slightly

4 Disagree Slightly

5 Disagree Moderately

6 Disagree Strongly

The items: a

1. I believe that sexual intercourse is acceptable for me on a first date.

2. I believe that sexual intercourse is acceptable for me when I'm casually dating my partner (dating less than one month).

3. I believe that sexual intercourse is acceptable for me when I'm seriously dating my partner (dating almost a

year).

4. I believe that sexual intercourse is acceptable for me when I am pre-engaged to my partner (we have seriously discussed the

possibility of getting married).

5. I believe that sexual intercourse is acceptable for me when I'm engaged to my partner.

a The researcher may also ask about the acceptability of other sexual behaviors. For example, the researcher may include similar items that ask about

acceptability of heavy petting (e.g., touching of genitals) and oral-genital sex for the five different relationship stages, as was done in Sprecher et al. (1988).

Furthermore, the researcher may ask about acceptability of sexual behaviors for different targets—for example, for a male and a female (see Sprecher,

1989; Sprecher et al., 1988). An example item to measure standards for a female would be "I believe that sexual intercourse is acceptable for a female

who is seriously dating her partner." An example item from the male version is "I believe that sexual intercourse is acceptable for a male who is engaged

to his partner."

Personality (also see Assertiveness, Erotophobia-Erotophilia, Narcissism, Sensation Seeking, and Sexual Perfectionism)

Exhibit

Need for Sexual Intimacy Scale

Directions: The next few items address things we may “need” in life. Some say we “need” many things in order to survive (e.g., food,

shelter, etc.). Below we have presented a series of items and would like you to rate each item as to how much you agree or disagree

with them as things you may “need.” The term “partner” below refers to a sexual partner (e.g. dating partner, boyfriend/girlfriend,

long-term partner/spouse). Please read each statement carefully, and then fill in the blank (____) with a number that corresponds to

the scale description.

Disagree Agree

Definitely Definitely

1 2 3 4 5

I need . . .

_____ 1. To have more sex.

_____ 2. Sex every day.

_____ 3. To have an orgasm every day.

_____ 4. To let myself go sexually with someone.

_____ 5. Sex every couple of days.

_____ 6. Someone who is “great in bed.”

_____ 7. Sex with a lot of partners.

_____ 8. To take control of my partner when we are

intimate.

_____ 9. A partner who loves me.

_____ 10. Somebody to love.

_____ 11. Companionship.

_____ 12. A companion in life.

_____ 13. Complete trust in the people I am intimate with.

_____ 14. Nobody special in my life. [R]

_____ 15. Somebody to hold my hand.

_____ 16. A few really good friends.

_____ 17. Someone to sleep next to me.

_____ 18. My partner to tell me where they are at all times.

_____ 19. Control over my partner.

_____ 20. My partner to give me what I want (such as financial support, clothes, a car).

_____ 21. A partner I can manipulate.

_____ 22. The ability to order my partner to have sex with me if I want to.

Pornography (see Sexually Explicit Material)

Barnett, N. J., & Feild, H. S. (1977). Sex differences in university students' attitudes toward rape. Journal of College Student Personnel, 18, 93–96.

Bell, S., Kuriloff, P., Lottes, I., Nathanson, J., Judge, T., & FogelsonTuret, K. (1992). Rape callousness in college freshmen: An empirical investigation of a sociocultural model of aggression towards women. Journal of College Student Development, 33, 454–461. Bell, S., Lottes, I., & Kuriloff, P. (1995). Understanding rape callousness in college students: Results of a panel study. Unpublished manuscript. Burt, M. R. (1980). Cultural myths and supports for rape. Journal of Personality and Social Psychology, 38, 217–230. Koss, M. P. (1981). Hidden rape on a university campus (Grant No. R01MH31618). Rockville, MD: National Institute of Health. Lottes, I. L. (1991). Belief systems: Sexuality and rape. Journal of Psychology and Human Sexuality, 4, 37–59. Marolla, J., & Scully, D. (1982). Attitudes toward women, violence, and rape: A comparison of convicted rapists and other felons (Grant No. R01MH33013-01A1). Rockville, MD: National Institute of Health. Mosher, D. L., & Sirkin, M. (1984). Measuring a macho personality constellation. Journal of Research in Personality, 18, 150–163. Russell, D. (1975). The politics of rape. New York: Stein and Day. Wheeler, J. R., & Utigard, C. N. (1984, June). Gender, stereotyping, rape attitudes, and acceptance of interpersonal violence. Paper presented at the combined annual meeting of the Society for the Scientific Study of Sex and the American Association of Sex Educators, Counselors, and Therapists, Boston, MA. Williams, J. E., & Holmes, K. A. (1981). The second assault: Rape and public attitudes. Westport, CT: Greenwood Press.

Exhibit

Rape Supportive Attitude Scale

Directions: Write all your responses on the computer answer sheet. Use a No. 2 lead pencil. To indicate your opinion about each state

ment, shade in the number corresponding to one of the five circles. Indicate whether you strongly disagree (1), disagree (2), are undecided

or have no opinion (3), agree (4), or strongly agree (5).

Strongly Disagree (1) Agree (2) Undecided (3) Disagree (4) Strongly Agree (5)

Remember: Be sure that the statement you are reading corresponds to the statement number you are marking on the answer sheet.

Mark only one response for each statement.

1. Being roughed up is sexually stimulating to many women.

2. A man has some justification in forcing a female to have sex with him when she led him to believe she would go to bed with him.

3. The degree of a woman's resistance should be the major factor in determining if a rape has occurred.

4. The reason most rapists commit rape is for sex.

5. If a girl engages in necking or petting and she lets things get out of hand, it is her fault if her partner forces sex on her.

6. Many women falsely report that they have been raped because they are pregnant and want to protect their reputation.

7. A man has some justification in forcing a woman to have sex with him if she allowed herself to be picked up.

8. Sometimes the only way a man can get a cold woman turned on is to use force.

9. A charge of rape two days after the act has occurred is probably not rape.

10. A raped woman is a less desirable woman.

11. A man is somewhat justified in forcing a woman to have sex with him if he has had sex with her in the past.

12. In order to protect the male, it should be difficult to prove that a rape has occurred.

13. Many times a woman will pretend she doesn't want to have intercourse because she doesn't want to seem loose, but she's really hoping the man will force her.

14. A woman who is stuck-up and thinks she is too good to talk to guys deserves to be taught a lesson.

15. One reason that women falsely report rape is that they frequently have a need to call attention to themselves.

16. In a majority of rapes the victim is promiscuous or had a bad reputation.

17. Many women have an unconscious wish to be raped, and may then unconsciously set up a situation in which they are likely to be attacked.

18. Rape is the expression of an uncontrollable desire for sex.

19. A man is somewhat justified in forcing a woman to have sex with him if they have dated for a long time.

24. One of the reasons I chose my sexual partner is because of our similar backgrounds.

25. Before I made love with my sexual partner, I considered how s/he would reflect on my family.

26. It was important to me that my sexual partner be a good parent.

27. I thought about the implications for my career before I made love with my sexual partner.

28. I didn't have sex with my partner until after I had considered our hereditary backgrounds.

29. When sex with my partner isn't going right, I become upset.

30. If my sexual relationship with my partner ended, I would become extremely despondent and depressed.

31. Sometimes I am so sexually attracted to my partner that I simply can't sleep.

32. When my partner sexually ignores me, I feel really sick.

33. Since my partner and I started having sex, I have not been able to concentrate on anything else.

34. If my partner became sexually involved with someone else, I wouldn't be able to take it.

35. If my partner doesn't have sex with me for a while, I sometimes do stupid things to get her/his sexual attention.

36. If my partner were having a sexual difficulty, I would definitely try to help as much as I could.

37. I would rather have a sexual problem myself than let my partner suffer though one.

38. I could never be sexually satisfied unless first my partner was sexually satisfied.

39. I am usually willing to forsake my own sexual needs in order to let my partner achieve her/his own sexual needs.

40. My partner can use me the way s/he chooses in order for

him/her to be sexually satisfied.

41. When my partner is sexually dissatisfied with me, I still accept him/her without reservations.

42. I would do practically any sexual activity that my partner wanted.

43. It would bother me if my sexual partner neglected my needs.

44. If I were to make love with a sexual partner, I'd take that person's needs and feelings into account.

45. If a sexual partner were to do something sensual for me, I'd try to do the same for him/her.

46. I expect a sexual partner to be responsive to my sexual needs and feelings.

47. I would be willing to go out of my way to satisfy my sexual partner.

48. If I were feeling sexually needy, I'd ask my sexual partner for help.

49. If a sexual partner were to ignore my sexual needs, I'd feel hurt.

50. I think people should feel obligated to repay an intimate partner for sexual favors.

51. I would feel somewhat exploited if an intimate partner failed to repay me for a sexual favor.

52. I would probably keep track of the times a sexual partner asked me for a sensual pleasure.

53. When a person receives sexual pleasures from another, s/he ought to repay that person right away.

54. It's best to make sure things are always kept "even" between two people in a sexual relationship.

55. I would do a special sexual favor for an intimate partner, only if that person did some special sexual favor for me.

56. If my sexual partner performed a sexual request for me, I would probably feel that I'd have to repay him/her later

on.

57. I responded to the following items based on:

(A) A current sexual relationship.

(B) A past sexual relationship.

(C) An imagined sexual relationship.

1 Address all correspondence to William E. Snell, Jr., Department of Psychology, Southeast Missouri State University, One University Plaza, Cape

Girardeau, MO 63701; e-mail: wesnell@semo.edu

Sexual Relationship Scale

WILLIAM E. SNELL, JR., 1 Southeast Missouri State University

Clark and Mills (1979) proposed a theory of relationship

orientation based on the rules governing the giving and

receiving of benefits. An exchange-relationship orienta

tion was defined as one in which benefits are given on the

Exhibit

Sexual Relationship Scale

Instructions: Listed below are several statements that concern the topic of sexual relationships. Please read each of the following state

ments carefully and decide to what extent it is characteristic of you. Some of the items refer to a specific relationship. Whenever pos

sible, answer the questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your

most recent partner in mind. If you have never had a relationship, answer in terms of what you think your responses would most likely

be. Then, for each statement fill in the response on the

answer sheet that indicates how much it applies to you by using the following

scale:

A = Not at all characteristic of me.

B = Slightly characteristic of me.

C = Somewhat characteristic of me.

D = Moderately characteristic of me.

E = Very characteristic of me.

Note: Remember to respond to all items, even if you are not completely sure. Your answers will be kept in the strictest confidence. Also,

please be honest in responding to these statements.

1. It would bother me if my sexual partner neglected my needs.

2. When I make love with someone, I generally expect something in return.

3. If I were to make love with a sexual partner, I'd take that person's needs and feelings into account.

4. If a sexual partner were to do something sensual for me, I'd try to do the same for him/her.

5. I'm not especially sensitive to the feelings of a sexual partner.

6. I don't think people should feel obligated to repay an intimate partner for sexual favors. (R)

7. I don't consider myself to be a particularly helpful sexual partner.

8. I wouldn't feel all that exploited if an intimate partner failed to repay me for a sexual favor. (R)

9. I believe sexual lovers should go out of their way to be sexually responsive to their partner.

10. I wouldn't bother to keep track of the times a sexual partner asked for a sensual pleasure. (R)

11. I wouldn’t especially enjoy helping a partner achieve their own sexual satisfaction.

12. When a person receives sexual pleasures from another, s/he ought to repay that person right away.

13. I expect a sexual partner to be responsive to my sexual needs and feelings.

14. It’s best to make sure things are always kept “even” between two people in a sexual relationship.

15. I would be willing to go out of my way to satisfy my sexual partner.

16. I would do a special sexual favor for an intimate partner, only if that person did some special sexual favor for me.

17. I don’t think it’s wise to get involved taking care of a partner’s sexual needs.

subscale was significantly and positively correlated with

the Communal Orientation scale for females and for the

subjects as a whole. Significant and positive correlations

were also found between the sexual exchange orienta

tion subscale and scores on the Exchange Orientation

scale for males, females, and both together. In addition,

the SRS was found to be related to relationship satisfac

tion. Among males, a significant negative relationship

was found between an exchange approach to sexual rela

tions and their relationship satisfaction. The analysis for

the females, in contrast, revealed a statistically significant

positive correlation between relationship satisfaction and

a communal approach to sexual relations.

These patterns of correlations thus provide preliminary evidence for the construct validity of the SRS, in that (a) those individuals characterized by a stronger communal approach to their sexual relations were expected to report

Safer-Sex Behaviors (see Sexual Risk)

Hudson, W. W., Harrison, D. F., & Crosscup, P. C. (1981). A short-form

scale to measure sexual discord in dyadic relationships. The Journal

of Sex Research, 17, 157–174. Murphy, G. J. (1978). The family in later life: A cross-ethnic study in marital and sexual satisfaction. Unpublished doctoral dissertation, Tulane University, New Orleans. Murphy, G. J., Hudson, W. W., & Cheung, P. P. L. (1980). Marital and sexual discord among older couples. Social Work Research & Abstracts, 161, 11–16. Nurius, P. S., & Hudson, W. W. (1993), Human services practice, evaluation & computers. Pacific Grove, CA: Brooks/Cole Publishing.

Interpersonal Exchange Model of Sexual

Satisfaction Questionnaire

KELLI-AN LAWRANCE, Brock University

E. S ANDRA BYERS, 1 University of New Brunswick

JACQUELINE N. COHEN, Correctional Service of Canada

The Interpersonal Exchange Model of Sexual Satisfaction

(IEMSS) Questionnaire assesses the components of the

IEMSS, a conceptual framework for understanding sexual

satisfaction within relationships. It addresses a number

of methodological limitations associated with previous

research on sexual satisfaction, namely use of single-item

measures with unknown reliability and validity, inclusion

in multi-item scales of items that are used as predictors of

sexual satisfaction (e.g., sexual frequency), and failure to

validate measures for sexual-minority individuals. The IEMSS proposes that sexual satisfaction is influ

enced by (a) the balance of sexual rewards and sexual costs

in the relationship, (b) how these rewards and costs com
pare to the expected levels of rewards and costs, (c) the
perceived equality of rewards and costs between partners,
and (d) the nonsexual aspects of the relationship (Lawrance
& Byers, 1995). Sexual rewards are exchanges that people
experience as pleasurable and gratifying; sexual costs are
exchanges that demand effort or cause pain, anxiety, or
other negative affect. Because sexual satisfaction is a func
tion of the history of sexual exchanges, repeated assess
ments of these components provides a better indication of
sexual satisfaction than does a single assessment (Byers &
MacNeil, 2006; Lawrance & Byers 1995).

Description and Scoring

The IEMSS Questionnaire comprises three self-report mea
sures that assess the components of the model as well as a
checklist of sexual rewards and costs. The Global Measure
of Sexual Satisfaction (GMSEX) assesses overall sexual
satisfaction. Respondents rate their sex life on five
7-point
dimensions: Good-Bad, Pleasant-Unpleasant, Positive
Negative, Satisfying-Unsatisfying, Valuable-Worthless.
Ratings are summed such that possible scores range from
5 to 35, with higher scores indicating greater sexual satis
faction. The Global Measure of Relationship Satisfaction
(GMREL) is identical to the GMSEX except that respon

dents rate their overall relationship satisfaction. Higher summed scores indicate greater relationship satisfaction. The Exchanges Questionnaire assesses respondents' levels of sexual rewards and costs. Using 9-point scales, respondents indicate (a) their level of rewards, from Not at all Rewarding to Extremely Rewarding, (b) how their level of rewards compares to the level of rewards they expected to receive, from Much Less Rewarding in Comparison to Much More Rewarding in Comparison, and (c) how their level of rewards compares with the level of rewards their partner receives, from My Rewards Are Much Higher to My Partner's Rewards Are Much Higher. Parallel items are used to assess respondents' level of sexual costs, relative level of sexual costs, and perceived equality of sexual costs. The perceived equality items are coded such that the midpoint, which represents perfect equality, is assigned a score of 4 and the endpoints are assigned scores of 0. Thus higher scores represent greater equality between partners. Scores on the two equality scales (EQ REW and EQ CST) consitute one of the components of the IEMSS. The two other components (REW – CST and CL REW – CL CST) are calculated by subtracting the cost score from the reward score so that the possible range of scores is –8 to 8. The 58-item Rewards/Costs Checklist (RCC) was developed based on open-ended questions about the sexual rewards and costs experienced by university students in mixed-sex relationships (Lawrance & Byers, 1992) and revised to include the sexual rewards and costs identified by lesbians and gay men (Cohen, Byers, & Walsh, 2008). Respondents are presented with the checklist twice (in counterbalanced order). They indicate whether each item is a reward in their sexual relationship and whether each item is a cost in their sexual relationship. The total number of sexual rewards and costs are determined by summing the number of rewards and costs endorsed. Responses to individual items indicate the types of rewards and costs experienced. Response Mode and Timing For each item, respondents mark a response on a Likerttype scale or checklist. Together, the GMSEX, GMREL, and Exchanges Questionnaire take 10 minutes to complete. The RCC takes another 10 minutes to complete. Reliability Studies using married or cohabiting individuals in mixedsex relationships, married individuals in China, and sexualminority women indicate that the GMSEX and GMREL

1 Address correspondence to E. Sandra Byers, Department of Psychology, University of New Brunswick, Bag Service #45444, Fredericton, New Bruns

wick, Canada E3B 6E4; e-mail: byers@unb.ca

have high internal consistency, ranging from .90 to .96 for the GMSEX and from .91 to .96 for GMREL (Cohen, 2008; Lawrance & Byers, 1992, 1995; Peck, Shaffer, & Williamson, 2004; Renaud, Byers, & Pan, 1997). Test retest reliabilities also are high: .84 at 2 weeks, .78 at 3 months, and .73 at 18 months for GMSEX, and .81 at 2 weeks, .70 at 3 months, and .61 at 18 months for GMREL (Byers & MacNeil, 2006; Lawrance & Byers, 1995). As anticipated, for individuals in long-term relationships, test-retest reliabilities are moderate for REW, CST, CL REW , CL CST , REW – CST, and CL REW – CL CST , ranging from .43 to .67 at 3 months and from .25 to .56 at 18 months (Byers & MacNeil, 2006; Lawrance & Byers, 1995).

Validity

Evidence for the validity of the IEMSS Questionnaire is based on a sample of university students (Lawrance & Byers, 1992). Construct validity for GMSEX was sup ported by a significant correlation of −.65 ($p < .001$) with scores on the Index of Sexual Satisfaction (ISS; Hudson, Harrison, & Crosscup, 1981). For GMREL, construct validity was supported by a significant correlation with the Dyadic Adjustment Scale (Spanier, 1976; $r = .69$, $p < .001$).

Further, a higher level of rewards was negatively correlated with the ISS ($r = -.66$, $p < .001$) as well as a single-item measure of sexual satisfaction ($r = .64$, $p < .001$). The level of costs was significantly correlated with the ISS ($r = .30$, $p < .01$) and a single-item measure of sexual satisfaction ($r = .70$, $p < .001$); however, it was not significantly correlated with a single-item measure of sexual satisfaction ($r = -.15$) Recent researchers have found that higher scores on the GMSEX and/or GMREL are associated with each other as well as with multiple indicators of sexual and relationship functioning, including sexual communication, sexual esteem, sexual cognitions, sexual desire, sexual frequency, and communality (Cohen, 2008; MacNeil & Byers, 2009; Peck et al., 2004; Renaud & Byers, 2001). Finally, the items

Exhibit

Interpersonal Exchange Model of Sexual Satisfaction Questionnaire

GMSEX

Overall, how would you describe your sexual relationship with your partner?

1.

Very Bad Very Good

□ □ □ □ □ □ □

2.

Very Unpleasant Very Pleasant

□ □ □ □ □ □ □

3.

Very Negative Very Positive

□ □ □ □ □ □ □

4.

Very Unsatisfying Very Satisfying

□ □ □ □ □ □ □

5.

Worthless Very Valuable

□ □ □ □ □ □ □

GMREL

In general, how would you describe your overall relationship with your partner?

1.

Very Bad Very Good

□ □ □ □ □ □ □

2.

Very Unpleasant Very Pleasant

□ □ □ □ □ □ □

3.

Very Negative Very Positive

□ □ □ □ □ □ □

4.

Very Unsatisfying Very Satisfying

□ □ □ □ □ □ □

5.

Worthless Very Valuable

□ □ □ □ □ □ □

Exchanges Questionnaire

When people think about their sexual relationship with their partner, most can think of both rewards and costs about their sexual

relationship. Rewards are things that are positive or pleasing: things they like about their sexual relationship. Costs are things that are

negative or displeasing: things they don’t like about their sexual relationship.

1. Think about the rewards that you have received in your sexual relationship with your partner within the past three months. How rewarding is your sexual relationship with your partner?

□ □ □ □ □ □ □

Not at all Rewarding Extremely Rewarding

2. Most people have a general expectation about how rewarding their sexual relationship “should be.” Compared to this general expectation, they may feel that their sexual relationship is more rewarding, less rewarding, or as rewarding as it “should be.”

Based on your own expectation about how rewarding your sexual relationship with your partner “should be,” how does your level of rewards compare to that expectation?

□ □ □ □ □ □ □

Much Less Much More

Rewarding in Rewarding in

Comparison Comparison

3. How does the level of rewards that you get from your sexual relationship with your partner compare to the level of rewards that your

partner gets from the relationship?

□ □ □ □ □ □ □

My Rewards Partner’s

Are Much Rewards Are

Higher Much Higher

4. Think about the costs that you have incurred in your sexual relationship with your partner within the past three months. How costly is

your sexual relationship with your partner?

□ □ □ □ □ □ □

Not at all Extremely

Costly Costly

5. Most people have a general expectation about how costly their sexual relationship “should be.” Compared to this general expectation,

they may feel that their sexual relationship is more costly, less costly, or as costly as it “should be.” Based on your own expectation

about how costly your sexual relationship with your partner “should be,” how does your level of costs compare to that expecta

tion?

□ □ □ □ □ □ □

Much Less Much More

Costly in Costly in

Comparison Comparison

6. How does the level of costs that you incur in your sexual relationship with your partner compare to the level of costs that your

partner gets from the relationship?

□ □ □ □ □ □ □

My Costs Partner’s

Are Much Costs Are

Higher Much Higher

Rewards/Costs Checklist (RCC)

Note to researcher: The presentation order of the Rewards Checklist and the Costs Checklist is counterbalanced across participants.

The items are identical in both Checklists. The response options for the Rewards Checklist are Reward and Not a Reward. The

response options for the Costs Checklist are Cost and Not a Cost.

Instructions. We will be asking you some more questions about your sexual relationship with your partner. Before answering them, it

is important that you carefully read the following information.

When people think about their sexual relationship with their partner, most can give concrete examples of positive/pleasing things

they like about their sexual relationship. These are rewards. Most people can also give concrete examples of negative/displeasing things

they don’t like about their sexual relationship. These are costs.

For example, take oral sex.

Oral sex would be a reward if you feel that you engage in this sexual activity “just the right amount” and you enjoy it.

Oral sex would be a cost if you would like to engage in oral sex more often or less often than you do, or you do not enjoy it.

You will be asked to complete the same list twice. One time you will be asked to indicate whether each item in this

list is generally

a reward in your sexual relationship with your partner or not a reward. The other time you will be asked to indicate whether each

item is a cost in your sexual relationship with your partner or not a cost.

Note that things can be both rewards and costs. For example, oral sex would be both a reward and a cost if you enjoy oral sex but want

it more or less frequently. Further, some items may be neither rewards nor costs in your sexual relationship.

Rewards Checklist

This is a list of possible rewards and costs in your sexual relationship. Please indicate whether each item in this list is generally a reward

in your sexual relationship with your partner or not a reward.

In brief, things that are positive, pleasing, or “just right” are rewards.

1. Level of affection you and your partner express during sexual activities

2. Degree of emotional intimacy (feeling close, sharing feelings)

3. Extent to which you and your partner communicate about sex

4. Variety in sexual activities, locations, times

5. Extent to which you and your partner use sex toys

6. Sexual activities you and your partner engage in to arouse each other

7. How often you experience orgasm (climax)

8. How often your partner experiences orgasm (climax)

9. Extent to which you and your partner engage in intimate activities (e.g., talking, cuddling) after sex

10. Frequency of sexual activities

11. How much privacy you and your partner have for sex

12. Oral sex: extent to which your partner stimulates you

13. Oral sex: extent to which you stimulate your partner

14. Physical sensations from touching, caressing, hugging

15. Feelings of physical discomfort or pain during/after sex

16. How much fun you and your partner experience during sexual interactions

17. Who initiates sexual activities

18. Extent to which you feel stressed/relaxed during sexual activities

19. Extent to which you and your partner express enjoyment about your sexual interactions

20. Extent to which you and your partner communicate your sexual likes and dislikes to each other

21. Ability/inability to conceive a child

22. Extent to which you and your partner engage in role-playing or act out fantasies

23. How you feel about yourself during/after engaging in sexual activities with your partner

24. Extent to which your partner shows consideration for your wants/needs/feelings

25. How your partner treats you (verbally and physically) when you have sex

26. Having sex when you’re not in the mood

27. Having sex when your partner is not in the mood

28. Extent to which you let your guard down with your partner

29. Extent to which your partner lets their guard down with you

30. Method of protection (from sexually transmitted infections and/or pregnancy) used by you and your partner

31. Extent to which you and your partner discuss and use protection (from sexually transmitted diseases and/or pregnancy)

32. How comfortable you and your partner are with each other

33. Extent to which/way in which your partner influences you to engage in sexual activity

34. Extent to which you and your partner argue after engaging in sexual activity

35. Extent to which you and your partner are/are not sexually exclusive (i.e., have sex only with each other)

36. How much time you and your partner spend engaging in sexual activities

37. How easy it is for you to have an orgasm (climax)

38. How easy it is for your partner to have an orgasm (climax)

39. Extent to which your sexual relationship with your partner reflects or breaks down stereotypical gender roles (the way women and men are expected to behave sexually)

40. How your partner responds to your initiation of sexual activity

41. Being naked in front of your partner

42. Your partner being naked in front of you

43. Extent to which your partner talks to other people about your sex life

44. Extent to which you and your partner read/watch sexually explicit material (e.g., erotic stories, pornographic videos)

45. Pleasing/trying to please your partner sexually

46. Extent to which sexual interactions with your partner make you feel secure in the relationship

47. Extent to which you get sexually aroused

The New Sexual Satisfaction Scale and Its

Short Form

ALEKSANDAR ŠTULHOFER 1 AND VESNA BUŠKO, University of Zagreb

PAMELA BROUILLARD, Texas A&M University-Corpus Christi

1 Address correspondence to Aleksandar Štulhofer, Sexology Unit, Department of Sociology, Faculty of Humanities and Social Sciences, I. Lučića 3,

10000 Zagreb, Croatia; e-mail: astulhof@ffzg.hr

48. Amount of spontaneity in your sex life

49. Extent of control you feel during/after sexual activity

50. Extent to which you engage in sexual activities that you dislike but your partner enjoys

51. Extent to which you engage in sexual activities that you enjoy but your partner dislikes

52. Worry that you or your partner will get a sexually transmitted infection from each other

53. How confident you feel in terms of your ability to please your partner sexually

54. Extent to which you and your partner engage in anal sex/anal play

55. Your partner’s ability to please you sexually

56. Extent to which you think your partner is physically attracted to/sexually desires you

57. Extent to which you are physically attracted to/sexually desire your partner

58. Extent to which you and your partner are sexually compatible (i.e., well matched in terms of your sexual likes/dislikes)

Costs Checklist

This is a list of possible rewards and costs in your sexual relationship. Please indicate whether each item in this list is a cost in your sexual

relationship with your partner or not a cost.

In brief, things that are negative, displeasing, or “too little or too much” are costs.

Note to researcher: The same 58 checklist items are repeated here.

The New Sexual Satisfaction Scale (NSSS; k = 20) was

developed as a universal tool for assessing sexual satis

faction and tested in two cultures (Croatia and the United

States; Štulhofer, Buško, & Brouillard, in press). Unlike

the majority of similar measures, the NSSS is not gender,

sexual orientation, or relationship status specific. Its con

ceptual framework is derived from the sex counseling and

psychotherapy literature and includes the following five

dimensions: (a) sexual sensations, (b) sexual presence/

awareness, (c) sexual exchange, (d) emotional connection/

closeness, and (e) sexual activity. In order to facilitate the

use of the NSSS in clinical and nonclinical studies, a short

version of the scale (NSSS-S; k = 12) was developed. The

NSSS-S demonstrates reliability and validity comparable

to the full-scale instrument.

Description

The NSSS was created within a research project more

broadly focused on the impact of pornography on young

people’s sexual socialization (Štulhofer, Buško, &

Landripet, 2010; Štulhofer et al., 2007). Scale construction and validation were carried out using seven independent samples with over 2,000 participants, aged 18–55 years, in Croatia and the U.S. Of the seven, three were college student samples, two were community samples, one was a clinical sample (sex therapy clients), and the final one was a sample of nonheterosexual Croatian men and women. In all but two samples, online surveying tools were used to collect data. Principal component analysis was carried out on an initial pool of 35 Likert items generated by the proposed five-dimensional conceptual framework. It extracted six components with eigenvalues > 1, which were than rotated to oblique position using the oblimin method. Closer inspection of this structure suggested that a forced twofactor solution would be the best strategy to pursue. The obtained two-factor solution proved stable in both student and adult Croatian and the U.S. samples, among female and male participants, as well as in the nonheterosexual Croatian sample. The first factor was primarily focused on personal experiences and sensations, whereas the second

factor reflected the participant's perception of the partner's

reactions and sexual activity in general. Taking into account

the strong association between the two domains (factor cor

relations ranged from .52 to .61), our findings pointed to a

relatively high homogeneity of the sexual satisfaction con

struct. The selection of items per component was performed

according to standard criteria of simple structure, factor

loadings, and content overlap (redundancy). Respecting

both statistical and content-related characteristics, 20 items

(10 per component) were retained from the initial set. The

two following subscales were created: the Ego-Centered

subscale, which measures sexual satisfaction generated by

personal experiences/sensations, and the Partner/Sexual

Activity-Centered subscale, which measures sexual sat

isfaction derived from an individual's perception of the

partner's sexual behaviors and reactions, and the diversity

and/or frequency of sexual activities. The two subscales

represent the New Sexual Satisfaction Scale (NSSS). The
Short Version of the NSSS (NSSS-S) was created

following a somewhat different procedure. The 20 NSSS

items were first divided into five clusters representing

the initial conceptual dimensions, and then two to three

items per cluster were selected (depending on cluster size)

according to their item-total correlation in the NSSS sub

scales. Additional principal component analysis of the 12

NSSS-S items showed that all items loaded highly (> .59 in

student, and > .58 in community samples) on a single factor

with eigenvalue > 1. In all samples, the NSSS scores ranged
between 20 and

100, and the NSSS-S scores between 12 and 50, covering

the full range. The NSSS, its subscales, and the NSSS-S

scores displayed a characteristic asymmetric distribution

with the mean scores leaning toward more satisfaction. No

differences in sexual satisfaction scores between students

and adults were found. However, Croatian participants

consistently displayed higher sexual satisfaction than the

U.S. participants.

Response Mode and Timing

For each item, respondents are asked to circle the number

that best reflects their satisfaction with a particular aspect of

their sex life in the preceding six months (“Thinking about

your sex life during the last six months, please rate your

satisfaction with the following aspects”). Respondents rate

their level of satisfaction using the following 5-point Likert

type scale: 1 = Not at all Satisfied, 2 = A Little Satisfied, 3

= Moderately Satisfied, 4 = Very Satisfied, 5 = Extremely

Satisfied. Most respondents complete the full scale within

5 minutes.

Scoring

The Ego-Centered subscale (Items 1–10), Partner

and Activity-Centered subscale (Items 11–20), NSSS

(Items 1–20), and NSSS-S (Items 2–3, 5–6, 8, 10–12, 14, 17, 19–20) are computed by summing the related items. Reliability Internal consistency in two student samples (N CRO = 544, M age = 21.3; N US = 356, M age = 20.4), two community samples (N CRO = 729, M age = 34.1; N US = 212, M age = 40.7), and a sample of Croatian nonheterosexual men and women (N = 360, M age = 26.1) was satisfactory for the full scale (α = .94–.96), both subscales (α = .91–.93 and .90–.94, respectively), and the short version (α = .90–.93). No substantial differences related to either gender or sexual orientation were observed. Additional analysis performed on the Croatian student sample dataset showed that the NSSS and NSSS-S internal consistency coefficients were similar in the group of participants currently in a relationship and those who were single (α = .87–.96). This remained the case even after separate analyses were done for men and women. Test-retest reliability of the NSSS and NSSS-S was shown to be satisfactory in a sample of Croatian students (N = 219) over a 1-month period. Stability coefficients ranged from .72 to .84, with somewhat stronger associations reported among women. Validity Both the NSSS and the NSSS-S

were shown to be significantly associated with a global measure of life satisfaction, in the expected direction. Negative correlations with the shortened Sexual Boredom Scale (Watt & Ewing, 1996) scores and positive correlations with relationship intimacy, partner communication about sex, and relationship status were also found to be significant among men and women in both the Croatian and the U.S. student samples. In support of convergent validity, associations between a global (single-item) measure of sexual satisfaction and the NSSS/NSSS-S scores were significant and strong in both samples ($r = .44–.67$). Correlation coefficients were systematically lower in the U.S. sample. There were significant differences in the average NSSS and NSSS-S scores between participants in the clinical sample (sex therapy clients; $N = 54$; M age = 34.6) and nonclinical community sample ($N = 729$; M age = 34.1), t NSSS = −8.64, $df = 709$, $p < .001$; t NSSS-S = −8.74, $df = 735$, $p < .001$. Participants with sexual difficulties systematically reported lower sexual satisfaction. Cohen's d values (ranging from −1.07 to −1.39) suggested that the observed differences are large in size. For example, the overlap between the full NSSS scores in the clinical and nonclinical sample was 32%. Discriminant analysis was carried out to predict membership in the clinical vs. nonclinical community sample. The inclusion criterion in the first group was the persistent or recurrent distressful presence of one or more sexual disorders related to sexual desire, sexual arousal, orgasm, or sexual pain according to the Diagnostic and Statistical

Exhibit

The New Sexual Satisfaction Scale (NSSS)

Subscale A Subscale B (Partner Short Version

(Ego-Focused) and Activity-Focused) (NSSS-S)

Thinking about your sex life during the last six months, please rate your

satisfaction with the following aspects: a

1. The intensity of my sexual arousal X

2. The quality of my orgasms X X

3. My “letting go” and surrender to sexual pleasure during sex X X

4. My focus/concentration during sexual activity X

5. The way I sexually react to my partner X X

6. My body’s sexual functioning X X

7. My emotional opening up in sex X

8. My mood after sexual activity X X

9. The frequency of my orgasms X

10. The pleasure I provide to my partner X X

11. The balance between what I give and receive in sex X X

12. My partner’s emotional opening up during sex X X

13. My partner’s initiation of sexual activity X

14. My partner’s ability to orgasm X X

15. My partner’s surrender to sexual pleasure (“letting go”) X

16. The way my partner takes care of my sexual needs X

17. My partner’s sexual creativity X X

18. My partner’s sexual availability X

19. The variety of my sexual activities X X

20. The frequency of my sexual activity X X

a Responses are anchored on the following scale: 1 = Not at all Satisfied, 2 = A Little Satisfied, 3 = Moderately Satisfied, 4 = Very Satisfied, 5 = Extremely

Satisfied.

Manual of Mental Disorders (DSM-IV-TR) criteria

(American Psychiatric Association, 2000). With the prob

ability of group membership set to equal, the analysis cor

rectly classified a total of 80.3% of cases. In the clinical

group, the procedure correctly classified 64.8% of cases.

Using the NSSS-S as independent variable resulted in only

slightly lower percentages of correct classifications (79.6%

and 63%, respectively).

American Psychiatric Association. (2000). Diagnostic and statistical

manual of mental disorders (text rev.). Washington, DC: Author. Štulhofer, A., Buško, V., & Brouillard, P. (in press). Development and bicultural validation of the New Sexual Satisfaction Scale. The Journal of Sex Research. Štulhofer, A., Buško, V., & Landripet, I. (2010). Pornography, sexual socialization, and satisfaction among young men. Archives of Sexual Behavior, 39, 168–178. Štulhofer, A., Landripet, I., Momčilović, A., Matko, V., Kladarić, P. G., & Buško, V. (2007). Pornography and sexual satisfaction in young women and men. In S. V. Knudsen, L. Lofgren-Martenson, & S. A. Mansson (Eds.), Generation P? Youth, gender and pornography (pp. 66–84). Copenhagen: Danish University Press. Watt, J. D., & Ewing, J. E. (1996). Toward the development and validation of a measure of sexual boredom. The Journal of Sex Research, 33, 57–66.

Self-Concept (also see Female Sexuality)

Exhibit

The Meaning of My Sexual Self

Please circle the number which comes closest to the way you feel about your sexual self.

Good 1 2 3 4 5 6 7 Bad

Sad 7 6 5 4 3 2 1 Happy

Beautiful 1 2 3 4 5 6 7 Ugly

Dirty 7 6 5 4 3 2 1 Clean

Honest 1 2 3 4 5 6 7 Dishonest

Worthless 7 6 5 4 3 2 1 Valuable

Pleasant 1 2 3 4 5 6 7 Unpleasant

Unfair 7 6 5 4 3 2 1 Fair

Healthy 1 2 3 4 5 6 7 Sick

Rigid 7 6 5 4 3 2 1 Flexible

Assertive 1 2 3 4 5 6 7 Submissive

Tense 7 6 5 4 3 2 1 Relaxed

Together 1 2 3 4 5 6 7 Fragmented

Unloved 7 6 5 4 3 2 1 Loved

Involved 1 2 3 4 5 6 7 Uninvolved

Inactive 7 6 5 4 3 2 1 Active

Strong 1 2 3 4 5 6 7 Weak

Subjective 7 6 5 4 3 2 1 Objective

Comments you wish to make about your sexual self:

1 Address correspondence to Lucia F. O'Sullivan, Department of Psychology, 38 Dineen Drive, Keirstead Hall, Rm. 216, University of New Brunswick,

Fredericton, New Brunswick, Canada E3B 5A3; e-mail: osulliv@unb.ca

Sexual Self-Concept Inventory

LUCIA F. O'SULLIVAN, 1 University of New Brunswick

H EINO F. L. MEYER-BAHLBURG, New York State Psychiatric Institute

IAN MCKEAGUE, Columbia University

This measure was designed to assess the gender-specific sexual self-concepts of early adolescent girls based on extensive formative work with ethnically diverse samples. Respondents complete 34 items assessing three dimensions of sexual self-concepts. Details regarding this measure can be found in O'Sullivan, Meyer-Bahlburg, & McKeague (2006).

Description

The Sexual Self-Concept Inventory (SSCI) is a 34-item instrument comprising three scales that are shown to be distinct and reliable dimensions of early adolescent

Exhibit

Sexual Self-Concept Inventory

The questions below are about your views about yourself and other people your age. Please read each statement carefully and then rate

each statement according to how much you agree with it using a number from 1 (Strongly Disagree) to 6 (Strongly Agree). An answer is

correct to the extent it truly reflects how much you agree with it.

1 2 3 4 5 6

Strongly Disagree Strongly Agree

(SEXUAL AROUSABILITY)

___ 1. I sometimes think I'd like to try doing the sexual things my friends are doing with their boyfriends.

___ 2. When I kiss a guy, I get hot.

___ 3. I would really want to touch a boyfriend if we were left alone together.

___ 4. I sometimes want to know how different types of sex feel.

___ 5. If I'm going to see a guy I like, I like to dress sexy.

___ 6. If a guy kisses me, I also want him to touch my body.

___ 7. When I flirt with a guy, I like to feel him up.

___ 8. Sometimes I dress sexy to get attention from guys.

___ 9. If I were to kiss a guy, I'd get really turned on.

___ 10. There are things about sex I want to try.

___ 11. If a boy kisses me, my body feels good.

___ 12. I enjoy talking about sex or talking sexy with boys I know really well.

___ 13. If I were kissing and touching a guy, I would get hyped, real excited.

___ 14. I enjoy talking about sex with my girl friends.

___ 15. It's okay to feel up on a guy.

___ 16. I like it when a guy tells me I look good.

___ 17. I think I'm ready to have sex.

(SEXUAL AGENCY)

___ 1. Girls always wonder what sex is going to be like

the first time.

___ 2. I sometimes think about who I would want to have sex with.

___ 3. When I decide to have sex with a guy, it will be because I wanted to have sex and not because he really wanted me to have sex with him.

___ 4. Girls sometimes have sex because they're curious and want to see what it's like.

___ 5. Sex is best with a guy you love.

___ 6. I like to let a guy know when I like him.

___ 7. If I have sex, my friends will want to know all about it.

___ 8. If I had sex with a guy, I would be running the risk of being played (taken advantage of).

___ 9. Flirting is fun and I am good at it.

___ 10. If I have sex with a guy, I would worry that I could get my feelings really hurt.

(NEGATIVE SEXUAL AFFECT)

___ 1. If I kiss a guy I don't really know, I'm afraid of what people will think about me.

___ 2. Sex is nasty.

___ 3. Sex isn't fun for girls my age.

___ 4. I would be scared to be really alone with a boyfriend.

___ 5. Some girls have sex just to be accepted or popular.

___ 6. I think I am too young to have sex.

___ 7. If I have sex, my friends will want to know all about it.

Rosenthal, D., Moore, S., & Flynn, I. (1991). Adolescent self-efficacy, self-esteem and sexual risk-taking. Journal of Community and Applied Social Psychology, 1, 77-88.

Treboux, D., & Busch-Rossnagel, N. A. (1990). Social network influences on adolescent sexual attitudes and behavior. Journal of Adolescent Research, 5, 175–189.
Unger, J. B., Molina, G. B., & Teran, L. (2000). Perceived consequences of teenage childbearing among adolescent girls in an urban sample. Journal of Adolescent Health, 26, 205–212. Multidimensional Sexual Self-Concept Questionnaire WILLIAM E. SNELL, JR., 1 Southeast Missouri State University The Multidimensional Sexual Self-Concept Questionnaire (MSSCQ; Snell, 1995) is an objective self-report instrument designed to measure the following 20 psychological aspects of human sexuality: (1) sexual anxiety, defined as the tendency to feel tension, discomfort, and anxiety about the sexual aspects of one's life; (2) sexual self-efficacy, defined as the belief that one has the ability to deal effectively with the sexual aspects of oneself; (3) sexual consciousness, defined as the tendency to think and reflect about the nature of one's own sexuality; (4) motivation to avoid risky sex, defined as the motivation and desire to avoid unhealthy patterns of risky sexual behaviors (e.g., unprotected sexual behavior); (5) chance/luck sexual control, defined as the belief that the sexual aspects of one's life are determined by chance and luck considerations; (6) sexual preoccupation, defined as the tendency to think about sex to an excessive degree; (7) sexual assertiveness, defined as the tendency to be assertive about the sexual aspects of one's life; (8) sexual optimism, defined as the expectation that the sexual aspects of one's life will be positive and rewarding in the future; (9) sexual problem self-blame, defined as the tendency to blame oneself when the sexual aspects of one's life are unhealthy, negative, or undesirable in nature; (10) sexual monitoring, defined as the tendency to be aware of the public impression which one's sexuality makes on others; (11) sexual motivation, defined as the motivation and desire to be involved in a sexual relationship; (12) sexual problem management, defined as the tendency to believe that one has the capacity/skills to effectively manage and handle any sexual problems that one might develop or encounter; (13) sexual esteem, defined as a generalized tendency to positively evaluate one's own capacity to engage in healthy sexual behaviors and to experience one's sexuality in a satisfying and enjoyable way; (14) sexual satisfaction, defined as the tendency to be highly satisfied with the sexual aspects of one's life; (15) power-other sexual control, defined as the belief that the sexual aspects of one's life are controlled by others who are more powerful and influential than oneself; (16) sexual self-schemata, defined as a cognitive framework

that organizes and guides the processing of information about the sexual-related aspects of oneself; (17) fear of sex, defined as a fear of engaging in sexual relations with another individual; (18) sexual problem prevention, defined as the belief that one has the ability to prevent oneself from developing any sexual problems or disorders; (19) sexual depression, defined as the experience of feelings of sadness, unhappiness, and depression regarding one's sex life; and (20) internal sexual control, defined as the belief that the sexual aspects of one's life are determined by one's own personal control. The MSSCQ (Snell, 1995) was based on previous work by Snell and Papini (1989), Snell, Fisher, and Schuh (1992), Snell, Fisher, and Miller (1991), and Snell, Fisher, and Walters (1993). Scores on the MSSCQ can be treated as individual difference measures of the 20 sexuality-related constructs measured by this instrument or as dependent variables when examining predictive correlates of these concepts. Description The MSSCQ consists of 100 items arranged in a format in which respondents indicate how characteristic of them each statement is. A 5-point Likert-type scale is used to collect data on peoples' responses, with each item scored from 0 to 4: not at all characteristic of me (0), slightly characteristic of me (1), somewhat characteristic of me (2), moderately characteristic of me (3), and very characteristic of me (4). In order to create subscale scores (discussed below), the items on each subscale are averaged. Higher scores thus correspond to greater amounts of the relevant MSSCQ tendency. Response Mode and Timing People respond to the 100 items on the MSSCQ by marking their answers on separate machine-scoreable answer sheets. In most instances, the scale usually requires about 45–60 minutes to complete. Scoring After several items are reverse coded (Items 27, 47, 68, 77, 88, and 97, designated with an R), the relevant items on each subscale are then coded so that A = 0; B = 1; C = 2; D = 3; and E = 4. Next, the items on each subscale are averaged, so that higher scores correspond to greater amounts of each tendency. Scores on the 20 subscales can thus range from 0 to 4. The items on the MSSCQ subscales alternate in ascending numerical order for each subscale (e.g., Subscale 1 consists of Items 1, 21, 41, 61, and 81; Subscale 2 consists of Items 2, 22, 42, 62, and 82). Reliability The internal consistency of the 20 subscales on the MSSCQ was determined by calculating Cronbach alpha coefficients, using 473 participants (302 females; 170 1 Address correspondence to William E. Snell, Jr., Department of Psychology, One University Plaza, Southeast Missouri State University, Cape Girardeau, MO 63701; e-mail: wesnell@semo.edu

males; 1 gender unspecified) drawn from lower division psychology courses at a small midwestern university (Snell, 1995). Most of the sample (85%) was between 16 and 25 years of age. Based on five items per subscale, the alphas for all subjects on the 20 subscales were: .84, .85, .78, .72,

.88, .94, .84, .78, .84, .84, .89, .84, .88, .91, .85, .87, .85, .85,

.85, and .76 (respectively). In brief, the 20 MSSC subscales have more than adequate internal consistency.

Validity

Evidence for the validity of the MSSCQ comes from a research investigation in which Snell (1995) found that among university students, the MSSCQ subscales were related in predictable ways to men's and women's contra ceptive use. Among males, a history of reliable, effective contraception was negatively associated with (1) sexual anxiety, (5) chance/luck sexual control, (17) sexual fear, and (19) sexual depression; and positively associated with (2) sexual self-efficacy, (8) sexual optimism, (11) sexual motivation, (13) sexual esteem, (14) sexual satisfaction, and (16) sexual self-schemata. By contrast, among females, long-term effective contraception use was negatively asso ciated with (17) sexual fear, (19) sexual depression, and (20) internal sexual control; and positively associated with (2) sexual self-efficacy, (7) sexual assertiveness,

(11)

sexual motivation, (14) sexual satisfaction, and (16) sexual

Exhibit

Multidimensional Sexual Self-Concept Questionnaire

Instructions: The items in this questionnaire refer to people's sexuality. Please read each item carefully and decide to what extent it is

characteristic of you. Give each item a rating of how much it applies to you by using the following scale:

A = Not at all characteristic of me.

B = Slightly characteristic of me.

C = Somewhat characteristic of me.

D = Moderately characteristic of me.

E = Very characteristic of me.

Note: Remember to respond to all items, even if you are not completely sure. Your answers will be kept in the strictest confidence.

Also, please be honest in responding to these statements.

1. I feel anxious when I think about the sexual aspects of my life.

2. I have the ability to take care of any sexual needs and desires that I may have.

3. I am very aware of my sexual feelings and needs.

4. I am motivated to avoid engaging in "risky" (i.e., unprotected) sexual behavior.

5. The sexual aspects of my life are determined mostly by chance happenings.

6. I think about sex "all the time."

7. I'm very assertive about the sexual aspects of my life.

8. I expect that the sexual aspects of my life will be

positive and rewarding in the future.

9. I would be to blame if the sexual aspects of my life were not going very well.

10. I notice how others perceive and react to the sexual aspects of my life.

11. I’m motivated to be sexually active.

Self-Disclosure and Deception

Exhibit

Sexual Self-Disclosure Scale

Instructions: The following describe different situations in which people may or may not wish to discuss sexual matters. Imagine yourself

in each of the situations listed below and circle that number which best shows how easy or difficult it would be for you to reveal sexual

information in that situation. Use the key below as a guide for making your answer.

Key 1 Extremely easy 4 Somewhat difficult

2 Moderately easy 5 Moderately difficult

3 Somewhat easy 6 Extremely difficult

1. If you were asked to complete an anonymous questionnaire containing personal questions on sexuality, the answers to which

you had been told would never be publicly associated with you personally, how easy or diffi cult would this be in the following

situation:

a. In the privacy of your own home, with no one else present. a

b. During a large (25 or more people) group meeting, where most others are also fi lling-out the questionnaire.

2. If you were asked personal sexual questions in a private face-to-face situation (for instance, only you and an interviewer), the

answers to which you had been told would never be revealed, how much diffi culty or ease would you have in doing this in the

following situations:

a. With a young (20–30 years) female interviewer

b. With a young (20-30 years) male interviewer

c. With an older (50 years and older) female interviewer

d. With an older (50 years and older) male interviewer

e. With a young (25-35 years) female medical doctor

f. With a young (25-35 years) male medical doctor

g. With an older (50+ years) female medical doctor

h. With an older (50+ years) male medical doctor

3. How difficult or easy would it be for you to discuss a personal sexual problem or difficulty in the following situation (assume you are

in private circumstances)?

a. With a close female friend

b. With a close male friend

c. With a spouse or sexual partner

d. With a personal physician

e. With a specialist in sexual problems

4. How easy or difficult would it be for you to openly discuss your sex life and history in a group of three to five people who are:

a. Both female and male (mixed company) that you have known only briefly

b. All members of your own sex that you have known only briefly

5. How easy or diffi cult would it be for you to discuss a personal sexual problem or diffi culty with your parents, or if your parents

are deceased how easy or diffi cult would it have been to discuss such with them? (answer for both parents separately below):

a. With your mother

b. With your father

Sexual Self-Disclosure Scale—Short Form

1. Do you think that talking about sex in an AIDS survey is . . .

Very easy

Kind of easy

Kind of hard or

Very hard

Declined to answer

Don’t know b

2. How easy or hard would it be to fill out an anonymous questionnaire that asked questions about your sexual behavior in the privacy

of your own home with no one else present? Would it be . . .

3. How easy or hard would it be for you to fill out an anonymous questionnaire that asked questions about your sexual behavior in the

waiting room of a medical clinic with other patients present, who could not see what you were writing? Would it be . . .

4. How easy or hard would it be for you to answer questions about your sexual behavior if they were asked by a medical doctor in the privacy of his/her own office? Would it be . . .

5. How easy or hard would it be to answer questions about your sexual behavior if they were asked by a marriage counselor in the privacy of his/her office? Would it be . . .

6. How easy would it be for you to discuss a sexual problem (read each)

With a good friend? Would it be . . .

7. With a spouse or sexual partner? Would it be . . .

a The 1-6 scale is repeated after each item.

Exhibit

Sexual Self-Disclosure Scale

You are to read each item in the next section of the questionnaire and then indicate the extent that you have talked about that item

to each person (i.e., the extent to which you have made your attitudes and/or behaviours known to that person). Use the rating scale

below to describe the extent that you have talked about each item.

The rating scale is:

(1) Have told the person nothing about this aspect of me.

(2) Have talked only in general terms about this item.

(3) Have talked in some detail about this item but have not fully discussed my own attitudes or behaviors.

(4) Have talked in complete detail about this item to the other person. He or she knows me fully in this respect.

Choose one number in the row which corresponds to the amount of your disclosure. For example, if you have talked in general terms to

your mother about your attitudes and/or behaviors regarding masturbation, you would place a 2 in column 6 of the computer card.

Items: Disclosure to mother No Only General Some Complete

Disclosure Terms Detail Detail

1. My personal views on sexual morality. 1 2 3 4

2. Premarital sexual intercourse. 1 2 3 4

3. Oral sex. 1 2 3 4

4. Masturbation. 1 2 3 4

5. My sexual thoughts or fantasies. 1 2 3 4

6. Sexual techniques I find or would find pleasurable. 1 2 3 4

7. Use of contraception. 1 2 3 4

8. Sexual problems or diffi culties I might have. 1 2 3 4

Sexual Deception Scale

WILLIAM D. MARELICH 1 AND RHONA I. SLAUGHTER, California State University, Fullerton

1 Address correspondence to William D. Marelich, Dept. of Psychology, CSU Fullerton, 800 N. State College Blvd., Fullerton, CA 92834; e-mail:

wmarelich@fullerton.edu

The Sexual Deception Scale is designed to measure the use

of sexual deception in intimate relationships by specifically

focusing on the lies and deceptive practices individuals use

in order to engage in sexual activity with a current or pro

spective partner. The scale is designed for use with general

or college populations for research on intimate and close

relationships.

Description

In accordance with social exchange theory (Thibaut

& Kelley, 1959), the scale addresses the use of sexually deceptive practices in order to gain and/or maintain specific resources. In some cases, the rewards are sexual in nature (e.g., when one partner deliberately lies in order to have sexual intercourse with another partner). Likewise, the use of deception may occur when an individual uses sexual intimacy as a cost in order to maintain an existing resource (e.g., providing sexual services in order to maintain the relationship). The instrument consists of a 15-item questionnaire in a forced-choice, dichotomous format. Participants indicate

Yes or No to having ever engaged in a particular act or behavior. The measure consists of three subscales that reflect the different types of lies or deceptions used by individuals: blatant lies, self-serving lies, and lies told to avoid confrontation. Items that address blatant lying tactics involve the individual's use of deception to gain access to sexual activity. The use of deception for self-serving purposes employs the practice of engaging in sexual behavior in order to gain specific resources such as material items or companionship. Finally, items that address the use of deception to avoid confrontation signify the individual's willingness to engage in sexual behaviors to avoid conflict. Response Mode and Timing Respondents answer Yes or No to each item based on

whether they have ever participated in the act/behavior.

The instrument can be administered by traditional paper

and-pencil method or by utilizing online data collection

techniques. The measure takes 5 minutes to complete.

Scoring

The Sexual Deception Scale comprises three subscales

(Blatant Lying, Self-Serving, Avoiding Confrontation).

No total score is available, although a second-order factor

analysis (see Marelich, Lundquist, Painter, & Mechanic,

2008) suggests that a total score measure may be viable.

The Blatant Lying subscale consists of Items 1, 2, 9, 11,

12, 13, and 15. The Self-Serving subscale consists of Items

4, 7, and 8. The Avoiding Confrontation subscale con

sists of Items 3, 5, 6, 10, and 14. According to Marelich

et al. (2008), each item is assigned the value of 1 for a Yes

response and 2 for a No response. To obtain a score for each

individual subscale:

1. Reverse code all scale items (0 = No, 1 = Yes).

2. Sum the items of the particular subscale.

3. Divide by the number of items in that particular subscale.

Scores yielded for each subscale indicate the amount of

deception used; higher scores signify the greater use of

sexually deceptive practices.

Reliability

Principal components analysis was utilized, and an oblique

Exhibit

Sexual Deception Scale

Directions: Below are a number of items addressing things you may or may not have done sometime in your life. Please answer each item

Yes or No. “Sex” below can refer to intercourse or other forms of sexual intimacy (e.g., oral sex, manual stimulation).

Have you ever . . .

1. Told someone “I love you” but really didn’t just to have sex with them?

Yes _____ No_____

2. Told someone “I care for you” just to have sex with them?

Yes _____ No_____

3. Had sex with someone so they would leave you alone?

Yes _____ No_____

4. Had sex with someone so you would have someone to sleep next to?

Yes _____ No_____

5. Had sex with someone even though you didn’t want to?

Yes _____ No_____

6. Had sex with someone in order to maintain your relationship with them?

Yes _____ No_____

7. Had sex with someone in order to maintain resources you get from them (e.g., money, clothes, companionship)?

Yes _____ No_____

8. Had sex with someone in order to get resources from them (e.g., money, clothes, companionship)?

Yes _____ No_____

9. Had sex with someone just so you could tell your friends about it?

Yes _____ No_____

10. Had sex with someone so they wouldn't break up with you?

Yes _____ No_____

11. Gotten a partner really drunk or stoned in order to have sex with them?

Yes _____ No_____

12. Told someone they'd be your boyfriend/girlfriend just so they would have sex with you?

Yes _____ No_____

13. Had sex with someone, then never returned their calls after that?

Yes _____ No_____

14. Had sex with someone because you wanted to please them?

Yes _____ No_____

15. Faked "who you are" in order to have sex with somebody?

Yes _____ No_____

Sexual Self-Disclosure Scale

WILLIAM E. SNELL, JR., 1 Southeast Missouri State University

The literature on human sexuality emphasizes the need for people to discuss the sexual aspects of themselves with others. Snell, Belk, Papini, and Clark (1989) examined women's and men's willingness to discuss a variety of sexual topics with parents and friends by developing an objective self-report instrument, the Sexual Self-Disclosure Scale (SSDS). The first version of the SSDS consists of 12 subscales that measure the following sexual topics (Snell & Belk, 1987): sexual behavior, sexual sensations, sexual fantasies, sexual attitudes, the meaning of sex, negative sexual affect, positive sexual affect, sexual concerns, birth control, sexual responsibility, sexual dishonesty, and rape. In another study reported by Snell et al. (1989), women's and men's willingness to discuss a variety of sexual topics with an intimate partner was examined by extending the SSDS to include a greater variety of sexual topics. The Revised Sexual Self-Disclosure Scale (SSDS-R) consists of 24 three-item subscales measuring people's willingness to discuss the following sexual topics with an intimate partner (reported in Study 3 by Snell et al., 1989): sexual behaviors, sexual sensations, sexual fantasies, sexual preferences, meaning of sex, sexual accountability, distressing

and pregnancy, homosexuality, rape, AIDS, sexual moral

ity, sexual satisfaction, sexual guilt, sexual calmness, sexual

depression, sexual jealousy, sexual apathy, sexual anxiety,

sexual happiness, sexual anger, and sexual fear.

Description

The initial version of the SSDS consists of 120 items that

form 12 separate five-item subscales for each of two dis

closure targets (male and female therapists). To respond to

this version of the SSDS, individuals are asked to indicate

how willing they would be to discuss the SSDS sexual top

ics with the disclosure targets. A 5-point Likert-type scale

(scored 0 to 4) is used to measure the responses: (0) I am not

at all willing to discuss this topic with this person, (1) I am

slightly willing to discuss this topic with this person, (2) I

am moderately willing to discuss this topic with this person,

(3) I am almost totally willing to discuss this topic with this

person, and (4) I am totally willing to discuss this topic with

this person. Subscale scores are created for each disclosure

target person by summing the 5 items on each subscale.

Higher scores thus indicate greater willingness to disclose a

particular SSDS sexual topic with a particular person. The SSDS-R used by Snell et al. (1989) consists of 72

items that form 24 three-item subscales for the disclosure target (i.e., an intimate partner). In responding to the SSDSR, individuals are asked to indicate how much they are willing to discuss the SSDS-R topics with an intimate partner. A 5-point Likert-type scale is used to collected data on the subjects' responses, with each item being scored from 0 to 4: (0) I would not be willing to discuss this topic with an intimate partner, (1) I would be slightly willing to discuss this topic with an intimate partner, (2) I would be moderately willing to discuss this topic with an intimate partner, (3) I would be mostly willing to discuss this topic with an intimate partner, and (4) I would be completely willing to discuss this topic with an intimate partner. In order to create SSDS-R subscale scores, the three items on each subscale are summed (no items are reverse scored). Higher scores thus correspond to greater willingness to discuss the SSDS-R sexual topics with an intimate partner. The sample version of the SSDS-R in the exhibit is an example of how the SSDS-R may be modified for use with different target persons (e.g., mother, father, best female friend, best male friend). Response Mode and Timing Respondents indicate their responses typically on a computer scan sheet by darkening in a response from A to E. Alternatively, responses to the SSDS can be written directly on the questionnaire itself. Usually, 20–30 minutes are needed to complete the SSDS. Scoring The SSDS consists of 12 subscales, each containing five separate items. The labels and items for each of these subscales are: (a) Sexual Behavior (Items 1, 13, 25, 37, 49); (b) Sexual Sensations (Items 2, 14, 26, 38, 50); (c) Sexual Fantasies (Items 3, 15, 27, 39, 51); (d) Sexual Attitudes (Items 4, 16, 28, 40, 52); (e) Meaning of Sex (Items 5, 17, 29, 41, 53); (f) Negative Sexual Affect (Items 6, 18, 30, 42, 54); (g) Positive Sexual Affect (Items 7, 19, 31, 43, 55); (h) Sexual Concerns (Items 8, 20, 32, 44, 56); (i) Birth Control (Items 9, 21, 33, 45, 57); (j) Sexual Responsibility (Items 10, 22, 34, 46, 58); (k) Sexual Dishonesty (Items 11, 23, 35, 47, 59); and (l) Rape (Items 12, 24, 36, 48, 60). The items are coded so that A = 0; B = 1; C = 2; D = 3; and E = 4. The five items on each subscale are then summed, so that higher scores correspond to greater sexual self-disclosure. The SSDS-R consists of 24 subscales, each containing three separate items: (a) Sexual Behaviors (Items 1, 5, 9); 1 Address all correspondence to William E. Snell, Jr., Department of Psychology, Southeast Missouri State University, One University Plaza, Cape Girardeau, MO 63701; e-mail: wesnell@semo.edu

(b) Sexual Sensations (Items 2, 6, 10); (c) Sexual Fantasies

Meaning of Sex (Items 13, 18, 23); (f) Sexual Accountability

(Items 14, 19, 24); (g) Distressing Sex (Items 15, 20, 25);

(h) Sexual Dishonesty (Items 16, 21, 26); (i) Sexual Delay

(Items 28, 33, 38); (k) Homosexuality (Items 29, 34, 39);

(l) Rape (Items 30, 35, 40); (m) AIDS (Items 31, 36, 41); (n)

Sexual Morality (Items 32, 37, 42); (o) Sexual Satisfaction

(Items 43, 53, 63); (p) Sexual Guilt (Items 44, 54, 64); (q)

Sexual Calmness (Items 45, 55, 65); (r) Sexual Depression

(Items 46, 56, 66); (s) Sexual Jealousy (Items 47, 57, 67);

(t) Sexual Apathy (Items 48, 58, 68); (u) Sexual Anxiety

(Items 49, 59, 69); (v) Sexual Happiness (Items 50, 60, 70);

(w) Sexual Anger (Items 51, 61, 71); and (x) Sexual Fear

(Items 52, 62, 72).

Reliability

The internal consistency of the 12 subscales on the original

SSDS was determined by calculating Cronbach alpha coef

ficients. These alphas ranged from a low of .83 to a high of

.93 (average = .90) for the female therapist, and from a low

Exhibit

Sexual Self-Disclosure Scale

Instructions: This survey is concerned with the extent to which you have discussed the following 60 topics about sexuality with several

different people. Listed below you will notice four columns a which represent the following individuals: (A) your

mother, (B) your father,

(C) your best male friend, and (D) your best female friend. For each of these people, indicate how much you have discussed these topics

with them. Use the following scale for your responses:

Have not Have slightly Have moderately Have mostly Have fully

discussed discussed discussed discussed discussed

this topic: this topic: this topic: this topic: this topic:

(A) with your mother.

(B) with your father.

(C) with your best male friend.

(D) with your best female friend.

1. My past sexual experiences

2. The things that sexually arouse me

3. My imaginary sexual encounters

4. The sexual behaviors which I think people ought to exhibit

5. What sex means to me

6. How guilty I feel about sex

7. How satisfied I feel about the sexual aspects of my life

8. Times when sex was distressing for me

9. What I think about birth control

10. My private notion of sexual responsibility

11. The times I have faked orgasm

12. My private views about rape 13. The types of sexual behaviors I’ve engaged in 14. The sexual activities that “feel good” to me 15. My private sexual fantasies 16. What I consider “proper” sexual behaviors 17. What it

means to me to make love together with someone 18. How anxious I feel about my sex life 19. How content I feel about the sexual aspects of my life 20. Times when I had undesired sex 21. How I feel about abortions 22. The responsibility one ought to assume for one's sexuality 23. The times I have pretended to enjoy sex 24. The "truths and falsehoods" about rape 25. The number of times I have had sex 26. The behaviors that are sexually exciting to me 27. My sexually exciting imaginary thoughts 28. The sexual conduct that people ought to exhibit 29. What I think and feel about having sex with someone 30. How depressed I feel about my own sexuality 31. How happy I feel about my sexuality 32. Times when I was pressured to have sex 33. How I feel about pregnancy 34. My own ideas about sexual accountability 35. The times I have lied about sexual matters 36. What women and men really feel about rape 37. The sexual positions I've tried 38. The sensations that are sexually arousing to me 39. My "juicy" sexual thoughts 40. My attitudes about sexual behaviors 41. The meaning that sexual intercourse has for me 42. How frustrated I feel about my sex life 43. How much joy that sex gives me 44. The aspects of sex that bother me 45. My private beliefs about pregnancy prevention 46. The idea of having to answer for one's sexual conduct 47. What I think about sexual disloyalty 48. Women's and men's reactions to rape 49. The places and times-of-day when I've had sex 50. The types of sexual foreplay that feel arousing to me 51. The sexual episodes that I daydream about 52. My personal beliefs about sexual morality 53. The importance that I attach to making love with someone 54. How angry I feel about the sexual aspect of my life 55. How enjoyable I feel about my sexuality 56. Times when I wanted to leave a sexual encounter 57. The pregnancy precautions that people ought to take 58. The notion one is answerable for one's sexual behaviors 59. How I feel about sexual honesty 60. Women's and men's reactions to rape Revised Sexual Self-Disclosure Scale (illustrated for the "intimate partner" target only) Instructions: This survey is concerned with the extent to which you have discussed the following topics about sexuality with an intimate partner. To respond, indicate how much you have discussed these topics with an intimate partner. Use the following scale for your responses: b 1. My past sexual experiences 2. The kinds of touching that sexually arouse me

3. My private sexual fantasies

5. The types of sexual behaviors I have engaged in

6. The sensations that are sexually exciting to me

7. My “juicy” sexual thoughts

8. What I would desire in a sexual encounter

9. The sexual positions I have tried

10. The types of sexual foreplay that feel arousing to me

11. The sexual episodes that I daydream about

12. The things I enjoy most about sex

13. What sex in an intimate relationship means to me

14. My private beliefs about sexual responsibility

15. Times when sex was distressing for me

16. The times I have pretended to enjoy sex

17. Times when I prefer to refrain from sexual activity

18. What it means to me to have sex with my partner

19. My own ideas about sexual accountability

20. Times when I was pressured to have sex

21. The times I have lied about sexual matters

22. The times when I might not want to have sex

23. What I think and feel about having sex with my partner

24. The notion that one is accountable for one’s sexual behaviors

25. The aspects of sex that bother me

26. How I would feel about sexual dishonesty

27. My ideas about not having sex unless I want to

28. How I feel about abortions

29. My personal views about homosexuals

30. My own ideas about why rapes occur

31. My personal views about people with AIDS
32. What I consider “proper” sexual behavior
33. My beliefs about pregnancy prevention
34. Opinions I have about homosexual relationships
35. What I really feel about rape
36. Concerns that I have about the disease AIDS
37. The sexual behaviors that I consider appropriate
38. How I feel about pregnancy at this time
39. My reactions to working with a homosexual
40. My reactions to rape
41. My feelings about working with someone who has AIDS
42. My personal beliefs about sexual morality
43. How satisfied I feel about the sexual aspects of my life
44. How guilty I feel about the sexual aspects of my life
45. How calm I feel about the sexual aspects of my life
46. How depressed I feel about the sexual aspects of my life
47. How jealous I feel about the sexual aspects of my life
48. How apathetic I feel about the sexual aspects of my life
49. How anxious I feel about the sexual aspects of my life
50. How happy I feel about the sexual aspects of my life
51. How angry I feel about the sexual aspects of my life
52. How afraid I feel about the sexual aspects of my life
53. How pleased I feel about the sexual aspects of my life
54. How shameful I feel about the sexual aspects of my life
55. How serene I feel about the sexual aspects of my life

56. How sad I feel about the sexual aspects of my life

57. How possessive I feel about the sexual aspects of my life

58. How indifferent I feel about the sexual aspects of my life

59. How troubled I feel about the sexual aspects of my life

Self-Efficacy

Exhibit

Sexual Self-Efficacy Scale for Female Functioning

The attached form lists sexual activities that women engage in.

For women respondents only:

Under column I (Can Do), check (3) the activities you think you could do if you were asked to do them today. For only those

activities you checked in column I, rate your degree of confidence that you could do them by selecting a number from 10 to 100 using

the scale given below. Write this number in column II (Confidence).

For partners only:

Under column I (Can Do), check (3) the activities you think your female partner could do if she were asked to do them today. For

only those activities you checked in column I, rate your degree of confidence that your female partner could do them by selecting a

number from 10 to 100 using the scale given below. Write this number in column II (Confidence).

10 20 30 40 50 60 70 80 90
100

Quite Moderately Quite

Uncertain Certain Certain

If you think your partner is not able to do a particular activity, leave columns I and II blank for that activity.

I II

10 20 30 40 50 60 70 80 90 100 Check
if Rate

Quite Moderately Quite Female Confidence

Uncertain Certain Certain Can Do 10-100

1. Anticipate (think about) having intercourse without fear or anxiety.

2. Feel comfortable being nude with the partner.

3. Feel comfortable with your body.

4. In general, feel good about your ability to respond sexually.

5. Be interested in sex.

6. Feel sexual desire for the partner.

7. Feel sexually desirable to the partner.

8. Initiate an exchange of affection without feeling obliged to have sexual relations.

9. Initiate sexual activities.

10. Refuse a sexual advance by the partner.

11. Cope with the partner’s refusal of your sexual advance.

12. Ask the partner to provide the type and amount of sexual stimulation needed.

13. Provide the partner with the type and amount of sexual stimulation requested.

14. Deal with discrepancies in sexual preference between you and your partner.

15. Enjoy an exchange of affection without having sexual relations.

16. Enjoy a sexual encounter with a partner without having intercourse.

17. Enjoy having your body caressed by the partner (excluding genitals and breasts).

18. Enjoy having your genitals caressed by the partner.

19. Enjoy having your breasts caressed by the partner.

20. Enjoy caressing the partner’s body (excluding genitals).

21. Enjoy caressing the partner’s genitals.

22. Enjoy intercourse.

23. Enjoy a lovemaking encounter in which you do not reach orgasm.

24. Feel sexually aroused in response to erotica (pictures, books, films, etc.).

25. Become sexually aroused by masturbating when alone.

26. Become sexually aroused during foreplay when both partners are clothed.

27. Become sexually aroused during foreplay when both partners are nude.

28. Maintain sexual arousal throughout a sexual encounter.

29. Become sufficiently lubricated to engage in intercourse.

30. Engage in intercourse without pain or discomfort.

31. Have an orgasm while masturbating when alone.

32. Have an orgasm while the partner stimulates you by means other than intercourse.

33. Have an orgasm during intercourse with concurrent stimulation of the clitoris.

34. Have an orgasm during intercourse without concurrent stimulation of the clitoris.

35. Stimulate a partner to orgasm by means other than intercourse.

36. Stimulate a partner to orgasm by means of intercourse.

37. Reach orgasm within a reasonable period of time.

Lesbian, Gay, and Bisexual Affi rmative Counseling

Self-Effi cacy Inventory

FRANK R. DILLON, Florida International University

ROGER L. WORTHINGTON, 1 University of Missouri

1 Address correspondence to Roger L. Worthington, 217 Jesse Hall, University of Missouri, Columbia, MO 65211; e-mail: WorthingtonR@missouri.edu

LGB-affirmative psychotherapy is defined as “therapy that celebrates and advocates the authenticity and integ rity of lesbian, gay and bisexual persons and their relation ships” (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000, p. 328). Theoretical tenets of social cognitive theory (Bandura, 1986) were applied to LGB-affirmative psycho therapist training to better delineate ways to train psycho therapists in LGB-affirmative practices (Bieschke, Eberz, Bard, & Croteau, 1998). Exposure of psychotherapists and trainees to four sources of self-efficacy (performance accomplishments, vicarious learning, verbal reinforce ment, and physiological states/reactions) is posited to fos ter increases in LGB-affirmative counselor self-efficacy. An optimal level of LGB-affirmative counseling self-effi cacy may serve as a mechanism for implementing LGB affirmative counseling behaviors and positive therapeutic outcomes, as well as for promoting psychotherapists’ inter est in LGB-affirmative psychotherapy.

The Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory (LGB-CSI) measures participants’ self-efficacy to perform LGB-affirmative counseling behaviors. LGB-affirmative counseling behaviors include

(a) advocacy skills: identifying and utilizing community

resources that are supportive of LGB clients' concerns; (b)

application of knowledge: counseling LGB clients through

unique issues using knowledge of LGB issues in psychol

ogy; (c) awareness: maintaining awareness of attitudes

toward one's own and others' sexual identity development;

(d) assessment: assessing relevant issues and problems of LGB clients; and (e) relationship: building a working alliance with LGB clients. An optimal level of self-efficacy is one that slightly exceeds one's ability. Successful performance requires both high efficacy beliefs and acquisition of knowledge and skills (Bandura, 1986). Description The LGB-CSI consists of 32 items. Each item represents an LGB-affirmative counseling behavior. Higher scores are indicative of higher levels of self-efficacy to counsel gay, lesbian, and/or bisexual clients. The scale is intended for mental health professionals (e.g., psychologists, social workers, counselors) ranging in professional background and level of experience. The development and validation of the LGB-CSI included five studies. In Study 1, item development procedures and an exploratory factor analysis of an initial item pool were conducted. Item development involved investigating LGB-affirmative counseling competencies. First, literature was reviewed to determine the competencies. Five categories were hypothesized to represent the current conceptualization of LGB-affirmative counseling: (a) application of knowledge of LGB issues and the counseling behaviors reliant on a priori understanding of LGB issues, including: the impacts of race, ethnicity, gender, religion, locale, and other cultural variables on sexual identity development; internalized homophobia/ heterosexism and biphobia; anti-LGB violence; causality

questions; career issues; interpersonal isolation/margin

ality; relationship issues; LGB family issues; impact of

aging; HIV/AIDS; substance abuse; domestic violence;

sexual abuse; sexual identity theory; exploration of sexual

identity and management; (b) advocacy skills; (c) aware

ness of one's own and others' sexual identity development; (d) development of a working relationship with an LGB client; (e) assessment of the relevant issues and problems of an LGB client. Items were generated for each issue after a thorough review of the literature. A pool of 101 items was developed on the basis of the preliminary framework. The item pool included counseling behaviors that go beyond simple microskills to reflect the complexity of behaviors needed for effective LGB-affirmative counseling. Three counseling psychologists and two doctoral-level graduate students (one self-identified gay male, one self-identified bisexual male, two self-identified lesbian women, and one self-identified heterosexual woman), each of whom had extensive experience in the practice of LGB-affirmative and/or multicultural counseling and research, assessed the content validity of the 101 items. The experts were asked to examine the items to (a) determine whether they were reflective of the critical issues that were gleaned from the literature, (b) ensure coverage of the content domains, (c) eliminate unnecessary items, (d) revise any confusing items, and (e) provide general feedback that would assist in developing items representative of LGB-affirmative coun seling. The experts rated each item on content appropriate ness and clarity by using a 5-point scale that ranged from 1 (Not at all Appropriate or Clear) to 5 (Very Appropriate

or Clear). Items receiving a mean rating between 1 and 3 were reworded or deleted. Revisions to the LGB-CSI were made on the basis of feedback from experts. A principal axis factor extraction analysis (EFA) was performed on the remaining items of the LGB-CSI. A five-factor solution using a promax rotation yielded the most interpretable solution. In Study 2, the factor stability of the initial EFA solution was established via confirmatory factor analyses. Study 3 provided evidence of convergent and discriminant validity of the instrument, as well as internal consistency (described in Reliability section). In Study 4 we assessed the test-retest reliability of the instrument (described in Reliability section), and in Study 5 we investigated the sensitivity of the LGB-CSI to change across professionals and counselor trainees (described in Validity section).

Response Mode and Timing

Participants respond to each item using a 6-point Likert-type scale ranging from 1 (Not at all Confident) to 6 (Extremely Confident). It typically takes a participant 15 minutes to

Exhibit

Lesbian, Gay, and Bisexual Affirmative Counseling Self-Efficacy Inventory

Instructions: Below is a list of activities regarding counseling/psychotherapy. Indicate your confidence in your

current ability to perform

each activity by marking the appropriate answer below each question ranging from Not at all Confident to Extremely Confident.

Please answer each item based on how you feel now, not on your anticipated (or previous) ability. I am interested in your actual judg

ments, so please be honest in your responses.

How confident am I in my ability to . . .?

1. Directly apply sexual orientation/identity development theory in my clinical interventions with lesbian, gay, and bisexual (LGB) clients. a

Not at all Confident c c c c c c Extremely Confident

2. Directly apply my knowledge of the coming out process with LGB clients.

3. Identify specific mental health issues associated with the coming out process.

4. Understand the socially constructed nature of categories and identities such as lesbian, bisexual, gay, and heterosexual.

5. Explain the impact of gender role socialization on a client's sexual orientation/identity development.

6. Apply existing American Psychological Association guidelines regarding LGB-affirmative counseling practices.

7. Use current research findings about LGB clients' critical issues in the counseling process.

8. Assist LGB clients to develop effective strategies to deal with heterosexism and homophobia.

9. Evaluate counseling theories for appropriateness in working with an LGB client's presenting concerns.

10. Help a client identify sources of internalized homophobia and/or biphobia.

11. Select affirmative counseling techniques and interventions when working with LGB clients.

12. Assist in the development of coping strategies to help same-sex couples who experience different stages in their individual coming out processes.

13. Facilitate an LGB-affirmative counseling/support group.

14. Recognize when my own potential heterosexist biases may suggest the need to refer an LGB client to an LGB-affirmative counselor.

15. Examine my own sexual orientation/identity development process.

16. Identify the specific areas in which I may need continuing education and supervision regarding LGB issues.

17. Identify my own feelings about my own sexual orientation and how it may influence a client.

18. Recognize my real feelings versus idealized feelings in an effort to be more genuine and empathic with LGB clients.

19. Provide a list of LGB-affirmative community resources, support groups, and social networks to a client.

20. Refer an LGB client to affirmative social services in cases of estrangement from their families of origin.

21. Refer LGB clients to LGB-affirmative legal and social supports.

22. Provide a client with city, state, federal, and institutional ordinances and laws concerning civil rights of LGB individuals.

23. Help a same-sex couple access local LGB-affirmative resources and support.

24. Refer an LGB elderly client to LGB-affirmative living accommodations and other social services.

25. Refer an LGB client with religious concerns to an LGB-affirmative clergy member.

26. Integrate clinical data (e.g., mental status exam, intake assessments, presenting concern) of an LGB client.

27. Complete an assessment for a potentially abusive same-sex relationship in an LGB-affirmative manner.

28. Assess for post-traumatic stress felt by LGB victims of hate crimes based on their sexual orientations/identities.

29. Assess the role of alcohol and drugs on LGB clients' social, interpersonal, and intrapersonal functioning.

30. Establish an atmosphere of mutual trust and affirmation when working with LGB clients.

31. Normalize an LGB client's feelings during different points of the coming out process.

32. Establish a safe space for LGB couples to explore parenting.

a The 6-point scale is repeated after each item.

Sexual Self-Effi cacy Scale—Erectile Functioning

CATHERINE S. FICHTEN, 1 SMBD-Jewish General Hospital

J ILLIAN BUDD, Adaptech Research Network

I LANA SPECTOR, SMBD-Jewish General Hospital

RHONDA AMSEL, McGill University

L AURA CRETI, WILLIAM BRENDER, SALLY BAILES, AND EVA LIBMAN,

SMBD-Jewish General Hospital

The Sexual Self-Efficacy Scale—Erectile Functioning (SSES-E) is a brief self-report measure of the cognitive dimension of erectile functioning and adjustment in men. It evaluates a man's beliefs about his sexual and erectile competence in a variety of situations. The scale may be completed by a man to obtain self-ratings or by his partner to obtain corroboration. Self-efficacy refers to confidence in the belief that one can perform a certain task or behave adequately in a given situation (Bandura, 1982). Sexual

self-efficacy is of great concern to most men and a topic of increasing interest with an aging population.

Description

The SSES-E is a 25-item self-report measure that follows Bandura, Adams, and Beyer's (1977) format. Item content is based on questionnaires by Lobitz and Baker (1979) and Reynolds (1978). Respondents indicate which sexual activities they expect they can complete. For each, they rate their confidence level on a scale ranging from 10 to 100. To obtain both partners' views about the male's self-efficacy beliefs, the SSES-E can be completed by both the male subject and his partner.

Response Mode and Timing

The respondent places a check mark in the "Can Do" column next to each sexual activity that he expects he could do if he tried it today. For each activity checked, he also selects a number from 10 to 100 indicating confidence in his ability to perform the activity. The reference scale labels a confidence rating of 10 as Quite Uncertain, a rating of 50–60 as Moderately Certain, and a rating of 100 as Quite Certain. Partners rate sexual functioning according to the same format. This takes 10 minutes.

Scoring

The SSES-E yields a self-efficacy strength score obtained

by summing the values in the Confidence column and

dividing by 25 (the number of activities rated). Any activity not checked in the Can Do column is presumed to have a 0 confidence (i.e., strength) rating. Some are reluctant to use the 10-point interval, so any continuous number recorded may be used in the Confidence column. Higher scores indicate greater confidence in the man's erectile competence. In case of missing scores, prorating is possible. There must, however, be at least one response in either the Can Do or the Confidence column on items 14 to 25. To deal with missing data, if Can Do is checked and Confidence is left empty, mean score substitution can be used when this occurs fewer than three times. If it occurs more often, the test is invalid. Reliability To collect evidence for the reliability of the SSES-E, dysfunctional and control samples were examined. The dysfunctional sample consisted of 17 men presenting with sexual difficulties (13 with Erectile Disorder, 2 with Hypoactive Sexual Desire, 2 with Rapid Ejaculation) at the sex therapy service of a large metropolitan hospital (Libman, Rothenberg, Fichten, & Amsel, 1985). Nine men presented with their female sexual partners. The control group consisted of 15 married couples with nonproblematic sexual functioning, who were matched to the dysfunctional group on demographic variables: the entire sample was composed of middle-class Caucasians with a mean age of 34. To determine internal consistency, standardized alpha coefficients were calculated for the dysfunctional and control males and females separately. The following estimates were obtained: .92 for dysfunctional males and .94 for their female partners' ratings of their male partners, .92 for control males and .86 for their female partners. Test-retest reliability, using the control group, was calculated over a 1-month period. Results showed a reliability coefficient of .98 for males and .97 for females. Validity Concurrent validity estimates were reported in the original (Libman et al., 1985) study. Recently, Latini et al. (2002)

1 Address correspondence to Catherine S. Fichten, Behavioural Psychotherapy and Research Unit, Institute of Community and Family Psychiatry, SMBD

Jewish General Hospital, 4333 Cote St. Catherine Rd., Montreal, Quebec, Canada H3T 1E4; e-mail: catherine.fichten@mcgill.ca

correlated men's SSES-E and Psychological Impact of Erectile Dysfunction Scale (PIED) scores. The SSES E was significantly correlated (−.57 and −.51) with both PIED scales, suggesting that lower sexual self-efficacy about erectile functioning is associated with greater nega tive impact of erectile dysfunction.

Convergent validity was also established by Swindle, Cameron, Lockhart, and Rosen (2004), who found a cor relation of .67 between SSES-E and Psychological and Interpersonal Relationship Scales scores.

Predictive validity was shown by Kalogeropoulos (1991), who found that scores significantly improved in a sample of 53 males who had undergone vasoactive intracavern ous pharmacotherapy for erectile dysfunction. Similarly, Latini, Penson, Wallace, Lubeck, and Lue's (2006b) lon gitudinal study of therapy for erectile dysfunction showed that treatment had an important and significant effect on SSES-E scores. Godschalk et al. (2003) used low-dose human chorionic gonadotropin and placebo in the treatment of benign prostatic hyperplasia. In addition to significant improvement in urine flow in the active treatment sample, the authors also showed improved sexual self-efficacy after treatment relative to placebo subjects ($p < .036$).

The SSES-E has also demonstrated good criterion valid ity. For example, Latini, Penson, Wallace, Lubeck, and Lue

(2006a) found that the SSES-E score was the best predictor of erectile dysfunction severity out of a large number of clinical and psychosocial predictors. Evidence for known groups criterion validity has also been collected. In our initial sample of 17 dysfunctional men and 15 controls (Libman et al., 1985), dysfunctional men (M = 53.6, SD = 21.1) and their partners (M = 47.2, SD = 26.7) scored significantly ($p < .001$) lower on the SSES-E than did functional men (M = 88.0, SD = 10.0) and their partners (M = 89.5, SD = 10.4). Moreover, a stepwise discriminant analysis indicated that SSES-E scores were able to classify dysfunctional and nondysfunctional men with 88% accu racy. In addition, data indicate that older married men (age = 65+) had significantly lower self-efficacy scores (M = 54.10) than their middle-aged (age = 50–64) counterparts (M = 70.03; Libman et al., 1989). Also, men who under went a transurethral prostatectomy were found to rate their postsurgery sexual self-efficacy lower (M = 59.3, SD = 20.3) than presurgery (M = 64.3, SD = 18.8) (Libman et al., 1989, 1991). A study by Latini et al. (2006a) found that men with mild (M = 74.7, SD = 9.31), moderate (M = 56.3, SD = 10.69), and severe erectile dysfunction (M = 34.3, SD = 18.38) differed significantly, $p < .0001$. The findings above were replicated in studies of men with erectile dysfunction who had illness known to affect erectile functioning. For

example, Penson et al. found that men with erectile dys

function as well as prostate cancer (2003a) and diabetes

(2003b) reported worse sexual self-efficacy than men with

erectile dysfunction but no known underlying medical ill

ness (prostate cancer M = 37.7, no prostate cancer M = 50.6,

p < .001; diabetes M =38.2, SD = 17.75, no diabetes M =

Libman, E., Rothenberg, I., Fichten, C. S., & Amsel, R. (1985). The SSESE: A measure of sexual self-efficacy in erectile functioning. Journal of Sex and Marital Therapy, 11, 233-244.

Lobitz, W. C., & Baker, E. C. (1979). Group treatment of single males with erectile dysfunction. Archives of Sexual Behavior, 8, 127-138.

Penson, D. F., Latini, D. M., Lubeck, D. P., Wallace, K. L., Henning, J. M., & Lue, T. F. (2003a). Do impotent men with diabetes have more severe erectile dysfunction and worse quality of life than the general population of impotent patients? Results from the Exploratory Comprehensive Evaluation of Erectile Dysfunction (ExCEED) database. Diabetes Care, 26, 1093-1099. Penson, D. F., Latini, D. M., Lubeck, D. P., Wallace, K. L., Henning, J. M., & Lue, T. F. (2003b). Is quality of life different for men with erectile dysfunction and prostate cancer compared to men with erectile dysfunction due to other causes? Results from ExCEED data base. Journal of Urology, 169, 1458-1461. Reynolds, B. S., (1978). Erectile Difficulty Questionnaire. Unpublished manuscript, Human Sexuality Program, University of California, Los Angeles. Swindle, R. W., Cameron, A. E., Lockhart, D. C., & Rosen, R. C. (2004). The Psychological and Interpersonal Relationship Scales: Assessing psychological and relationship outcomes associated with erectile dysfunction and its treatment. Archives of Sexual Behavior, 33, 19-30.

Exhibit

Sexual Self-Efficacy Scale for Erectile Functioning

NAME:

DATE:

The following form lists sexual activities that men engage in.

For male respondents only:

Under column I (Can Do), check (3) the activities you expect you could do if you were asked to do them today.

For only those activities you checked in column I, rate your degree of confidence in being able to perform them by selecting a number from

10 to 100 using the scale given below. Each activity is independent of the others. Write this number in column II (Confidence).

Remember, check (3) what you can do. Then, rate your confidence in being able to do each activity if you tried to do it today. Each activ

ity is independent of the others.

For (female) partners only:

Under column I (Can Do), check (3) the activities you think your male partner could do if he were asked to do them today.

For only those activities you checked in column I, rate your degree of confidence that your male partner could do them by selecting a

number from 10 to 100 using the scale given below. Write this number in column II (Confidence).

Remember, check (3) what you expect your male partner can do. Then rate your confidence in your partner’s ability to do each activity

if he tried to do it today. Each activity is independent of the others.

I II 10 20 30 40 50 60 70 80 90 100 Check
if Rate

Quite Moderately Quite Female Confidence

Uncertain Certain Certain Can Do 10-100

1. Anticipate (think about) having intercourse without fear

or anxiety.

2. Get an erection by masturbating when alone.

3. Get an erection during foreplay when both partners are clothed.

4. Get an erection during foreplay while both partners are nude.

5. Regain an erection if it is lost during foreplay.

6. Get an erection sufficient to begin intercourse.

7. Keep an erection during intercourse until orgasm is reached.

8. Regain an erection if it is lost during intercourse.

9. Get an erection sufficient for intercourse within a reasonable period of time.

10. Engage in intercourse for as long as desired without ejaculating.

11. Stimulate the partner to orgasm by means other than intercourse.

12. Feel sexually desirable to the partner.

13. Feel comfortable about one's sexuality.

14. Enjoy a sexual encounter with the partner without having intercourse.

15. Anticipate a sexual encounter without feeling obliged to have intercourse.

16. Be interested in sex.

17. Initiate sexual activities.

18. Refuse a sexual advance by the partner.

19. Ask the partner to provide the type and amount of sexual stimulation needed.

20. Get at least a partial erection when with the partner.

21. Get a firm erection when with the partner.

22. Have an orgasm while the partner is stimulating the penis with hand or mouth.

23. Have an orgasm while penetrating (whether there is a firm erection or not).

24. Have an orgasm by masturbation when alone (whether there is a firm erection or not).

25. Get a morning erection.

NOM:

DATE:

Échelle d’efficacité sexuelle (Forme E)

Le questionnaire suivant donne la liste d’activités sexuelles dans lesquelles les hommes s’engagent.

Pour les hommes:

Cochez dans la colonne Peut le Faire, les activités que vous pensez être capable de faire si l’on vous demandait de les faire aujourd’hui.

Seulement pour les activités où vous avez coché Peut le Faire, évaluez votre degré de confiance dans le fait que vous pouvez les faire, en

choisissant un nombre de 10 à 100, en utilisant l’échelle en bas de la page.

Écrivez les nombres dans la colonne Confiance. Rappelez-vous de cocher ce que pensez que vous pouvez faire. Évaluez ensuite votre

Confiance dans le fait d’être capable de faire chaque activité si vous essayiez de le faire aujourd’hui. Chaque activité est indépendante

des autres.

Pour les femmes:

Cochez dans la colonne Peut le Faire, les activités que vous pensez que votre partenaire pourrait faire, si on lui demandait de les faire

aujourd’hui.

Seulement pour les activités où vous avez coché Peut le Faire, évaluez votre degré de confiance dans le fait que votre partenaire puisse

les faire, en choisissant un nombre de 10 à 100, en utilisant l’échelle en bas de la page.

Écrivez les nombres dans la colonne Confiance. Rappelez-vous: Cochez ce que vous pensez que votre partenaire peut faire. Évaluez

alors votre Confiance dans la capacité de votre partenaire de faire chaque activité, s’il essayait de les faire aujourd’hui. Chaque activité

est indépendante des autres.

I II 10 20 30 40 50 60 70 80 90 100
Cochez (T) Évaluez

Tout à fait Modérément Certain si l’Homme votre Degré de

Incertain Certain Peut le Confiance

Faire 10-100

1. Anticiper (penser à) la pénétration sans peur ni anxiété.

2. Obtenir une érection en se masturbant seul.

3. Obtenir une érection pendant les caresses préliminaires quand les deux partenaires sont habillés.

4. Obtenir une érection pendant les caresses préliminaires quand les deux partenaires sont nus.

5. Regagner une érection si elle a été perdue pendant les caresses préliminaires.

6. Obtenir une érection suffisante pour tenter la pénétration.

7. Conserver une érection pendant la pénétration jusqu’à ce que l’orgasme soit atteint par

l’homme.

8. Regagner une érection si elle est perdue durant la pénétration.

9. Obtenir une érection suffisante pour la pénétration dans un délai de temps raisonnable.

Self-Stimulation (also see Masturbation)

Crowne, D. P., & Marlowe, D. (1964). The approval motive: Studies in evaluative dependence. New York: Wiley.

Fisher, W. A., Byrne, D., White, L. A., & Kelley, K. (1988). Erotophobiaerotophilia as a dimension of personality. The Journal of Sex Research, 25, 123-151.

Gagnon, J. H. (1977). Human sexualities. Dallas, TX: Scott, Foresman.

Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. British Journal of Clinical Psychology, 44, 227-239. Hinkin, T. R. (1998). A brief tutorial on the development of measures for use in survey questionnaires. Organizational Research Methods, 1, 104-121. Netemeyer, R. G., Bearden, W. O., & Sharma, S. (2003). Scaling procedures: Issues and applications. Thousand Oaks, CA: Sage. Simpson, J. A., & Gangestad, S. W. (1991). Individual differences in sociosexuality: Evidence for convergent and discriminant validity. Journal of Personality and Social Psychology, 60, 870-883. Streiner, D. L. & Norman, G. R. (2008). Health measurement scales: A practical guide to their development and use (4th ed.). New York: Oxford University Press.

Exhibit

Clitoral Self-Stimulation Scale

Instructions: The following questions ask about your thoughts and feelings concerning your sexual experiences and sexual activities with

a partner. You are asked to rate each item on the scale provided. Please check off one box per item to indicate your response.

Stimulating myself (i.e., massaging my genitals/clitoris) to help me have an orgasm during intercourse with a partner would be:

1. Good

□ □ □ □ □ □ □

Very Good Moderately Slightly Neither Good Slightly

Moderately Very Bad

Good Good nor Bad Bad Bad

2. Important □ □ □ □ □ □ □

Very Moderately Very Neither Important Slightly Moderately Very

Unimportant Unimportant Unimportant nor Unimportant Important Important Important

3. Exciting □ □ □ □ □ □ □

Strongly Moderately Slightly Neither Agree Slightly Moderately Strongly

Disagree Disagree Disagree nor Disagree Agree Agree Agree

4. Embarrassing □ □ □ □ □ □ □

Strongly Moderately Slightly Neither Agree Slightly Moderately Strongly

Disagree Disagree Disagree nor Disagree Agree Agree Agree

5. Easy □ □ □ □ □ □ □

Very Moderately Slightly Neither Easy Slightly Moderately Very Easy

Difficult Difficult Difficult nor Difficult Easy Easy

6. When having sex with a partner, how often do you stimulate your clitoris to orgasm?

□ 0% of the time

□ 1-25% of the time

□ 26-50% of the time

□ 51-75% of the time

□ 76-99% of the time

□ 100% of the time

Berg, R. C. (2008). Barebacking among MSM Internet users. AIDS and Behavior, 12, 822–833.

Gaither, G. A., & Sellbom, M. (2003). The sexual sensation seeking scale: Reliability and validity within a heterosexual college student sample. Journal of Personality Assessment, 81, 157–167. Gutiérrez-Martínez, O., Bermúdez, M. P., Teva, I., & Buela-Casal, G. (2007). Sexual sensation-seeking and worry about sexually transmitted diseases (STD) and human immunodeficiency virus (HIV) infection among Spanish adolescents. Psicothema, 19, 661–666. Hart, T. A., Wolitski, R. J., Purcell, D. W., Gómez, C., Halkitis, P., & the Seropositive Urban Men's Study Team. (2003). Sexual behavior among HIV-positive men who have sex with men: What's in a label? The Journal of Sex Research, 40, 179–188. Hendershot, C. S., Stoner, S. A., George, W. H., & Norris, J. (2007). Alcohol use, expectancies, and sexual sensation seeking as correlates of HIV risk behavior in heterosexual young adults. Psychology of Addictive Behaviors, 21, 365–372. Kalichman, S. C., Adair, V., Rompa, D., Multhauf, K., Johnson, J., & Kelly, J. (1994). Sexual sensation-seeking: Scale development and predicting AIDS-risk behavior among homosexually active men. Journal of Personality Assessment, 62, 385–397. Kalichman, S. C., & Rompa, D. (1995). Sexual sensation seeking and sexual compulsivity scales: Reliability, validity, and predicting HIV risk behaviors. Journal of Personality Assessment, 65, 586–602. Kalichman, S. C., Simbayi, L., Jooste, S., Vermaak R., & Cain, D. (2008). Sensation seeking and alcohol use predict HIV transmission risks: Prospective study of sexually transmitted infection clinic patients, Cape Town, South Africa. Addictive Behaviors, 33, 1630–1633. Maisto, S. A., Carey, M. P., Carey, K. B., Gordon, C. M., Schum, J. L., & Lynch, K. G. (2004). The relationship between alcohol and individual differences variables on attitudes and behavioral skills relevant to sexual health among heterosexual young adult men. Archives of Sexual Behavior, 33, 571–584. O'Leary, A., Fisher, H. H., Purcell, D. W., Spikes, P. S., & Gomez, C. A. (2007). Correlates of risk patterns and race/ethnicity among HIV-positive men who have sex with men. AIDS and Behavior, 11, 706–715. Zuckerman, M. (1994). Biological expression and biological bases of sensation seeking. New York: Cambridge University Press

Exhibit

Sexual Sensation Seeking Scale

A number of statements that some people have used to describe themselves are given below. Read each statement and then circle the

number to show how well you believe the statement describes you.

Not at all Slightly Mainly Very Much

Like Me Like Me Like Me Like Me

1. I like wild “uninhibited” sexual encounters. 1 2 3 4

2. The physical sensations are the most important thing about having sex. 1 2 3 4

3. My sexual partners probably think I am a “risk taker.” 1 2 3 4

4. When it comes to sex, physical attraction is more important to me than how

well I know the person. 1 2 3 4

5. I enjoy the company of sensual people. 1 2 3 4

6. I enjoy watching “X-rated” videos. 1 2 3 4

7. I am interested in trying out new sexual experiences. 1 2 3 4

8. I feel like exploring my sexuality. 1 2 3 4

9. I like to have new and exciting sexual experiences and sensations. 1 2 3 4

10. I enjoy the sensations of intercourse without a condom. 1 2 3 4

Sex Education (see Education)

Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Fenigstein, A., Scheier, M. F., & Buss, A. H. (1975). Public and private self-consciousness: Assessment and theory. Journal of Consulting and Clinical Psychology, 43, 522–527.

Hays, R., & Hayashi, T. (1990). Beyond internal consistency reliability: Rationale and user's guide for Multitrait Analysis Program on the microcomputer. Behavior Research Methods, Instruments, and Computers, 22, 167–175.

Hendriks, T. (1997). Een hypothetisch cognitief verklaringsmodel voor seksuele dysfuncties [A hypothetical cognitive explanatory model of sexual dysfunction]. Unpublished master's thesis, Maastricht University, Maastricht, The Netherlands.

Meston, C. M. (2006). The effects of state and trait self-focused attention on sexual arousal in sexually functional and dysfunctional women. Behaviour Research and Therapy, 44, 515–532.

van Lankveld, J. J. D. M., & Bergh, S. (2008). The interaction of state and trait aspects of self-focused attention affects genital, but not subjective, sexual arousal in sexually functional women. Behaviour Research and Therapy, 46, 514–528.

van Lankveld, J. J. D. M., Geijen, W., & Sykora, H. (2008). Reliability and validity of the Sexual Self-Consciousness Scale: Psychometric properties. Archives of Sexual Behavior, 37, 925–933.

van Lankveld, J. J. D. M., van den Hout, M. A., & Schouten, E. G. (2004). The effects of self-focused attention, performance demand, and dispositional sexual self-consciousness on sexual arousal of sexually functional and dysfunctional men. Behaviour Research and Therapy, 42, 915–935.

Sexual History

Exhibit

Sexual History Questionnaire

Instructions: This questionnaire asks questions about your recent sexual history. Your answers are entirely confidential. Some words

used in this questionnaire may not be familiar to you, or you may not be sure of their exact meaning. The following definitions may be

helpful: Vaginal sex is sex in which the penis enters the vagina. Oral sex is sex in which the mouth or tongue is in contact with the genitals.

Anal sex is sex in which the penis enters the anus, or back passage. Penetrative sex is sex in which the penis enters the vagina or anus.

Nonpenetrative sex includes oral sex, and also many other forms of sex such as massage, touching, and mutual masturbation. Protected

sex refers to sex with a condom or oral sex with a latex barrier or condom. A regular partner, for the purposes of this study, is someone

with whom you have had sex more than once.

Please indicate your gender male/female

your age ____ years

your status undergraduate/postgraduate

the religion which influences you most (please circle):

1 Christianity 2 Judaism 3 Islam 4 Hinduism 5 Other

Section A

1. Who do you have sex with? (please circle):

1 only men 2 mostly men 3 equally men and women 4 mostly women 5 only women

2. Have you ever had penetrative sex (sex in which the

penis penetrates the vagina or anus)?

Yes/no

If yes, at what age did you first have penetrative sex? ____

3. Have you ever had unprotected penetrative sex (penetrative sex without a condom)?

Yes/no

Section B

The following questions relate to your sexual encounter(s) over the last month. This includes nonpenetrative sex such as oral sex and

mutual masturbation. If you have not had sex in the last month please move on to Section C. If you have never had sex please move on

to Section D.

4. In the last month how many sexual partners have you had? ____

5. How many of these were regular partners (people with whom you have had sex more than once)? ____

6. (a) How many times have you had sex with a regular partner in the last month? ____

(b) On how many of these occasions did you have penetrative sex? ____

(c) On how many of these occasions did you use a condom? ____

7. (a) How many times have you had sex with other partners in the last month? ___

(b) On how many of these occasions did you have penetrative sex? ____

(c) On how many of these occasions did you use a condom? ____

Section C

The following questions refer specifically to your last

sexual encounter.

8. How long ago was your last sexual encounter? Please circle.

1 less than a week ago

2 between one week and one month ago

3 between one month and three months ago

4 between three months and six months ago

5 between six months and one year ago

6 more than one year ago

9. What kind(s) of sex did you have on this occasion? Please answer yes or no to the following activities:

Unprotected vaginal sex yes/no

Vaginal sex with a condom yes/no

Unprotected anal sex yes/no

Anal sex with a condom yes/no Oral sex yes/no Other forms of nonpenetrative sex (such as massage and mutual masturbation) yes/no 10. What gender was your partner on this occasion? Male/female 11. On this occasion did you or your partner mention using a condom? 1 you 2 your partner 3 neither 12. On this occasion did you or your partner mention practicing nonpenetrative sex? 1 you 2 your partner 3 neither 13. Was s/he a regular sexual partner (a partner with whom you have had sex more than once)? Yes/no If yes, have you discussed practicing safer sex with this partner (using condoms or latex barriers, or having nonpenetrative sex)? Yes/no 14. If you had heterosexual vaginal sex on this occasion, did you use a form of contraception? Please circle one or more: 1 the condom 2 the pill 3 the diaphragm or cap 4 IUD (the coil) 5 spermicidal sponge, creams, or pessaries 6 the rhythm (calendar) method 7 the withdrawal method 8 other (please specify) _____ 9 none 15. With this partner, have you discussed what kind of sex you like and don’t like Yes/no Using the scale below, write a number beside each statement to indicate how you felt. 1 2 3 4 5 Not at all A Great Deal
16. How much did you feel like having sex on this occasion?

_____ 17. How much did your partner feel like having sex on this occasion? _____ 18. With this partner on this occasion, how able did you feel to express your wishes regarding sex? _____ Section D Using the same scale, answer the following, more general question. 1 2 3 4 5 Not at all A Great Deal 19. How much at risk do you consider yourself from HIV/AIDS? _____ 20. Have you ever had an HIV antibody test? Yes/no 21. Did you get the result of the test? Yes/no/nonapplicable 22. To your knowledge, do you know or have you known anyone personally with HIV or AIDS? Yes/no 23. Please feel free to add anything which may give a clearer picture of your answers to this questionnaire.

Sexual Motivation

Exhibit

Affective and Motivational Orientation Related to Erotic Arousal

Please be extremely honest and think about yourself very carefully when responding to each statement! There are no right or wrong answers. This questionnaire asks you about reasons that you typically experience sexual feelings or that you become interested in sexual issues

or behaviors. When you experience these feelings or interests, you may or may not always act on those feelings. “Sex,” “having sex,”

or “sexual activity” can include sexual behavior with another person (e.g., your spouse or lover), as well as sexual behavior by yourself

(e.g., masturbation, viewing or reading erotic materials). “Partner” can refer to either your spouse or regular romantic partner or any

individual with whom you have sex. If you have never had sex or are not currently involved sexually with anyone, respond to the state

ments below like you think you would feel if you were involved in a sexual relationship or were sexually active. Not all reasons for being interested in sexual issues or sexual behavior may be listed below. Many of the reasons included may not

describe you well at all. If this is the case, please indicate that they are not true for you when rating them. If a particular statement describes your typical reaction or feelings well, indicate that it is “Completely True” by filling in the letter “E”

on the computer sheet. If a particular statement does not describe you well or is opposite of the way you feel, indicate that it is “Not

at all True” by filling in the letter “A” on the computer sheet. Of course, you may choose any letter in between A and E to indicate the

degree to which the statement describes you or not. Please

use the rating scale below to indicate how true or descriptive each of following statements is for you:

A B C D E

Not at all Moderately Completely

True True True

1. Often when I need to feel loved, I have the desire to relate to my partner sexually because sexual intimacy really makes me feel

warm and cared for.

2. I enjoy having sex most intensely when I know that it will lift my partner's spirits and improve his or her outlook on life.

3. When bad or frustrating things happen to me, many times I feel like engaging in sexual fantasy or doing something sexual to try to

get to feeling better.

4. Sex is important to me largely for reproductive reasons.

5. Sexual activities and fantasies are most stimulating when my partner seems extremely self-assured and demanding during sex.

6. I find that I often feel a sense of superiority and power when I am expressing myself sexually.

7. One of the most exciting aspects of sex is the sense of power I feel in controlling the sexual pleasure and stimulation my partner

experiences.

8. Often while I am engaging in sex or fantasy, the idea that children might result from sexual behavior is extremely arousing.

9. Frequently, when I want to feel that I am cared for and that someone is concerned about me, relating to my partner sexually is one

of the most satisfying ways to do so.

10. Often the most pleasurable sex I have is when it helps my partner forget about his or her problems and enjoy life a little more.

11. I find sexual behavior and sexual fantasy most exciting when I can feel forceful and dominant with my partner.

12. Thinking about sex or engaging in sex sometimes seems to help me keep on going when things get rough.

13. It is frequently very arousing when my partner gets very forceful and aggressive during sex.

14. I frequently want to have sex with my partner when I need him or her to notice me and appreciate me.

15. I especially enjoy sex when my partner and I are trying to have a baby.

16. Often engaging in sex with my partner makes me feel like I have established myself as a force to be reckoned with.

17. A major reason I enjoy having sex with my partner is because I can communicate how much I care for and value him or her.

18. The sensations of physical pleasure and release are major reasons that sexual activity and fantasy are so important to me.

19. Sex and sexual fantasies are most exciting when I feel like my partner has totally overpowered me and has taken complete con

trol.

20. When I am going through difficult times, I can start feeling better simply by engaging in some type of sexual fantasy or behavior.

21. The idea of having children is not very significant in my feelings about why sexual activity is important to me.

22. In many ways, I think engaging in sex and sexual fantasy are some of the most exciting and satisfying activities I can experience.

23. Many times it is extremely thrilling when my partner takes complete charge and begins to tell me what to do

during sex.

24. I really value sexual activity as a way of enjoying myself and adding an element of adventure to my life.

25. Often I have a real need to feel dominated and possessed by my partner while we are engaged in sex or sexual fantasy.

26. One of the best ways of feeling like an important part of my partner's life is by relating to him or her sexually.

27. I find that thinking about or engaging in sexual activity can frequently help me get through unpleasant times in my life.

28. I often feel like fantasizing about sex or expressing myself sexually when life isn't going very well and I want to feel better about

myself.

29. Engaging in sexual activity is a very important way for me to experience and appreciate the personal strength and forcefulness that

my partner is capable of.

30. I find it extremely exciting to be playful and to have fun when I am expressing myself sexually.

31. Thinking about sex or engaging in sexual behavior can frequently be a source of relief from stress and pressure for me.

32. I would prefer to have sex primarily when I am interested in having a child.

33. Often when my partner is feeling down on life or is unhappy about something, I like to try to make him or her feel better by sharing

intimacy together sexually.

34. The experience of sexual tension and energy are in many ways the most thrilling and important aspects of sexual activity and fan

tasy.

35. I often feel like having sex with my partner when I need to feel understood and when I want to relate to him or her on a one-to-one

level.

36. When I need to feel a sense of belongingness and connectedness, having sex with my partner is really an important way of relating

to him or her.

37. Doing something sexual often seems to greatly improve my outlook on life when nothing seems to be going right.

38. I frequently feel like expressing my need for emotional closeness and intimacy by engaging in sexual behavior or fantasy with my

sexual partner.

39. Many times when I am feeling unhappy or depressed, thinking about sex or engaging in sexual activity will make me feel better.

40. When things are not going well, thinking about sex or doing something sexual is often very uplifting for me and helps me to forget

about my problems for a while.

41. Engaging in sexual activity is very important to me as a means of feeling powerful and charismatic.

42. One of the main reasons I am interested in sex is for the purpose of having children.

43. The sense of emotional bonding with my partner during sexual intercourse is an important way of feeling close to him or her.

44. One of the most satisfying aspects of engaging in sex is expressing the intensity of my feelings for my partner while we are having sex.

45. I often have a strong need to fantasize about sex or to do something sexual when I feel upset or unhappy.

46. I really enjoy having sex as a way of exerting dominance and control over my partner.

47. I often find it a real turn-on when my partner takes charge and becomes authoritative during sexual activity or fantasy.

48. I am often very excited by the sense of power that I feel I have over my partner when I am sexually attractive to him or her.

49. Being able to experience my partner's physical excitement and sexual release is incredibly thrilling and stimulating for me.

50. I find it very exciting when my partner becomes very demanding and urgent during sex and sexual fantasy, as if he or she needs to possess me completely.

51. I frequently become very aroused when I sense that my partner is excited by controlling and directing our sexual activity or fantasy.

52. I frequently want to have sex with my partner because I know how much he or she enjoys it and how good it makes my partner feel as a person.

53. Expressing myself sexually generally makes me feel personally strong and in control of things.

54. I am especially excited by the feeling of domination and being controlled by my partner during sex and sexual fantasy.

55. One of the most satisfying features of sex is when my partner really seems to need the love and tenderness it conveys.

56. Often the sense of power that I have over my sexual partner can be extremely exhilarating.

57. I find it very rewarding when I can help my partner get through rough times by showing how much I care and being sexually intimate with him or her.

58. I frequently find it quite arousing to be very directive and controlling while having sex with my partner.

59. Sexual intercourse is important in creating a great deal of emotional closeness in my relationship with my partner.

60. Sharing affection and love during sexual intercourse is one of the most intense and rewarding ways of expressing my concern for my partner.

61. The sense of emotional closeness I experience from having sex with my partner is one of the most satisfying ways I know of feeling valued.

62. To me, an extremely rewarding aspect of having sex is that it can make my partner feel good about himself or herself.

Sexual Wanting Questionnaire

ZOË D. PETERSON, 1 University of Missouri-St. Louis

CHARLENE L. MUEHLENHARD, University of Kansas

1 Address correspondence to Zoë Peterson, Department of Psychology, 325 Stadler Hall, University of Missouri-St. Louis, One University Blvd, St. Louis,

MO 63121; e-mail: petersonz@umsl.edu

Sexual activity is often classified as wanted or unwanted,

reflecting a unidimensional, dichotomous model of sexual

wanting. In reality, individuals' feelings about wanting or

not wanting sex often are more complex (Muehlenhard &

Peterson, 2005). The Sexual Wanting Questionnaire was

developed to measure a new, more complex model of sex

ual wanting. The questionnaire measures sexual wanting

taking into account the following: (a) multiple levels of

wanting rather than a dichotomy, acknowledging that sex

can be wanted and unwanted to varying degrees; (b) mul

tiple dimensions of wanting, acknowledging that sex can

be wanted in some ways and unwanted in other ways; (c) an act-consequences distinction, acknowledging that wanting or not wanting a sexual act differs from wanting or not wanting its consequences; and (d) a wanting-consenting

distinction, acknowledging that wanting or not wanting sex differs from consenting or not consenting to sex (Peterson & Muehlenhard, 2007). Description The Wanting Questionnaire consists of 106 items assessing participants' reasons for wanting or not wanting a particular sexual experience (e.g., respondents' first

sexual experience or most recent sexual experience). It

measures reasons for wanting and not wanting the sexual

act itself, the consequences of engaging in the sexual act,

and the consequences of not engaging in the sexual act.

Questionnaire items describe reasons for wanting or not

wanting sex that relate to sexual arousal, morals and val

ues, situational characteristics, social status, fear of preg

nancy and sexually transmitted infections (STIs), and

relationship concerns.

The scale was developed and tested for use with col

lege students, although it could be adapted for use with

other populations. The scale has been used to measure the

"wantedness" of college men's and women's first sexual

intercourse (Muehlenhard, Peterson, MacPherson, & Blair,

2002) and the wantedness of college women's experiences

with consensual and nonconsensual sexual intercourse

(Peterson & Muehlenhard, 2007).

Response Mode and Timing

For each item, respondents are asked to indicate whether

the statement was true for them prior to the particular sexual

experience in question. If the item was true, they are asked

to rate the extent to which that item was a reason for want
ing or not wanting the sexual activity using a 7-point scale
ranging from –3 (A Strong Reason for Not Wanting to Have
Sex), to 0 (Not a Reason for Wanting or Not Wanting to
Have Sex), to 3 (A Strong Reason for Wanting to Have Sex).
Participants also are asked to make three global ratings of
wantedness, which provide summaries of the wantedness
of the sexual act itself, the wantedness of the consequences
of the sexual activity, and the overall wantedness of the
sexual activity. These global wantedness items also are
rated on a scale ranging from –3 (Strongly Unwanted) to 3
(Strongly Wanted). It takes approximately 15 to 20 minutes
to complete the entire scale.

Scoring

In order to calculate scores on the Reasons for Wanting
and the Reasons for Not Wanting subscales, the “not true”
items are set equal to 0. When calculating the Reasons for
Wanting subscale scores, negative ratings are replaced with
zeros, and, when calculating the Reasons for Not Wanting
subscale scores, positive ratings are replaced with zeros.
Ratings for items on each subscale are averaged to calculate
subscale scores. Scores on the Reasons for Wanting sub
scales can range from 0 to 3; higher scores indicate
stronger
feelings of wanting to have sex for that reason. Scores on

the Reasons for Not Wanting subscales can range from −3

to 0; lower scores indicate stronger feelings of not wanting

to have sex for that reason. The following is a breakdown of

items belonging to each subscale:

Reasons for Wanting Subscales

In the Mood: 1a, 2a, 3a, 6a, 7a, 10, 11a, 12a, 13a, 14, 16a,

17, 19, 22a, 26, 78 Negative Consequences of Refusing: 49, 62, 66, 67, 68, 71, 75, 80, 82 Personal Gain: 47, 48, 54, 79a Social Benefits: 40a, 41a, 45 Fear of Physical Harm: 69, 74 Strengthen the Relationship: 50, 51, 59, 61 Not Intoxicated: 20a, 21a Not a Virgin: 29b, 30b Reasons for Not Wanting Subscales Not in the Mood: 1b, 2b, 3c, 5, 12b, 13b, 16b Negative Consequences: 23, 31, 33, 34, 35, 36, 37, 39 Lack of Confidence: 4b, 18, 25, 28, 29a Cheating: 63, 64 Disliked the Other Person: 6b, 7b Negative Social Consequences: 40b, 41b Reliability Based on a sample of 213 college women who answered the questionnaire based on their experiences with consensual and nonconsensual sexual intercourse, Cronbach's alphas for the subscales ranged from .72 to .95, providing evidence that the subscales had adequate internal consistency. Validity Items for the Sexual Wanting Questionnaire were developed based on themes identified in prior studies of individuals' reasons for wanting and not wanting sex (e.g., Muehlenhard & Cook, 1988; O'Sullivan & Allgeier, 1998; O'Sullivan & Gaines, 1998) and based on discussions with a group of undergraduate college students. The subscales were developed using exploratory factor analysis and scale reliability analyses. Because wanting and not wanting sex was conceptualized as distinct from consenting and not consenting to sex, scores on the Sexual Wanting Questionnaire were expected to be associated with—but distinct from—sexual consent. Peterson and Muehlenhard (2007) found evidence for this. A group of 87 college women who answered the questionnaire based on their most recent experience with consensual sexual intercourse (i.e., the consensual sex group) was compared with a group of 77 college women who answered based on their experience with nonconsensual sexual intercourse (i.e., the rape group). Not surprisingly, findings suggested that wanting sex and consenting to sex were closely related; on average, the rape group wanted the sexual intercourse significantly less than the consensual sex group. However, also as expected, there were large within-group variations

in the wantedness of women’s consensual and nonconsensual sexual experiences; the results demonstrated that individuals sometimes consent to unwanted sex and sometimes do not consent to wanted sex. These findings provide some evidence of construct validity.

Exhibit

Sexual Wanting Questionnaire

Indicate whether each statement was true for you shortly before the sexual activity started. • If this statement was not true for you at the time, check Not True and go to the next line. • If this statement was true for you at the time, then check True. Circle a number from −3 to 3 indicating how much, if at all, it was a reason for not wanting or wanting to engage in sexual inter

course, based on the scale below.

It was a reason for not wanting to engage in the It had no influence It was a reason for wanting to engage in the

sexual activity sexual activity

−3 −2 −1 0 1 2 3

a strong a moderate a weak not a reason a weak a moderate a strong

reason reason reason for wanting or not reason reason reason

for not wanting to have sex wanting to have sex for wanting to have sex

Was this statement true for you shortly Not True True

before the sexual activity began? Check and Check and A reason for A reason for

go to the then circle not wanting the wanting

next line your rating sexual activity the sexual activity

1a. I was sexually aroused before the sexual intercourse began. −3 −2 −1 0 1 2 3

1b. I was not sexually aroused before the sexual intercourse began. −3 −2 −1 0 1 2 3

2a. I expected to be aroused during the sexual intercourse. -3 -2 -1 0 1 2 3

2b. I did not expect to be aroused during the sexual intercourse. -3 -2 -1 0 1 2 3

3a. I felt interested in and excited about the possibility of the sexual act. -3 -2 -1 0 1 2 3

3b. I felt indifferent about the possibility of the sexual act; I didn't care one way or another. -3 -2 -1 0 1 2 3

3c. I felt uninterested in and bored about the possibility of the sexual act. -3 -2 -1 0 1 2 3

4a. I felt comfortable about my body. -3 -2 -1 0 1 2 3

4b. I felt uncomfortable about my body. -3 -2 -1 0 1 2 3

5. I felt disgusted or revolted by the possibility of the sexual intercourse. -3 -2 -1 0 1 2 3

Other Information

With appropriate citation, the Sexual Wanting Scale may

be copied and used for educational and research purposes

without permission. The authors would appreciate receiv

ing a summary of any research utilizing this scale.

Muehlenhard, C. L., & Cook, S. W. (1988). Men's self-reports of unwanted sexual activity. The Journal of Sex Research, 24, 58-72.

Muehlenhard, C. L., & Peterson, Z. D. (2005). Wanting and not wanting sex: The missing discourse of ambivalence. Feminism and Psychology, 15, 15-20. Muehlenhard, C. L., Peterson, Z. D., MacPherson, L. A., & Blair, R. L. (2002, June). First experiences with sexual intercourse: Wanted, unwanted, or both? Application of a multidimensional model. Paper presented at the Midcontinent and Eastern Region Joint Conference of the Society for the Scientific Study of Sexuality, Big Rapids, MI. O'Sullivan, L. F., & Allgeier, E. R. (1998). Feigning sexual desire: Consenting to unwanted sexual activity in heterosexual dating relationships. The Journal of Sex Research, 35, 234-243. O'Sullivan, L. F., & Gaines, M. E. (1998). Decision-making

in college students' heterosexual dating relationships: Ambivalence about engaging in sexual activity. Journal of Social and Personal Relationships, 15, 347-363. Peterson, Z. D., & Muehlenhard, C. L. (2007). Conceptualizing the "wantedness" of women's consensual and nonconsensual sexual experiences: Implications for how women label their experiences with rape. The Journal of Sex Research, 44, 72-88.

6a. I found the other person physically attractive. -3 -2 -1 0 1 2 3

6b. I found the other person physically unattractive. -3 -2 -1 0 1 2 3

7a. I liked the other person. -3 -2 -1 0 1 2 3

7b. I disliked the other person. -3 -2 -1 0 1 2 3

8. I didn't know the other person well. -3 -2 -1 0 1 2 3

9a. The sexual activity in question was socially acceptable. -3 -2 -1 0 1 2 3

9b. The sexual activity in question was socially unacceptable. -3 -2 -1 0 1 2 3

10. I felt curious to try sexual intercourse with this person in this situation. -3 -2 -1 0 1 2 3

11a. There was a good location available (it was comfortable, there was privacy, etc.). -3 -2 -1 0 1 2 3

11b. There was a problem with the location (it was uncomfortable, there was little privacy, etc.). -3 -2 -1 0 1 2 3

12a. I was in the mood to engage in sexual intercourse. -3 -2 -1 0 1 2 3

12b. I was not in the mood to engage in sexual intercourse. -3 -2 -1 0 1 2 3

13a. I found the other person's behavior appealing or attractive in this situation. -3 -2 -1 0 1 2 3

13b. The other person's behavior was unappealing or obnoxious in this situation. -3 -2 -1 0 1 2 3

14. It seemed that the other person wanted to engage in

the sexual intercourse at least to some degree. -3 -2 -1 0 1 2 3

15. It seemed that the other person was at least somewhat reluctant to engage in the sexual intercourse. -3 -2 -1 0 1 2 3

16a. I expected emotional closeness during this sexual activity. -3 -2 -1 0 1 2 3

16b. I did not expect emotional closeness during this sexual activity. -3 -2 -1 0 1 2 3

17. There would have been a great deal of physical closeness during this sexual activity. -3 -2 -1 0 1 2 3

18. I expected the sexual intercourse to be painful or physically uncomfortable. -3 -2 -1 0 1 2 3

19. I expected the sexual intercourse to be pleasurable. -3 -2 -1 0 1 2 3

20a. I was not intoxicated (on alcohol or drugs). -3 -2 -1 0 1 2 3

20b. I was mildly intoxicated (on alcohol or drugs). -3 -2 -1 0 1 2 3

20c. I was extremely intoxicated (on alcohol or drugs). -3 -2 -1 0 1 2 3

21a. The other person was not intoxicated (on alcohol or drugs). -3 -2 -1 0 1 2 3

21b. The other person was mildly intoxicated (on alcohol or drugs). -3 -2 -1 0 1 2 3

21c. The other person was extremely intoxicated (on alcohol or drugs). -3 -2 -1 0 1 2 3

22a. The other person consented (or agreed) to engage in the sexual intercourse. -3 -2 -1 0 1 2 3

22b. The other person did not consent (or agree) to engage in the sexual intercourse. -3 -2 -1 0 1 2 3

23. I felt that engaging in the sexual intercourse would make me feel uncomfortable because it would be going against my morals and values. -3 -2 -1 0 1 2 3

24. I or the other person was menstruating. -3 -2 -1 0 1 2 3

25. I was nervous about my ability to perform sexual intercourse. -3 -2 -1 0 1 2 3

26. I was confident about my ability to perform sexual intercourse. -3 -2 -1 0 1 2 3

27. I felt physically unwell or sick. -3 -2 -1 0 1 2 3

28. It would have been my first time engaging in the sexual activity in question. -3 -2 -1 0 1 2 3

29a. I was a virgin. -3 -2 -1 0 1 2 3

29b. I was not a virgin. -3 -2 -1 0 1 2 3

30a. The other person was a virgin. -3 -2 -1 0 1 2 3

30b. The other person was not a virgin. -3 -2 -1 0 1 2 3

31. I thought that, if I had sex, I might get a sexually transmitted disease. -3 -2 -1 0 1 2 3

32. I thought I might give the other person a sexually transmitted disease. -3 -2 -1 0 1 2 3

33. I thought I might get pregnant or get the other person pregnant. -3 -2 -1 0 1 2 3

34. I thought I might get into trouble (e.g., with my parents, my boss, the police). -3 -2 -1 0 1 2 3

35. I thought I might feel bad or guilty because it was against my morals or values. -3 -2 -1 0 1 2 3

36. I thought I might feel bad or guilty because it was against my parents' morals or values. -3 -2 -1 0 1 2 3

37. I thought my parents might find out. -3 -2 -1 0 1 2 3

38. I thought that having sex would improve my self-esteem or self-image at least in some ways. -3 -2 -1 0 1 2 3

39. I thought that having sex would harm my self-esteem or self-image at least in some ways. -3 -2 -1 0 1 2 3

40a. I thought it would improve my reputation among my female friends and acquaintances. -3 -2 -1 0 1 2 3

40b. I thought it would harm my reputation among my female friends and acquaintances. -3 -2 -1 0 1 2 3

41a. I thought it would improve my reputation among my male friends and acquaintances. -3 -2 -1 0 1 2 3

41b. I thought it would harm my reputation among my male friends and acquaintances. -3 -2 -1 0 1 2 3

42. I thought it would prevent me from doing something else I needed to do (e.g., studying, going to work). -3 -2 -1 0 1 2 3

43. I thought it would prevent me from doing something else fun or pleasant (e.g., watching TV, going to a movie). -3 -2 -1 0 1 2 3

44a. I thought it would make the other person happy. -3 -2 -1 0 1 2 3

44b. I thought it would make the other person unhappy -3 -2 -1 0 1 2 3

45. I thought it would give me something to talk about with friends and acquaintances. -3 -2 -1 0 1 2 3

46. I thought that, if I had sex, the other person might think I was cheap or easy. -3 -2 -1 0 1 2 3

47. I thought it might result in my getting something I really needed (e.g., food, money, transportation, shelter). -3 -2 -1 0 1 2 3

48. I thought it might result in my getting something I really wanted (e.g., a gift, a vacation). -3 -2 -1 0 1 2 3

49. I felt like it would fulfill my obligation to the other person. -3 -2 -1 0 1 2 3

50. I thought that it would demonstrate my love for the other person. -3 -2 -1 0 1 2 3

51. I thought that it would make me feel closer to the other person. -3 -2 -1 0 1 2 3

52. I thought that it would make the other person fall

in love with me. -3 -2 -1 0 1 2 3

53. I thought that it would make me feel needed or wanted. -3 -2 -1 0 1 2 3

54. I thought that it would result in the other person doing something I wanted. -3 -2 -1 0 1 2 3

55. I felt like it would be fair to the other person because, in the past, he/she had engaged in sexual intercourse with me when I wanted to. -3 -2 -1 0 1 2 3

56. I thought that it would result in my being accused of rape or sexual coercion. -3 -2 -1 0 1 2 3

57. I thought that I might regret it later. -3 -2 -1 0 1 2 3

58. I thought that the other person might regret it later. -3 -2 -1 0 1 2 3

59. I thought that having sex would strengthen my relationship with the other person in some ways. -3 -2 -1 0 1 2 3

60. I thought that having sex would damage my relationship with the other person in some ways. -3 -2 -1 0 1 2 3

61. I thought that it might lead to a steady relationship with the other person. -3 -2 -1 0 1 2 3

62. I thought that it would cause the other person to stop pressuring me. -3 -2 -1 0 1 2 3

63. It would have been “cheating,” and I was afraid that it would damage my relationship with my spouse or steady dating partner. -3 -2 -1 0 1 2 3

64. It would have been “cheating,” and I was afraid that it would hurt my spouse or steady dating partner. -3 -2 -1 0 1 2 3

65a. I wanted to be more sexually experienced. -3 -2 -1 0 1 2 3

65b. I did not want to be more sexually experienced. -3 -2 -1 0 1 2 3

66. I wanted to avoid hurting the other person’s

feelings. -3 -2 -1 0 1 2 3

67. Refusing sex would have made me feel guilty. -3 -2 -1 0 1 2 3

68. I was afraid that, if I refused, the other person would become angry. -3 -2 -1 0 1 2 3

69. I was afraid that, if I refused, the other person might harm me physically. -3 -2 -1 0 1 2 3

70. There was nothing else to do. -3 -2 -1 0 1 2 3

71. I was afraid that, if I refused, the other person might accuse me of being a tease or leading him/her on. -3 -2 -1 0 1 2 3

72. I was afraid that, if I refused, the other person might think I was ungrateful because he/she had done something for me. -3 -2 -1 0 1 2 3

73. I was afraid that refusing would make me seem selfish. -3 -2 -1 0 1 2 3

74. I was afraid that, if I refused, the other person might try to force me to do it. -3 -2 -1 0 1 2 3

75. I was afraid that the other person would be disappointed if we didn't have sex. -3 -2 -1 0 1 2 3

76. I thought that this was my only chance to have sex with this person—that it was now or never. -3 -2 -1 0 1 2 3

77. I was afraid that, if I refused, the other person might carry out some threat against me. -3 -2 -1 0 1 2 3

78. This was an experience that I didn't want to miss out on. -3 -2 -1 0 1 2 3

79a. I felt like having sex would have made me feel powerful. -3 -2 -1 0 1 2 3

79b. I felt like having sex would have made me feel powerless. -3 -2 -1 0 1 2 3

80. I thought that refusing might damage my relationship with the other person at least in some ways. -3 -2 -1 0 1 2 3

81. I thought that refusing might strengthen my relationship with the other person at least in some ways. -3 -2 -1 0 1 2 3

82. I was afraid that, if I refused, the other person might break up with me. -3 -2 -1 0 1 2 3

83. I was afraid that, if I refused, the other person might have sex with someone else. -3 -2 -1 0 1 2 3

84. It was a situation where sex was expected (e.g., it was prom night; the other person was my girlfriend/boyfriend visiting from out of town, etc.). -3 -2 -1 0 1 2 3

Overall, how much did you want or not want to engage in the sexual act itself (not considering the consequences)?

-3 -2 -1 0 1 2 3

Strongly Moderately Slightly No Slightly Moderately Strongly

unwanted unwanted unwanted opinion wanted wanted wanted

Overall, how much did you want or not want the possible consequences of engaging in the sexual activity?

-3 -2 -1 0 1 2 3

Strongly Moderately Slightly No Slightly Moderately Strongly

unwanted unwanted unwanted opinion wanted wanted wanted

Overall, how much did you want or not want to engage in sexual activity in this situation (taking into account the sexual act itself, the

possible consequences of engaging in the sexual act, and the possible consequences of not engaging in the sexual act)?

-3 -2 -1 0 1 2 3

Strongly Moderately Slightly No Slightly Moderately Strongly

unwanted unwanted unwanted opinion wanted wanted wanted

Age, Gender, and Sexual Motivation Inventory

DAVID QUADAGNO, 1 Florida State University

The Age, Gender, and Sexual Motivation Inventory (AGSMI) was originally developed to measure the relationships between gender and age and motivations for engaging in sexual activities, favored part of a sexual experience (foreplay, intercourse, and afterplay), ideal benefit to be gained from engaging in sexual activities, and other aspects of sexual behavior and satisfaction (Sprague & Quadagno, 1989). The literature on sexual motivation consistently indicates that males are primarily motivated by physical and women by emotional factors when college-aged individuals are the subjects (e.g., see Bardwick, 1971; Carroll, Volk, & Hyde, 1985; Denney, Field, & Quadagno, 1984). When a diverse age group was sampled, the results from AGSMI indicated very clearly that inferences about sexual motivations for the whole population couldn't be drawn from studies of a very limited and relatively inexperienced segment of it. In addition, in using the AGSMI, we found only a moderate relationship between usual motive for engaging in sexual intercourse and the respondent's assessment of its most important benefit. The AGSMI can be used to examine gender differences in many aspects of sexual behaviors, satisfaction, and motivations in a similar age group, or

changes

in sexuality in men and women at varying ages.

Description

The AGSMI begins with a demographic section, in which

the respondents record information including, but not

limited to, age, gender, marital status, employment sta

tus, sexual orientation, and combined family income. The

demographic section is followed by 25 questions, 23 of

which are multiple choice and 2 of which call for short

answers. The sample used in the development of the instru

ment included 95 women and 84 men ranging in age from

22 to 57 years of age; mean age for the women was 31.2 and

for the men was 31.7 years.

Response Mode and Timing

Respondents can circle the letter of choice for each question

on the instrument and can also write their responses to the

short-answer items on the instrument. As an alternative, if it

is administered to a large group at the same time, a separate

answer sheet can be used to record responses. The majority of

the test items have three to five response choices. The inven

tory requires approximately 5 to 8 minutes to complete.

Scoring

The instrument is not designed to produce any combined

1 Address correspondence to David Quadagno, Department of Biological Science, Florida State University, Tallahassee, FL 32306-2043; e-mail:

quadagno@bio.fsu.edu

Exhibit

Age, Gender, and Sexual Motivation Inventory

1. Age _____

2. Sex _____; For women only: Past menopause? Yes _____; No _____

3. What is your marital status? (Check one)

_____ never married

_____ separated

_____ married

_____ divorced

_____ widowed

4. If married, how long in current marriage? _____

5. Age of current spouse _____

6. What is your employment status? (Check one)

_____ full-time homemaker

_____ employed part-time outside the home

_____ employed full-time outside the home

_____ student

7. What is your approximate yearly household income? (Check one)

_____ below $20,000

_____ $20,001–30,000

_____ $30,001–40,000

_____ $40,001-50,000

_____ $50,001-60,000

_____ $60,001-80,000

_____ over $80,000

8. Sexual orientation (Check one)

_____ heterosexual; _____ bisexual; _____ homosexual

9. How religious do you think you are? (Check one)

_____ very religious

_____ moderately religious

_____ not religious

For the remainder of the questions please circle the best answer.

10. How many individuals have you had sexual intercourse with?

a. none

b. only one

c. between two and five

d. between six and ten

e. between eleven and twenty

f. over twenty

11. How many times per week do you usually engage in sexual intercourse?

a. less than once

b. between one and two

c. between three and four

d. between five and seven

e. more than seven

12. How often do you experience orgasm during your sexual encounters (does not have to be sexual intercourse)?

a. never

b. 1-25% of the time

c. 26-50% of the time

d. 51-75% of the time

e. 76-99% of the time

f. 100% of the time

Foreplay is a word that has been used to refer to sexual activity that occurs before intercourse. Afterplay refers to interactions such as

hugging, holding, talking, etc. that occur after intercourse. Not all sexual encounters involve sexual intercourse, but foreplay and after

play are defined here because many of the following questions will refer to them.

13. During which of the following phases of a sexual encounter are you most likely to experience an orgasm?

a. foreplay

b. sexual intercourse

c. afterplay

d. equally in foreplay, intercourse, or afterplay

e. I don’t experience orgasms in my sexual encounters

14. For women only: If you experience orgasm during foreplay do you usually like to then have intercourse?

a. yes

b. no

15. When you engage in sexual intercourse or other intimate sexual acts, which of the following reasons best describes

your motivation

on most occasions?

a. I want the physical release

b. I want to show my love for my partner

c. I am afraid my partner will leave me if I don’t

16. Which aspect of a sexual experience do you enjoy the most?

a. foreplay

b. intercourse

c. afterplay

17. Which of the following is the most important thing that you could get from a sexual experience?

a. a feeling of being emotionally close to my partner

b. the physical release and/or orgasm

c. a feeling that I am in control of my partner

18. Do you usually want to spend more or less time in foreplay than your partner(s)?

a. I want to spend more time

b. I want to spend less time

c. We want to spend about the same amount of time

19. Do you usually want to spend more or less time in afterplay than your partner(s)?

a. I want to spend more time

b. I want to spend less time

c. We want to spend about the same amount of time

20. When you and your partner(s) disagree on the amount of time that should be spent in foreplay, who is more likely to get his/her

way?

a. I am more likely to get my way

b. My partner is more likely to get his/her way

c. We are each likely to get our way half of the time

d. We don’t disagree

21. When you and your partner(s) disagree on the amount of time that should be spent in afterplay, who is more likely to get his/her

way?

a. I am more likely to get my way

b. My partner is more likely to get his/her way

c. We are each likely to get our way half of the time

d. We don’t disagree

22. When you and your partner(s) disagree on the amount of time that should be spent in foreplay or afterplay do you discuss the

problem?

a. We do communicate our disagreements

b. We do not communicate our disagreements

c. We do not disagree on this

23. Which of the following rank orders best describes the importance of the various parts of a sexual encounter to you (the first listed

part should be the most important and the last the least important to you)?

a. foreplay, intercourse, afterplay

b. intercourse, foreplay, afterplay

c. afterplay, intercourse, foreplay

d. foreplay, afterplay, intercourse

e. intercourse, afterplay, foreplay

f. afterplay, foreplay, intercourse

24. How often do you initiate your sexual encounters?

a. never

b. 1-25% of the time

c. 26-50% of the time

d. 51-75% of the time

e. 76-99% of the time

f. 100% of the time

25. Would you prefer your partner(s) to initiate sexual encounters?

a. more than she/he does

b. less than she/he does

c. the same as she/he does

26. In most cases, do you get more sexually aroused by initiating or being pursued during a sexual encounter?

a. initiating the encounter

b. being pursued by my partner

27. What percentage of your sexual encounters would you say you find to be satisfying?

a. none

b. 1-25%

c. 26-50%

d. 51-75%

e. 76-99%

f. 100%

28. How satisfied are you with your typical sexual encounter?

a. extremely satisfied

b. moderately satisfied

c. slightly satisfied

d. not at all satisfied

29. During which of the three phases (foreplay, intercourse, afterplay) of a sexual encounter are you usually most dissatisfied with how your partner responds?

a. foreplay

b. intercourse

c. afterplay

d. I am not dissatisfied with any part

30. Have you ever communicated your dissatisfaction to your partner(s)?

a. yes

b. no

31. If you are dissatisfied, why are you dissatisfied?_____

32. With which of the three phases (foreplay, intercourse, afterplay) are you most satisfied with how your partner responds?

a. foreplay

b. intercourse

c. afterplay

d. I am not satisfied with any part

33. If you are satisfied, what do you find particularly satisfying?_____

34. Do you sometimes have sex to please your partner even though you don’t want to have sex?

a. yes

b. no

Sexual Perfectionism

Exhibit

Multidimensional Sexual Perfectionism Questionnaire

Instructions: Listed below are several statements that concern the topic of sexual relationships. Please read each item carefully and

decide to what extent it is characteristic of you. Some of the items refer to a specific sexual relationship. Whenever possible, answer the

questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your most recent part

ner in mind. If you have never had a sexual relationship, answer in terms of what you think your responses would most likely be. Then,

for each statement fill in the response on the answer sheet that indicates how much it applies to you by using the following scale:

A = Not at all characteristic of me.

B = Slightly characteristic of me.

C = Somewhat characteristic of me.

D = Moderately characteristic of me.

E = Very characteristic of me.

1. I will respond to the following items based on:

(A) A current sexual relationship.

(B) A past sexual relationship.

(C) An imagined sexual relationship.

2. I set very high standards for myself as a sexual partner.

3. Others would consider me a good sexual partner even if I’m not responsive every time.

4. My partner sets very high standards of excellence for

her/himself as a sexual partner.

5. My partner expects me to be a perfect sexual partner.

6. I expect my partner to be a top-notch and competent sexual partner.

7. I must always be successful as a sexual partner.

8. People often expect more of me as a sexual partner than I am capable of giving.

9. My partner is perfectionistic in that this person expects to sexually satisfy me each and every time.

10. My partner demands nothing less than perfection of me as a sexual partner.

11. My partner should never let me down when it comes to my sexual needs.

12. One of my goals is to be a “perfect” sexual partner.

13. Most people expect me to always be an excellent sexual partner.

14. It makes my partner uneasy for him/her to be less than a perfect sexual partner.

15. My partner always wants me to try hard to sexually please him/her.

Sexual Risk

Bandura A. (1986). Social foundations of thought and action. Englewood Cliffs, NJ: Prentice Hall.

Basen-Engquist, K., Masse, L., Coyle, K., Parcel, G. S., Banspach, S., Kirby, D., et al. (1996). Validity of scales measuring the psychosocial determinants of HIV/STD-related risk behavior in adolescents. Unpublished manuscript.

Coyle, K., Kirby, D., Parcel, G., Basen-Engquist, K., Banspach, S., Rugg, D., et al. 1996). Safer Choices: A multi-component school-based HIV/ STD and pregnancy prevention program for adolescents. Journal of School Health, 66, 89-94. Fishbein, M., & Ajzen, I.(1975). Beliefs, attitudes, intentions, and behavior: An introduction to theory and research. Reading, MA: AddisonWesley. Rosenstock, I. M. (1974). Historical origins of the Health Belief Model. In: M. H. Becker (Ed.), The Health Belief Model and personal health behavior (Vol. 2, pp. 328-335). Thorofare, NJ: Charles B. Slack.

Exhibit

Student Health Questionnaire

Your beliefs

Please fill in the answer for each question that best describes how you feel.

ASI1. I believe people my age should wait until they are older before they have sex.

*ASI2. I believe it’s OK for people my age to have sex with a steady boyfriend or girlfriend.

ACU1. I believe condoms (rubbers) should always be used if a person my age has sex.

ACU2. I believe condoms (rubbers) should always be used if a person my age has sex, even if the girl uses birth control pills.

ACU3. I believe condoms (rubbers) should always be used if a person my age has sex, even if the two people know each other very well.

What do your friends believe?

The following questions ask you about your FRIENDS and what they think. Even if you're not sure, mark the answer that you think best

describes what they think.

NSI1. Most of my friends believe people my age should wait until they are older before they have sex.

*NSI2. Most of my friends believe it's OK for people my age to have sex with a steady boyfriend or girlfriend.

NCU1. Most of my friends believe condoms (rubbers) should always be used if a person my age has sex.

NCU2. Most of my friends believe condoms (rubbers) should always be used if a person my age has sex, even if the girl uses birth control pills.

NCU3. Most of my friends believe condoms (rubbers) should always be used if a person my age has sex, even if the two people know each other very well.

How sure are you?

What if the following things happened to you? Imagine that these situations were to happen to you. Then tell us how sure you are that

you could do what is described.

SER1. Imagine that you met someone at a party. He or she wants to have sex with you. Even though you are very attracted to each other, you're not ready to have sex. How sure are you that you could keep from having sex?

SER2. Imagine that you and your boyfriend or girlfriend have been going together, but you have not had sex. He or she really wants to have sex. Still, you don't feel ready. How sure are you that you could keep from having sex until you feel ready?

SER3. Imagine that you and your boyfriend or girlfriend decide to have sex, but he or she will not use a condom (rubber). You do not want to have sex without a condom (rubber). How sure are you that you could keep from having sex, until your partner agrees it is OK to use a condom (rubber)?

SECM1. Imagine that you and your boyfriend or girlfriend

have been having sex but have not used condoms (rubbers). You really want to start using condoms (rubbers). How sure are you that you could tell your partner you want to start using condoms (rubbers)?

SECM2. Imagine that you are having sex with someone you just met. You feel it is important to use condoms (rubbers). How sure are you that you could tell that person that you want to use condoms (rubbers)?

SECM3. Imagine that you or your partner use birth control pills to prevent pregnancy. You want to use condoms (rubbers) to keep from getting STD or HIV. How sure are you that you could convince your partner that you also need to use condoms (rubbers)?

SECU1. How sure are you that you could use a condom (rubber) correctly or explain to your partner how to use a condom (rubber) correctly?

SECU2. If you wanted to get a condom (rubber), how sure are you that you could go to the store and buy one?

SECU3. If you decided to have sex, how sure are you that you could have a condom (rubber) with you when you needed it? What do you think about condoms? Please tell us how much you agree or disagree with the following statements. BCU1. It would be embarrassing to buy condoms (rubbers) in a store. BCU2. I would feel uncomfortable carrying condoms (rubbers) with me. BCU3. It would be wrong to carry a condom (rubber) with me because it would mean that I'm planning to have sex. Key to identification of scale items and description of response formats: ASI = Attitudes about sexual intercourse ACU = Attitudes about condom use NSI = Norms about sexual intercourse NCU = Norms about condom use Response format for attitude and norm items: 4 = Definitely Yes 3 = Probably Yes 2 = Probably No 1 = Definitely No SER = Self-efficacy for refusing sexual intercourse SECM = Self-efficacy for communicating about condom use SECU = Self-efficacy for buying and using condoms Response format for self-efficacy items: 1 = Not Sure at All 2 = Kind of Sure 3 = Totally Sure BCU = Barriers to condom use Response format for barrier items: 4 = I Strongly Agree 3 = I Kind of Agree 2 = I Kind of Disagree 1 = I Strongly Disagree *Item should be scored in reverse. Health Protective Sexual Communication Scale JOSEPH A. CATANIA, 1 University of California, San Francisco 1 Address correspondence to Joseph A. Catania, College of Health and Human Sciences, Oregon State University, 320B Waldo Hall, Corvallis, OR 97331; e-mail:

Joseph.Catania@oregonstate.edu 2 Portions of the NABS survey data collected from the NABS cohort study used to report indexes of reliability and validity are available on request from the author. The Health Protective Sexual Communication Scale (HPSC) is a self-report scale that assesses how often respondents discuss health protective topics while interacting with a new, first-time sexual partner. Items address health protective concerns related to safer sex, sexual histories, and contraceptive use. Moreover, the scale assesses communication that has health protective consequences as distinct from sexual communication that may be related to enhancement of sexual pleasure. The expanded 10-item scale was based on an extension of two brief scales that have been used in two national survey studies to assess the ability to discuss sexual histories and condom use with prospective sexual partners. Findings indicate both the brief and expanded HPSC scales to be strongly linked to high-risk sexual behaviors that include multiple partners, condom use, and alcohol use before sex (Catania, 1995; Catania, Coates, & Kegeles, 1994; Dolcini, Coates, Catania, Kegeles, & Hauck, 1995). 2

3 For further details on sampling methods for the AMEN cohort study, see Catania, Coates, Kegeles, et al. (1992).

Description

The original self- or interviewer-administered scale is com

posed of three items rated on a 3-point scale (1, happened

with all partners; 2, happened with some partners; 3, didn’t

happen). The revised, expanded scale is a 10-item Likert

type rating scale with two questions that need to be excluded

when administering the scale to gay individuals. Each item

is rated on a 4-point scale (4 = always, 1 = never).

Response Mode and Timing

The scales are available in Spanish and English. Both the

short and the expanded forms are self- or interviewer

administered and take approximately 1–2 minutes to com

plete.

Scoring

Total scores on the brief three-item HPSC scale are pro
duced by reverse scoring and summing across items for a
total scale score. Total scores on the expanded HPSC scale
are obtained by summing across items.

Reliability and Validity

The HPSC scale has been administered to varied popula
tions, including adolescents and national urban probability
samples constructed to adequately represent White, Black,
and Hispanic ethnic groups, as well as high HIV-risk
groups (Catania et al., 1994; Catania, Kegeles, & Coates,
1990; Dolcini et al., 1995). The original brief version of
the
HPSC scale was used on a population of 114 adolescent
females who participated in a study (Catania et al., 1990)
that examined psychosocial correlates of condom use and
multiple partner sex. Respondents, recruited from a family
planning clinic in California, were White (92%), Hispanic
(4%), and other (4%) and ranged in age from 12 to18 years.
The majority of respondents were heterosexual, unmar
ried, and sexually active. Reliability was good (Cronbach's
alpha = .67). A hierarchical multiple regression model, in
which several predictor variables known to be related to
sexual risk were examined, revealed that a greater willing

ness to request partners to use condoms as indicated by HPSC scores was associated with more frequent condom use and multiple partners (Catania et al., 1990).

The original three-item Health Communication Sexual Scale was also administered to respondents who participated in a study (Catania et al., 1994) examining the incidence of multiple partners and related psychosocial correlates, as part of the AIDS in Multi-Ethnic Neighborhoods (AMEN) 3 study (Catania, Coates, Kegeles, et al., 1992). The AMEN study is a longitudinal study (three waves) examining the distribution of HIV, sexually transmitted diseases (STDs), related risk behaviors, and their correlates across social strata. The multiple partner study sample, which used data generated from Wave 2, restricted inclusion criteria to unmarried heterosexuals who revealed an HIV-related risk marker at Wave 2, and being sexually active between Wave 1 and 2. Respondents ranged from 20–44 years of age. Reliability was excellent (Cronbach's alpha = .84). The mean, standard deviation, median, range, and reliabilities of ethnic groups, gender, and levels of education are provided in Table 1. TABLE 1 Normative Data for the Health Protective Sexual Communication Scale n Mean SD Range Mdn Alpha NABS study a National sample 155 23.82 8.21 30.0 24.0 .88 High-risk cities 810 22.93 7.32 30.0 22.0 .84 Ethnicity White National sample 101 23.06 8.19 30.0 22.3 .88 High-risk cities 342 22.53 7.02 30.0 21.9 .83 Black National sample 47 25.62 8.13 29.0 28.0 .87 High-risk cities 329 24.35 7.33 30.0 24.0 .83 Hispanic National sample 8 23.01 3.30 15.0 24.0 .60 High-risk cities 125 21.90 8.12 30.0 21.0 .87 Gender Male National sample 81 22.57 8.22 29.0 22.1 .90 High-risk cities 414 21.22 6.72 29.0 20.0 .64 Female National sample 68 25.88 7.85 30.0 27.2 .84 High-risk cities 379 25.30 7.46 30.0 25.0 .82 Education < 12 years National sample 14 22.24 6.01 17.0 24.0 .76 High-risk cities 97 24.78 7.89 30.0 24.0 .55 = 12 years National sample 49 23.67 8.50 29.0 22.9 .88 High-risk cities 196 22.36 7.53 30.0 22.0 .85 > 12 years National sample 91 24.53 8.48 30.0 25.0 .88 High-risk cities 517 22.74 7.02 30.0 22.0 .83 The AMEN b

Study Total 320 22.82 7.81 30.0 22.0 .84 Ethnicity White 146 23.05 7.86 30.0 22.1 .86 Black 72 23.69 7.79 30.0 23.0 .83 Hispanic 85 21.57 7.65 30.0 20.0 .84 Gender Male 155 20.64 7.34 30.0 19.0 .84 Female 165 24.86 7.71 30.0 24.0 .83 Education < 12 years 41 20.32 7.30 24.0 21.0 .83 = 12 years 65 23.34 8.34 30.0 22.0 .87 > 12 years 212 23.11 7.72 30.0 22.0 .84 a National AIDS Behavior Survey b AIDS in Multi-Ethnic Neighborhoods In earlier analysis with the HPSC scale, we examined whether its relationship to condom use was continuous across all scale values (Catania, Coates, Kegeles, et al., 1992). The scale was found to have a significant relationship to condom use primarily for those respondents scoring in the upper one third of the scale, indicating that people who consistently communicate about sexual matters across sexual encounters and partners are significantly more likely to use condoms. Thus, the HPSC scale was scored by dichotomizing the measure so that high scores included the upper one third of scores and low scores were composed of the lower two thirds of scores. Findings from the AMEN study revealed that high levels of health protective sexual communication were significantly correlated with high levels of condom use. In another AMEN cohort analysis, the original HPSC scale was examined in relationship to incidence of multiple partners (Dolcini et al., 1995). Reliability was fair (Cronbach's alpha = .50) for respondents who also reported two or more sex partners in the past year. A regression model for all respondents with a primary sexual partner revealed that those who also had a new sexual partner in the past year (n = 201), and low heath protective communication (odds ratio = 1.3 per unit decrease in health protective communication, 95% confidence interval = 1.05, 1.5), were associated with having multiple partners. We conducted further analyses on the expanded Health Communication Scale Measure used in the 1990-1991 National AIDS Behavior Survey 4 (NABS) longitudinal

study (Wave 2), which was composed of three interlaced

samples designed to oversample African Americans and

Hispanics for adequate representation. The interlaced

samples included a national sample, an urban sample of 23

cities with high prevalences of AIDS cases, and a special

Hispanic urban sample. In our analyses of the expanded

HPSC scale, we limited our sample to respondents who

reported having at least one partner in the past 12 months, were heterosexual (defined as respondents who only had opposite gender sexual partners in the past 5 years), aged 18–49, and completed the HSPC scale. Respondents who described themselves as Asians, Native Americans, and Pacific Islanders were excluded because they were not adequately represented for analysis purposes (n = 24). Because the intent of our analyses was to examine relation ships between variables, sample segments were combined without the use of poststratification weights. The result ing increase in power allowed for the detection of even very small relationships. Internal reliability was excellent (Cronbach's alpha = .85). Means, standard deviations, range, median, and reliability are given for White, Black, and Hispanic ethnic groups; males and females; and levels

Exhibit

Health Protective Sexual Communication Scale

Instructions: Now I am going to read a list of things that people talk about before they have sex with each other for the first time. How

often in the past 12 mos. have you . . . (read each).Would you say always, almost always, sometimes, or never?

1 = Never 2 = Sometimes 3 = Almost always 4 = Always 6 = Don't know 7 = Declined to answer

1. Asked a new sex partner how (he/she) felt about using condoms before you had intercourse.

2. Asked a new sex partner about the number of past sex partners (he/she) had.

3. Told a new sex partner about the number of sex partners you have had.

4. Told a new sex partner that you won't have sex unless a condom is used.

5. Discussed with a new sex partner the need for both of you to get tested for the AIDS virus before having sex.

6. Talked with a new sex partner about not having sex until you have known each other longer.

7. Asked a new sex partner if (he/she) has ever had some type of VD, like herpes, clap, syphilis, gonorrhea.

8. Asked a new sex partner if (he/she) ever shot drugs like heroin, cocaine, or speed.

9. Talked about whether you or a new sex partner ever had homosexual experiences.

10. Talked to a new sex partner about birth control before having sex for the first time.

Note. Items 1, 2, and 4 were used in the original short version. Items 9 and 10 are excluded for gay men and lesbians.

Safe Sex Behavior Questionnaire

COLLEEN DIIORIO, 1 Emory University

1 Address correspondence to Colleen DiIorio, Emory University, Rollins School of Public Health, Department of Behavioral Sciences and Health

Education, 1518 Clifton Road NE, Atlanta, GA 30322; e-mail: cdiiori@emory.edu

The Safe Sex Behavior Questionnaire (SSBQ) was

designed to measure frequency of use of recommended

practices that reduce one's risk of exposure to, and trans

mission of, HIV.

Description

An information pamphlet sent in May and June of 1988

to all U.S. households by the Surgeon General's office,

Understanding AIDS, was used as a guide to select items

that reflect safe-sex practices (DiIorio, Parsons, Lehr,

tices within the pamphlet were identified and classified

into one of the following categories: (a) protection during

intercourse, (b) avoidance of risky behaviors, (c) avoid

ance of bodily fluids, and (d) interpersonal skills. Based

on these statements, 27 items were written and selected for

review by content experts. Experts were asked to evalu

ate each item for meaning, clarity, and correspondence to

Risk Behavior Assessment

DENNIS G. FISHER, 1 LUCY E. NAPPER, AND GRACE L. REYNOLDS, California State

University, Long Beach

MARK E. JOHNSON, University of Alaska, Anchorage

1 Address correspondence to Dennis G. Fisher, Center for Behavioral Research and Services, 1090 Atlantic Ave., Long Beach, CA 90813; e-mail:

dfisher@csulb.edu

*15. I engage in anal intercourse. 1 2 3 4

16. I ask my potential sexual partners about a history of IV drug use. 1 2 3 4

17. If I know an encounter may lead to sexual intercourse, I have a mental plan to practice

safer sex. 1 2 3 4

18. If my partner insists on sexual intercourse without a condom, I refuse to have sexual

intercourse. 1 2 3 4

19. I avoid direct contact with my sexual partner's blood. 1 2 3 4

*20. It is difficult for me to discuss sexual issues with my sexual partners. 1 2 3 4

21. I initiate the topic of safer sex with my potential sexual partner. 1 2 3 4

*22. I have sexual intercourse with someone who I know is a bisexual or gay person. 1 2 3 4

*23. I engage in anal intercourse without using a condom. 1 2 3 4

*24. 1 drink alcoholic beverages prior to or during sexual intercourse. 1 2 3 4

*Negatively worded items.

© Colleen DiIorio, 2009

The instrument was developed to document behaviors

that put individuals at risk for infection with the Human

Immunodeficiency Virus (HIV). A companion instrument,

the Risk Behavior Follow-up Assessment (RBFA), is avail

able in 3-month and 6-month versions. The RBA-RBFA

system was originally designed to measure intervention

effects in the National Institute on Drug Abuse (NIDA)

Cooperative Agreement for HIV/AIDS Community-Based

Outreach/Intervention Research program (CA).

Description

The instrument was developed by the Community

Research Branch of NIDA along with principal investiga

tors in the NIDA CA. The original RBA was revised twice

with the final version consisting of the following sections:

preliminary data, such as ID number, and interview date

and time (Section P); demographics (A); drug use (B); C

is only for those respondents who have injected drugs in

the 30 days prior to interview (C); recent drug use in the

last 48 hours (D); drug treatment history (E); sexual risk

behavior with separate subsections for men who have sex

with men, men who have sex with women, men who have

sex with both men and women, women who have sex with

Exhibit

Risk Behavior Assessment (sample items)

Now, we are going to talk about your sexual practices, including each of the times you have had vaginal, oral, and anal sex. We are also

talking about all types of partners: regular partners, partners for money, drugs, or whatever.

Q25. How many days in the last 30 days have you had sex (vaginal, oral, and/or anal)?

DK/Unsure Refused

Days ___ ___ 77 88

Q26. During the last 30 days, how many different people have you had vaginal, oral, and/or anal sex with?

DK/Unsure Refused Skip

___ ___ ___ 777 888 999

Q27. How many of your sex partners were likely to have been drug injectors or shooters?

DK/Unsure Refused Skip

___ ___ ___ 777 888 999

Q28. How many of your sex partners were female?

DK/Unsure Refused Skip

___ ___ ___ 777 888 999

Q29. How many of your sex partners were male?

DK/Unsure Refused Skip

___ ___ ___ 777 888 999

Now I want to ask you more specific questions about your vaginal, oral, and/or anal sexual practices. When I ask you these questions, I

want you to think about all the partners that you have had sex with in the last 30 days, not just your main or last partner.

Q30. How many times in the last 30 days when you had sex did you put your penis in your partner’s vagina?

DK/Unsure Refused Skip NA

Times ___ ___ ___ 777 888 999 666

(IF “000,” GO TO Q31.)

Q30a. Of these ____ (NUMBER FROM Q30) times, how many times did you use a condom?

DK/Unsure Refused Skip NA

Times ___ ___ ___ 777 888 999 666

Q31. How many times in the last 30 days when you had sex did you put your penis in your partner’s mouth?

DK/Unsure Refused Skip NA

Times ___ ___ ___ 777 888 999 666

(IF “000,” GO TO Q32.)

Q31a. Of these ____ (NUMBER FROM Q31) times, how many times did you use a condom?

DK/Unsure Refused Skip NA

Times ___ ___ ___ 777 888 999 666

Q32. How many times in the last 30 days when you had sex did you put your mouth on your partner’s vagina?

DK/Unsure Refused Skip NA

Times ___ ___ ___ 777 888 999 666

(IF “000,” GO TO Q33.) Q32a. How many of those ____ (NUMBER FROM Q32) times did your partner use latex or other barrier protection? DK/Unsure Refused Skip NA Times ___ ___ ___ 777 888 999 666 Q33. How many times in the last 30 days when you had sex did you put your penis in your partner’s anus? DK/Unsure Refused Skip NA Times ___ ___ ___ 777 888 999 666 Q33a. Of these ____ (NUMBER FROM Q33) times, how many times did you use a condom? DK/Unsure Refused Skip NA Times ___ ___ ___ 777 888 999 666 Q58. In the last 30 days, how many times have you used the following drugs immediately before or during sex? Times DK/Unsure Refused Skip A Alcohol __ __ __ 777 888 999 B Marijuana/hashish __ __ __ 777 888 999 (weed, grass, reefers)? C Crack? __ __ __ 777 888 999 D Cocaine by itself __ __ __ 777 888 999 (other than crack) that you injected or snorted? E Heroin (by itself)? __ __ __ 777 888 999 F Heroin and cocaine mixed together (e.g., speedball)? __ __ __ 777 888 999 G Nonprescription methadone? __ __ __ 777 888 999 H Other opiates (e.g., demerol, codeine, dilaudid)? __ __ __ 777 888 999 I Amphetamines (e.g., speed, uppers, bennies)? __ __ __ 777 888 999 J Some other drug? __ __ __ 777 888 999 (Specify: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __)

Sexual Risk Survey

JESSICA A. TURCHIK 1 AND JOHN P. GARSKE, Ohio University

Risky sexual behavior among college students is a signifi

cant problem that warrants scientific investigation. Other

measures of sexual risk taking either are too narrowly

focused to be used with college students or do not have

adequate psychometric properties. The Sexual Risk Survey

(SRS; Turchik & Garske, 2009) was developed to provide

a broad and psychometrically sound measure of sexual risk

taking to researchers interested in studying college stu
dents.

Description

The SRS was developed to assess the frequency of sexual risk behaviors in the past 6 months among college students. The SRS was developed at a midsized midwestern univer
sity with a sample of 613 male and female undergraduate students (Turchik & Garske, 2009). The survey was origi
nally composed of 37 items taken from past surveys of sex
ual risk behaviors and from suggestions in the literature. Descriptive analyses and a principal components analysis with varimax rotation were used to reduce data from the original 37 SRS items. Items were eliminated based on low number of responses above 0 (< 10%), low item-total cor
relations (< .40), low communalities (< .40), and low factor loadings (< .40). Fourteen items were eliminated based on these criteria; the final survey comprises 23 items.

Response Mode and Timing

Participants are asked to read the 23 items, each describing a sexual risk behavior, and to indicate in a free-response format the number of times they engaged in each behavior over the past 6 months. The SRS was developed as a paper and-pencil self-administered survey that can be given in groups. The survey typically takes participants 5 to 10 minutes to complete. The SRS has also been given in an

individual-structured interview format. The responses to the survey and the interview were found to be highly cor related (r = .90).

Scoring

Given that sexual risk-taking scores are typically posi tively skewed, the data will likely need to be recoded or transformed to reduce skewness in the frequencies reported by the students. In the original study (Turchik & Garske, 2009), the responses to the 23 items were recoded into an ordinal series of categories to reduce the variability and skewness in the raw score totals. The raw numbers for each item were recoded into categories coded as 0 to 4. Codes of “0” only included frequencies of 0. Next, the remaining frequencies were examined for the sample and were treated as if they represented 100% of the frequencies. Because the data were negatively skewed, the following guideline was used to classify the frequencies greater than 0: 1 = 40% of responses, 2 = 30% of responses, 3 = 20% of responses, and 4 = 10% of responses. However, in practice, with the restricted variability of frequencies in many of the items, it was often not possible to classify the frequencies in this manner. Also, the distribution of frequencies will likely be different based on the sample, and researchers should not assume the ordinal categories used in one study would be valid in another sample. An alternative way to reduce skewness in the data is to perform some other normalizing technique, such as a logarithmic or inverse transformation, because the distribution will likely not be normally distributed. Researchers should refer to the original article for more discussion on this issue (Turchik & Garske, 2009). Once the items are recoded with scores from 0 to 4, all 23 items are summed for the total sexual risk-taking score, with scores ranging from 0 to 92 based on the original score “blocking” technique. A principal components analysis revealed five subscales that can also be scored: Sexual Risk Taking With Uncommitted Partners (8 items), Risky Sex Acts (5 items), Impulsive Sexual Behaviors (5 items), Intent to Engage in Risky Sexual Behaviors (2 items), and Risky Anal Sex Acts (3 items). Reliability The SRS has demonstrated good internal consistency and

test-retest reliability (Turchik & Garske, 2009). The internal consistency of the total Sexual Risk Survey with all 23 items was .88. For the five subscales, the Cronbach's alphas were .88, .80, .78, .89, and .61 for Sexual Risk Taking With Uncommitted Partners, Risky Sex Acts, Impulsive Sexual Behaviors, Intent to Engage in Risky Sexual Behaviors, and Risky Anal Sex Acts, respectively. The 2-week testretest reliability for the total Sexual Risk Survey was .93. The 2-week test-retest reliabilities for the Sexual Risk Taking With Uncommitted Partners, Risky Sex Acts, Impulsive Sexual Behaviors, Intent to Engage in Risky Sexual Behaviors, and Risky Anal Sex Acts factors were .90, .89, .79, .70, and .58, respectively. The inclusion or exclusion of the Risky Anal Sex Act items did not affect

1 Address correspondence to Jessica A. Turchik, Ohio University, 200 Porter Hall, Athens, OH 45701; e-mail: jt865504@ohio.edu the internal consistency or test-retest reliability of the total scale. Validity The SRS has demonstrated evidence of content, concurrent, and convergent validity (Turchik & Garske, 2009). Content validity was supported by inclusion of items based on a review of the literature, an examination of previous measures of sexual risk taking, and a pilot study of college students. The SRS demonstrated evidence of convergent and concurrent validity by its relationships with a number of other measures predicted to be related to sexual risk behaviors based on past literature. The SRS evidenced discriminant validity with low correlations with measures of social desirability and sexual threat of disclosure. Other Information The measure was originally given with a glossary of terms that might not be familiar to some participants and with a calendar of the last 6 months. Questions to help participants remember their sexual experiences over this time period were also included to help enhance accurate recall. Further information concerning the measure can be found in the original article (Turchik & Garske, 2009) or by contacting the first author. Reference Turchik, J. A., & Garske, J. P. (2009). Measurement of sexual risk taking among college students. Archives of Sexual Behavior, 38, 936–948.

Exhibit

Sexual Risk Survey

Instructions: Please read the following statements and record the number that is true for you over the past six months for each ques

tion on the blank. If you do not know for sure how many times a behavior took place, try to estimate the number as close as you

can. Thinking about the average number of times the behavior happened per week or per month might make it easier to estimate an

accurate number, especially if the behavior happened fairly regularly. If you've had multiple partners, try to think about how long you

were with each partner, the number of sexual encounters you had with each, and try to get an accurate estimate of the total number of

each behavior. If the question does not apply to you or you have never engaged in the behavior in the question, put a "0" on the blank.

Please do not leave items blank. Remember that in the following questions "sex" includes oral, anal, and vaginal sex and

that "sexual behavior" includes passionate kissing, making out, fondling, petting, oral-to-anal stimulation, and hand

to-genital stimulation. Refer to the Glossary a for any words you are not sure about. Please consider only the last six months when

answering and please be honest.

In the past six months:

1. ____ How many partners have you engaged in sexual behavior with but not had sex with?

2. ____ How many times have you left a social event with someone you just met?

3. ____ How many times have you "hooked up" but not had sex with someone you didn't know or didn't know well?

4. ____ How many times have you gone out to bars/parties/social events with the intent of "hooking up" and engaging in sexual behavior but not having sex with someone?

5. ____ How many times have you gone out to bars/parties/social events with the intent of “hooking up” and having sex with someone?

6. ____ How many times have you had an unexpected and unanticipated sexual experience?

7. ____ How many times have you had a sexual encounter you engaged in willingly but later regretted?

For the next set of questions, follow the same direction as before. However, for questions 8-23, if you have never had sex (oral, anal, or vaginal), please put a “0” on each blank.

8. ____ How many partners have you had sex with?

9. ____ How many times have you had vaginal intercourse without a latex or polyurethane condom? Note: Include times when you have used a lambskin or membrane condom.

10. ____ How many times have you had vaginal intercourse without protection against pregnancy?

11. ____ How many times have you given or received fellatio (oral sex on a man) without a condom?

12. ____ How many times have you given or received cunnilingus (oral sex on a woman) without a dental dam or “adequate protection” (please see definition of dental dam for what is considered adequate protection)?

13. ____ How many times have you had anal sex without a condom?

Sexually Explicit Material

Exhibit

Sexual Scripts Overlap Scale—Short Version

The “Great Sex” Script Items The Pornographic Script Items

How important for great sex do you personally find: a How important for pornographic depiction of sex do you find:

1 = Not at all 2 = Somewhat 3 = Moderately 4 = A Great Deal 5 = Exceptionally

1. I am always ready for sex b 1. Men are always ready for sex

2. My partner is always ready to have sex c 2. Women are always ready for sex

3. It is easy to initiate sex 3. (same)

Sexually Transmitted Infections (see also specific diseases)

Exhibit

STI Education Efficacy Survey

The following statements are to assess your understanding of STIs.

If you definitely know that a statement is True, answer 1

If you definitely know that a statement is False, answer 2

If you do not definitely know the answer (Don’t Know), answer 3

1. About one-half of 12th graders have engaged in intercourse and one-half have not.

2. About one in five young people have had intercourse before their 15th birthday.

3. Oral sex is more common among many teenagers than is engaging in vaginal-penile intercourse.

4. About one in 10 sexually active youth have a sexually transmitted infection (STI).

5. Half of the people in the U.S. will acquire at least one STI by age 35.

6. Human papilloma virus (HPV) is the most common bacterial STI in the U.S.

7. The majority of females with chlamydia do not have any detectable symptoms.

8. Vaginal infections, like trichomoniasis, can not be transmitted to males.

9. People know when they get syphilis because a very painful sore, or chancre, appears.

10. Females are more likely to have symptoms of gonorrhea than are males.

11. All bacterial STIs can be cured with penicillin.

12. HPV accounts for about 90% of cervical cancer risk.

13. HPV can still be spread even when there are no warts present.

14. The most effective method to cure genital warts is through surgical removal.

15. Herpes is only infectious when there are open lesions present.

16. Herpes Simplex I (oral herpes/cold sores) can not be transmitted to the genital area.

17. Hepatitis B is more infectious than HIV.

18. HIV can not be transmitted through oral sex.

19. A person can be HIV-infected but still test negative.

20. Heterosexual females and males are at little risk for AIDS.

21. The most common cause of infertility among U.S. females is chlamydial infection.

22. Currently there are no vaccines to prevent becoming infected with any type of STI caused by a virus.

23. Natural membrane condoms are more effective in preventing STIs than latex condoms.

24. Oil-based products, such as Vaseline, are good to use for added lubrication with condoms so that they don't break.

25. Because of an emphasis on abstinence-only education, the U.S. has lower rates of STIs than western European countries.

Adolescents and Sexuality/Sex Education

Please indicate your reactions to the following statements on your response sheet:

1 Strongly Disagree

2 Disagree

3 Uncertain

4 Agree

5 Strongly Agree

26. Sexual expression is a natural part of development for adolescents.

27. Most high school students are not mature enough to act sexually responsible even when they know the facts.

28. Young people need to remain sexually abstinent until marriage.

29. Young people should not think of sexuality as taboo, shameful, or dirty.

30. Most teenagers do not want sexuality education from their parents or in school.

31. Having information about contraceptives, including condoms, only encourages young people to be promiscuous.

32. Young people need as much information as possible in order to make responsible decisions.

33. Abstinence-only education is more effective in preventing STIs than education that discusses safer sex as well.

34. Young people who receive more comprehensive sexuality education are less likely to engage in intercourse at younger ages and are more likely to use contraception when they do have intercourse.

35. Most parents in the U.S. do not support the teaching of sexuality education in the schools. STI Education Efficacy In teaching about STIs/HIV, please indicate how you feel about the following using this scale: 1 No Confidence at all 2 Very Little Confidence 3 Somewhat Confident 4 Very Confident 5 Extremely Confident 36. The currency and accuracy of my knowledge. 37. The comprehensiveness of my knowledge. 38. My comfort level in talking about these topics with young people. 39. My comfort level in talking about these topics with my colleagues and supervisors. 40. My ability to develop lessons and learning activities to effectively teach about these topics. 41. My skill in developing open communication with young people about these topics. 42. My ability to develop curriculum or programs on these topics. 43. My understanding of the experiences of today’s young people

that impact their sexuality and STI risk. When it comes to STI education, how would you describe your readiness (including your willingness and ability) to: 1 Not Ready at all 2 Hardly Ready 3 Somewhat Ready 4 Very Ready 5 Extremely Ready 44. Advocate for better education and services for teens. 45. Share my knowledge and skills with my colleagues. 46. Serve as a resource person for people who need help with these topics. 47. Influence curriculum/program development in my school or agency related to these topics. 48. Influence policy either in my school, agency, or community related to these topics. STD Attitude Scale WILLIAM L. YARBER, 1 AND MOHAMMAD R. TORABI, Indiana University C. HAROLD VEENKER, Purdue University 1 Address correspondence to William L. Yarber, Department of Applied Health Science, Indiana University, HPER Building, Bloomington, IN 47405; e-mail: yarber@indiana.edu. Researchers have found that attitudes are best described as multidimensional, having the three components of cognitive (belief), affective (feeling), and conative (intention to act). Beliefs express one's perceptions or concepts toward an attitudinal object; feelings are described as an expression of liking or disliking relative to an attitudinal object; and intention to act is an expression of what the individual says he/she would do in a given situation (Bagozzi, 1978; Kothandapani, 1971; Ostrom, 1969; Torabi & Veenker, 1986). Attitudes are one important component determining individual health-risk behavior. More attention is now given by health educators to improving or maintaining health-conducive attitudes. A scale designed specifically to measure the components of attitudes toward sexually transmitted diseases (STDs) can be valuable to educators and researchers in planning STD education and determining risk correlates of individuals.

Description

The STD Attitude Scale was developed to measure young

adults' beliefs, feelings, and intentions to act regarding

sexually transmitted diseases. The scale discriminates

between individuals with high-risk attitudes toward STD

contraction and those with low-risk attitudes. A sum

mated rating scale utilizing the 5-point Likert-type format

and having three subscales reflecting the attitude compo

nents was constructed. Items were developed according to a table of specifications containing three conceptual areas: nature of STD, STD prevention, and STD treatment. Each subscale contained items from the three conceptual areas. An extensive pool of items was generated from the literature, expert contribution, and via item solicitation from students. To avoid the possibility of a response set, both positive and negative items were developed. Attention was given to the readability of each item. From the item pool, three preliminary forms with 45 items each (15 items per subscale) were administered to 457 college students. Following statistical analysis, one scale containing the 45 items (15 per subscale) that best met item selection criteria of internal consistency and discrimination power was given to 100 high school students. A further refined scale of 33 items (11 items per subscale), subjected to jury review, was given to 2,980 secondary school students. Analysis of these data produced the final scale of 27 items, 9 items for each subscale. The final scale has items with highly significant levels of internal consistency (item score vs. subscales and total scale score) and discriminating power (upper group vs. lower group for each item).

Response Mode and Timing

Respondents indicate whether they strongly agree, agree, are undecided, disagree, or strongly disagree with each statement. The scale takes an average of 15 minutes to complete.

Scoring

Scoring is as follows: Total scale, Items 1–27; Belief subscale, Items 1–9; Feeling subscale, Items 10–18; and Intention to Act subscale, Items 19–27. Calculate total points for each subscale and total scale by using the follow ing point values. For Items 1, 10–14, 16, and 25: strongly agree = 5, agree = 4, undecided = 3, disagree = 2, and strongly disagree = 1. For Items 2–9, 15, 17–24, 26, and 27: strongly agree = 1, agree = 2, undecided = 3, disagree = 4,

Signaling (see Initiative/Initiation)

Questionnaire of Cognitive Schema Activation

in Sexual Context

PEDRO J. NOBRE, 1 Universidade de Trás-os-Montes e Alto Douro, Portugal

J OSÉ PINTO-GOUVEIA, Universidade de Coimbra, Portugal

1 Please address correspondence to Pedro Nobre, Universidade de Trás-os-Montes e Alto Douro, Apartado 1013, 5001-801 Vila Real, Portugal; e-mail:

pnobre5@gmail.com

3 = Somewhat Uncharacteristic of Me

4 = Somewhat Characteristic of Me

5 = Rather Characteristic of Me

6 = Very Characteristic of Me

1. When I am in the middle of sexual play and am aroused, but do not want the activity to progress any further, I am often able to change my aroused feelings so that I am able to prevent the activity from progressing.

2. I often give in to unwanted sexual activity.

3. When I feel upset while engaged in unwanted sexual activity, I try not to think about it.

4. When I am faced with unwanted sexual activity/advances, I have no difficulty leaving the situation.

5. While engaged in unwanted sexual activity, I think I’m making a mistake, but I’m at a loss to do anything about it.

6. I usually consent to unwanted sexual activity when my partner is pressuring me.

7. When I am experiencing unwanted sexual activity/advances, I prefer to not think about it and go along with the activity instead.

8. If I was in the middle of sexual play which I no longer

wanted to continue, I could tell him to stop.

9. When I have become aroused from sexual play, but do not want to continue any further, I am able to resist engaging in the sexual activity by thinking about the good reasons for stopping.

10. Although I feel bad about hurting my partner's feelings, I am able to let him know when I am uncomfortable with a sexual situation.

11. I feel good about myself when I resist unwanted sexual advances.

12. When experiencing unwanted sexual activity/advances, I often tell myself that I can do something about it.

13. When I am about to engage in unwanted sexual activity, I tell myself to stop and think before I do anything.

14. I consider my actions very carefully when deciding whether or not to participate in unwanted sexual activity.

15. I always have a back-up plan for when I am faced with unwanted sexual advances/activity that get out of control.

16. It takes a lot of effort on my part to bring unwanted sexual advances/activity to a halt.

17. When presented with unwanted sexual advances/activity, I base my decision on my arousal and how I feel in the moment, even if I know I will regret it later.

18. When engaging in unwanted sexual activity, I try to divert my thoughts from how uncomfortable I feel.

19. I plan in advance how far I want to go with any sexual activity, and am able to stop the activity before it goes too far.

a This scale follows each of the scale statements.

The Questionnaire of Cognitive Schema Activation in

Sexual Context (QCSASC; Nobre & Pinto-Gouveia, 2009)

assesses the activation of negative self-schemas to negative

sexual events. The measure assesses the activation of these

self-schemas (using a list proposed by Judith Beck, 1995), following the presentation of four negative sexual events associated with the most common sexual dysfunctions in men and women. The QCSASC is a measure that might be clinically useful in helping to assess the role of cognitive variables on sexual functioning, and eventually contributing to a better understanding of cognitive processes underlying sexual problems. Description The QCSASC is a 28-item instrument that assesses cognitive schemas presented by the participants when facing negative sexual situations. The first part consists of the presentation of four sexual situations related to the most common sexual dysfunctions: desire disorder, erectile TABLE 1 Items, Minimums, and Maximums of the QCSASC Factors Item Numbers Minimum Maximum Undesirability/ Rejection 15, 17, 19, 20, 24, 26, 27 7 35 Incompetence 2, 4, 8, 9, 10, 11, 13 7 35 Self-Deprecation 16, 21, 22 3 15 Difference/ Loneliness 5, 23, 28 3 15 Helpless/Betrayed 1, 6 2 10 Total 22 110 disorder, premature ejaculation, and orgasmic difficulties in the male version and desire disorder, subjective arousal difficulties, orgasmic problems, and vaginismus in the female version. These four situations are presented in the questionnaire in the form of vignettes and were developed by a panel of sex therapists based on material from clinical cases. The QCSASC also presents a list of 10 emotions (worry, sadness, disillusion, fear, guilt, shame, anger, hurt, pleasure, and satisfaction) in order to assess the emotional response to the negative sexual events previously presented. Finally, the QCSASC uses a list of 28 self-statements reproducing the core beliefs or self-schemas proposed by Beck (1995). The list of 28 self-schemas of the QCSASC was submitted to factor analysis (Nobre & Pinto-Gouveia, 2009). A principal component analysis with varimax rotation identified five factors accounting for 62% of the total variance: (a) Undesirability/Rejection, (b) Incompetence, (c) SelfDeprecation, (d) Difference/Loneliness, and (e) Helpless (see Table 1). Response Mode and Timing Participants may respond to the QCSASC using paper and pencil or computer. The response scales are Likert-type. Respondents first indicate the negative event (if any) which is most similar to their sexual experience, and rate the frequency with which it usually happens (from 1 = Never Happens to 5 = Happens Often). They are also asked to

identify the emotions aroused by the situation (checking all that apply from a list of 10 emotions: worry, sadness, disillusion, fear, guilt, shame, anger, hurt, pleasure, satisfaction). After being instructed to concentrate on the identified situation and emotions, they are asked to rate on a 5-point Likert-type scale the degree of concordance with 28 selfschemas. Respondents take an average of 10 minutes to complete the QCSASC. Scoring Specific indexes for the five domains and for the total scale can be calculated through the sum of the schema items (higher scores reflecting greater negative schema activation). Reliability Internal consistency. Internal consistency was assessed using Cronbach's alpha statistics for the full scale and the different domains of the questionnaire. High inter-item correlations were observed for the subscales and the total scale. Cronbach's alpha values ranged from .59 (Difference/ Loneliness) to .91 (Undesirability/Rejection), with the full scale presenting .94. Except for the Difference/Loneliness and the Helpless domains, all other Cronbach's alpha results were higher than .71, supporting the homogeneity of the scale and the contribution from all the factors to the overall score (Nobre & Pinto-Gouveia, 2009). Test-retest reliability. Test-retest reliability was assessed by computing correlations for the total scale in two consecutive administrations of the questionnaire with a 4-week interval. The results ranged between r = .49 and r = .74 for the specific domains, with the full scale presenting r = .66. Although some correlations were not so strong, all reliability coefficients were statistically significant ($p < .01$). These results indicated a moderate stability of the scale over time (Nobre & Pinto-Gouveia, 2009). Validity Convergent validity. Convergent validity was assessed by correlating the QCSASC with validated measures oriented to assess cognitive structures linked to psychopathology: the Schema Questionnaire (SQ; Young, 1990) and the Sexual Self-Schema (SSS; Andersen & Cyranowski, 1994; Andersen, Cyranowski, & Espindle, 1999). The QCSASC was significantly correlated with the SQ, indicating that the measure assesses concepts that are partially related to more general cognitive schemas. Results regarding the relationship between the QCSASC and the Sexual Self-Schema Questionnaire showed moderate to high correlations, supporting our prediction that negative views about oneself as a sexual individual (particularly conservative ideas) would be related to the activation of negative self-schemas when facing unsuccessful sexual situations (Nobre & PintoGouveia, 2009). Incremental validity. Findings from the incremental validity analysis indicate that the QCSASC presents with higher clinical

utility compared to already existing related measures (e.g., SQ, SSS). Partial correlations with measures of sexual functioning in men (IIEF) and women (FSFI) were higher for the QCSASC compared to the SQ and SSS, suggesting that this new measure presents a unique contribution for the explanation of sexual functioning beyond previous existing measures (Nobre & PintoGouveia, 2009). Discriminant validity. A discriminant validity analysis was conducted, using a clinical (men and women with sexual dysfunction) and a control group (matched men and women without sexual dysfunction). We hypothesized that the higher the activation of negative cognitive schemas facing unsuccessful sexual situations, the

greater the probability of developing a sexual dysfunc

tion. Regarding women, we found statistically significant

differences between clinical and control groups in three

of the five domains of the QCSASC: Incompetence, Self

Deprecation, and Difference/Loneliness. Women with

sexual dysfunction also scored significantly higher in the

total QCSASC scale. Men with sexual dysfunction pre

sented significantly higher scores, compared to the con

trol group, on the Incompetence dimension, and the total

scale (Nobre & Pinto-Gouveia, 2009, in press).

Other Information

For more information regarding the QCSASC and permis

sion for its use please contact Pedro J. Nobre (pnobre5@

Exhibit

Questionnaire of Cognitive Schema Activation in Sexual Context

Female Version

Read carefully each one of the episodes presented below and indicate the extent to which they have ever happen to you by circling a

number (1 Never to 5 Often).

I’m alone with my partner. He looks as if he wants to have sex, and he’s going to extraordinary lengths to try to arouse me. However,

I don’t feel like it at all. So instead, I pretend to be tired and change the subject. Yet he persists. He looks disappointed, and says that I

don’t love him as much as I used to. Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

I’m having sex with my partner. He is really trying to arouse me, but I am experiencing no pleasure at all. Instead, I feel as if I am fulfilling

an obligation. I ask myself, “Does it always have to be like this?” Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

My partner is touching me and I am very aroused. A few moments later he tries to penetrate me, but my vaginal muscles seem to clamp

shut and my partner can’t penetrate. He persists with no success, and what could have been an unforgettable moment turns into a

frustrating experience. Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

My partner and I are engaged in foreplay, and he has tried different ways of stimulating me, which I’m enjoying. But in spite of it all I can’t

reach orgasm. My partner seems to be getting tired and I start to feel frustrated. I begin to feel anxious as I realize that the likelihood of

reaching orgasm is becoming more and more remote. Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

Circle all emotions you felt when you imagined the episode which more often happens to you. Worry Sadness Disillusionment Fear Guilt Shame Anger Hurt Pleasure Satisfaction

Keeping in mind the episode which more often happens to you, read the statements presented below carefully and circle the degree to

which they describe the way you think and feel about yourself (1 Completely False to 5 Completely True). Schemas 1. I'm helpless 1 2 3 4 5 2. I'm powerless 1 2 3 4 5 3. I'm out of control 1 2 3 4 5 4. I'm weak 1 2 3 4 5 5. I'm vulnerable 1 2 3 4 5 6. I'm needy 1 2 3 4 5 7. I'm trapped 1 2 3 4 5 8. I'm inadequate 1 2 3 4 5 9. I'm ineffective 1 2 3 4 5 10. I'm incompetent 1 2 3 4 5 11. I'm a failure 1 2 3 4 5 12. I'm disrespected 1 2 3 4 5 13. I'm defective (less than others) 1 2 3 4 5 14. I'm not good enough (achieve) 1 2 3 4 5 C o m p l e t e l y F a l s e F a l s e S o m e t i m e s T r u e s o m e f a l s e T r u e C o m p l e t e l y T r u e

Male Version

Read carefully each one of the episodes presented below and indicate the extent to which they usually happen to you by circling a

number (1 Never to 5 Often).

I'm alone with my partner. She looks as if she wants to have sex, and she's going to extraordinary lengths to try to arouse me. However,

I don't feel like it at all. So instead, I pretend to be tired and change the subject. Yet she persists. She looks disappointed, and says that

I don't love her as much as I used to. Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

I'm caressing my partner, and she is enjoying it and seems to be ready for intercourse. Upon attempting penetration, I notice that my

erection isn't as firm as it normally is and full penetration seems impossible. I try to no avail, and finally quit. Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

My partner is stimulating me, and I'm becoming very aroused. I'm getting very excited and I immediately try to penetrate her. I feel out

of control and reach orgasm very quickly, at which point

intercourse stops. She looks very disappointed, as if she expected much more

from me. Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

I’m completely involved in lovemaking and I start to penetrate my partner. In the beginning everything is going fine, but time passes and

I can’t seem to reach orgasm. She seems to be getting tired. No matter how hard I try, orgasm seems to be farther and farther out of

my reach. Never Happened 1 _____ 2 _____ 3 _____ 4 _____ 5 Happened Often

Circle all emotions you felt when you imagined the episode which more often happens to you Worry Sadness Disillusionment Fear Guilt Shame Anger Hurt Pleasure Satisfaction

Keeping in mind the episode which more often happens to you, read the statements presented below carefully and circle the degree to

which they describe the way you think and feel about yourself (1 Completely False to 5 Completely True). Schemas 15. I’m unlovable 1 2 3 4 5 16. I’m unlikable 1 2 3 4 5 17. I’m undesirable 1 2 3 4 5 18. I’m unattractive 1 2 3 4 5 19. I’m unwanted 1 2 3 4 5 20. I’m uncared for 1 2 3 4 5 21. I’m bad 1 2 3 4 5 22. I’m unworthy 1 2 3 4 5 23. I’m different 1 2 3 4 5 24. I’m defective (not loved) 1 2 3 4 5 25. I’m not good enough (loved) 1 2 3 4 5 26. I’m bound to be rejected 1 2 3 4 5 27. I’m bound to be abandoned 1 2 3 4 5 28. I’m bound to be alone 1 2 3 4 5 C o m p l e t e l y F a l s e F a l s e S o m e t i m e s T r u e s o m e f a l s e T r u e C o m p l e t e l y T r u e

Sociosexual Orientation

For the following questions, please provide your answer using the 7-point scale provided. Check the circle that best describes where

you fall between those two extremes. Please remember that the definition of sex is any form of intimate physical contact involving more

than kissing between you and another person (opposite or same sex).

Never Frequently

1 2 3 4 5 6 7

7. Given the chance, how often

would you choose to have sex? { { { { { { {

8. How often have you had sex to end a fight? { { { { { { {

9. How often do you go somewhere (e.g., bar,

social event) to find someone to have sex with? { { { { { { {

10. How often would you have anonymous sex with

someone you are very attracted to if you are/were

single? { { { { { { {

11. How often do you masturbate? { { { { { { {

12. How often do you use sex toys alone? { { { { { { {

13. How often have you been paid for sex? { { { { { { {

14. How often do you fantasize about having sex with

someone other than your current partner? { { { { { { {

15. How often have you had sex to keep your

partner in the relationship? { { { { { { {

16. How often have you had sex to help get a

promotion or some other benefit at work or

school? { { { { { { {

17. How often do you cheat sexually on a partner? { { { { {
{ {

18. How often do you purchase sex toys? { { { { { { {

19. How often do you pay for sex? { { { { { { {

20. How often do you talk to your friends about your

sexual experiences? { { { { { { {

21. How often do you say what you want or need

during sex? { { { { { { {

22. How often do you have sex outside of an

exclusive relationship? { { { { { { {

23. How often would you have anonymous sex with

someone you were very attracted to if you were

in a relationship and knew for sure that your

partner would not find out? { { { { { { {

24. How often do you buy an X-rated video? { { { { { { {

25. How often do you go to a strip club? { { { { { { {

26. How often do you use sex to get something you

want? { { { { { { {

27. How often do you fantasize about having sex with

your current partner? { { { { { { {

28. Do you ever have sex with a friend with whom

you are not interested in dating (so-called

“friends with benefits”)? { { { { { { {

29. How often do you have sex with someone you

just met? { { { { { { {

30. How often have you had sex to get someone to

do something for you? { { { { { { {

31. How often do you watch pornography alone? { { { { { { {

32. How often do you have phone-sex or cyber-sex

with someone you are not in a relationship with? { { { { {
{ {

For the following questions, please indicate to what extent you agree or disagree with the following statements. Keep in mind that the

definition of sex is any form of intimate physical contact involving more than kissing between you and another person (opposite or

same sex).

Strongly Neutral Strongly

Disagree Agree

1 2 3 4 5 6 7

33. Sex should be unplanned, rather than

planned ahead of time. { { { { { { {

34. One should always be ready for sex. { { { { { { {

35. Sex can be a useful tool in some situations. { { { { {
{ {

36. Hugging and kissing should not always lead

to sex. { { { { { { {

37. I am not sexually satisfied with any

behavior other than intercourse. { { { { { { {

38. Orgasm is not a necessary part of sex

for me. { { { { { { {

39. I would not use sex to get something

I wanted. { { { { { { {

40. Sex should only take place between two

people who are in love. { { { { { { {

Revised Sociosexual Orientation Inventory

LARS PENKE, 1 University of Edinburgh

1 Address correspondence to Lars Penke, Centre for Cognitive Ageing and Cognitive Epidemiology, Department of Psychology, University of Edinburgh,

7 George Square, Edinburgh, EH8 9JZ, UK; e-mail: lars.penke@ed.ac.uk

The construct of sociosexuality or sociosexual orienta

tion captures individual differences in the tendency to

have casual, uncommitted sexual relationships. The term

was introduced by Alfred Kinsey, who used it to describe

the individual differences in sexual permissiveness and

promiscuity that he found in his groundbreaking survey

studies on sexual behavior (Kinsey, Pomeroy, & Martin,

1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). The

amount of scientific research on sociosexuality increased

markedly when Simpson and Gangestad (1991) published

the Sociosexual Orientation Inventory (SOI), a 7-item

self-report questionnaire that assesses sociosexual orienta

tions along a single dimension from restricted (indicating a

tendency to have sex exclusively in emotionally close and

committed relationships) to unrestricted (indicating a ten

dency for sexual relationships with low commitment and investment, often after short periods of acquaintance and with changing partners). On average, men tend to be more unrestricted than women in their sociosexual orientations, though there are also large individual differences within both sexes (Schmitt, 2005). The SOI has been successfully applied in over 50 published studies from fields as diverse as social, personality, and evolutionary psychology, sexuality research, gender studies, biological anthropology, and cross-cultural research (Simpson, Wilson, & Winterheld, 2004). Despite its popularity, the SOI has repeatedly been criticized (Asendorpf & Penke, 2005; Penke & Asendorpf, 2008; Townsend, Kline, & Wasserman, 1995; Voracek, 2005; Webster & Bryan, 2007). Conceptually, it has been doubted that a single unitary dimension accurately reflects individual differences in sociosexuality. Psychometrically, the SOI has received criticism for its sometimes low internal consistency, its multifactorial structure, its skewed score distribution, its open response items that invite exaggerated responses, its multiple alternative scoring methods that yield incoherent results, and the formulation of one item (number 4) that makes the SOI inappropriate for singles.

The Revised Sociosexual Orientation Inventory (SOI-R) is a nine-item self-report questionnaire that was developed to fix all these issues (Penke & Asendorpf, 2008). It assesses three facets of sociosexuality: past Behavior in terms of number of casual and changing sex partners, the explicit Attitude towards uncommitted sex, and sexual Desire for people with whom no romantic relationship exists.

Description

The SOI-R consists of nine items, three for each of the three facets. All are answered on rating scales. The first two items of the Behavior facet are taken from the original SOI.

They ask for the number of sexual partners in the last 12 months and the lifetime number of “one-night stands.” The third behavioral item assesses the number of partners with whom one had sex despite a lack of long-term relationship interest. Similarly, the first two Attitude items (asking for acceptance of sex without love and for comfort with casual sex) are identical with two items from the SOI, whereas a new item (asking for requiring the prospect of a long-term relationship before consenting to sex) replaces an SOI attitude item with overly long and complicated text. Finally, three new items assess the Desire facet, which was not very well represented in the original SOI (Penke & Asendorpf, 2008). They ask for the frequency with which one experiences spontaneous sexual fantasies or sexual arousal when encountering people in everyday life with whom no committed romantic relationship exists. In a series of studies, the SOI-R items were chosen from a pool of 47 items using exploratory factor analysis and item analysis (Penke, 2006). Confirmatory factor analysis supported that they represent distinctive facets of sociosexuality with low to moderate positive intercorrelations (.17 to .55). The correlation between the Attitude and Behavior facets was significantly larger in women than in men, but otherwise the factorial structure is invariant between the sexes, showing that the SOI-R is equally appropriate for

men and women (Penke & Asendorpf, 2008). An analysis of 8,522 participants from an online study

indicates that the SOI-R is appropriate for individuals of any

normal-range educational level, including hetero-, bi- and

homosexuals, singles and individuals of any relationship/

marital status, and at least the age range of 18 to 60 years

(Penke, 2006; data partly available on www.larspenke.eu/

soi-r/). However, some facets do not work very well for

sexually inexperienced and asexual individuals.

Response Mode and Timing

All items of the SOI-R use Likert-type rating scales with

the same number of response alternatives, which makes the

SOI-R appropriate for both paper-and-pencil and online

studies. Two alternative response scale formats exist for

the SOI-R, one with nine and the other with five response

alternatives. Both show comparable psychometric proper

TABLE 1

Descriptive Statistics, Reliabilities, and Effect Sizes for Sex

Differences for Both SOI-R Response Scale Formats

N Cronbach's r tt M SD Cohen's

α (1 year) d

5-point scale

SOI-R male 2728 .85 — 2.19 1.10 .00

Behavior female 5821 .78 — 2.19 .95

SOI-R male 2706 .81 — 3.54 1.18 .45

Attitude female 5794 .81 — 3.01 1.20

SOI-R male 2687 .82 — 3.45 1.01 .86

Desire female 5748 .82 — 2.61 .96

SOI-R male 2647 .82 — 3.07 .82 .57

female 5632 .83 — 2.60 .80

9-point scale

SOI-R male 1026 .85 .83 2.76 1.83 .06

Behavior female 1682 .84 .86 2.65 1.73

SOI-R male 1026 .87 .73 6.42 2.33 .43

Attitude female 1682 .83 .79 5.41 2.37

SOI-R male 1026 .86 .68 5.62 1.91 .86

Desire female 1682 .85 .39 3.96 1.94

SOI-R male 1026 .83 .83 4.93 1.50 .61

female 1682 .83 .78 4.01 1.52

Note. r tt = test-retest correlation. The results for the 5-point response scale are from

an unpublished online study (Penke, 2006). The results for the 9-point response

scale are from Study 1 in Penke and Asendorpf (2008). More detailed results, split

by subsamples, can be found on www.larspenke.eu/soi-r/.

attractiveness, self-perceived mate value, and female flirt

ing behavior, whereas Attitude appeared responsible for the

mating, and a romantic partner's flirtatiousness outside

the relationship, and Desire had strong independent effects

on relationships with sex drive, relationship quality, and

male flirting behavior. Furthermore, Behavior and Desire,

but not Attitude, predicted the number of sexual partners

and changes in romantic relationship status over the next

12 month. Thus, Behavior, Attitude, and Desire appar

ently reflect rather unique components of sociosexuality

that should be studied separately in order to understand the

Exhibit

Revised Sociosexual Orientation Inventory a

Please respond honestly to all of the following questions.
Your responses will be treated confidentially and
anonymously.

1. With how many different partners have you had sex within
the past 12 months? b

0 1 2 to 3 4 to 7 8 or More

0 1 2 3 4 5–6 7–9 10–19 20 or More

2. With how many different partners have you had sexual
intercourse on one and only one occasion?

3. With how many different partners have you had sexual
intercourse without having an interest in a long-term
committed relation

ship with this person?

4. Sex without love is OK. c

1 2 3 4 5

Totally Disagree Totally Agree

1 2 3 4 5 6 7 8
9

Strongly Disagree Strongly Agree

5. I can imagine myself being comfortable and enjoying “casual” sex with different partners.

6. I do not want to have sex with a person until I am sure that we will have a long-term, serious relationship.

7. How often do you have fantasies about having sex with someone you are not in a committed romantic relationship with? d

1 □ 2 □ 3 □ 4 □ 5 □

Never Very Seldom About Once a Month About Once a Week Nearly Every Day

1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □

Never Very About Once About About Once About Several Nearly At Least

Seldom Every Two Once a Every Two Once a Times per Every Day Once a

or Three Month Weeks Week Week Day

Months

8. How often do you experience sexual arousal when you are in contact with someone you are not in a committed romantic relationship with?

9. In everyday life, how often do you have spontaneous fantasies about having sex with someone you have just met?

a Both the 5-response option and the 9-response option are shown in the exhibit that follows.

b These response options are used for the first three questions.

c These response options are used for the next three questions.

d These response options are used for the last three questions.

Sociosexual Orientation Inventory

JEFFRY A. SIMPSON, 1 University of Minnesota

S TEVEN W. GANGESTAD, University of New Mexico

1 Address correspondence to Jeffry A. Simpson, Department of Psychology, University of Minnesota, Minneapolis, MN 55455; e-mail:

simps108@umn.edu or to Steven W. Gangestad, Department of Psychology, University of New Mexico, Albuquerque, NM 87131.

In the 1940s and 1950s, comprehensive surveys of the sexual practices of North American men (Kinsey, Pomeroy, & Martin, 1948) and women (Kinsey, Pomeroy, Martin, & Gebhard, 1953) documented that people differ dramatically on several "sociosexual" attitudes and behaviors. Although men, as a group, displayed greater sexual permissiveness than women on most sociosexual attitudes and behaviors (e.g., men have more permissive attitudes toward casual sex, and they are more likely to have sexual affairs), one of the most striking features of the Kinsey data is that much more variability in sociosexual attitudes and behaviors exists within each sex than between men and women. Some women, for example, are more sexually permissive than most men, and some men are less permissive than most women. The Sociosexual Orientation Inventory (SOI; Simpson & Gangestad, 1991) was developed to measure individual differences in willingness to engage in casual, uncommitted sexual relationships. The SOI assesses individuals' past sexual behavior, anticipated (future) sexual behavior, the content of their sexual fantasies, and their attitudes toward engaging in casual sex without commitment and emotional investment. Individuals who score high on the SOI have an unrestricted sociosexual orientation. These individuals report having a larger number of different sexual partners in the past year, anticipate having more

partners in the next

5 years, have had more one-night stands (“hook-ups”), fan

tasize more often about having sex with people other than

their current (or most recent) romantic partner, and believe

that sex without emotional ties is acceptable. Individuals

who score low on the SOI have a restricted sociosexual ori

entation. These individuals report fewer sexual partners in

the past year, anticipate fewer partners in the next 5 years,

are less likely to engage in “one-night stands,” rarely fanta

size about extra-pair sex, and do not believe in having sex

without love and commitment.

Description

The SOI has seven items. Two items ask respondents to

report on their past sexual behavior: Item 1 (the number of

sexual partners in the past year) and Item 3 (the number of

times they have had sex with someone on only one occa

sion). Item 2 assesses future sexual behavior (the number of

partners anticipated in the next 5 years). Item 4, answered

on a Likert-type scale, inquires about sexual fantasies

(how often they fantasize about having sex with someone

other than their current [or most recent] romantic partner).

Items 5, 6, and 7, all answered on Likert-type scales, ask

about respondents’ attitudes toward engaging in casual sex.

These seven items load on a higher-order factor labeled

sociosexuality.

Response Mode and Timing

Items 1–3 on the SOI (those that inquire about past and future sexual behavior) require respondents to write down specific numbers of sexual partners. Items 4–7 (those that inquire about fantasies and sexual attitudes) are answered on Likert-type scales. The SOI takes 1–2 minutes to com plete.

Scoring

Item 7 of the SOI must be reverse keyed. Items 5, 6, and 7 are then aggregated (summed) to create the attitudinal com ponent of the SOI. The following weighting scheme is used when aggregating the five components: SOI = 5X (Item 1) + 1X (Item 2) + 5X (Item 3) + 4X (Item 4) + 2X (aggregate of Items 5–7). To ensure that Item 2 does not have dispro portionate influence on the total SOI score, the maximum value of Item 2 is limited to 30 partners. This weighting scheme approximates the scores that individuals would receive if the five SOI components were transformed to z scores, unit-weighted, and then summed. Scores based on the current weighting scheme correlate at or above .90 with a unit-weighting system (Simpson & Gangestad, 1991).

SOI scores can range from 10 (a maximally restricted ori entation) to 1,000 (a maximally unrestricted orientation). The normal range in college samples is 10–250. Because

men tend to score higher on the SOI than women (Simpson & Gangestad, 1991, 1992), respondents' gender should be partialed before statistical analyses are conducted, or analyses should be performed separately on women and men. Some respondents will occasionally report very high numbers for Items 1–3. In college samples, 30 is the maximum value for Item 2. If respondents report more than 20 partners for Items 1 or 2, these individuals may be outliers who could have undue influence on the results. Thus, outlier detection should always be done prior to analyzing SOI scores. Reliability The SOI is internally consistent (average Cronbach alpha = .75; Simpson & Gangestad, 1991, 1992). Test-retest reliability over 2 months is high (r = .94; Simpson & Gangestad, 1991; see Simpson, Wilson, & Winterheld, 2004, for additional information). Validity Predictions for individuals who have restricted or unrestricted sociosexual orientations can be derived from the theoretical construct of sociosexuality (see Gangestad & Simpson, 1990; Simpson et al., 2004). Predictive validity evidence for the SOI is reviewed in Simpson et al. (2004). Evidence for its convergent and discriminant validity properties also exists. With regard to convergent validity, for example, more unrestricted individuals (relative to more restricted ones): (a) engage in sex earlier in their romantic relationships, (b) are more likely to have sex with more than one partner during a given time period, and (c) tend to be involved in sexual relationships characterized by less investment, less commitment, less love, and weaker emotional ties (Simpson & Gangestad, 1991). More unrestricted individuals also score higher on other scales known to tap related constructs (e.g., sexual permissiveness, impersonal sex). More unrestricted people also desire, choose, and acquire romantic partners who have different attributes compared to more restricted people (Simpson & Gangestad, 1992). For example, more unrestricted individuals prefer partners who are more physically attractive and have higher social status, and they place less emphasis on kindness, loyalty, and stability. More restricted persons prefer partners who are kinder and more affectionate, more faithful and loyal, and more responsible, and they place less weight on attractiveness and social status. In dating initiation studies (Simpson, Gangestad, & Biek, 1993), more unrestricted persons—especially men—display more nonverbal behaviors known to facilitate rapid relationship development (e.g., more smiling, laughing, maintaining direct eye contact, flirtatious glances; for further

validity information, see Simpson et al., 2004). In terms of discriminant validity, Simpson and Gangestad (1991) found that more restricted persons (a) do not have appreciably lower sex drives and (b) do not score higher on scales assessing sexuality-based constructs that should not correlate with the SOI (e.g., sexual satisfaction, sex guilt, sex-related anxiety).

Exhibit

Sociosexual Orientation Inventory

Please answer all of the following questions honestly. Your responses will be treated as confidential and anonymous. For the questions

dealing with behavior, write your answers in the blank spaces provided. For the questions dealing with thoughts and attitudes, circle the

appropriate number on the scales provided. The term “sexual intercourse” refers to genital sex.

1. With how many different partners have you had sex (sexual intercourse) within the past year? _____

2. How many different partners do you foresee yourself having sex with during the next five years? (Please give a specific, realistic estimate.) _____

3. With how many different partners have you had sex on one and only one occasion? _____

4. How often do you fantasize about having sex with someone other than your current dating partner (when you are in a relationship)? (Circle one.)

1 Never

2 Once Every Two or Three Months

3 Once a Month

4 Once Every Two Weeks

5 Once a Week

6 A Few Times Each Week

7 Nearly Every Day

8 At Least Once a Day

5. Sex without love is OK.

1 2 3 4 5 6 7 8 9

I Strongly Disagree I Strongly Agree

6. I can imagine myself being comfortable and enjoying "casual" sex with different partners.

1 2 3 4 5 6 7 8 9

I Strongly Disagree I Strongly Agree

7. I would have to be closely attached to someone (both emotionally and psychologically) before I could feel comfortable and fully enjoy having sex with him or her.

1 2 3 4 5 6 7 8 9

I Strongly Disagree I Strongly Agree

Source. This scale was originally published in "Individual Differences in Sociosexuality: Evidence for Convergent and Discriminant Validity" by J. A.

Simpson and S. Gangestad, 1991, Journal of Personality and Social Psychology, 60, 870-883. Reprinted with permission.

Gangestad, S., & Simpson, J. A. (1990). Toward an evolutionary history of female sociosexual variation. Journal of Personality, 58, 69-96.

Kinsey, A., Pomeroy, W., & Martin, C. (1948). Sexual behavior in the human male. Philadelphia: Saunders.

Kinsey, A., Pomeroy, W., Martin, C., & Gebhard, P. (1953). Sexual behavior in the human female. Philadelphia: Saunders.

Simpson, J. A., & Gangestad, S. (1991). Individual differences in sociosexuality: Evidence for convergent and discriminant validity. Journal of Personality and Social Psychology, 60, 870-883. Simpson, J. A., & Gangestad, S. (1992). Sociosexuality and romantic partner choice. Journal of Personality, 60, 31-51. Simpson, J. A., Gangestad, S. W., & Biek, M. (1993). Personality and nonverbal social behavior: An ethological perspective of relationship

initiation. Journal of Experimental Social Psychology, 29, 434–461. Simpson, J. A., Wilson, C. L., & Winterheld, H. A. (2004). Sociosexuality and romantic relationships. In J. H. Harvey, A. Wenzel, & S. Sprecher (Eds.), Handbook of sexuality in close relationships (pp. 87–112). Mahwah, NJ: Erlbaum.

Tactics

Use humor 0 1 2 3 4

Say you might break partner’s property 0 1 2 3 4

Wait until he/she is sleeping 0 1 2 3 4

Attempt to blackmail 0 1 2 3 4

Caress near/on partner’s genitals 0 1 2 3 4

Rub leg with his/her legs 0 1 2 3 4

Whisper in his/her ear 0 1 2 3 4

Softly kiss his/her ears, neck, or face 0 1 2 3 4

Question partner’s sexual orientation 0 1 2 3 4

Break partner’s property 0 1 2 3 4

Say sweet things 0 1 2 3 4

Provide him/her with alcohol 0 1 2 3 4

Explain that your needs should be met 0 1 2 3 4

Take advantage of him/her if he/she’s already drunk or stoned 0 1 2 3 4

Slap or hit 0 1 2 3 4

Caress his/her chest/breasts 0 1 2 3 4

Physically restrain 0 1 2 3 4

Suppose you were with your partner this evening, and he/she did not want to have sex with you: Please rate how likely you would

engage in the following acts to persuade your partner into having sex. Remember, you may skip questions you are uncomfortable in

answering.

Likelihood You Would Use Acts

Definitely Not Unlikely Maybe Probably Definitely

Massage his/her neck or back 0 1 2 3 4

Threaten to leave 0 1 2 3 4

Try to make him/her feel bad about not having sex 0 1 2 3 4

Play with his/her hair 0 1 2 3 4

Suggest you may harm him/her 0 1 2 3 4

Offer to buy him/her something 0 1 2 3 4

Lie down near him/her 0 1 2 3 4

Tie partner up 0 1 2 3 4

Block partner's retreat 0 1 2 3 4

Tickle 0 1 2 3 4

Provide him/her with drugs 0 1 2 3 4

Call him/her names 0 1 2 3 4

Threaten self-harm 0 1 2 3 4

Massage feet/thighs 0 1 2 3 4

Use humor 0 1 2 3 4

Say you might break partner's property 0 1 2 3 4

Wait until he/she is sleeping 0 1 2 3 4

Attempt to blackmail 0 1 2 3 4

Caress near/on partner's genitals 0 1 2 3 4

Rub leg with his/her legs 0 1 2 3 4

Whisper in his/her ear 0 1 2 3 4

Softly kiss his/her ears, neck, or face 0 1 2 3 4

Question partner's sexual orientation 0 1 2 3 4

Break partner's property 0 1 2 3 4

Say sweet things 0 1 2 3 4

Provide him/her with alcohol 0 1 2 3 4

Explain that your needs should be met 0 1 2 3 4

Take advantage of him/her if he/she's already drunk or stoned 0 1 2 3 4

Slap or hit 0 1 2 3 4

Caress his/her chest/breasts 0 1 2 3 4

Physically restrain 0 1 2 3 4

Burt, M. R. (1980). Cultural myths and supports for rape. Journal of

Personality and Social Psychology, 38, 217–230.

Mosher, D. L., & Sirkin, M. (1984). Measuring a macho personality con

stellation. Journal of Research in Personality, 18, 150–163.

Muehlenhard, C. L., & Felts, A. S. (1998). Sexual Beliefs Scale. In C. M.

Davis, W. L. Yarber, R. Bauserman, G. Shreer, & S. L. Davis (Eds.),

Handbook of sexuality-related measures (pp. 116–118). Newbury

Park, CA: Sage.

Muehlenhard, C. L., Friedman, D. E., & Thomas, C. M. (1985). Is date

rape justifiable? The effects of dating activity, who initiated, who paid,

and men’s attitudes toward women. Psychology of Women Quarterly,

9, 297–309.

Muehlenhard, C. L., & Hollabaugh, L. C. (1988). Do women sometimes

say no when they mean yes? The prevalence and correlates of women’s

token resistance to sex. Journal of Personality and Social Psychology,

54, 872–879. Muehlenhard, C. L., & Linton, M. A. (1987). Date rape and sexual aggression in dating situations: Incidence and risk factors. Journal of Counseling Psychology, 34, 186–196. Osman, S. L. (1995, April). Predispositional and situational factors influencing men’s perceptions of date rape. Paper presented at the Eastern Regional Meeting of the Society for the Scientific Study of

Sexuality, Atlantic City, NJ. Osman, S. L. (2003). Predicting men's rape perceptions based on the belief that "no" really means "yes." Journal of Applied Social Psychology, 33, 683-692. Osman, S. L. (2004). Victim resistance: Theory and data on understanding perceptions of sexual harassment. Sex Roles, 50, 267-275. Osman, S. L. (2007a). The continuation of perpetrator behaviors that influence perceptions of sexual harassment. Sex Roles, 56, 63-69. Osman, S. L. (2007b). Predicting perceptions of sexual harassment based on type of resistance and belief in token resistance. The Journal of Sex Research, 44, 340-346. Osman, S. L., & Davis, C. M. (1997). Predicting men's perceptions of date rape using the heuristic-systematic model. Journal of Sex Education and Therapy, 22, 25-32. Osman, S. L., & Davis, C. M. (1999a). Belief in token resistance and type of resistance as predictors of men's perceptions of date rape. Journal of Sex Education and Therapy, 24, 189-196. Osman, S. L. & Davis, C. M. (1999b). Predicting perceptions of date rape based on individual beliefs and female alcohol consumption. Journal of College Student Development, 40, 701-709. Shotland, R. L., & Goodstein, L. (1983). Just because she doesn't want to doesn't mean it's rape: An experimental based causal model of the perception of rape in a dating situation. Social Psychology Quarterly, 46, 220-232.

Exhibit

Token Resistance to Sex Scale

Respond to the following statements by indicating the degree to which you agree or disagree with the statement. Respond using the

following scale for each statement.

1 = Strongly Disagree

2 = Disagree

3 = Slightly Disagree

4 = Undecided, Neither Agree nor Disagree

5 = Slightly Agree

6 = Agree

7 = Strongly Agree

___1. Women usually say “no” to sex when they really mean “yes.”

___2. When a man only has to use a minimal amount of force on a woman to get her to have sex, it probably means she wanted him to force her.

___3. When a woman waits until the very last minute to object to sex in a sexual interaction, she probably really wants to have sex.

___4. A woman who initiates a date with a man probably wants to have sex.

___5. Many times a woman will pretend she doesn’t want to have intercourse because she doesn’t want to seem too loose, but she’s really hoping the man will force her.

___6. A woman who allows a man to pick her up for a date probably hopes to have sex that night.

___7. When a woman allows a man to treat her to an expensive dinner on a date, it usually indicates that she is willing to have sex with him.

___8. Going home with a man at the end of a date is a woman’s way of communicating to him that she wants to have sex.

Transvestism

1 Address correspondence to Ray Blanchard, Centre for Addiction and Mental Health, 250 College Street, Toronto, Ontario M5T 1R8, Canada; e-mail:

Ray_Blanchard@camh.net

Exhibit

Cross-Gender Fetishism Scale

Instructions to Subjects

The following questions ask about your experiences in dressing or making up as the opposite sex. These questions are meant to

include experiences you may have had during puberty or early adolescence as well as more recent experiences.

Please circle one and only one answer to each question. If you are not sure of the meaning of a question, you may ask the person

giving the questionnaire to explain it to you. There is no time limit for answering these questions.

1. Have you ever felt sexually aroused when putting on women’s underwear, stockings, or a nightgown?

a. Yes (1.0)

b. No (−1.1)

c. Have never put on any of these (−1.1)

2. Have you ever felt sexually aroused when putting on women’s shoes or boots?

a. Yes (1.5)

b. No (−.7)

c. Have never put on either of these (−.7)

3. Have you ever felt sexually aroused when putting on women’s jewelry or outer garments (blouse, skirt, dress, etc.)?

a. Yes (1.2)

b. No (-1.0)

c. Have never put on any of these (-1.0)

4. Have you ever felt sexually aroused when putting on women's perfume or make-up, or when shaving your legs?

a. Yes (1.3)

b. No (-.8)

c. Have never done any of these (-.8)

5. Have you ever masturbated while thinking of yourself putting on (or wearing) women's underwear, stockings, or a nightgown?

a. Yes (1.1)

b. No (-1.0)

6. Have you ever masturbated while thinking of yourself putting on (or wearing) women's shoes or boots?

a. Yes (1.7)

b. No (-.4)

7. Have you ever masturbated while thinking of yourself putting on (or wearing) women's jewelry or outer garments?

a. Yes (1.4)

b. No (-.8)

8. Have you ever masturbated while thinking of yourself putting on (or wearing) women's perfume or make-up, or while thinking of yourself shaving your legs (or having shaved legs)?

a. Yes (1.5)

b. No (-.7)

9. Has there ever been a period in your life of one year (or longer) during which you always or usually felt sexually aroused when putting on female underwear or clothing?

a. Yes (1.1)

b. No (-1.0)

c. Have never put on female underwear or clothing (-1.0)

Variations (also see Gender Identification, and specific variations)

Exhibit

Attitudes About Sadomasochism Scale

Instructions: For each of the following statements, please note whether you agree or disagree using the following scale:

1 2 3 4 5 6 7

Disagree Disagree Disagree Neither Agree Agree Agree

Strongly Moderately Mildly Agree nor Mildly Moderately Strongly

Disagree

Use the following definitions when considering your responses:

Sadomasochism: sexual practices that involve dominance and submission (the appearance that one person has control over the other),

sometimes involve role-playing (such as Master-Slave or Teacher-Student), and are always consensual (all partners participate willingly

and voluntarily)

Sadomasochist: someone who deliberately uses physical stimulation (possibly pain) and/or psychological stimulation and control to

produce sexual arousal and to achieve sexual pleasure

Dominant: someone who always or mostly is the person in control during an SM sexual encounter

Submissive: someone who always or mostly is the person who does not have control during an SM sexual encounter

Factor 1: Socially Wrong

Sadomasochists just don’t fit into our society.

Practicing sadomasochists should not be allowed to be

members of churches or synagogues.

Sadomasochism is a perversion.

Sadomasochistic behavior is just plain wrong.

Sadomasochism is a threat to many of our basic social institutions.

I think sadomasochists are disgusting.

Sadomasochistic activity should be against the law.

Parents who engage in SM are more likely to physically abuse their children.

Sadomasochism is an inferior form of sexuality.

If I was alone in a room with someone I knew to be a Dominant, I would feel uncomfortable.

SM rarely exists in a psychologically healthy individual.

If I was alone in a room with someone I knew to be a Submissive, I would feel uncomfortable.

Factor 2: Violence

People who engage in SM are more likely to become involved in domestic violence.

A Dominant is more likely to rape a romantic partner than the average person.

A Dominant is more likely to rape a stranger than the average person.

A Dominant is more likely to sexually molest a child than the average person.

A variety of serious psychological disorders are associated with sadomasochism.

Factor 3: Lack of Tolerance

Sadomasochists are just like everybody else. (R)

Sadomasochism is erotic and sexy. (R)

Many sadomasochists are very moral and ethical people. (R)

Sadomasochistic activity should be legal, as long as all participants are consenting adults. (R)

Factor 4: Real Life

Submissives are passive in other aspects of their lives (besides sex).

Dominants are aggressive and domineering in other aspects of their lives (besides sex).

Virginity Beliefs Scale

JONAS ERIKSSON AND TERRY P. HUMPHREYS, 1 Trent University

The Virginity Beliefs Scale (VBS) assesses beliefs and

motivations for engaging in sexual intercourse for the first

time.

Description

The statements contained in the VBS were developed

using Carpenter's (2002) qualitative study of virginity

loss. Carpenter found that individuals generally perceived

of their virginity loss in three different ways: as a gift, a

stigma, or a process. Gift individuals were proud of their

virginity and considered it to be a valuable gift to their first

partner. Those identified as perceiving their virginity as a

stigma were anxious to lose their virginity, believing it to be

an embarrassment. Process individuals saw their virginity

loss as a step in their natural development towards becoming

an adult. Carpenter suggested that these three frameworks

influence first intercourse experiences. For example, those

identifying virginity as a stigma were more likely to choose their first sexual partner based on opportunity, whereas those identifying virginity as a gift chose their partner based on love and commitment. Carpenter presented support for the notion that how individuals perceive their virginity loss may shape their sexual development and behavior in the years following their first sexual intercourse experience. For instance, individuals identifying virginity as a gift take a risk when deciding to lose their virginity. If their partner does not reciprocate, it is likely that these individuals feel that their experience was a mistake.

Response Mode and Timing

The scale can be completed either in paper-and-pencil form or as an online survey. In both modes, individuals indicate their agreement with each statement on a Likert-type scale from 1 (Strongly Disagree) to 7 (Strongly Agree). The VBS can be completed in approximately 10 minutes.

Scoring

The three frames contained in the VBS are scored sepa rately. Items are scored 1 for Strongly Disagree and 7 for Strongly Agree. Mean gift scores are calculated by summing Items 2, 3, 5, 7, 10, 12, 14, 16, 18, and 20 and dividing by

10. Mean stigma scores are calculated by summing Items 1, 6, 8, 11, 15, 17, 19, and 21 and dividing by 8. Process mean scores are calculated by summing Items 4, 9, 13, and 22 and dividing by 4. Mean scores on all three subscales can thus range between 1 and 7. Reliability In a sample of undergraduates (N = 243) from a small university in Ontario, Canada, reliability was .89 for gift, .92 for stigma, and .80 for process (Eriksson & Humphreys, 2009). Validity Gift individuals tend to engage in intercourse for the first time for reasons related to improving their relationship with their partner and therefore choose their first partner with care (Carpenter, 2002). The concept of virginity as a gift is compatible with mainstream religious conceptions of virginity. As such, we expected that individuals scoring high on the gift subscale would generally hold less permissive attitudes towards sexuality and be more religious. As expected, gift individuals reported having had fewer lifetime sexual partners, $r(243) = -.267$, $p < .001$. These individuals also reported less sexual permissiveness as measured by the permissiveness subscale of the Brief Sexual Attitudes Scale (Hendrick, Hendrick, & Reich, 2006), $r(243) = -.495$, $p < .001$, and greater involvement in religion (i.e., frequency of religious services/activities), $r(242) = .144$, $p = .025$ (Eriksson & Humphreys, 2009). Individuals perceiving of their virginity as a stigma hold more traditional sex role beliefs as indicated by the Double Standard Scale (DSS; Caron, Davis, Halteman, & Stickle, 1993), $r(243) = -.316$, $p < .001$, and also hold more hypergendered beliefs as measured by the Hypergender Ideology Scale (HIS; Hamburger, Hogben, McGowan, & Dawson, 1996), $r(243) = .356$, $p < .001$. The concept of virginity as a stigma is closely tied to traditional masculine beliefs having to do with greater sexual readiness and activity. Along the same lines, individuals scoring high on the stigma subscale are also more sexually permissive (Hendrick et al., 2006), $r(243) = .436$, $p < .001$. Individuals perceiving their virginity as a process typically fall in between gift and stigma individuals in terms of traditional gender roles. Although their agreement with such roles is not as strong as stigma individuals, significant relationships exist between process scores and the HIS, $r(243) = .190$, $p < .003$, and the DSS, $r(243) = -.183$, $p = .004$. They also hold more permissive beliefs than gift individuals, but less permissive beliefs than stigma individuals, $r(243) = .266$, $p < .001$.

1 Address correspondence to Terry P. Humphreys, Psychology Department, Trent University, 1600 West Bank Drive, Peterborough, Ontario, Canada, K9J

7B8; e-mail: terryhumphreys@trentu.ca

Other Information

Permission to use the Virginity Beliefs Scale may be

obtained from T. Humphreys.

Caron, S. L., Davis, C. M., Halteman, W. A., & Stickle, M. (1993). Predictors of condom-related behaviors among first-year college students. The Journal of Sex Research, 30, 252–259. Carpenter, L. M. (2002). Gender and the meaning and experience of virginity loss in the contemporary United States. Gender and Society, 16, 345–365. Eriksson, J., & Humphreys, T. (2009). [Reliability and validity of the Virginity Beliefs Scale]. Unpublished raw data. Hamburger, M. E., Hogben, M., McGowan, S., & Dawson, L. J. (1996). Assessing hypergender ideologies: Development and initial validation of a gender-neutral measure of adherence to extreme gender-role beliefs. Journal of Research in Personality, 30, 157–178. Hendrick, C., Hendrick, S. S., & Reich, D. A. (2006). The Brief Sexual Attitudes Scale. The Journal of Sex Research, 43, 76–86.

Exhibit

Virginity Beliefs Scale

Instructions: Please think back to the first time you engaged in sexual intercourse. Indicate on the following scale how much you agree

with each statement in regard to your first sexual intercourse experience.

1 = Strongly Disagree

2 = Disagree

3 = Somewhat Disagree

4 = Neutral

5 = Somewhat Agree

6 = Agree

7 = Strongly Agree

1. I actively tried to hide my status as a virgin.

2. I chose the person I lost my virginity to with care.

3. I planned my first time carefully.

4. I saw my virginity loss as a natural step in my development.

5. It was important to me that the circumstances under which I lost my virginity were perfect.

6. I felt my virginity was a burden that I needed to get rid of as soon as possible.

7. It was important to me that my first time was romantic.

8. I felt embarrassed over being a virgin.

9. I considered virginity loss to be an inevitable part of growing up.

10. I dated the person I lost my virginity to for a long time before we engaged in intercourse.

11. I was worried about what others might think if they found out I was a virgin.

12. The reason I did not lose my virginity earlier was because I had not found the right partner.

13. I felt that losing my virginity was an important step towards becoming a man/woman.

14. I believed I would stay in a relationship with the person I lost my virginity to for a long time.

15. I lost my virginity later than I would have wanted.

16. I felt in love with the person I lost my virginity to.

17. I regarded my virginity as something negative.

18. My virginity was a gift to my first partner.

19. I was afraid my partner would find out I was a virgin.

20. I planned my virginity loss with my partner.

21. I was afraid to tell my partner that I was a virgin.

22. I felt losing my virginity was a step in the transition between adolescence and becoming an adult.

Victimization (see Abuse)

i. Not at all Very

Exploited 1 2 3 4 5 6 7 Exploited

j. Not at all Very

Happy 1 2 3 4 5 6 7 Happy

k. Not at all Very

Embarrassed 1 2 3 4 5 6 7 Embarrassed

l. Not at all Very

Excited 1 2 3 4 5 6 7 Excited

m. Not at all Very

Fearful 1 2 3 4 5 6 7 Fearful

3. Directions: The following items deal with your anticipated reactions to your first sexual intercourse. Please answer all items “a”

through “m” by using a 7-point scale, in which “1” represents not anticipating the feeling at all, and “7” represents strongly anticipating

the feeling, with the numbers in between representing various gradations between these extremes. Please circle the number in each item

that most closely represents the way you anticipate feeling.

How do you think you will react to your first sexual intercourse at the time that it occurs?

I anticipate feeling: (The 13 responses for Question 2 are repeated.)

1. Meeting a boyfriend/girlfriend.
2. Telling a boyfriend or girlfriend that you have genital herpes.
3. Having sex.
4. Getting married.
5. Having children.

Emotional Reaction Scale

People may have different reactions to contracting genital herpes. How would you react? For each emotion listed below indicate if you would: 1. not react with the emotion, 2. mildly feel the emotion, 3. moderately feel the emotion or 4. strongly experience the emotion.

1. Angry.
2. Punished.
3. Fearful.
4. Numbed.
5. Damaged.
6. That it was expected.
7. Guilty.

Inventory of Dyadic Heterosexual Preferences and Inventory of Dyadic Heterosexual Preferences—Other

Daniel M. Purnine, Michael P. Carey,[1] and Randall S. Jorgensen, *Syracuse University*

The Inventory of Dyadic Heterosexual Preferences (IDHP) was developed to measure men's and women's affinity for a broad range of fairly conventional sexual behavior preferences within the context of a dyadic heterosexual relationship. Six scales, reflecting different domains of behavioral preference, are derived. The IDHP allows researchers to explore relationships between specific preferences or profiles of preference and various behavioral, personality, or dyadic correlates. Sex therapists may be interested in comparing the profile of one's sexual preferences with that of one's partner. An other-focused version of the inventory (IDHP-O) asks the respondent to indicate how he or she believes the partner would respond to the IDHP.

Description

A complete description of the IDHP and its development may be found elsewhere (Purnine, Carey, & Jorgensen, 1996). The IDHP is a 27-item self-report inventory that measures the following six areas of sexual preference: Erotophilia, Use of Contraception, Conventionality, Use of Erotica, Use of Drugs/Alcohol, and Romantic Foreplay.

Seventy-four statements, applicable to both men and women, were generated to elicit responses to specific behaviors or elements of a sexual scene. Each item was followed by a 6-point Likert-type scale, ranging from *strongly agree* to *strongly disagree*. Items regarding fantasy, opinion, or motivation were generally excluded. The perfect tense ("I would enjoy") rather than the present tense ("I enjoy") was employed in order that items outside one's habitual range of experience may be applicable. This use of the hypothetical allows the IDHP to be applicable to those not currently involved in a sexually intimate relationship.

The 74 items were administered to 258 undergraduate and graduate university students (Sample 1), aged 18 to 59 years of age ($M = 23$). After eliminating items that failed to elicit a broad range of responses or that were unreliable over a 1- to 2-week period, 46 items remained. Factor analyses suggested a six-factor, 27-item solution. This solution was based on a covariance matrix in which the variance attributable to gender had been removed. A gender-neutral factor structure was considered necessary in order to allow meaningful comparisons between the profiles of male and female partners.

[1]Address correspondence to Michael P. Carey, Department of Psychology, 430 Huntington Hall, Syracuse University, Syracuse, NY 13244–2340; e-mail: mpcarey@psych.syr.edu

These results were cross-validated using new data (Sample 2) from 228 students, aged 17 to 53, ($M = 21$). Six items were reworded to improve their clarity. Three new items were introduced to enlarge certain factors. A six-factor maximum likelihood solution, with promax rotation, incorporated the new items and suggested the elimination of three others. The final 27-item factor structure accounted for 51% of the variance among the 27 items.

Response Mode and Timing

Using a paper/pencil format, respondents circle the number indicating their personal level of agreement/disagreement with each statement of preference. It takes approximately 5 minutes to complete the IDHP and, if administered, an additional 5 minutes to complete the IDHP-O.

Scoring

IDHP scale scores (individual preferences). Higher scores on each of the six IDHP scales indicate stronger preference for the behaviors in that scale. First, Items 3, 24, and 26 must be reverse scored by subtracting the number circled from 7. Each scale is then derived by adding across the items as follows—Erotophilia: 1, 7, 8, 11, 16, 17, 18; Use of Contraception: 3, 6, 13, 26; Conventionality: 5, 10, 22, 23; Use of Erotica: 4, 9, 24, 27; Use of Drugs/Alcohol: 12, 14, 15, 20; and Romantic Foreplay: 2, 19, 21, 25. To standardize the scales, each ranging from 1 to 6, sums may be divided by the number of items added.

Exploratory scores. Several dyadic variables are currently under investigation. Agreement, or similarity between two partners' preferences may be observed by comparing the IDHP of each partner. Female Understanding (of the male) is reflected by comparing the male's IDHP with the IDHP-O of the female; Male Understanding (of the female) is reflected by comparing the female's IDHP with the male's IDHP-O. An individual variable, Perceived Agreement, is reflected in the difference between one's own IDHP and IDHP-O. These variables may be generated through correlational procedures or as difference-scores (by adding the absolute value of point differences across the 27 items). Because these variables are exploratory, the following sections pertain only to the IDHP scale scores.

Reliability

Listed in Table 1 are alpha coefficients, test-retest reliability correlations, means and standard deviations across the six IDHP scales, based on data from Sample 2. The scales are internally consistent (mean alpha coefficient = .72) and stable over time (mean test-retest $r = .84$). Item analysis from Sample 1 required a test-retest reliability of .70 for each item.

Validity

In a subgroup of 45 women and 20 men from Sample 2, seven additional scales were administered for purposes of establishing concurrent and discriminant validity with the six IDHP scales. Of 42 predictions in this 6 x 7 matrix of correlations, 36 were supported. Absence of any relationship between each IDHP scale and the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) provides discriminant evidence that the IDHP is not confounded by a bias toward presenting oneself in a socially desirable light. The Sexual Opinion Survey (SOS; Fisher, White, Byrne, & Kelley, 1988), a 21-item measure of erotophilia, correlated with the IDHP scale, Erotophilia ($r = .54$). However, discriminant validity for this scale is currently lacking, because the SOS also was related to Use of Erotica, Use of Drugs/Alcohol, and Conventionality. It should be noted, however, that similar relationships exist among the IDHP factors themselves. This is an allowance of oblique factor rotation. In fact, it would be surprising if erotophilia were *not* related to other, possibly more specific, domains of preference.

Both concurrent and discriminant validity were evidenced for the following IDHP scales: Use of Contraception, Conventionality, and Use of Drugs/Alcohol. The Use of Contraception scale positively correlated only with a measure entitled Affective Response Toward Contraceptive Topics and Behavior (Kelley, 1979). Conventionality was related to the Sexual Irrationality Questionnaire (Jordan & McCormick, 1988), a measure with factors such as "conformity," and "cautious control." Both the global and sexual subscales of the Alcohol Expectancy Questionnaire (Brown, Christiansen, & Goldman, 1987) were positively related to the IDHP Use of Drugs/Alcohol only. Validity of Romantic Foreplay and Use of Erotica remain without support, as the former was uncorrelated with its criterion measure and no relevant measure was available to test the latter.

TABLE 1
Psychometric Properties of the Inventory of Dyadic Heterosexual Preferences (IDHP)

Scale	Alpha Coefficients	Test-Retest Correlations[a]	Means (*SD*) Male		Means (*SD*) Female	
1. Erotophilia	.73	.84	4.77	(.56)	4.27	(.73)
2. Use of Contraception	.65	.80	4.36	(.93)	4.59	(.84)
3. Conventionality	.59	.83	2.89	(.83)	3.20	(.91)
4. Use of Erotica	.83	.92	4.04	(.97)	3.22	(1.12)
5. Use of Drugs/Alcohol	.87	.91	3.15	(1.34)	2.43	(1.18)
6. Romantic Foreplay	.62	.73	4.43	(.71)	4.91	(.71)

[a]Test-retest interval was 2 weeks, including 45 women and 20 men ($N = 65$).

Other Information

Further research regarding reliability, validity, and factor structure across diverse populations is encouraged for clinicians and researchers using the IDHP and IDHPO.

References

Brown, S. A., Christiansen, B. A., & Goldman, M. S. (1987). The Alcohol Expectancy Questionnaire: An instrument for the assessment of adolescent and adult alcohol expectancies. *Journal of Studies on Alcohol, 48*, 483–491.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*, 349–354.

Fisher, W. A., White, L. A., Byrne, D., & Kelley, K. (1988). Erotophilia-erotophobia as a dimension of personality. *The Journal of Sex Research, 25*, 123–151.

Jordan, T. J., & McCormick, N. B. (1988). Sexual Irrationality Questionnaire. In C. M. Davis, W. L. Yarber, & S. L. Davis (Eds.), *Sexually-related measures: A compendium* (pp. 46–49). Lake Mills, IA: Graphic Publishing Company.

Kelley, K. (1979). Socialization factors in contraceptive attitudes: Roles of affective responses, parental attitudes, and sexual experience. *The Journal of Sex Research, 15*, 6–20.

Purnine, D. M., Carey, M. P., & Jorgensen, R. S. (1996). The Inventory of Dyadic Heterosexual Preferences: Development and psychometric evaluation. *Behaviour Research and Therapy, 34*, 375–387.

Exhibit

Inventory of Dyadic Heterosexual Preferences

Instructions.[a] Please read the following statements carefully and indicate how much you agree or disagree that the statement is true for you. Respond to each item as you would actually like things to be in relations with your partner. Feel free to ask the investigator about any statement that is not clear to you. Please respond to all items.

There are no right or wrong answers; respond as truthfully as possible.

1. I would like to initiate sex.

Strongly agree	Agree	Somewhat agree	Somewhat disagree	Disagree	Strongly[b] disagree
6	5	4	3	2	1

2. An intimate, romantic dinner together would be a real turn on to me.
3. Using spermicide would spoil sex for me.
4. I would like to use a vibrator or other sexual toy (or aid) during sex.
5. I would prefer to have sex under the bedcovers and with the lights off.
6. Having myself or my partner use a condom would not spoil sex for me.
7. Having sex in rooms other than the bedroom would turn me on.
8. I would prefer to have sex everyday.
9. Looking at sexually explicit books and movies would turn me on.
10. I would not enjoy looking at my partner's genitals.
11. I would like to have sex after a day at the beach.
12. I would like to mix alcohol and sex.
13. Using a contraceptive would not affect my sexual satisfaction or pleasure.
14. I would enjoy having sex after smoking marijuana.
15. I would prefer to have sex while using drugs that make me feel aroused.
16. I would enjoy having sex outdoors.
17. My preferred time for having sex is in the morning.
18. Swimming in the nude with my partner would be a turn-on.
19. I would enjoy dressing in sexy/revealing clothes to arouse my partner.
20. I would like to mix drugs and sex.
21. I would get turned on if my partner touched my chest and nipples.
22. I would prefer to avoid having sex during my (partner's) period.
23. I would not enjoy having my partner look at my genitals.
24. Sexually explicit books and movies are disgusting to me.
25. I would find deep kissing with the tongue quite arousing to me.
26. Using a vaginal lubricant (KY jelly) would spoil sex for me.
27. Watching erotic movies with my partner would turn me on.

[a]Instructions for the IDHP-O: Please read the following statements carefully and indicate how much you believe that *your partner* would agree or disagree that the statement is true for him/her. That is, respond to each item *as you think your partner would respond*—how he or she would actually like things to be in relations with you.

[b]This scale is repeated after each item.