

Sexual Self-Efficacy Scale—Erectile Functioning

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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)

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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 negative impact of erectile dysfunction.

Convergent validity was also established by Swindle, Cameron, Lockhart, and Rosen (2004), who found a correlation 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 intracavernous pharmacotherapy for erectile dysfunction. Similarly, Latini, Penson, Wallace, Lubeck, and Lue's (2006b) longitudinal 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 validity. 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% accuracy. 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 underwent 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 dysfunction as well as prostate cancer (2003a) and diabetes (2003b) reported worse sexual self-efficacy than men with erectile dysfunction but no known underlying medical illness (prostate cancer $M = 37.7$, no prostate cancer $M = 50.6$, $p < .001$; diabetes $M = 38.2$, $SD = 17.75$, no diabetes $M = 47.5$, $SD = 20.30$, $p = .063$).

These results indicate that the SSES-E has excellent psychometric properties. The measure has good internal consistency and test-retest reliability as well as good concurrent, convergent, criterion, and predictive validity. Moreover, the measure has been successfully used in studies of psychological and medical interventions for men with erectile difficulties caused by known disease processes as well as erectile dysfunction of unknown etiology.

Other Information

GlaxoSmithKline (2009) had the measure, which was originally developed in English and French, translated into several languages (cf. Eremenco, 2003) and has been using it in its worldwide Levitra evaluation program. A companion measure, the Sexual Self-Efficacy Scale for Female Functioning (SSES-F), is available in this volume (Bailes et al., 2010).

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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 (✓) 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 (✓) what you can do. Then, rate your confidence in being able to do each activity if you tried to do it today. Each activity is independent of the others.

For (female) partners only:

Under column I (*Can Do*), check (✓) 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 (✓) 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.

10	20	30	40	50	60	70	80	90	100	I	II
Quite Uncertain				Moderately Certain					Quite Certain	Check if Female Can Do	Rate Confidence 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.											

10. S'engager dans la pénétration pour aussi longtemps que désiré sans éjaculer.		
11. Stimuler la partenaire jusqu'à l'orgasme de façon autre que par la pénétration.		
12. Se sentir sexuellement désirable pour la partenaire.		
13. Se sentir à l'aise au niveau sexuel.		
14. Avoir du plaisir au cours d'une activité sexuelle avec la partenaire sans qu'il n'y ait de pénétration.		
15. Anticiper une activité sexuelle sans se sentir obligé de faire la pénétration.		
16. Être intéressé au sexe.		
17. Initier les activités sexuelles.		
18. Refuser les avances sexuelles de la partenaire.		
19. Demander à la partenaire de procurer le type et la quantité de stimulation sexuelle désirée.		
20. Obtenir au moins une érection partielle en présence de la partenaire durant les activités sexuelles.		
21. Obtenir une érection ferme en présence de la partenaire durant les activités sexuelles.		
22. Obtenir un orgasme avec la partenaire pendant qu'elle stimule le pénis avec ses mains ou sa bouche.		
23. Obtenir un orgasme pendant la pénétration (que l'érection soit ferme ou non).		
24. Obtenir un orgasme en se masturbant seul (que l'érection soit ferme ou non).		
25. Obtenir une érection le matin au réveil.		

Clitoral Self-Stimulation Scale

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This scale assesses the frequency of women's self-stimulation of the clitoris and genitals in the presence of a partner, as well as their attitudes and affective reactions to such self-stimulation.

Description

The scale is composed of five items measuring attitudinal and affective states in relation to self-stimulation of the clitoris and genitals in the context of sexual interaction with a partner, and one item assessing the frequency of self-stimulation in such situations. Response options vary, reflecting the content of the item.

Scale development followed an iterative process, whereby items were developed and refined over a series of three studies. An initial pool of 18 items was developed and administered to 198 female undergraduate students. Items were subject to individual item analyses and exploratory factor analyses. Ten items were deleted owing to poor empirical performance or poor conceptual overlap with the construct. The eight remaining items and four new items were provided to 16 graduate students, who rated the items for clarity and provided feedback and suggestions for wording changes (see Hinkin, 1998; Streiner & Norman, 2008, for evidence for the use of students as item judges). Recommendations to improve item wording were considered if two or more people suggested them; word-

ing changes were made to three items. The 12 items were then administered to a second sample of 242 female undergraduate participants, and items were subjected to item analyses and exploratory factor analyses. Five items were deleted and two additional items were written. The seven items were administered to 211 female undergraduate participants, and responses were subjected to item analyses and test-retest reliability analyses. Six 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) low clarity ratings by expert raters ($M < 5.5$ on a 7-point scale), (g) poor item wording as judged by expert raters, (h) redundancy with other items, (i) 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 years ($M = 18.83$ – 19.24 , $SD = 2.67$ – 3.38), who were heterosexually active

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