Fichten, C. S., Budd, J., Spector, I., Amsel, R., Creti, L., Brender, W., Bailes, S., & Libman, E. (2019). Sexual Self-Efficacy Scale - Erectile Functioning (SSES-E). In R. Milhausem J. Sakauluk, C. M. Davis, W. L. Yarber, & T Fisher (Eds.), Handbook of Sexuality-related Measures (4th edition, pp. 612-615). New York: Routledge.

Sexual Self-Efficacy Scale—Erectile Functioning

Catherine S. Fichten,[8] *Jewish General Hospital/McGill University/ Dawson College*
Jillian Budd, *McGill University/Adaptech Research Network*
Ilana Spector, *Jewish General Hospital/McGill University*
Rhonda Amsel, *McGill University*
Laura Creti, *Jewish General Hospital/McGill University*
Sally Bailes, *Jewish General Hospital/McGill University*
Eva Libman, *Jewish General Hospital/McGill University*

The Sexual Self Efficacy Scale—Erectile Functioning (SSES-E; Libman, Rothenberg, Fichten, & Amsel, 1985) 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

[8] Address correspondence to: catherine.fichten@mcgill.ca

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.

Development

Item content of the 25 item SSES-E is based on questionnaires by Lobitz and Baker (1979) and Reynolds (1978).

Response Mode and Timing

The respondent places a check mark in the "Can Do" column next to each sexual activity which 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*. To obtain both partners' views about a man's self-efficacy beliefs, the SSES-E can be completed by both the male subject and his partner. Partners rate the male subject's 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 14–25. 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

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 a sex therapy service (Libman et al., 1985). Nine men presented with their female sexual partners. The control group consisted of 15 married couples with non-problematic sexual functioning matched to the dysfunctional group on demographic variables. The entire sample was composed of middle-class Caucasians, with a mean age of 34. Test–retest reliability, using the control group, was calculated over a one month period. Results showed a reliability coefficient of .98 for males and .97 for partners.

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. In a Portuguese version (N = 138 men, age range 18–62), the Cronbach's alpha was similar to the original Canadian sample (Rodrigues Jr., Catão, Finotelli Jr., Silva, & Viviani, 2008), and in a recent Iranian version involving 115 married men, the Cronbach's alpha was .95 (Rajabi, Dastan, & Shahbazi, 2012).

Validity

Concurrent validity estimates were reported in the original study (Libman et al., 1985). More recently, Latini et al. (2002) correlated men's SSES-E and Psychological Impact of Erectile Dysfunction Scale (PIED) scores. The SSES-E was significantly correlated with both PIED scales (–.57 and –.51).

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. Reissing, Andruff, and Wentland (2012) found that lower SSES-E score was related to lower level of sexual adjustment (r = .49) and higher sexual aversion (r = –.33) in 170 young men aged 18 to 29.

Predictive validity was shown by Kalogeropoulos (1991), who found that SSES-E 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 improvement in urine flow, the authors showed improved SSES-E after treatment relative to placebo subjects (p < .036). Similarly, Zafarghandi, Nik, Birashk, Assari, and Khanehkeshi (2016) showed that not only did aspects of sexual functioning improve among men with opiate dependence who underwent methadone maintenance therapy, but also that SSES-E scores improved significantly. In a study of Iranian substance addicted couples, results show that after a 9-week therapy program, SSES-E scores of treated men were significantly higher than those of the control group (Nooripour, Bass, & Apsche, 2013; Nooripour et al., 2014).

The SSES-E has also demonstrated good criterion validity. For example, Latini, Penson, Wallace, Lubeck, and Lue (2006a) found that SSES-E score was the best predictor of erectile dysfunction severity out of a large

number of clinical and psychosocial predictors. In addition, Reissing et al. (2012) found that in a sample of 170 men aged 18–29, SSES-E scores not only significantly contributed to variance in sexual adjustment but also that these mediated the relationship between affective reaction to first intercourse and current sexual adjustment.

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 and their partners scored significantly lower on the SSES-E than did functional men and their partners. Moreover, a stepwise discriminant analysis indicated that SSES-E scores were able to classify dysfunctional and non-dysfunctional men with 88 percent accuracy. In addition, older married men had significantly lower self-efficacy scores than their middle aged counterparts (Libman et al., 1989). Also, men who underwent a transurethral prostatectomy rated their post-surgery SSES-E lower than their pre-surgery score (Libman et al., 1989, 1991). In addition, Latini et al. (2006a) found that men with mild, moderate and severe erectile dysfunction differed significantly. The findings above were replicated in studies of men with erectile dysfunction who had illness known to affect erectile functioning (Penson et al., 2003a, 2003b). In a study of 138 Brazilian men, results show that, as expected, men with erectile problems had significantly higher SSES-E scores that those with rapid ejaculation (Rodrigues Jr. et al., 2008).

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

Originally developed in English and French, Glaxo SmithKline (2009) had the measure translated into several languages (cf. Eremenco, 2003) and used it in its worldwide Levitra evaluation program. Since that time, a Portuguese version (Rodrigues Jr. et al., 2008) and a version for use in Iran (Rajabi et al., 2012) have been developed.

References

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, *37*, 122–147. https://doi.org/10.1037/0003-066X.37.2.122

Eremenco, S. (2003). *FACIT Multilingual Translations Project, > Center on Outcomes, Research, and Education (CORE)*. Evanston, IL: Evanston Northwestern Healthcare.

GlaxoSmithKline. (2009). *BAY38-9456, 5/10/20mg, vs. placebo in erectile dysfunction—clinical trial*. Retrieved from http://clinicaltrials.gov/ct2/show/NCT00665054

Godschalk, M. F., Unice, K. A., Bergner, D., Katz, G., Mulligan, T., & McMichael, J. (2003). A trial study: The effect of low dose human chorionic gonadotropin on the symptoms of benign prostatic hyperplasia. *Journal of Urology*, *170*, 1264–1269. https://doi.org/10.1097/01.ju.0000084514.49252.64

Kalogeropoulos, D. (1991). *Vasoactive intracavernous pharmacotherapy for erectile dysfunction*. Unpublished doctoral dissertation, Concordia University, Montreal, QC.

Latini, D. M., Penson, D. F., Colwell, H. H., Lubeck, D. P., Mehta, S. S., Henning, J. M., & Lue, T. F (2002). Psychological impact of erectile dysfunction: Validation of a new health related quality of life measure for patients with erectile dysfunction. *Journal of Urology*, *168*, 2086–2091. https://doi.org/10.1097/01.ju.0000034365.57110.b7

Latini, D. M, Penson, D. F., Wallace, K. L., Lubeck, D. P., & Lue, T. F. (2006a). Clinical and psychosocial characteristics of men with erectile dysfunction: Baseline data from ExCEED. *Journal of Sexual Medicine*, *3*, 1059–1067. https://doi.org/10.1111/j.1743-6109.2006.00331.x

Latini, D. M, Penson, D. F., Wallace, K. L., Lubeck, D. P., & Lue, T. F. (2006b). Longitudinal differences in psychological outcomes for men with erectile dysfunction: Results from ExCEED. *Journal of Sexual Medicine*, *3*, 1068–1076. https://doi.org/10.1111/j.1743-6109.2006.00332.x

Libman, E., Fichten, C., Creti, L., Weinstein, N., Amsel, R., & Brender, W. (1989). Transurethral prostatectomy: Differential effects of age category and presurgery sexual functioning on post prostatectomy sexual adjustment. *Journal of Behavioral Medicine*, *12*, 469–485. https://doi.org/10.1007/BF00844879

Libman E., Fichten, C. S., Rothenberg, P., Creti, L., Weinstein, N., Amsel, R., . . . Brender, W. (1991). Prostatectomy and inguinal hernia repair: A comparison of the sexual consequences. *Journal of Sex and Marital Therapy*, *17*, 27–34. https://doi.org/10.1080/00926239108405466

Libman, E., Rothenberg, I., Fichten, C. S., & Amsel, R. (1985). The SSES-E: A measure of sexual self-efficacy in erectile functioning. *Journal of Sex and Marital Therapy*, *11*, 233–244. https://doi.org/10.1080/00926238508405450

Lobitz, W. C., & Baker, E. C. (1979). Group treatment of single males with erectile dysfunction. *Archives of Sexual Behavior*, *8*, 127–138. https://doi.org/10.1007/BF01541233

Nooripour, R., Bass, C. K., & Apsche, J. (2013). Effectiveness of quality of life therapy aimed at improving sexual self-efficacy and marital satisfaction in addict couples of treatment period. *International Journal of Behavioral Consultation and Therapy*, *8*, 26–29. https://doi.org/10.1037/h0100973

Nooripour, R., de Velasco, B. P., ZadeMohammadi, A., Ventegod, S., Bayles, S., Blossom, P., & Apsche, J. (2014). Effectiveness of quality of life therapy on sexual self-efficacy and quality of life in addicted couples. *International Journal of Behavioral Consultation and Therapy*, *9*, 43–45. https://doi.org/10.1037/h0101015

Penson, D. F., Latini, D. M., Lubeck, D. P., Wallace, K. L., Henning, J. M., & Lue, T. F. (2003a). 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. https://doi.org/10.1097/01.ju.0000054462.88306.43

Penson, D. F., Latini, D. M., Lubeck, D. P., Wallace, K. L., Henning, J. M., & Lue, T. F. (2003b). 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. https://doi.org/10.2337/diacare.26.4.1093

Rajabi, G., Dastan, N., & Shahbazi, M. (2012). Reliability and validity of the Sexual Self-Efficacy Scale-Erectile Functioning. *Iranian Journal of Psychiatry and Clinical Psychology*, *18*, 74–82.

Reissing, E. D., Andruff, H. L., & Wentland, J. J. (2012). Looking back: The experience of first sexual intercourse and current sexual adjustment in young heterosexual adults. *Journal of Sex Research*, *49*, 27–35. https://doi.org/10.1080/00224499.2010.538951

Reynolds, B. S., (1978). *Erectile Difficulty Questionnaire*. Unpublished manuscript, UCLA, Human Sexuality Program, Los Angeles, CA.

Rodrigues Jr., O. M., Catão, E. C., Finotelli Jr., I., Silva, F. R. C. S. & Viviani, D. H. (2008). Escala de Autoeficacia Sexual-Función Eréctil (Versión E): Estudio de validación clínica en Brasil. *Revista Peruana de Psicometría*, *1*, 12–17.

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. https://doi.org/10.1023/B:ASEB.0000007459.48511.31

Zafarghandi, M. B. S., Nik, M. M., Birashk, B., Assari, A., & Khanehkeshi, A. (2016). Sexual dysfunction among males with opiate dependence undergoing Methadone Maintenance Therapy (MMT). *International Journal of High Risk Behaviors & Addiction*, *5*, e37740. https://doi.org/10.5812/ijhrba.3774

Exhibit

Sexual Self-Efficacy Scale—Erectile Functioning

The following form lists sexual activities that men engage in.

For male respondents only

Under column I (*Can do*), check the activities that *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 from 10 to 100 using the scale 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 partner respondents only

Under column I (*Can do*), check the activities that 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 from 10 to 100 using the scale below. Each activity is independent of the others. 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 you tried to do it today. Each activity is independent of the others.

	I	II
	Check if Male Can Do	Rate Confidence (10–100)
10 20 30 40 50 60 70 80 90 100 Quite Uncertain — Moderately Certain — Quite Certain		
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 naked.	○	___
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.	○	___

The SexFlex Scale

Stéphanie E. M. Gauvin, *Queen's University*
Caroline F. Pukall,[9] *Queen's University*

The 6-item SexFlex scale (Gauvin & Pukall, 2018) is a measure of people's flexibility in changing their sexual approach—or "sexual script"—when they encounter a sexual issue. Examples of sexual issues include different sexual preferences or differing levels of sexual desire between partners, roadblocks in sexual communication, navigating sexual activity in the presence of genital pain or arousal difficulties, dealing with performance anxiety, and dissatisfaction with the timing of one's—or one's partner's—orgasm.

Development

The two authors generated an initial pool of 13 items, inspired from themes that emerged from the sexual scripts literature and components of the Coping Flexibility Scale (Kato, 2012). These initial 13 items were administered, as a part of a larger survey (Gauvin & Pukall, 2018), to an online sample (N = 951) of individuals in same-gender and mixed-gender relationships (n = 118 males with a male partner, n = 236 males with a female partner, n = 485 females with a male partner, n = 112 females with a female partner). Individuals were randomly assigned using SPSS 23.0 to one of two subsamples; subsample A for exploratory factor analysis (n = 483) or subsample B for confirmatory factor analysis (n = 468).

Using data from subsample A (n = 483), both the minimum average partial (MAP) test and parallel analyses indicated that a two-factor solution was appropriate: Approach Flexibility and Reflective Flexibility. Three items were removed prior to initial confirmatory factor analysis based on the criteria of cross loadings greater than |0.3|. The two-factor solution remained robust across rotations.

Data from subsample B (n = 468) were subjected to a confirmatory factor analysis using maximal likelihood method with the lavaan package (Rosseel, 2012) in R 3.3.0. The two-factor SexFlex scale had adequate model fit (RMSEA = .073, SRMR = .052, CFI = .96), and a structure that was invariant across females and males in same and mixed-gender relationships.

As the Reflective Flexibility subscale showed inadequate reliability and validity in subsequent studies, a final single factor solution was retained (SRMR = .025, CFI = .098, RMSEA = .078), resulting in a final 6-item scale.

Response Mode and Timing

The measure can be completed electronically or using paper-and-pencil in under 5 minutes. Participants indicate on a 4-point Likert-type scale, from *seldom or never* to *almost always*, the point that reflects how frequently they respond in the way indicated by the item. The items were worded to reflect a person's sexual flexibility during partnered sexual activity.

Scoring

A total score on the SexFlex scale is obtained by summing the 6 items. No items are reverse coded and higher scores indicate a greater frequency of flexible responses when dealing with a sexual issue.

Reliability

The SexFlex shows a consistent high internal consistency, with Cronbach's alpha values ranging from .86 to 90 across

[9] Address correspondence to: caroline.pukall@queensu.ca