22. Enjoy intercourse. ________ ________
23. Enjoy a lovemaking encounter in which you do not reach orgasm. ________ ________
24. Feel sexually aroused in response to erotica (pictures ________ ________
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. ________ ________

Sexual Self-Efficacy Scale–Erectile Functioning

Catherine S. Fichten,[1] *SMBD-Jewish General Hospital and Douglas Hospital*
Ilana Spector, *Douglas Hospital and McGill University*
Rhonda Amsel, *McGill University*
Laura Creti, William Brender, and Eva Libman, *SMBD-Jewish General Hospital and Concordia University*

The Sexual Self-Efficacy Scale–Erectile Functioning (SSES-E) is a measure of the cognitive dimension of erectile functioning and adjustment in men. Specifically, it evaluates a man's beliefs about his sexual and erectile competence in a variety of sexual situations. The scale may be completed by a male to obtain self-ratings or by his partner to obtain corroboration.

Self-efficacy—confidence in the belief that one can perform a certain task or behave adequately in a given situation (Bandura, 1982)—is important in sexual relationships, where it is believed that negative thinking about sexual behaviors may lead to increased performance anxiety, poorer sexual function, and perhaps, avoidance of sexual activity. The SSES-E was developed to measure sexual self-efficacy with respect to erectile functioning.

The SSES-E can be used in the clinical assessment of sexual dysfunction (e.g., Carey, Wincze, & Meisler, 1993). It can also be used to measure sexual self-efficacy as it relates to other cognitive, affective, behavioral, or physiological variables. The measure can differentiate functional from dysfunctional groups, as well as other groups that are hypothesized to have varying levels of erectile confidence (e.g., older and younger men). The SSES-E has also been shown to be useful in evaluating how self-efficacy changes in relation to biological events, such as surgery, as well as in relation to biological interventions for erectile problems, such as injection therapy. Finally, the SSES-E is appropriate as a measure of treatment outcome for sex therapy, where the goal is not only improved sexual behavior but also more adaptive cognitions and positive affect.

Description

The SSES-E is a 25-item measure designed to follow Bandura, Adams, and Beyer's (1977) format. Item content is based on the Goals for Sex Therapy questionnaire (Lobitz & Baker, 1979) and the Erectile Difficulty Questionnaire (Reynolds, 1978).

Respondents first indicate which sexual activities they expect they (or their partner) can complete. For each of these activities, they then rate their confidence level on a

[1]Address correspondence to Catherine S. Fichten, Department of Psychology, Dawson College, 3040 Sherbrooke Street West, Montreal, Quebec H3Z 1A4, Canada.

10-point interval scale ranging from 10-100. The questionnaire can be completed by both the male respondent and by 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 given 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.* Instructions allow partners to rate sexual functioning according to the same format. The scale takes an average of 10 minutes to complete.

Scoring

The SSES-E yields a self-efficacy strength score. This is obtained by summing the values in the Confidence column and dividing by 25 (the number of activities rated). Any activity that the respondent does not check off in the Can Do column is presumed to have a zero confidence rating. Higher scores indicate greater confidence in the man's erectile competence.

Reliability

A group of dysfunctional men and a control group were examined. The dysfunctional sample consisted of 17 men presenting with sexual dysfunctions (13 with male erectile disorder, 2 with hypoactive sexual desire, and 2 with premature ejaculation) at the sex therapy service of a large metropolitan hospital (Libman, Rothenberg, Fichten, & Amsel, 1985). Nine of these 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.

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

Using the same sample, concurrent validity estimates were obtained by correlating the dysfunctional men's SSES-E scores with selected items on the Sexual History Form (Nowinski & LoPiccolo, 1979). Correlations ranged from .47 to .68 for those items asking about quality of erections and feelings of sexual arousal. These findings were replicated and/or extended by Kalogeropoulos (1991), Creti and Libman (1989), and by Libman, Fichten, and Brender (1987), who found that SSES-E scores were logically and significantly related to age, couple sexual adjustment, frequency and breadth of sexual repertoire, and global male sexual functioning, in a sample of middle-aged and older men. Also, results reported by McPhee and colleagues (McPhee, 1985; McPhee, Sullivan, & Brender, 1986) indicate that men with lower SSES-E scores have more negative cognitive schemata about sexual functioning.

Evidence for known-groups validity has also been collected. In our 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 as lower (M = 59.3, SD = 20.3) than presurgery (M = 64.3, SD = 18.8) (Libman et al., 1989; Libman et al., 1991).

The SSES-E is also sensitive to changes with therapy. Kalogeropoulos (1991) found that scores significantly improved in a sample of 53 males who had undergone vasoactive intracavernous pharmacotherapy for erectile dysfunction.

Other Information

The SSES-E is also available in French (Échelle d'Efficacité Sexuelle–Le Fonctionnement Érectile, Version E). A validation study currently in progress (Fichten, Wright, Spector, Sabourin, Brender, & Libman, 1995) shows promising results. This measure was developed with research funding from the Conseil Québécois de la Recherche Sociale. We would like to thank Ian Rothenberg for assistance with various stages of this investigation.

References

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37,* 122-147.

Bandura, A., Adams, N. E., Beyer, J. (1977). Cognitive processes mediating behavioral change. *Journal of Personality and Social Psychology, 35,* 125-139.

Carey, M. P., Wincze, J. P., & Meisler, A. W. (1993). Sexual dysfunction: Male erectile disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (2nd ed., pp. 442-480). New York: Guilford.

Creti, L., & Libman, E. (1989). Cognitions and sexual expression in the aging. *Journal of Sex & Marital Therapy, 15,* 83-101.

Fichten C. S., Libman, E., Amsel, R., Creti, L., Weinstein, N., Rothenberg, P., Liederman, G., & Brender, W. (1991). Evaluation of the sexual consequences of surgery: Retrospective and prospective strategies. *Journal of Behavioral Medicine, 14,* 267-285.

Fichten, C. S., Wright, J., Spector, I., Sabourin, S., Brender, W., & Libman, E. (1995). *Validation de l'Échelle d'Efficacité Sexuelle–Le Fonctionnement Érectile (Version E).* Manuscript in preparation.

Kalogeropoulos, D. (1991). *Vasoactive intracavernous pharmacotherapy for erectile dysfunction: Its effects on sexual, interpersonal,*

and psychological functioning. Unpublished doctoral dissertation, Concordia University, Montreal, Quebec.

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 post prostatectomy sexual adjustment. *Journal of Behavioral Medicine, 12,* 469-485.

Libman, E., Fichten, C. S., & Brender, W. (1987). *Prostatectomy and sexual functioning in the aging male: Final report to the Conseil Québécois de la Recherche Sociale.* Montreal, Quebec: Sir Mortimer B. Davis-Jewish General Hospital.

Libman E., Fichten, C. S., Rothenberg, P., Creti, L., Weinstein, N., Amsel, R., Liederman, G., & Brender, W. (1991). Prostatectomy and inguinal hernia repair: A comparison of the sexual consequences. *Journal of Sex & Marital Therapy, 17,* 27-34.

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 & 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.

McPhee, D. C. (1985). *An investigation of cognitive patterns associated with erectile dysfunctional males.* Unpublished honor's thesis, Concordia University, Montreal, Quebec.

McPhee, D. C., Sullivan, M., & Brender, W. (1986). *Perceptions of females as associated with low erectile confidence in males.* Presentation at the Canadian Psychological Association annual conference. Abstracted in *Canadian Psychology, 21,* 370.

Nowinski, J. K., & LoPiccolo, J. (1979). Assessing sexual behavior in couples. *Journal of Sex & Marital Therapy, 5,* 225-243.

Reynolds, B. S., (1978). *Erectile Difficulty Questionnaire.* Unpublished manuscript, Human Sexuality Program, University of California, Los Angeles.

Rosen, R. C., Leiblum, S. R., & Spector, I. P. (1994). Psychologically based treatment for male erectile disorder: A cognitive-interpersonal model. *Journal of Sex & Marital Therapy, 20,* 67-85.

Spector, I. P., & Carey, M. P. (1990). Incidence and prevalence of the sexual dysfunctions: A critical review of the empirical literature. *Archives of Sexual Behavior, 19,* 389-408.

Exhibit

Sexual Self-Efficacy Scale-E

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
Quite uncertain				*Moderately certain*					*Quite certain*

		I Check if male can do	II 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.	______	______
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.		

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 respondents (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 cannot be drawn from studies of a very limited and relatively inexperienced

[1]Address correspondence to David Quadagno, Department of Biological Science, Florida State University, Tallahassee, FL 32306-2043.

HANDBOOK *of* SEXUALITY-RELATED MEASURES

Edited by
Clive M. Davis
William L. Yarber
Robert Bauserman
George Schreer
Sandra L. Davis

1998

SAGE Publications
International Educational and Professional Publisher
Thousand Oaks London New Delhi