46. (Men only) Do you ever have pain and/or burning during or after ejaculation?

1) never \hspace{1cm} 5) usually, about 75% of the time
2) rarely, less than 10% of the time \hspace{1cm} 6) nearly always, over 90% of the time
3) seldom, less than 25% of the time \hspace{1cm} 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

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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 five 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 five 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 modifications 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, multidimensional 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 efficacy or effectiveness trials, or may be implemented solely at pre- and post-intervention without significant “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
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 efficacy or effectiveness trials, in which the test is administered sequentially.

Reliability and Validity
The DISF and DISF-SR have both demonstrated favorable profiles of psychometric characteristics. Internal consistency coefficients 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 definitions 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 defined 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 find 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 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 definitions 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 defined 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 find 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.

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Much of the clinical research done with the DISF/DISF-SR has involved corporate-sponsored clinical drug trials. Although preliminary data from these studies indicated that the tests were highly sensitive to sexual dysfunction, and to a broad range of therapeutic agents, most of the data were proprietary and have not been made generally available. In two studies that have been published (Zinreich et al., 1990a, 1990b), the DISF was utilized with males suffering from prostate cancer about to undergo a course of radiation therapy. At the time of initial cancer diagnosis, the DISF was utilized in a logistic regression model as a screen for impotence, with detailed clinical evaluation as the ultimate criterion. In this study, sensitivity was found to be 86%, specificity was 80%, and the predictive value of a positive was 86%. Subsequent to treatment, patients were assigned to three functional categories on the basis of clinical evaluation: (a) totally functional, (b) marginally functional, and (c) impotent. Scores on the five domains of the DSFI were significantly different across the three groups, with mean DISF total scores being 48.2, 21.5, and 14.0, respectively. In this study, with a complex sample of patients, the DISF did a superior job of identifying those individuals who were dysfunctional prior to treatment, and it validly reflected differences in quality of sexual functioning subsequent to therapeutic intervention.

Other studies utilizing the DISF/DISF-SR have been conducted, and several new norms (e.g., geriatric, gay men) were in the process of being developed, however this information has not been updated.

Other Information
The instruments are available in English, French, Italian, Spanish, Dutch, Danish, and Norwegian. The DISF and DISF-SR are distributed exclusively by Clinical Psychometric Research, Inc. (www.derogatis-tests.com).

References