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Terri D. Fisher, Clive M. Davis, William L. Yarber, Sandra L. Davis

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William E. Snell
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Sexuality Scale

WILLIAM E. SNELL, JR.,1 Southeast Missouri State University

The Sexuality Scale (SS; Snell & Papini, 1989) is an objective, self-report instrument designed to measure three aspects of human sexuality: sexual esteem, defined as positive 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 (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.

1Address 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 coefficient 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-depression 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 depression, and .96 and .92 for sexual preoccupation (Wiederman & Allgeier, 1993).

Validity

Evidence for the validity of the SS comes from a variety of sources. Snell and Papini (1989) found that among university students, women’s and men’s scores on sexual esteem and sexual depression were negatively correlated. However, for women, sexual preoccupation was positively correlated with sexual esteem. In contrast, for men, sexual preoccupation was positively correlated with sexual depression. Snell et al. (1992) provided evidence that the SS measures of sexual esteem, sexual depression, and sexual preoccupation were related in predictable ways to men’s and women’s sexual behaviors and attitudes; evidence for the discriminant validity of the SS was also documented by Snell et al. (1992). Wiederman and Allgeier (1993) indicated that men score higher than do women on both the sexual-esteem and sexual-preoccupation scales. Finally, other researchers have used the SS within a therapy treatment context (Hurlbert, White, Powell, & Apt, 1993).

References


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:

<table>
<thead>
<tr>
<th>(A) Agree</th>
<th>(B) Slightly agree</th>
<th>(C) Neither agree nor disagree</th>
<th>(D) Slightly disagree</th>
<th>(E) Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am a good sexual partner.</td>
<td></td>
<td></td>
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<tr>
<td>2. I am depressed about the sexual aspects of my life.</td>
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<tr>
<td>3. I think about sex all the time.</td>
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<td>4. I would rate my sexual skill quite highly.</td>
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<tr>
<td>5. I feel good about my sexuality. (R)</td>
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<td>6. I think about sex more than anything else.</td>
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<tr>
<td>7. I am better at sex than most other people.</td>
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<tr>
<td>8. I am disappointed about the quality of my sex life.</td>
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<td>9. I don’t daydream about sexual situations. (R)</td>
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<tr>
<td>10. I sometimes have doubts about my sexual competence. (R)</td>
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<td>11. Thinking about sex makes me happy.</td>
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<tr>
<td>12. I tend to be preoccupied with sex.</td>
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<tr>
<td>13. I am not very confident in sexual encounters. (R)</td>
<td></td>
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</tbody>
</table>
15. I’m constantly thinking about having sex.
16. I think of myself as a very good sexual partner.
17. I feel down about my sex life.
18. I think about sex a great deal of the time.
19. I would rate myself low as a sexual partner. (R)
20. I feel unhappy about my sexual relationships.
21. I seldom think about sex. (R)
22. I am confident about myself as a sexual partner.
23. I feel pleased with my sex life. (R)
24. I hardly ever fantasize about having sex. (R)
25. I am not very confident about my sexual skill. (R)
26. I feel sad when I think about my sexual experiences.
27. I probably think about sex less often than most people. (R)
28. I sometimes doubt my sexual competence. (R)
29. I am not discouraged about sex. (R)
30. I don’t think about sex very often. (R)

Condom Use Errors/Problems Survey

RICHARD A. CROSBY, University of Kentucky
CYNTHIA A. GRAHAM, University of Oxford
ROBIN R. MILHAUSEN, University of Guelph
STEPHANIE A. SANDERS AND WILLIAM L. YARBER, Indiana University

For sexually active persons wanting to prevent sexually transmitted infections (STIs) and pregnancy, condom use for all sexual episodes is necessary. Consistent use of the male, latex condom is an effective method of reducing the risk of transmitting and acquiring many STIs, including HIV infection, and unintended pregnancy (Centers for Disease Control and Prevention [CDC], 2009; Holmes, Levine, & Weaver, 2004). However, consistently using condoms is not sufficient—condoms must also be used correctly (CDC, 2009; Crosby, DiClemente, Holtgrave, & Wingood, 2002; Steiner, Cates, & Warner, 1999). Indeed, evidence suggests that condom failure typically stems from user error rather than product defect (Graham, Crosby, Sanders, & Yarber, 2005). Thus, identifying prevalent user errors and problems can be a valuable starting point toward the goal of promoting improved quality of condom use (Crosby, Yarber, Sanders, Graham, & Arno, 2008).

Description

The Condom Use Errors/Problems Survey (CUES) is a comprehensive assessment of errors and problems that people may experience when using male condoms that may lead to condom failures. Errors such as forms of incorrect use (e.g., putting condom on after starting sex) and problems such as breakage or slippage, erection difficulties, and discomfort are assessed using the CUES. The questionnaire has been refined through use in several studies involving samples of adolescent and adult men and women recruited from STI clinics, college students, rural men from a random telephone sampling, and participants from an online survey (e.g., Crosby, Milhausen, Sanders, Graham, & Yarber, 2008; Crosby, Sanders, Yarber, Graham, & Dodge, 2002; Graham et al., 2006; Sanders et al, 2003; Sanders, Milhausen, Crosby, Graham, & Yarber, 2009; Yarber, Graham, Sanders, & Crosby, 2004; Yarber et al., 2005). We

1Authors listed alphabetically.
2Address correspondence to William L. Yarber, Department of Applied Health Science, Indiana University, Bloomington, Indiana 47405; e-mail: yarber@indiana.edu