

**Sexual Dysfunction:
Conceptual and Measurement
Issues**

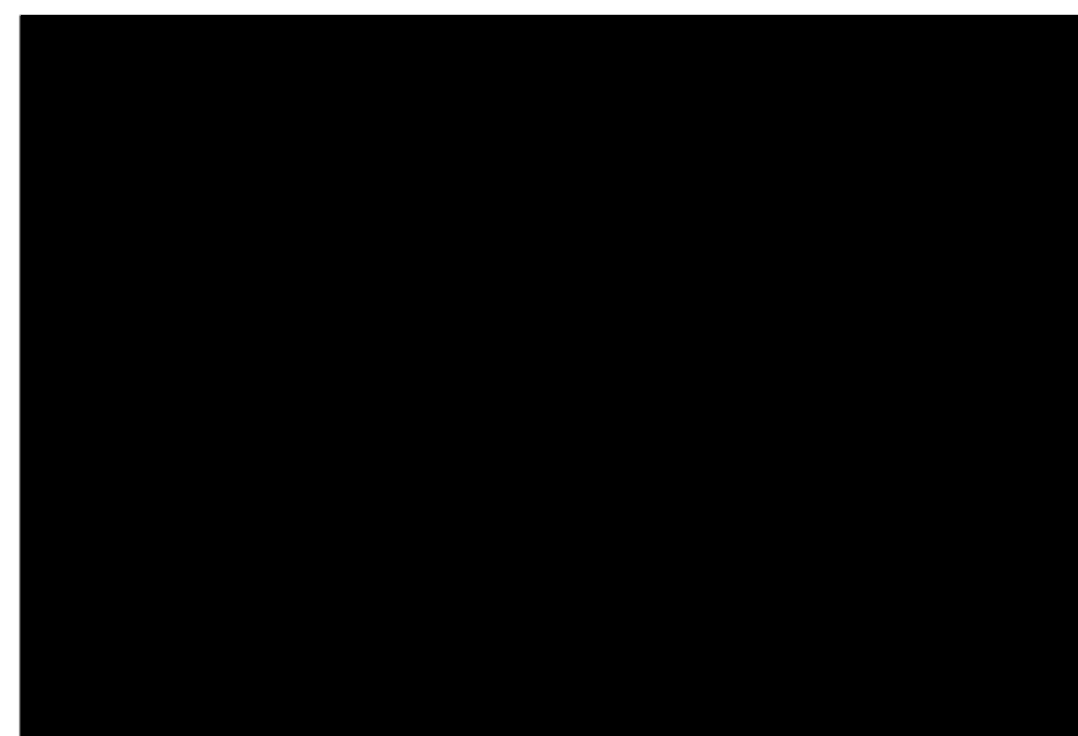
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Abstract

Despite a standard classification and array of self-report questionnaires, there is little consensus about how to define and measure sexual dysfunction. Recently the debate has been influenced by the pharmaceutical industry, leading to an increasingly medicalised view of sexual difficulties.

The aim of this thesis was to explore the meaning of sexual (dys)function to those who have and have not experienced sexual difficulties; and to use these meanings to create a conceptual model and population prevalence measure of sexual dysfunction for use in UK community surveys. Thirty-two semi-structured interviews were conducted with individuals recruited from a GP practice, an HIV/AIDS Charity and a Sexual Problems Clinic. The data were analysed using principles derived from Grounded Theory.

Variation in individual meaning was expressed in terms of three distinct versions of functional sex – the erotic, the interpersonal and the mechanistic – which framed the purpose of sexual activity, the criteria determining ideal sex, and threats to this ideal. The data highlighted several coping strategies that individuals adopted when their lived reality failed to match their ideal: changing circumstances to fit goals, for instance by seeking a medical cure; changing goals to fit circumstances, for instance by lowering expectations; and living with the gap between ideal and actual experience, for instance by avoiding the problem. Choice of strategy and the likelihood of successful adjustment were influenced by the severity of the problem, causal attributions made about the problem, and the partnership context. Thirty-one potential components of a functioning sex life were identified from the data. Using evidence both from the literature and from this study, 12 of these components were selected for inclusion in a conceptual model of sexual function. This model was transformed into a 19-item draft prevalence measure of sexual dysfunction ready for psychometric testing and validation.

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Acronyms

APA	American Psychiatric Association
COREC	Central Office for Research Ethics Committees
DSM	Diagnostic and Statistical Manual of Mental Disorders
ESRC	Economic and Social Research Council
LREC	Local Research Ethics Committee
LSHTM	London School of Hygiene & Tropical Medicine
MRC	Medical Research Council
NATSAL	National Survey of Sexual Attitudes and Lifestyles (UK)
NHS	National Health Service
WHO	World Health Organisation
GUM	Genitourinary Medicine
ED	Erectile Dysfunction
FSAD	Female Sexual Arousal Disorder
FOD	Female Orgasmic Disorder
HSDD	Hypo-sexual Desire Disorder
IELT	Intravaginal Ejaculatory Latency Time
PE	Premature Ejaculation
SD	Sexual Dysfunction

Chapter 1

Introduction

1.1 Background

Within public health, the field of sexual health is sometimes narrowly construed as protection from the adverse consequences of sex such as unwanted pregnancy and sexually transmitted infections. This focus has tended to persist despite widespread acceptance of a much broader concept of sexual health promoted by the WHO (World Health Organisation, 2006):

“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

According to this definition, sexual health concerns the possibility of pleasure and well-being as well as safety, and is characterised by a positive and respectful attitude. Sexual function is central to this definition. A well functioning sex life engenders social and psychological well-being, and is beneficial to physical health (Levin, 2007). Positive sexual expression is fundamental to individual identity as well as to the couple relationship; sexual satisfaction and relationship satisfaction are closely intertwined (Rust, Golombok & Collier, 1988; Hawton, Gath & Day, 1994; Dunn, Croft & Hackett, 2000; Althof et al., 2005a).

Yet, according to existing prevalence estimates, a significant number of people experience difficulties with this fundamental act. Sexual function problems are common.

Roughly 6% of men and 15% of women in the UK reported at least one persistent¹ sexual function problem to a recent national survey (Mercer et al., 2003). Sexual function problems can impact significantly on the well-being of individuals and their partners (Cayan et al., 2004). They often involve profound and complex personal and relationship issues (Metz & McCarthy, 2007). In the short term they can cause frustration and distress; in the longer-term, problems may lead to anxiety, depression, harmed relationships and disruptions to other areas of life (Arrington, Cofrancesco & Wu, 2004). Sexual dysfunction is thus an important impediment to quality of life (McCabe, 1997; Beutel et al., 2007). A significant proportion of difficulties remain unresolved; while many people avoid sex because of their problems, few actually seek professional help (Read, King & Watson, 1997; Mercer et al. 2005).

Sexual function problems have lately begun to attract considerable interest (Laumann, Paik & Rosen, 1999), not only from the media but from the medical profession and the pharmaceutical industry. Several socio-cultural trends underlie this recent interest. The second half of the 20th Century witnessed the increasing sexualisation of society, rapid changes in gender roles, more fluid partnership arrangements, liberalisation of laws regarding sexual practices and more open discussion of sex. However, the heritage of repression and ongoing lack of decent education has meant that many people still feel uncomfortable and inadequately informed about sex, continuing to rely on experts and authorities (Tiefer, 1996). Alongside the demographic fact of increased longevity, there are rising expectations for a satisfying sex life into later adulthood (Grigg, 1999; Meston, 1997). It has been suggested that 'sexual retirement' is not necessarily accepted as an inevitable milestone of older age per se, but is more often enforced by widowhood or health problems (Gott & Hinchliff, 2003b). And across all ages, sexual fulfillment is expected (Nicholson & Burr, 2003), standards are unfeasibly high and inadequacy carries stigma (Tiefer, 1996). The growing "media barrage about sexuality" with aims of "titillation, gossip, education and moralising" (Tiefer, 1994; pg 363/365) both drives and reflects societal obsession with sexual matters. Indeed, "the high prevalence of sexual dysfunction reflects the escalating sexualisation of our culture – our obsession with

¹ Defined as occurring for 6 months or more.

sexual gratification has undoubtedly increased people's expectations, and it may have increased people's feelings of inadequacy" (Hart & Wellings, 2002; pg 899). Such expectations have also been reinforced by significant pharmacological developments, such as PDE5 inhibitors, leading to heightened belief in the medical profession's ability to 'fix' sexual difficulties (Tiefer, Hall & Travis, 2002; Moynihan, 2003). The media collude in this expectation by giving far greater exposure to quick medical fixes than more laborious options such as therapy (Riley, 2007; Goldacre, 2007). In developing and promoting quick fixes, the pharmaceutical industry and media play on a pre-existing societal unwillingness to properly explore the real "depressingly complex causes" and "taxing and unsatisfactory" solutions to sexual difficulties (Goldacre, 2007; pg 932). In general there is a societal unwillingness to consider anything other than quick fixes to achieve happiness (whether through drugs, leisure activities, wealth and material goods) (Wylie, 2004, reporting on a survey by the Henley Centre in 2002). Dissatisfaction is the flip-side of high expectation; a recent study suggested that a quarter of GP attendees in England were dissatisfied with their sex lives (Dunn, Croft & Hackett, 2000). And when promised cures (such as PDE5 inhibitors) fail, there is often a detrimental impact on individual morale and self-worth (Tomlinson & Wright, 2004). Despite all the funding, development in pharmacological treatment (apart from the PDE-5 inhibitors) has been fairly modest (Levine, 2007; Balon, 2007). And even the 'success' of PDE-5 inhibitors is limited (Potts et al., 2003; Carroll, 2007, Levine, 2007; Pukall & Rensing, 2007), yet the pharmaceutical industry continues to dominate the research agenda leading to an increasingly medicalised view of sexual difficulties (Bass, 1995; Tiefer 1996; Tiefer, 2000; Bancroft, Graham & McCord, 2001).

Despite both lay obsession and proven burden of ill health, care and treatment for people with sexual dysfunction is currently "fragmented and inconsistent" (MedFASH, 2005; pg 20; Lewin & King, 1997). Studies suggest a high level of unmet need, for instance among GUM clinic attendees (Goldmeier, Judd & Schroeder, 2000). Yet the Government health strategy says very little on the subject (Beattie, 2003; Wylie, 2001a), barely considering it in the current English National Strategy for Sexual Health and HIV, except for a call for "consistent standards of care" and training of practitioners to ensure

appropriate management of patients with sexual dysfunction (Department of Health, 2001; para 4.35). This is a striking omission, given that positive and pleasurable sexual experiences are central to the WHO definition of sexual health. There have long been calls for better integration, with medical specialties working together to provide holistic evaluation and care (Wylie, Hallam-Jones & Perrett, 1999; Lewin & King, 1997; Althof et al., 2005a). The Medical Foundation for AIDS and Sexual Health recommended that sexual dysfunction be included as part of the standard package offered by sexual health providers with better referral across services (MedFASH, 2005). In the mean time, most people seeking help for their sexual difficulties visit their GP initially (Mercer et al., 2003). Yet general practitioners often feel inadequately equipped to handle these cases, fear causing offence or simply feel embarrassed (Humphrey & Nazareth, 2001; Gott, Hinchliff & Galena, 2004).

Lack of clarity regarding optimal service provision for sexual dysfunction reflects a deeper confusion about who has the authority and expertise to operate this specialty. For several decades a paradigm war has raged between those who view sexual dysfunction as primarily psychosocial (psychologists and sex therapists for instance) and those who view it as primarily biomedical (urologists and gynaecologists for instance). The biomedical model has been criticised for splitting mind and body, assuming a universal sexual body independent of social and relational influences, and reducing sexuality to the physical function of the genitals (biological reductionism) (Tiefer, 1996). In particular, the biomedical model is said to be inadequate to explain female sexuality because vaginal intercourse often fails to meet women's needs; because female sexual responses are more variable and often best understood as adaptations to circumstance; and because female sexuality is more prone to influence by social and cultural constraints (Bancroft, 2002). On the other hand, the psychosocial model has been labeled "ideological" and criticised for being unable to offer patients effective and evidence-based treatment, whilst failing to acknowledge the efficacy of pharmacological treatment (Seidman, 2007; pg 472).

The difficulty of conceptualising sexual dysfunction both reflects and contributes to this paradigm struggle. The official nosology is widely contested and this lack of consensus

has limited progress in epidemiological research (Derogatis & Burnett, 2008). Indeed, there is still no universally accepted population prevalence measure of sexual dysfunction. It was against this background that I set out to design such a measure. My aim was to adopt a multi-disciplinary approach which would find synergy between paradigms.

1.2 Study Origins

My interest in sexual health began in 1996 when I joined the Sexual Health Programme at the London School of Hygiene and Tropical Medicine, to work on a study of young people's communication about sexual matters. A year later, the Programme Director, Kaye Wellings, introduced me to the NATSAL team (National Survey of Sexual Attitudes and Lifestyles; see Johnson et al., 2001), who were then preparing for the 2000 survey. I joined the team, using qualitative methods to explore aspects of the survey design. Five years later, after working on HIV/AIDS issues in Uganda, I returned to Kaye, sensing that it was the right time for me to do a PhD but feeling short on ideas. Kaye told me that the NATSAL team was desperate for a good measure of sexual dysfunction for the next survey (scheduled for 2010). I was reluctant at first. Sexual dysfunction seemed altogether more personal, intrusive and taboo than the public health perspective of my recent experience. On the other hand, it was an important aspect of sexual health that I had never seriously considered before. And I liked the idea of tackling an aspect of sexuality somewhat neglected by Public Health. I knew that both the topic and proposed methodology would stretch me both professionally and personally. So I took the plunge.

Originally I set out to design a conceptual model of sexual function and to develop and test an epidemiological measure. Half way through the study, during the qualitative data analysis, I came to two conclusions: the first was that the proposed work was too ambitious to manage within the timeframe as a student working alone; the second was that the qualitative data was exceptionally rich and to restrict the analysis to measure development would be a wasted opportunity. So I wrote to my funding body

(ESRC/MRC), who duly approved my proposed shift in focus to a more in-depth analysis of the data. That was a good decision, particularly since I will still be involved in the development of the measure after completion of this thesis.

1.3 Thesis Outline

This thesis begins with a synthesis of the literature on the conceptualisation and classification of sexual function. I start by briefly situating the contemporary study of sexual function within its historical context and by exploring how meanings attached to the construct are not static and immutable, but created and shaped by social, cultural and corporate forces. I then describe the emergence of the modern concept of sexual dysfunction as a standard classification and trace its development through successive revisions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). This is followed by a critique of the standard classification in particular and the biomedical model in general. I briefly describe and critique recently proposed alternative models of sexual dysfunction, concluding the chapter with a brief summary of prevalence and aetiological studies.

Following the literature review, I introduce the research question and objectives and provide a rationale for the proposed study (chapter 3). In the same chapter, I provide a theoretical framework and justify my methodological and theoretical approach. I then describe the study methods in detail (chapter 4).

These three introductory chapters are followed by three substantive results chapters from my qualitative fieldwork involving 32 semi-structured interviews with individuals who had and had not experienced sexual difficulties. In chapter 5, I set aside the notion of a universal model of sexual function and explore instead how respondents themselves construed this concept. I show that the variation in individual meanings can be expressed in terms of three distinct versions of functional sex – the erotic, the interpersonal and the mechanistic – which frame the purpose of sexual activity, the criteria determining ideal

sex, and threats to this ideal. The next chapter (6) explores specific components of sexual function rated as important by respondents. At this stage I do not argue definitively for the inclusion of each component in a measure of sexual function but merely present the evidence for the significance of each component within the data. In chapter 7, I reverse the focus to look at difficulties or dysfunction. I focus specifically on how respondents cope when they perceive a gap between their notion of function (or ideal) and their lived reality. From the data I identify a series of coping strategies as well as a number of factors that influence the choice of strategy and the likelihood that it will lead to successful adjustment. This chapter is not central to the development of the measure but is included because of the unique and useful contribution it makes to the sparse data on coping with sexual difficulties.

The third part of the thesis concerns the measurement of the prevalence of sexual function at community level. In chapter 8 I review current methods for measuring sexual dysfunction, in both clinical and community settings, including an extensive review of self-report measures. I also look at methodological challenges specific to the design of community based (prevalence) measures. The purpose of this second literature review is to provide an evidence base for subsequent decisions regarding the design of the conceptual model and measure. The starting point for chapter 9 is a summary of the components of sexual function identified in chapter 6. I briefly summarise the evidence for each proposed component, both from my data and the existing literature. Based on this evidence, I use a set of decision criteria to include or exclude each component from the conceptual model. I then turn this model into a draft measure, proposing a question for each component. The wording for each item draws substantially from items in existing measures, compiled as part of an inventory of items (see appendix 16). In chapter 10, I briefly describe the proposed methodology (to be undertaken post this thesis) for the psychometric development and validation of the measure. I conclude by summarising the main contributions of this research, highlighting the limitations of the study, and describing some of the key lessons learned.

Chapter 2

What is Sexual Dysfunction?

Literature Review I

2.1 Introduction

This review synthesises the literature on the conceptualisation and classification of sexual function. I begin by providing the historical context and go on to explore how meanings attached to the construct are not static and immutable, but fluid and shaped by social, cultural and corporate forces. I then describe the emergence of the modern concept of sexual dysfunction as classified in successive revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). I critique the current classification and briefly discuss recently proposed alternative conceptual models of sexual function. I conclude the chapter with a brief summary of the prevalence and aetiology of sexual dysfunction.

During work on this thesis, I was privileged to work with Dr. Cindy Graham on a paper exploring issues pertinent to the classification of sexual dysfunction (Mitchell, K & Graham, C. (2008) Two Challenges for the Classification of Sexual Dysfunction doi:10.1111/j.1743-6109.2008.00846.x © 2008 International Society for Sexual Medicine; see appendix one). Cindy is an experienced clinical psychologist, editor of the *Journal of Sex Research* and a member of the advisory panel for the sexual dysfunction entry of the next version of DSM (version V). Since our paper explored the exact issues I would want to discuss in this section, presented a coherent and comprehensive analysis, and has benefited from professional external peer review, I reproduce sections of it verbatim throughout this chapter. I also worked with Dr. Cath Mercer on secondary analysis of the NATSAL 2000 data on sexual dysfunction. We explored in detail factors associated with reporting lack of sexual interest. Our paper is currently under review by the Archives of Sexual Behaviour but the most recent draft can be viewed in appendix two.

2.2 The Early Sexologists

During the mid 19th century, the traditional authority of religion and moralists in defining 'acceptable' sexual behaviour partially gave way to science and in particular, to the medical profession (Hart & Wellings, 2002). Medicine, like religion before it, tended to conflate sexual health with sexual morality (Bancroft, 2005). At the same time it permitted the use of scientific methods to study sexual behaviour. The 'founding fathers' of modern sexology, such as von Krafft-Ebing (1840-1902), Havelock-Ellis (1859-1939), Hirschfeld (1868-1935) and Freud (1856 to 1939), were medically trained but generally viewed as outsiders in their time. Among their rich and controversial heritage were two contributions of particular note. The first was to query the notion of normal sexuality and sexual activity (Hoenig, 1976). Freud, for instance, argued in favour of sexual variation, claiming that although convenient, it was a fallacy to view normal and abnormal as distinct categories:

“We have seen that it is not scientifically feasible to draw a line of demarcation between what is psychically normal or abnormal; so that that distinction, in spite of its practical importance, possesses only a conventional value” (Freud 1953, Vol XXIII, p195, cited in Hoenig, 1976; pg 197)

The second contribution was to use science to challenge moral condemnation attached to certain sexual practices. Havelock-Ellis, for instance, argued against the vilification of masturbation, claiming that it was important for sexual development (Levin, 2007). And Hirschfeld and Havelock-Ellis were in advance of their time in concluding that homosexuality was not criminal, immoral or perverted (Hoenig, 1976). Freud too argued that heterosexuality needed to be explained as much as homosexuality (Hoenig, 1976). Though radical in some respects, much of their work simply reflected the milieu of their time, particularly with regard to gender. Notions of female sexuality were derived from male as the norm; von Krafft-Ebing viewed women as essentially sexually passive, while Freud's analysis of female sexuality was heavily phallogentric (women as castrated

males, for instance), a perspective which earned him criticism subsequently (Pertot, 2006; McLaren, 1999). Their work was also marked by disagreement with each other and contradictions within themselves (Weeks, 1986). And some argue that whilst enabling a discourse of diversity, they effectively established a normative classification (heterosexual, procreative, male); “a unitary model of sexuality from which it has been difficult to escape” (Ibid.; pg 74-75; see also Hart & Wellings, 2002).

The notion of wide variability in sexual expression was given irrefutable empirical credence by Kinsey’s detailed study of sexual behaviour in a US population (Kinsey, Pomeroy & Martin, 1948; Kinsey, Pomeroy & Martin, 1953). As an entomologist, he was fascinated by the great variation in human sexual behaviour and refused to classify any biological act as normal or abnormal. Although his study undoubtedly had methodological problems, it was still the most systematic, moral free, large-scale investigation of sexual behaviour ever conducted and debunked many assumptions about the prevalence of ‘minority’ or ‘deviant’ sexual practices (Granzig, 2006). A particular contribution to the field of female sexual function was Kinsey’s assertion that the clitoris, not the vagina, was the key to female pleasure. He also noted that near to 50% of the women in his sample did not find sex pleasurable (McLaren, 1999; pg 176-177).

Just as Kinsey was the first to adequately document sexual behaviour at a population level, Masters and Johnson were the first to systematically investigate sexual activity at an intra-personal or physiological level (Masters & Johnson, 1966; Masters & Johnson, 1970). Under laboratory conditions, they observed and measured physiological response indicators (such as vasodilation, vasocongestion and respiratory rates) during sexual activity between healthy volunteers. They used their data to refute several widely held misconceptions regarding, for instance, the mechanism of female lubrication. Viewed by some as the “heirs” of Kinsey, keen to assist women in their demand for sexual fulfilment, and particularly orgasm (McLaren, 1999; pg 177), they were subsequently criticised for their narrow selection criteria, in particular their exclusion of lesbian women and heterosexual women who did not reach orgasm via coitus (widely regarded as the majority) (Boyle, 1993; Maines, 1999; Tiefer, 1991; Tiefer, 2001d). Their observations led them to identify four distinct temporal phases characteristic of

heterosexual intercourse: excitement or arousal; plateau phase; orgasm; resolution. This became known as the Human Sexual Response Cycle (HSRC), and modified by later work on desire by Kaplan and Lief (Kaplan, 1974; Lief, 1977), became the basis for contemporary classifications of sexual dysfunction (see section 3 below).

While the early sexologists were delineating and classifying sexual practices, the early writers of sex manuals sought to reassure, educate and encourage eroticism and sexual fulfilment in marriage. Marie Stopes (1880-1958) following the shame of her own unconsummated marriage, wrote 'Married Love' (1918) which exhorted couples to maintain passion and physical intimacy. This was followed in 1926 by 'Ideal Marriage: Its Physiology and Technique' by Theodore van de Velde. These early manuals were ground breaking in their attempt to reassure, educate and advise on matters of eroticism, intimacy and sexual fulfilment, thereby legitimising sexual pleasure, albeit within the narrow confines of a married and heterosexual relationship controlled by the male partner (McLaren, 1999; pg 46-63). These early versions were ancestral to the present plethora of self-help guides (see for instance, Godson, 2002; Pertot, 2007; Perel, 2007), although in their day were probably accessible only to a small and rich minority.

2.3 Social, Cultural and Corporate Influences

“Debate is best settled by science but it sometimes requires shouting that the emperor has no clothes – that is, a paradigm has only weak merit.”

(Levine, 2007; pg 452)

In this section I argue that the concept of sexual function is neither static nor immutable but historically and culturally variable and socially constructed (Hart & Wellings, 2002). Various scholars have explored the ways in which institutions (notably medicine, religion and law), social movements (notably feminism) and historical events (such as the introduction of contraceptive technology) have shaped the meaning of sexuality (see Gagnon & Simon, 1973; Weeks, 1981; Weeks, 1986; Foucault, 1979; Giddens, 1992). There has also been interest in how sexual beliefs and behaviour vary across cultures (see

Bhugra & De Silva, 1993; Lavee, 1991; Levinson, 1999; and also the seminal work by Malinowski, 1927). For instance, there is ongoing debate about whether the apparently culture-bound syndrome, Dhat (semen loss anxiety), really is a “neurosis of the Orient” or has actually existed in many other places in previous times (Sumathipala, Siribaddana & Bhugra, 2004; pg 200) and is better viewed as a culturally determined symptom associated with depression (Mumford, 1996).

I briefly describe two examples, one historical and one contemporary, which attest to the social construction of sexuality: the diagnosis and classification of hysteria and the influence of the pharmaceutical industry on present-day sexological research. These examples warn against assuming that the ways in which things are currently conceptualised is necessarily the only way they can be categorised, or even the best. They also highlight the fact that just as the cultural construction of sexual dysfunction changes over time, so the ‘winners’ and ‘losers’ will also change. For example, not so long ago, those who practised masturbation were regarded by some as deviant, whereas in the present milieu those showing ‘insufficient’ interest in sex are regarded by some as dysfunctional (Pertot, 2006).

2.3.1 History and Hysteria

There are several historical examples of sexual disorders that ceased to exist when shifts in political and social mores exposed them as artefactual. For instance, ‘spermatorrhea’, supposedly caused by masturbation and with symptoms including nocturnal emissions and inaptitude for work, was later exposed as the creation of a mid 19th century doctor, William Acton (Hart & Wellings, 2002; see Acton, 1857). The decision to remove homosexuality from the American Psychiatric Association (APA) classification system was taken in 1974 (Bancroft, 2005), and from ICD-10 in 1992 (Smith, Bartlett & King, 2004), but not before many men had been subjected to potentially harmful and ultimately ineffective ‘treatment’ such as aversion therapy (using electric shocks or apomorphine to induce nausea), castration, and incarceration in a mental institution (Hart & Wellings, 2002; Smith, Bartlett & King, 2004; King, Smith & Bartlett, 2004).

The story of hysteria has been beautifully documented by historian Rachel Maines (1999) who stumbled upon the topic of vibrators - advertised within the pages of women's needlework magazines as early as 1906 - while researching textile history. She traced the origin of the vibrator to a labour-saving device for physicians treating their hysterical patients by using digital stimulation to bring them to orgasm. Hysteria stems from the Greek, meaning "that which proceeds from the uterus" (Ibid.; pg 21) and evidence of the disease paradigm, in various forms, is found as early as 2000 B.C. in the medical corpus of Egypt, until 1952 when 'Hysteroneurasthenic disorders' were finally removed from the APA classification (Ibid.; pg 11). Over the centuries, the myriad symptoms (from fainting through muscle spasms to tendency to cause trouble for others) varied greatly, as did the supposed aetiology. Galen (a.d. 129-200) attributed hysteria to sexual deprivation, while Plato believed it might be caused by the womb wandering about the body (Ibid.; pg 24). After 1900, Freud dominated the field with his theory that hysterical symptoms were caused by childhood experiences and sexual development arrested at a juvenile stage (Ibid.; pg 9). What is clear is that centuries of physicians, wittingly or unwittingly confused the hysterical paroxysm with the female orgasm. Androcentric misconceptions about female sexuality in general, and the female orgasm in particular, thus resulted in the pathologisation of centuries of normal but unfulfilled women.

The story of hysteria provides a cautionary tale, in two parts. The first is to recognise the power of social and political trends to drive diagnosis. We have progressed a little way from the androcentric models described in Maines's book, but current trends such as increasingly high expectations of an ideal sex life into later years (see chapter 1) and greater acceptance of sexual diversity (in some spheres) are as likely to influence the contemporary conceptualisation of sexual dysfunction. The second caution concerns the recognition that labels and categories imposed on a set of symptoms may not necessarily be correct/true and may hinder effective diagnosis and treatment of those symptoms. This is a criticism often levelled at current sexual dysfunction labels (see section 4 below). It has been referred to as 'label grip'; the paralysis of analytical judgment created by authoritative diagnostic labels (Hughes, 1996, cited in Sumathipala 2004). There are

clear historical examples of systems that have been later found to lack validity, such as the early Greek classification of matter into fire, water, air and soil (Strangeways, 2006). At the very least, it is important to be aware of how labels and terminology shape the way we view sexual dysfunction (Gagnon, Rosen & Lieblum, 1982).

2.3.2 The Corporate Construction of Sexual Disorder

The rise of the pharmaceutical industry as the ‘driver’ of scientific investigations into sexual dysfunction can be traced to a political environment, fostered by the Thatcher-Reagan era, that favoured corporate funding of research and closer alliances between business and academia (Tiefer, 2000). This era also witnessed the rise of pharmaceuticals as the most profitable US industry, together with increasing recognition that ‘lifestyle’ drugs had the potential to become ‘blockbusters’ with high profit margins (Ibid., 2000; see also Rowland, 2007). The pharmaceutical industry enlisted clinical and academic sexologists to help research and promote their products, bestowing funding and legitimacy on an academic discipline traditionally lacking in both. Interestingly, similar trends can be observed in the classification and treatment of depression, where “diagnostic concepts are shaped and reinforced by drug company marketing and research strategies” (Pilgrim & Bentall, 1999; pg 266).

There has been widespread criticism of this close relationship. Medical journalist Ray Moynihan recently asked whether the “social construction of illness is being replaced by the corporate construction of disease” (Moynihan, Heath & Henry, 2002; pg 886). He accused the pharmaceutical industry of “disease mongering”, defined as “broadening the definitions of diseases in such a way as to include the greatest number of people” with the purpose of creating demand for treatment (Payer, 1992; pg 54). The transformation of socially created worries into diagnoses amenable to pharmacological intervention (Tiefer, 2006) was said to be achieved by tactics such as encouraging mild symptoms to be viewed as severe and using prevalence estimates to suggest that large numbers of people suffer from the disease (see Moynihan, Heath & Henry, 2002 and Payer, 1992 for further

disease mongering tactics). Others have argued that the business imperatives of secrecy and profit conflict with scientific openness, and the focus on pharmacological intervention risks denying the influence of complex psychological, relational, political and socio-cultural factors on sexual dysfunction (Tiefer, 2000; Hart & Wellings, 2002; Levine, 2007; Rowland, 2007; Waldinger, 2008). For these reasons “the commercial cart cannot be permitted to pull the empirical and theoretical horses” (Tiefer, 2001b; pg 625), though in the absence of non-industry funding (Brotto, 2007; Giraldi & Kristensen, 2007), this situation may be difficult to avoid.

Opposition to the ‘corporate construction of disease’ argument did not just come from pharmaceutical company representatives and industry funded academics. Much of the most vociferous opposition to Moynihan’s article came from women, some of them with ‘desire disorder’, who were concerned that Moynihan was denying the existence of the disease, or at least the organic aspects of it. Others have pointed to the fact that providing efficacious treatment can lead to reduced stigma and silence about sexual difficulties (Pukall & Reissing, 2007), and that not all patients want counselling or therapy (Segraves et al., 1982).

2.4 Previous, Current and Proposed Classifications

There are currently two standard definitions of sexual dysfunction: The American Psychiatric Association (2000) defines sexual dysfunction as:

“Disturbance in sexual desire and in the psycho-physiological changes that characterise the sexual response cycle causing marked distress and interpersonal difficulty”

In contrast, the WHO definition (1994) does not explicitly refer to the sexual response cycle, nor does it specify that distress must be present:

“The various ways in which an individual is unable to participate in a sexual relationship as he or she would wish. Sexual response is a psychosomatic process and both psychological and somatic processes are usually involved.”

Masters and Johnson have been credited with introducing the term sexual dysfunction into medical nomenclature during the seventies (Graham & Bancroft, 2005). The concept of ‘psychosexual dysfunction’ first appeared in the third edition of the DSM in 1980 (DSM-III) (American Psychiatric Association, 1980). Since this edition, several revisions of the DSM have reflected advances in research coupled with ongoing debate concerning the nature of sexual difficulties. The trend over successive editions of the DSM, has been the convergence of male and female problems and increasing numbers of diagnostic categories. This latter trend reflects the proliferation of categories of mental disorders more generally. In 1840, the US census contained only one category of mental disorder. By 1917, the DSM system comprised 59 disorders; by 1987 (DSM-III-R) this had increased to 292 (Pincus et al., 1992). The evolution of the classification of sexual dysfunction in the DSM is charted in table 2.1.

Version	Date	General Heading	Subcategories
DSM-I	1952	Psychophysiological autonomic & visceral disorders	Frigidity; Impotence; premature ejaculation of semen; vaginismus
DSM-II	1968	Psychophysiologic genito-urinary disorders	Dyspareunia; Impotence
DSM-III	1980	Psychosexual dysfunction	Inhibited sexual desire; inhibited sexual excitement; inhibited orgasm (m and f); functional dyspareunia; functional vaginismus; premature ejaculation
DSM-III-R	1987	Sexual dysfunction	Male & female: Hypoactive sexual desire disorder; Sexual Aversion Disorder and Dyspareunia Female: Female sexual arousal disorder; Inhibited female orgasm; vaginismus Male: Male erectile disorder; Inhibited male orgasm; premature ejaculation Sub-typing introduced (e.g. lifelong v. acquired)
DSM-IV TR	2000	Sexual dysfunction	See table 2.2

Table 2.1 Classification of Sexual Dysfunction in Successive Editions of the DSM

The fourth (revised) edition of the DSM (American Psychiatric Association, 2000) and tenth edition of the ICD (World Health Organisation, 1994) provide the current standard classifications of sexual dysfunction. The diagnostic criteria for each system are summarised in table 2.2 and table 2.3 overleaf.

DSM-IV TR
<p><i>In order for diagnosis to be made, the following criteria must be met:</i></p> <ul style="list-style-type: none"> • <i>Disturbance is major part of the clinical picture</i> • <i>Dysfunction is <u>not</u> entirely attributable to organic factors</i> • <i>Dysfunction is <u>not</u> due to another Axis I mental disorder</i> • <i>Symptoms should be persistent and recurrent</i> • <i>Symptoms should cause marked distress and interpersonal difficulty</i>
<p>Both sexes</p> <p>302.71 – Hypoactive Sexual Desire Disorder: deficient or absent sexual fantasies and desire for sexual activity</p> <p>302.79 – Sexual Aversion Disorder: extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner</p> <p>302.76 – Dyspareunia – genital pain associated with sexual intercourse (that is not due to a general medical condition)</p>
<p>Men</p> <p>302.72 – Male erectile Disorder: inability to attain or maintain until completion of sexual activity, an adequate erection</p> <p>302.74 – Male orgasmic disorder: delay in, or absence of, orgasm following a normal sexual excitement phase</p> <p>302.75 – Premature ejaculation: ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it.</p>
<p>Women</p> <p>302.72 – Female sexual arousal disorder: inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement</p> <p>302.73 – Female Orgasmic Disorder: delay in, or absence of, orgasm following a normal sexual excitement phase</p> <p>306.51 – Vaginismus: involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse (that is not due to a general medical condition)</p>
<p>302.70 – Sexual Dysfunction not otherwise specified: sexual dysfunctions that do not meet the criteria for any of the specific sexual dysfunctions.</p>
<p>Sub-types:</p> <ul style="list-style-type: none"> • <i>Situational (dysfunction limited to certain types of stimulation, situations or partners) v. Generalised (not limited to certain types of stimulation, situations or partners).</i> • <i>Life-long (present since onset of sexual functioning) v. Acquired (dysfunction develops after a period of normal functioning)</i> • <i>Due to psychological factors (psychological factors play the major role in onset, severity, exacerbation or maintenance) v. Due to combined factors (both psychological factors and a general medical condition play a role)</i>

Table 2.2 The Classification of Sexual Dysfunction in DSM-IV TR (American Psychiatric Association, 2000)

In contrast to the DSM, the ICD-10 Classification of Mental and Behavioural Disorders (WHO, 1994) provides fewer diagnostic criteria and does not specify that personal distress or interpersonal difficulty must be present in order to make a diagnosis. In addition, WHO publishes the Diagnostic Criteria for Research (DCR-10) (WHO, 1993), which is compatible with ICD-10. An abridged version of ICD-10 is shown in table 2.3:

ICD-10 Classification of Sexual Dysfunction (abridged)
F52.0 Lack or loss of sexual desire <ul style="list-style-type: none"> • Loss of desire is principal problem • Lack of desire does not preclude enjoyment but makes initiation less likely
F52.1 Sexual aversion and lack of sexual enjoyment F52.10 Sexual aversion <ul style="list-style-type: none"> • Prospect of sexual interaction is associated with strong negative feelings. • Fear and anxiety leads to avoidance of sexual activity F52.11 Lack of sexual enjoyment <ul style="list-style-type: none"> • Normal sexual response but lack of appropriate pleasure • Affects women more than men
F52.2 Failure of genital response <ul style="list-style-type: none"> • Men – difficulty in developing or maintaining an erection suitable for satisfactory intercourse • Women – vaginal dryness/failure of lubrication
F52.3 Orgasmic dysfunction <ul style="list-style-type: none"> • Orgasm does not occur or is markedly delayed • May be situational or invariable • More common in women
F52.4 Premature ejaculation <ul style="list-style-type: none"> • Inability to control ejaculation sufficiently for both partners to enjoy sexual interaction
F52.5 Nonorganic vaginismus <ul style="list-style-type: none"> • Spasm of the muscles surrounding the vagina, causing occlusion of vaginal opening • Penile entry either impossible or painful
F52.6 Nonorganic dyspareunia <ul style="list-style-type: none"> • Pain during sexual intercourse • Only used if no other primary sexual dysfunction and no pathological condition • Occurs in men and women
F52.7 Excessive sexual drive <ul style="list-style-type: none"> • Only diagnosed if not secondary to an affective disorder
F52.8 Other sexual dysfunction, not caused by organic disorder or disease
F52.9 Unspecified sexual dysfunction, not caused by organic disorder or disease

Table 2.3 The Classification of Sexual Dysfunction in ICD-10 (World Health Organisation, 1994)

Since the latest version of DSM (American Psychiatric Association, 2000), various panels have met to suggest further revisions: the National Institutes of Health Consensus Development Conference on Impotence, the International Consensus Development Conference on Female Sexual Dysfunction and the second International Consultation on Sexual Medicine (NIH Consensus Development Panel on Impotence, 1993; Basson et al., 2000; Lue et al., 2004a). However, there have been no paradigm shifts and most of the suggested revisions have been minor (Bancroft, Graham & McCord, 2001), what Carson earlier described as “more tinkering on a superficial level with operational diagnostic criteria that tend over time to approach the status of revealed truths” (Carson, 1991; pg 304). The deliberations of each of these meetings are summarised here.

The main contribution of the 1992 US National Institutes of Health Consensus Development Conference on Impotence (National Institutes of Health, 1993), comprising a panel of 21 experts (five sexologists, one epidemiologist, and 15 urologists/basic scientists) was to produce a new definition of erectile dysfunction, and guidelines for clinical diagnosis. Later, the American Foundation for Urologic Disease convened an International Consensus Development panel comprising 19 leading professionals from the field of female sexual dysfunction. Their task was to develop a definition and classification system for female sexual dysfunction (Basson et al., 2000; Basson et al., 2001). Support for the revised classification came mainly from urologists, and those keen to see a greater emphasis on the physiological aspects of female sexual function (see Burnett, 2001; Montorsi, 2001). However the proposed system was criticised for its lack of any theoretical basis (Bancroft, Graham & McCord, 2001; Everaerd & Both, 2001; McCabe, 2001) as well as its over-emphasis on organic factors.

In July 2003, experts on male and female dysfunction came together for the second International Consultation on Erectile and Sexual Dysfunction. This meeting merged the parallel consensus meetings described above, and engaged open debate on the findings of 17 expert committees who had spent two prior years gathering evidence. Table 2.4 summarises this classification.

2003 International Consultation Definitions of Sexual Dysfunction	
Men and women	<ul style="list-style-type: none"> • Sexual Interest/Desire Dysfunction. Diminished or absent feelings of sexual interest or desire, absent sexual thoughts or fantasies and a lack of responsive desire. <u>Motivations</u> for attempting to become sexually aroused are scarce or absent. Lack of interest considered to be <u>beyond normative lessening</u> with life cycle and relationship duration • Sexual aversion disorder. Extreme anxiety and/or disgust at the anticipation of or attempt to have any sexual activity
Men	<ul style="list-style-type: none"> • Erectile dysfunction. The consistent or recurrent inability to attain and/or maintain penile erection sufficient for sexual activity. <u>Symptoms must be present for at least 3 months</u> • Rapid or Early Ejaculation. Persistent or recurrent ejaculation with minimal stimulation before, on, or shortly after penetration, and before the person wishes it. <u>Three essential criteria</u> (all must be present) – 1) brief ejaculatory latency (less than two minutes); 2) loss of control; 3) psychological distress in the patient and/or partner • Male Orgasmic Dysfunction: A <u>spectrum of disorders</u> in men ranging from delayed ejaculation (undue delay), through orgasmic dysfunction (inability to achieve an orgasm, diminished intensity or orgasmic sensations or marked delay of orgasm from any kind of sexual stimulation) to anejaculation (absence of ejaculation during orgasm) and retrograde ejaculation. • Priapism: Unwanted erection not associated with sexual desire or sexual stimulation and lasting for more than 4 hours • Peyronie's Disease: Acquired disorder of the tunica albuginea characterised by the formation of a plaque of fibrous tissue and often accompanied by penile pain and deformity on erection
Women	<ul style="list-style-type: none"> • Subjective sexual arousal dysfunction The absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure) from <u>any type of sexual stimulation</u>. Vaginal lubrication or other signs of physical response still occur • Genital Sexual arousal dysfunction. Characterised by complaints of impaired genital sexual arousal. Subjective sexual excitement still occurs from nongenital sexual stimuli • Combined genital and subjective arousal dysfunction. Absent or markedly diminished feelings of sexual arousal from any type of sexual stimulation as well as complaints of absent or impaired genital sexual arousal • Women's Orgasmic Disorder. <u>Despite the self-report of high sexual arousal/excitement</u>, there is either lack of orgasm, markedly diminished intensity of orgasmic sensations or marked delay of orgasm from any kind of stimulation • Persistent genital arousal dysfunction. Spontaneous, intrusive and unwanted genital arousal in the absence of sexual interest and desire • Dyspareunia. Persistent or recurrent pain with <u>attempted or complete</u> vaginal entry and/or penile vaginal intercourse • Vaginismus. Persistent or recurrent difficulties of the woman to allow vaginal entry of a penis, a finger, and/or any object <u>despite the woman's expressed wish to do so.</u>

Table 2.4 The 2004 International Consensus Classification

The definition of female sexual dysfunction was revised once again and the new version, based on emerging evidence of female sexual problems, attempted to address many of the criticisms of the previous Consensus Development Conference (Basson et al., 2003; Basson et al., 2004b; Lue et al., 2004b; Basson et al., 2004a). The key changes from DSM-IV TR were the sub-typing of female arousal disorder into subjective, genital and combined types; the sub-typing of male orgasmic dysfunction; the three essential criteria added to premature ejaculation; the addition of a new category of persistent genital arousal disorder among women; and the addition of Peyronie's Disease and priapism among men. Other key changes to definition wording are underlined in table 2.4. The inclusion of Peyronie's Disease, Priapism and Persistent genital arousal reflects a move to catalogue all disorders of the genital organs rather than disorders associated only with sexual activity. The Consensus classifications have not been officially endorsed by the American Psychiatric Association, with the risk that two parallel systems will emerge, although the hope is that the consensus classification will be incorporated into the next version of the DSM (V) (Segraves, Balon & Clayton, 2007).

A particular barrier to substantive change has been the requirement that there be substantial empirical data before modifications can be considered (Ibid., 2007). Attempts to ground the DSM in empirical research date back to DSM-III (Carson, 1991); however, in practice it seems that maintaining "continuity" with the classification system in place may sometimes take precedence over research evidence. Segraves and colleagues provided an example of this in the work leading up to DSM-IV (Segraves, Balon & Clayton, 2007). A literature review suggested that the subjective criteria for female arousal disorder be retained. The DSM-IV work group overruled this in order that the DSM-IV diagnosis be similar to the ICD-9 criteria and "to maintain male-female similarity in diagnostic categories" (Ibid, 2007; pg 569), a key feature of the DSM IV nosology. The process by which the DSM is compiled may also present barriers to substantive change; in particular, the selection of DSM working group and task force members and the need for consensus. For example, lack of "satisfactory consensus" was one of the key reasons that "sexual satisfaction disorder" failed to be introduced as a new category following deliberations of the International Consensus Development Conference on Female Sexual Dysfunction. This occurred despite a majority in favour

and despite the relevance of the category to a significant proportion of women seeking help for sexual problems (Basson et al., 2000). It is noticeable that much of the “tinkering” has been towards increasingly precise operational criteria designed to provide quantitative end points for clinical trials and clear-cut delineations for insurance companies. This is not surprising, given the lack of non-clinical representation on consensus panels, and pervasive links between panellists and the pharmaceutical industry (Bancroft, Graham & McCord, 2001; Hall, 2001; Shaw, 2001; Tiefer, 2001c).

As preparations for DSM-V step up, suggestions for improving the system are being brought to the table. Segraves and colleagues (Segraves, Balon & Clayton, 2007) recently proposed that DSM-V include specific criteria related to duration and severity of symptoms, in order to avoid labelling transient (and possibly adaptive) alterations in sexual function as “sexual dysfunction” (Bancroft, Loftus & Long, 2003). These seem reasonable suggestions and ones that have some empirical support (Mercer et al., 2003; Öberg, Fugl-Meyer & Fugl-Meyer, 2004). However, in my view there are also a number of more fundamental issues that need to be addressed in the next revision. I discuss these in the next section.

2.5 Challenges of Classification

The specific purposes of the DSM and APA diagnostic systems are to facilitate communication among professionals, help clinicians determine which particular disorder is present and guide treatment decisions and research; in the U.S., the DSM also provides the basis for reimbursements to insurance companies. Many authors have argued that current classification systems fall far short of the above goals. Indeed it has been suggested that DSM criteria have hampered research into the aetiology, pathophysiology, and treatment of mental disorders (Carson, 1991; Kendell & Jablensky, 2003; Hyman, 2003). The DSM system for classifying sexual disorders has not escaped these criticisms, particularly in recent years (Tiefer, 1991; Tiefer, 2001c; also see above). In this section I investigate the criticisms of the current conceptualisation of sexual dysfunction via the exploration of two particular challenges: How can the relational context of sexual

dysfunction be effectively acknowledged? And how can we avoid pathologising normal variation?

2.5.1 How can the Relational Context be Effectively Acknowledged?

Unlike most health behaviours, sex is essentially dyadic in nature. The field of sexual function thus deals primarily with relationships between people (Conaglen, 2001). This is because relationship factors – the sexual partner as well as the interaction between partners – are often fundamental to the aetiology and experience of sexual difficulties (Fisher et al., 2005). In reality, a sexual problem for one partner generally implies a problem for the other (Maurice, 2001). In around one third of patients with sexual dysfunction, the partner also has dysfunction (Gregoire, 1999). These facts are well supported by empirical evidence (Bancroft, Lotus & Long, 2003; Dennerstein et al., 1999; Ellison, 2000). A recent British study showed that between half and two thirds of women thought that difficulties with their partner lay at the base of their sexual problems (King, Holt & Nazareth, 2007). We also know that co-morbidity of sexual problems in partners is common, and that when one partner receives individual therapy for a sexual problem, there is often also improvement in sexual functioning for the other partner (Gregoire, 1999; Cayan et al., 2004; Heiman et al., 2007). Women in particular, tend to view their relationship as central to their sexuality (Tiefer, 2001c). There is increasing recognition that medications such as PDE5 inhibitors may prove ineffective if significant relationship issues are not also dealt with and there has been a related interest in combining medical and sex therapy approaches to treatment (Rosen, 2007b; Riley, 2007). In practice, the relational context is almost always a central focus of clinical therapy for sexual problems (Graham & Bancroft, 2008).

Given this evidence and the realities of clinical management, it is puzzling that the possibility of formally acknowledging relational components within the classification system does not appear to have been seriously considered (Tiefer, 1996). In fact recent proposals to revise DSM have, if anything, placed even more emphasis on the individual rather than the couple. For instance, the International Consensus Group on Female

Sexual Dysfunction recommended replacing the DSM criterion of “marked distress and interpersonal difficulty” with “personal distress” (Basson et al., 2000). More recently, Segraves et al. recommended, “decrease in desire related to [...] discrepancies in sexual desire between sexual partners, should not be diagnosed as desire disorders” (Segraves, Balon & Clayton, 2007; pg 576). The ostensible rationale for both of these recommendations was that the system should not pathologise individuals on the basis of their relationship context.

To an extent, the case made by Segraves and colleagues is persuasive: discrepancies in desire should not result in the partner with the lower level being labelled as “dysfunctional”. But the mismatch itself can be seen, at a systems level, as a problem belonging to the “interactional dynamics of the couple” (Clement, 2002; pg 243). In fact, it has long been recognised that within couples, the assessment of desire is relative; individuals make judgments about their level of desire primarily in comparison with the level of their partner (Zilbergeld & Ellison, 1980). If we are interested in a classification that is clinically meaningful, then this couple-level dysfunction is important because it is such a common problem for which individuals seek help. Clement questioned whether sexual desire might be more usefully construed as a “function of the structural matching of partners” than as an individual trait (Clement, 2002; pg243). Relevant here is the large body of literature on “relational disorders”, defined as “persistent and painful patterns of feelings, behaviour, and perceptions involving two or more partners in an important personal relationship” (First et al., 2002; pg 161). Work is being done to develop diagnostic criteria for relational disorders such as marital conflict disorder and marital abuse disorder (First, 2006). In a similar vein, it may be worth exploring the possibility of an additional sub-category of sexual disorder where the focus is primarily relational.

Incorporating relational processes need not imply as radical a step as the creation of new categories. Although the DSM highlights relational processes in the V codes and in some of the supplementary materials, “currently relational problems are poorly described [...] and not very useful for clinical or research purposes” (Beach et al., 2006; pg 360). In response to this, various authors have discussed the possibilities for integrating relational

issues into DSM (First et al., 2002; First, 2006; Beach et al., 2006; Denton, 2007; Kaslow, 1996). For instance, Beach and colleagues suggested that reference to the presence or absence of specific relational processes associated with a sexual disorder could be made via “relationship specifiers” (Beach et al., 2006; pg 364). Specifiers are usually used to “describe the course of the disorder or to highlight prominent symptoms” or to “indicate associated behavioural patterns of clinical interest” (Beach et al., 2006; pg 364). Alternatively, relationship patterns of relevance could be elaborated as part of the symptom criteria for the disorder.

A third approach to acknowledging the relational and cultural contexts of sexual problems is to develop a classification system that is based on aetiology of sexual difficulties, rather than discrete categories of symptoms. Such an approach has been put forward by the ‘New View of Women’s Sexual Problems’ developed by an independent group of clinicians and social scientists (The Working Group for a New View of Women’s Sexual Problems, 2001; see section on alternative perspectives below).

All of the above approaches would require further research and elaboration, but in my view have the potential to rectify DSM’s problematic “erasure of the relationship context in DSM” (The Working Group for a New View of Women’s Sexual Problems, 2001; pg 3). Without such fundamental shifts in thinking, we will continue to get tied up in knots trying to classify an inherently relational act in purely individual terms.

2.5.2 What is the Best Way to Avoid Pathologising Normal Variation?

The variability of sexual expression is well established. yet the medical model of sexuality on which the DSM classification is predicated negates this variation by assuming universality in sexual activity, i.e. vaginal penetration (Boyle, 1993; Potts et al., 2004), in physiological response patterns (Tiefer, 1996; Tiefer, 2001c) and in temporal sequence (Conaglen, 2001; Sugrue & Whipple, 2001). This assumption of universality effectively sets up a ‘normal’ way of having sex, such that diversity becomes problematic or pathologised (Potts et al., 2004).

Establishing the boundary between normal and pathological has always been a key issue and is still being raised with respect to the next edition of the DSM (Balon, Segraves & Clayton, 2007). This is a similar challenge to that faced by mental health practitioners in deciding when 'sad' becomes 'depressed'.

Some argue that more reliable cut-off points could be established if there was sufficient normative data. This lack is frequently bemoaned but what little data we have actually suggests substantial variability in sexual interest and behaviour across age, gender, cultural context and sexual orientation (Potts & Bhugra, 1995; Laumann et al., 2005; Lippa, 2007). For instance, the variability in women's experience of desire and arousal (and indeed whether these constructs are separable) has posed an ongoing headache for the classification of female desire and arousal disorders (Tiefer, 2001c; Rosen et al., 2000; Basson, 2000; Graham et al., 2004). Given this variation, and the fact that what counts as normal is so culturally dependent, attempts to define normal need to be met with extreme caution (Potts & Bhugra, 1995).

Against this background, at least three strategies have been proposed to avoid pathologising this normal variation. I discuss each in turn.

One option that is increasingly fashionable is to aim for precise and evidence-based cut off points using what normative data is available. An example is the recently proposed cut-off point of 1.5 minutes intravaginal ejaculation latency time (IELT) in the diagnosis of premature ejaculation (PE) (Waldinger & Schweitzer, 2006b). Thus ejaculations deemed 'too quick' by men themselves (or their partners) but that occur longer than 1.5 minutes after penetration, are construed as normal variation. The difficulty with precise cut-off criteria is that it feeds an unhelpful obsession with a particular criterion of 'health' (in this instance, time to ejaculation) and might risk measuring 'performance' according to this indicator. If we accept that some men are 'designed' to come sooner than others (in the same way that some men are better at sprinting and others at long-distance running), then it is harder for some men to 'achieve' the cut-off point than

others. Given the association between performance anxiety and PE, do we want to (further) encourage men to think about their sexual life as governed by a stopwatch? On a more practical level it is questionable how feasible it would be to use such precise criteria in clinical settings.

A second option is to specify distress as a necessary, but not sufficient, criterion for diagnosing dysfunction. 'Marked distress or interpersonal difficulty' is currently an essential criterion for any DSM diagnosis of sexual dysfunction and distress or disability is a necessary condition for the diagnosis of all psychiatric disorders (American Psychiatric Association, 2000). But this criterion was apparently added in haste, and with insufficient consultation, to DSM-IV and has been the source of controversy ever since (Segraves, Balon & Clayton, 2007).

The issue of whether distress should be a criterion for classification, unless it is contributing to the problem (e.g., 'performance anxiety' contributing to erection difficulties), is a difficult one. On the one hand, if we accept that sex is an inherently psychosocial act, essentially variable, primarily relational, and influenced as much by culture as by biology, then it would seem to follow that if individuals do not see themselves as having a problem, they cannot be deemed by others to do so. The problem is that the experience and reporting of distress are influenced by socio-cultural factors such as the expectations of a partner or messages from the media. This means that patients may be inappropriately distressed by their sexual function (O'Donahue, 2001) or may be in denial about an objectively problematic symptom (Sugrue & Whipple, 2001). Personal psychological distress is also difficult to define and measure objectively (O'Donahue, 2001) and therefore "detracts from [psychiatry's] attempts to maintain scientific rigour" (Althof, 2001). It may also be difficult to establish causality: did the dysfunction cause personal distress or did personal distress lead to dysfunction? (Derogatis & Meyer, 1979).

Furthermore, we know that some individuals with sexual dysfunction (as defined by standard classifications) are not distressed by it. Studies that have measured distress have

found that only a proportion of women with sexual difficulties (up to two-thirds) also report distress (Hayes et al., 2006). In one national survey of women that examined distress about sexual relationships, the best predictors of distress were general emotional well-being and emotional relationship with partners (Bancroft, Loftus & Long, 2003). In contrast, DSM-related physical aspects of sexual functioning, such as lubrication and orgasm, were poor predictors, suggesting that distress may be more closely associated with relationship quality than with physical function.

A study by Öberg and colleagues demonstrated that from an epidemiological standpoint, measuring dysfunction per se as opposed to dysfunction plus distress² results in similar patterns of reporting across age and type of difficulty but with higher prevalence rates (Öberg, Fugl-Meyer & Fugl-Meyer, 2004). Alternatively, they suggested that the distinction between the reporting of mild (defined as 'hardly ever' or 'quite rarely') versus manifest ('quite often'; 'nearly all the time'; and 'all the time') symptoms alone, can provide epidemiologically useful information. The importance of specifying duration and intensity of symptoms has been discussed earlier (Segraves, Balon & Clayton, 2007).

Clearly, anyone who is not distressed or troubled is unlikely to seek treatment and clinically, it is important to assess the degree of distress engendered by a problem. However, logically it seems that lack of distress should not exclude a problem from a diagnostic category, even if it means that the non-distressed individual does not wish treatment. It would also seem important that research into the aetiology, course, and prognosis of individuals with sexual dysfunction include individuals in this latter group as well as those who are motivated to seek help for a problem.

There are certainly difficulties with the requirement that personal or interpersonal distress should be present for the diagnosis of sexual dysfunction (Althof, 2001; Segraves, Balon & Clayton, 2007). One possibility, suggested by Althof is that distress be included as a 'specifier', rather than an essential criterion for diagnosis (Althof, 2001). Other specifiers might indicate developmental or biological features of a disorder.

¹i.e., comparing the DSM A and B categories to differentiate dysfunction from its emotional impact.

A third option is to use a dimensional model of classification of sexual disorder rather than a categorical one. The former views sexual dysfunction as “arbitrary distinctions along dimensions of functioning”; whilst the latter views them as “discrete clinical conditions” (Widiger, 2005; pg 211). In a categorical system, a ‘case’ is an individual who meets the criteria for the attribute; using a dimensional model, ‘caseness’ is a matter of degree, and a ‘cut-off’ point may be imposed, depending on circumstance (Streiner & Norman, 1995; pg 11). A dimensional system avoids the need to claim distinct boundaries between normal and pathological and gets around the problem of overlap between diagnostic categories.

Stages along a continuum are used elsewhere in medicine, for instance in heart failure, where there is no universally accepted Gold Standard diagnostic criteria (Criteria Committee, New York Heart Association, 1964). The New York Heart Association Functional Classification specifies four stages of functional ability for patients with heart conditions, from no limitation on physical activity (category I) to inability to carry on any physical activity without discomfort (category IV). However, it should be noted that this classification is not without criticism (Raphael et al., 2007).

The question of whether a dimensional model should supplant the categorical perspective used in the DSM is a longstanding issue but one that seems to be gaining momentum (Carson, 1991; First et al., 2002; Widiger, 2005; Widiger & Samuel, 2005). At the 2007 Annual Meeting of the American Psychiatric Association, a symposium was held on the feasibility of adding dimensions as well as categories of mental disorders to DSM-V. It was noted that the purpose of a diagnostic system such as the DSM is not to say what is ‘normal’ or ‘acceptable’ but to describe the presentation of an individual who comes to get clinical help (Busko, 2007). The debate around a categorical vs. dimensional classification system seems highly relevant to the debate around medicalisation of sexual problems (Bancroft, Graham & McCord, 2001). However, it is interesting that, again, there have been no proposals for using a dimensional model of sexual functioning as a possible basis of classification of sexual disorders in DSM.

Part of the reluctance to consider dimensional classification stems from a fear that it is less clinically useful (Widiger, 2005). Yet the current categorical system has been criticised for its weak clinical utility, both in predicting the best form of treatment or the prognosis (Bancroft, Graham & McCord, 2001; Potts & Bhugra, 1995; Bancroft, in press). It has been described as “a list of symptoms not necessarily synonymous with diagnoses” (Davis, 2001; pg 131). Significant co-morbidity between diagnostic categories is a further problem, not only with respect to sexual dysfunction, but in the DSM generally (Gregoire, 1999; Bancroft, Graham & McCord, 2006; First, 2005). For instance, of 45 consecutive patients attending Bancroft’s clinic (2001), over a third met criteria for more than one diagnostic category. Sole or primary cases of sexual arousal disorder are rare while sexual desire disorders and sexual pain disorders have such mixed and little-understood aetiologies that diagnosis is no more than a starting point (Beck, 1995). As Carson argued, “the notion that the patient may simultaneously harbour a plurality of separate diagnoses with considerable feature overlap seems on its face to involve enormous classificatory difficulties” (Carson, 1991; pg 303).

Finally, a strong argument in favour of a dimensional rather than categorical model is the fallacy of the ‘one model fits all’ idea. This was amply demonstrated in a recent study by Sand and Fisher (Sand & Fisher, 2007) in which a community sample of women, when asked which best represented their own sexual experience, were equally likely to endorse each of three different current models of sexual response – those of Masters and Johnson, Kaplan and Basson (Masters & Johnson, 1966; Kaplan, 1974; Basson, 2000). The findings underline the heterogeneity of women’s sexual response and highlight the need for more research into how women (and men) themselves actually experience sexual problems. The presumption that the current DSM categorical system represents an underlying ‘model’ of sexual response that is uniform across and within individuals is a likely source of many of its shortcomings and lack of clinical utility. Although the Sand and Fisher study had limitations e.g., the descriptions of the models were fairly brief, it is one of few studies that has employed such a ‘bottom-up’ approach and is a refreshing

alternative to the 'consensus' conferences that have required expert members to reach agreement about recommendations for diagnostic criteria.

I stated above that the purposes of the DSM are to facilitate communication among professionals, help clinicians determine which particular disorder is present, guide treatment decisions and research and, in the U.S., provide the basis for reimbursements to insurance companies. In my opinion, a dimensional classification system, which includes relational aspects as one dimension, may facilitate a valid conceptualisation, enabling clinicians to understand, treat and research difficulties holistically and in context. It would also facilitate dialogue across disciplines by formally requiring clinicians to consider dimensions beyond their immediate clinical focus and by avoiding the unhelpful split between psychosocial and biomedical perspectives. It may also simplify US reimbursement procedures by avoiding plural and over-lapping diagnoses.

2.6 *Alternative Perspectives*

Although the biomedical paradigm and DSM classification currently dominate research and clinical practice, a number of alternative ways of thinking about sexual difficulties have been proposed and are receiving significant attention. I present four particular models here.

2.6.1 An Alternative Classification: The 'New View' Classification of Women's (and Men's) Sexual Difficulties

The 'New View' perspective and classification (introduced above) rejects the notion that sexual experience has a universal set of stages (i.e. desire, arousal, orgasm) and that there is therefore a standard and normative set of dysfunctions. Instead it recognises diseases as socially created labels, views problems as non-medical as well as medical, and seeks to provide a person-centred conceptualisation of sexual difficulties (Tiefer, 1996). Sexual problems are defined as: "discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience" (Kaschak and Tiefer 2001, pg 5). Unlike the

classifications of the DSM and ICD-10, the New View does not classify symptoms according to a normative list; rather it classifies sources of difficulties, situating them in the context of individual lives.

Problems may arise in one or more of four interrelated aspects of sexual lives: Socio-cultural, political or economic (for example, 'ignorance and anxiety due to inadequate sex education' or 'inhibitions due to conflict between the sexual norms of one's subculture or culture or origin and those of the dominant culture'); partner and relationship (for example, 'discrepancies in desire for sexual activity or in preferences for various sexual activities' and 'loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money'); psychological factors (for example, sexual aversion due to past experiences of physical, sexual or emotional abuse); medical factors (for example, iatrogenic, numerous local or systemic medical conditions). The emphasis of the model is on the first of these areas.

The New View is compatible with the biopsychosocial approach (Candib, 2001), providing a holistic understanding of sexual problems and balancing socio-cultural, interpersonal, psychological and biomedical factors. Several authors have demonstrated its usefulness in understanding women's difficulties (Candib, 2001; Iasenza, 2001). However it is likely to be more useful in treatment and therapy than in clinical research. Originally designed as a classification for women, the New View has recently been adapted to incorporate difficulties affecting men

(<http://www.medscape.com/viewprogram/5737>; accessed June 9th, 2008).

2.6.2 An Explanatory Model: The Dual Control Model

The Dual Control Model (Bancroft, 1999; Bancroft & Janssen, 2000) seeks to provide a conceptual model of sexual dysfunction that is appropriate and useful in understanding both male and female sexual difficulties. It posits that sexual response depends on a balance between excitatory and inhibitory mechanisms in the brain, and that there is wide variation in individual propensity for both excitation and inhibition, with most individual

responses occurring within an adaptive range (Bancroft & Janssen, 2000). The tendency for excitation is fairly independent from the tendency for inhibition (Bancroft, 2002). The model posits that 'inhibition of sexual response' is for most individuals, an adaptive response to situations in which sexual activity may be inappropriate or disadvantageous. This differs fundamentally from a non-adaptive sexual response resulting from increased inhibition or reduced excitation and caused by 'malfunctioning of the sexual response system'. The challenge then, is to differentiate between an adaptive response, for which the focus of intervention would be the situation giving rise to the response (such as poor communication with sexual partner) and a non-adaptive response for which the focus might centre on treatment for the dysfunction.

From this theoretical model, two measures have been developed; the Sexual Excitation/Sexual Inhibition Inventory for Women (SESII-W) (Graham, Sanders & Milhausen, 2006) and the Sexual Inhibition/Sexual Excitation Scale (SIS/SES) for men (Janssen et al., 2002) (see appendix 15). Both measures have been used to explore whether the Dual Control Model might be able to predict sexual difficulties. Among women, two inhibition factors from the measure – Arousal Contingency (potential for arousal to be easily inhibited or disrupted by situational factors) and Concerns About Sexual Function (tendency for worries about sexual functioning to negatively influence arousal) – were the strongest statistical predictors of both current and lifetime sexual problems (Sanders, Graham & Milhausen, 2008). Among men, inhibition proneness (particularly due to threat of performance failure) has been shown to predict lifetime and current erectile problems (Bancroft & Janssen, 2000), and one sexual inhibition scale correlates with low sexual desire (Bancroft et al., 2005b) but none of the scales have been shown to predict premature ejaculation (Bancroft et al., 2005a; Bancroft et al., 2005b). The Dual Control Model has also been used to explore sexual addiction, compulsivity and impulsivity (Bancroft & Vukadinovic, 2004), sexual risk taking (Bancroft, Janssen & Carnes, 2004), and the relation between mood and sexuality (Bancroft et al., 2003 b and c; Lykins, Janssen & Graham, 2006).

2.6.3 An Explanatory Model: The Female Sexual Response Model.

Basson recently proposed alternative models of female sexual response (Basson, 2000) and in particular sexual arousal (Basson, 2001b; Basson, 2002). The central tenets of her proposed alternative model are that women have a lower biological need to be sexual; that women often engage in sexual activity from a standpoint of “sexual neutrality”; that they are motivated to be sexual out of a desire for emotional closeness (intimacy) or other non-sexual reasons; and that female sexual arousal concerns “subjective mental excitement that may or may not be accompanied by awareness of vasocongestive changes in the genitalia” (Basson, 2000; pg 52). Thus her model represents an attempt to resolve disparities between the HSRC and women’s actual experience (Basson, 2000).

The critics of Basson’s model include Both and Everaerd, who argue that desire is always responsive, although it will sometimes be experienced as spontaneous. They suggest that Basson’s concept of motivation is therefore unnecessary (as well as being poorly explained). They also point out that women have sex for many reasons other than intimacy (Both & Everaerd, 2002; Meston & Buss, 2007).

Building on her models, Basson has tried to accommodate the complexity of the female experience by introducing additional sub-types and categories of desire and arousal within the confines of the traditional biomedical model. For instance, she further subtypes women with sexual arousal disorder into: those where the stimulus is not mentally exciting (no genital changes); those where the stimulus is not appreciated as mentally exciting (genital changes happening but not registered); those in which the stimulus is mentally exciting but no genital changes occur; and those where the stimulus is mentally exciting and genital changes occur but the woman is not aware of them (Basson, 2000). The first would seem to be more a problem of the partner and the fourth of little clinical relevance and thus there seems little gain to this additional differentiation. To my mind, this proposed classification defies the law of parsimony,

“that no more causes or forces should be assumed than are necessary to account for the facts”³.

2.6.4 A Therapeutic Model: The ‘Good-Enough Sex’ Model for Couple Sexual Satisfaction.

The Good-Enough Sex Model (Metz & McCarthy, 2007) is part of a growing movement within sex therapy attempting to counteract societal pressure to have ‘great sex’ and promote instead a “different but equal” framework (Pertot, 2006; pg 12). The model proposes 12 dimensions associated with ‘good-enough sex’, with couple intimacy and satisfaction as the ultimate goal. The model is based on several important premises, including: that difficulties have complex aetiologies and are rarely amenable to the ‘quick fix’ approach; that realistic expectations are essential; and that variability is inherent and a focus on perfection is self-defeating.

This model is laudable for its attempt to promote the idea of good-enough sex (in contrast to perfection), in its emphasis on realistic expectations. In addition, I like the fact that the dimensions of the model focus on relaxation, flexibility, personal preferences and pleasure as much as function. It also promotes the view of sex as wholly integrated into the ongoing couple relationship. As will become apparent in later chapters, this model fitted well with some of the priorities described by my respondents. And I imagine that it will provide a very useful basis for therapeutic counselling. However, there are some important drawbacks; not least that Metz and McCarthy fail to provide any empirical evidence to support their choice of dimensions. This is also a model of sex primarily of relevance to heterosexual couples in long term relationships.

2.7 Prevalence and Co-factors

Given the complexity and intensity of the debate surrounding the definition and classification of sexual dysfunction, it should come as no surprise to learn that estimated rates of prevalence are highly variable depending on the criteria of measurement

³ The Concise Oxford Dictionary, 1982

employed by the study. Thus, although sexual function difficulties are said to be relatively common, reliable estimates are difficult to obtain and comparisons across time and population groups have been of limited usefulness. I explore the challenges of accurately measuring population prevalence in the second literature review (chapter eight). For the moment, it is helpful for the reader to have a rough idea of the scale of the problem.

In the US, the most widely quoted study suggests prevalence estimates of 43% for women and 31% for men (Laumann, Paik & Rosen, 1999). In the UK, the NATSAL 2000⁴ study found that 34.8% of men and 53.8% of women reported at least one sexual problem lasting at least one month in the previous year (Mercer et al. 2003), but these figures fell to 6.2% and 15.6% for problems lasting at least 6 months in the previous year. Across prevalence studies, low sexual desire appears to be the most common problem experienced by women (with estimated prevalence rates ranging from 10% to 64% across studies), and premature ejaculation the most common difficulty among men (with estimated prevalence rates ranging from 14% to 30%) (Derogatis & Burnett, 2008).

Until relatively recently, sexual difficulties were generally thought to derive from symptoms of neuroses (Nathan, 1986) or personality disturbances caused by early childhood experiences (Nicolson & Burr, 2003). Now it is understood that there are often a number of interacting causes and co-factors which may be organic, psychogenic and/or psychosocial. The latter two may be categorised as predisposing (for instance, childhood sexual abuse), precipitating (a trigger such as a relationship break-up) or maintaining (for instance, performance anxiety) (Althof et al., 2005a).

The relationship of these co-factors with sexual function is often complex and circular, and rarely simple, causal or consequential (Gregoire, 1999), and significant associations between sexual problems and various co-factors are not always in the same direction for men and women (Mercer et al., 2005). The aetiology of female sexual problems in particular is “notoriously multi-factorial” (Davis 2001; pg 131). For instance, recent

⁴ A national stratified probability sample of 11,161 men and women aged 16-44.

research on diabetes and female sexual problems suggests that fatigue and other psychological issues stemming from the condition are more important than organic factors such as autonomic neuropathy, as seen in men (Jackson 2004). And among HIV positive women, factors to do with 'oppression' (Bova & Durante, 2003) and fear of transmitting the disease (Denis & Hong, 2003) are said to have as great an impact on sexual function as the virus itself.

Furthermore, there is not always agreement across studies concerning the strength and direction of associations, particularly for socio-demographic variables. For instance, Mercer and colleagues (2005) found that neither education nor marital status was associated with reporting persistent problems (6 months or more), whilst Laumann and colleagues found that unmarried status (single, divorced, separated, or widowed) and lower educational status were both associated with an elevated risk of reporting difficulties for men and women. With regard to age, Mercer and colleagues (2005) found no association between age and reporting of difficulties lasting one month or more but found that reporting of persistent problems increased with age for both men and women. Laumann and colleagues (1999), investigating problems reported in the past 12 months, found an increase in reporting with age only for lubrication among women, and erectile difficulties and lack of desire among men. In their report on the impact of aging on sexual dysfunction among women, Hayes and Dennerstein found strong evidence from cross-sectional studies for a decline in sexual function with age among women (Hayes & Dennerstein, 2005), but no evidence for a concomitant rise in sexual dysfunction (defined as absence of function plus distress). They suggested that an age-related decline in distress about sexual function may explain this apparent contradiction; a supposition shared by various authors (Hawton, Gath & Day, 1994; Derogatis & Burnett, 2008).

Other co-factors are less contentious. For instance, the association between use of anti-depressants and sexual dysfunction is widely accepted (Gregoire, 1999; Basson & Schultz, 2007). And there is significant evidence suggesting a link between sexual dysfunction and a number of conditions including depression, diabetes and coronary artery disease (Jackson, 2004; Baldwin, 2001; Basson & Schultz, 2007). Overall health

status (Derogatis & Burnett, 2008), as well as the menopausal transition (Chen & Ho, 1999; Dennerstein, Dudley & Burger, 2001), have also both been reliably associated with sexual dysfunction.

2.8 Conclusions

In summary, the origins of the contemporary scientific study of sexuality (sexology) can be traced to a number of independently minded European physicians (including Freud and Havelock-Ellis) who sought to explain sexual behaviour using scientific methods. Acknowledging variation in sexual practices, their work precipitated several attempts to survey and classify sexual behaviour, notably by Kinsey in the 1940s/50s. Masters and Johnson were the first to systematically investigate the physiology of sexual intercourse and their proposed Human Sexual Response Cycle became the foundation for the contemporary classification and understanding of sexual dysfunction.

The veil of scientific objectivity provided by Masters and Johnson among others belies the fact that the sexual act is not a static natural fact but is more accurately viewed as historically and culturally variable and socially constructed. For example, sexually related disorders, such as homosexuality and hysteria, have come and gone with changing social milieu. Recently, concern has been expressed about the extent to which the corporate agenda of the pharmaceutical industry shapes the definition and understanding of sexual dysfunction.

Standard definitions and classifications of sexual dysfunction are provided by the American Psychiatric Association (the DSM) and the World Health Organisation (the ICD). Both systems have been widely criticised and contested and there are ongoing calls for revisions. A number of expert panel meetings have been convened to improve the diagnostic criteria of the DSM but most suggestions have been minor and have failed to assuage the critics. The task is not easy; two particular challenges for current classifications concern the best way to acknowledge the relational context and the best way to avoid pathologising normal variation. A number of alternative models have been

proposed but none have managed to precipitate a paradigm shift in the way that sexual dysfunction is conceptualised.

Prevalence estimates vary widely because of differences in study methodology as well as the criteria of sexual dysfunction employed. In general, low sexual desire appears to be most common among women and premature ejaculation appears most common among men. The aetiology of sexual dysfunction often involves a complex and circular relationship between co-factors and disease. Whilst the evidence for many of the co-factors is inconsistent, several aetiological agents are uncontested. These include depression and diabetes.

In conclusion, the definition and classification of sexual dysfunction is by no means established. Emerging evidence, new treatments, pharmaceutical interest and societal expectations will no doubt continue to shape the way the concept is understood.

Chapter 3

Rationale, Research Question and Theoretical Framework

3.1 Introduction

In this chapter I provide the rationale for the study, present the research question and study objectives, and outline the theoretical framework for my research. From my reviews of the literature (chapters two and eight), the need for a measure should be clearly apparent. In this section, I have used the salient points from these reviews to make a coherent justification for the study. However, each literature review should be read in the context of an emerging rationale for the study.

3.2 Rationale

In this section I ask whether there is a need to question the meaning of sexual function and whether there is a need for another measure.

In justifying the need for this study, the first question to consider is whether definitions and classification systems matter. Classification systems impose meaning and structure upon complex phenomena and can create a common language for the advancement of knowledge (Leiblum, 2001). For the practicing clinician, classification systems enable understanding of problems presented at clinics (Wylie, 2001b). In academic research, Binik (2005) points out that how the problem is defined, determines who studies it, and that, indirectly, the classification system defines who has the expertise for the construct. Classification systems channel the understanding and diagnosis of disease in fundamental ways. History shows that conceptual frameworks “can determine what observers actually see and therefore what they report in their accounts of the

observation” (Maines, 1999; pg 51). I illustrated this point with regard to hysteria in section 2.3.1 of chapter two.

Secondly, does measurement matter? Measurement is not difficult to justify. At community level, measurement of prevalence provides epidemiological data on rates of sexual dysfunction that are essential in planning services and advocating for better service provision (Wylie, 2001b). Such data can bolster prevention efforts by highlighting high-risk groups (Nathan, 1986; Spector & Carey, 1990), as well as determining the number of people who might benefit from professional help but who do not present (Dunn et al., 2002). Research in sexual medicine is dependent on reliable epidemiological data to generate hypotheses about causal factors and challenge existing definitions of sexual dysfunction (Nathan, 1986; Spector & Carey, 1990; Derogatis & Burnett, 2008). At a clinical level, accurate measurement is essential to diagnose reliably and evaluate the impact of clinical treatment or therapy. Measurement also provides normative data to assist with these latter two functions (Derogatis, 1997).

As I mentioned in chapter one, research and treatment of sexual dysfunction finds itself in the middle of a paradigm struggle. Despite standard definitions and classification systems from WHO (1994) and APA (2000) (see chapter two for further details), and despite a plethora of measures purporting to measure sexual dysfunction, both concept and measurement continue to be contested. Within the field of sexology, the rationale for this thesis has been succinctly summed up by the psychiatrist Richard Balon:

“We [sexologists] have not addressed some basic, quite important issues. [...] Our diagnostic system is not very useful. Our definitions of sexual dysfunction as defined in the Diagnostic and Statistical Manual of Mental Disorders are very vague. The experts argue about minute points but we do not even have a consensus on how long the disturbance should last to call it a dysfunction. We cannot agree how to reasonably quantify changes in sexual functioning as we have not invented or selected a few standard instruments out of those hundreds of scales used in the literature. [...] Thus, I believe that to truly revive the field of sexology we have to redefine our research agenda.

We should start with clear definitions (=diagnosis) of what sexual dysfunctions are and with some consensus on how to measure them. Then we should establish more accurately the prevalence of sexual dysfunctions. Only then can we appropriately address the treatment issues” (Balon, 2007; pg 407).

Balon’s chief complaints about the weaknesses of the current system and lack of consensus on how to improve it are supported by many leading academics in the field (Bancroft, Graham & McCord, 2001; Althof et al, 2005c; Derogatis & Burnett, 2008; among others). According to Balon then, the focus of this thesis represents an early step in enabling sexology to move forward rather than stagnate. As far as sexology is concerned then, the need for this thesis is beyond doubt.

As Balon (above) points out, there are already many measures of sexual dysfunction. Is there need for another? I answer this question in detail in chapter 8 when I document and appraise existing measures. Here I present a bullet point summary from that chapter based on the main findings of successive reviews of measures of sexual dysfunction (Conte, 1983; Daker-White, 2002; Arrington, Cofrancesco & Wu, 2004; Corona, Jannini & Maggi, 2006) and community prevalence studies (Spector & Carey 1990; Simons & Carey 2001; Dunn et al., 2002; Hayes et al., 2006):

- Few measures incorporate patient perspectives into their design. Most are based on expert opinion and/or a literature review;
- Increasingly, measures are designed as end points in clinical trials and therefore focused on biomedical aspects of sexual dysfunction;
- There is no measure of sexual dysfunction designed to give population prevalence estimates that is applicable across gender, sexual orientation, and health status;
- In the absence of a population prevalence measure, community based surveys usually adopt a set of un-validated questions;
- Community prevalence studies vary widely in the way they define and measure sexual dysfunction. This lack of standardisation has made it difficult to accurately assess the burden of disease.

3.3 Research Question

To summarise, there appears to be a gap in the field for a measure of sexual dysfunction based on lay perspectives, driven by a holistic understanding of the meaning of sexual function, and specifically designed to give accurate population prevalence estimates from a UK community sample. This gap exists partly because of the lack of consensus regarding the definition of sexual function, and partly because of the current emphasis of the field on designing end point measurements for clinical trials.

Against this background, the aim of this research study was to undertake development work for a measure of sexual dysfunction with demonstrated acceptability, reliability and validity.

The study posed two specific research questions. Firstly, **what does sexual function mean to those who have and have not experienced sexual difficulties?** The answer to this question led to a second question: **how can this concept of sexual function be accurately captured in a population prevalence measure?**

In answering these questions, the work was guided by four objectives:

1. To explore the meaning of sexual function and sexual dysfunction among individuals in clinical and non-clinical populations;
2. To design a conceptual model comprising the key components of sexual function;
3. From this model, to select key domains for a population-based measure;
4. To identify preliminary items to be included in the measure.

In addition, objective one (the main objective) was met through qualitative fieldwork with the following specific aims:

1. To understand how individuals define a satisfactory/acceptable sex life;

2. To explore perceptions of the severity and impact of problems that can affect an individual's sex life and sexual relationships;
3. To look at the language that people use to describe their sexual life and probe for understanding of terms;
4. To compare lay perceptions of sexual function with the prevalent medical model and existing literature.

The end product of this thesis is a draft measure of sexual function which is ready to be tested psychometrically. Given the gaps outlined above, the study aimed to produce a measure that was short, user-friendly, and grounded in patient/respondent perceptions; that did not assume equivalency across genders, orientations and age; that represented social, psychological and physiological dimensions of sexual function; and that differentiates those with dysfunction, from those with adaptive and temporary problems.

The key purpose of the measure is to provide population based estimates of sexual dysfunction, through inclusion in large-scale national surveys. A secondary purpose may be as a component of a quality of life questionnaire, examining the impact of a disease, condition or medical intervention on the sexual life of the patient.

My underlying hypothesis was that an approach grounded in the perceptions of respondents in clinical and non-clinical settings, and incorporating both biomedical and psychosocial perspectives, would generate a conceptual model and subsequent measure of sexual dysfunction that most comprehensively captured the phenomenon. I assumed that it would be feasible to design a measure that adequately captured the concept and yet was still practical for measuring population estimates.

3.4 Theoretical and Methodological Framework

In this section I make explicit the underlying assumptions of my thesis. I describe my theoretical perspective and the methodological decisions resulting from this perspective. As C. Wright Mills (1959) states, "What method and theory properly amount to is clarity

of conception and ingenuity of procedure” (Wright Mills, 1959; reprinted in Seale, 2004; pg 20). Thus in this section I clarify how I have conceived the problem and justify the approach I have taken in tackling it. I have also set out the boundaries of the thesis in terms of what is included and excluded, and conclude by briefly defining the key terms and providing notes on style.

My theoretical perspective regarding the problem of how to conceptualise and measure sexual dysfunction comprises a set of assumptions. These assumptions have infused my handling of the literature and methodological design and may be already apparent to the discerning reader but I have described them explicitly here:

Firstly, I believe that sex should be regarded as part of everyday life, not something special or extraordinary. I agree with Stevi Jackson that “sexuality should be kept in proportion, not treated as a ‘special’ area of life or as a powerful force (whether dangerous or subversive) beyond the social” (Jackson, 2008; pg 35). This is particularly pertinent to sexual dysfunction; I suspect that problems occur when sex is regarded as special or put on a pedestal, thereby creating expectations of the act that are difficult to fulfil in reality.

I also believe that although an everyday act, sex is connected in fundamental ways to self-identities and relationships between individuals. It is also imbued with powerful social meanings. Because of this, it cannot be simplified or reduced to a mere physical act. To understand the biological mechanisms underlying sexual activity is to understand only part of the picture. It is like trying to understand a murder by learning only about the act itself; the mechanism by which the gun was fired, the position it was fired from and the direction in which the victim fell. The pitfalls of biological reductionism have been amply illustrated by the widespread failure of technology to provide simple fixes; they fail because they focus on function and “disregard the meaning of intimacy and sexuality for the couple” (Metz & McCarthy, 2007, pg 352). Because of the importance of this interpersonal meaning, I believe that sex can be most reliably understood and measured at the level of the individual and their (reported) relationship. As Derogatis argues, the individual “represents the most parsimonious and straightforward unit to

work with and [...], regardless of context, quality of sexual functioning is ultimately appreciated by the individual” (Derogatis, 1998; pg 269).

At the same time, I do believe that an understanding of physiological function is important (just as an understanding of how the victim was shot can be critical in solving a murder). I have therefore taken a multi-disciplinary perspective to understanding the problem, incorporating evidence from a wide range of disciplines including sexual medicine, psychiatry, psychology, sex therapy and social science. This multi-disciplinary perspective is congruent with the biopsychosocial model of sex which recognises the importance of physical, emotional, mental and social aspects as described in the WHO definition (World Health Organisation, 2006; see chapter one). While integrating these perspectives, this is primarily a public health PhD by a public health social scientist and it is public health concerns that have been at the forefront of many of the methodological decisions.

This multi-disciplinary perspective falls between two distinct traditional approaches to understanding sex. The classical essentialist perspective is premised on three core beliefs: that there are underlying true forms, ‘facts’ or essences; that there is discontinuity between different ‘facts’ rather than continuous variation; and that these facts remain constant over time (DeLamater & Shibley Hyde, 1998). Thus, the ‘essentialist’ notion of sex views it as an instinctive and natural drive; essentially heterosexual and procreative. It is a powerful force that must find appropriate outlet and be controlled by social and cultural forces. Belief in sex as a natural act often leads to positivist scientific inquiry which assumes that sexual behaviour follows stable and regular patterns which can be studied using the (deductive) methods of the natural sciences. The alternative view (the anti-essentialist critique) rejects the notion of sex as a natural force which must be controlled, viewing it instead as an ideological construct created and defined by forces, such as language, culture and (patriarchal) history. Among the prominent anti-essentialists are Foucault (1979), Gagnon & Simon (1973) and Plummer (1975). The anti-essentialist or social constructionist paradigm owes much to Berger & Luckmann (1966) whose core ideas have been précised by DeLamater & Shibley Hyde as follows:

firstly an individual's experience of the world is ordered rather than chaotic; secondly, individuals make sense of their lived reality through language; and thirdly, reality is shared with others and these shared interpretations become institutionalised but are not necessarily universally shared between sub-groups in society (DeLamater & Shibley Hyde, 1998). The social constructionist perspective is associated with interpretivist methods of enquiry which are usually inductive and qualitative. The Interpretivist or Interactionist perspective (encompassing traditions such as Symbolic Interactionism, Social Constructionism and Phenomenology) focuses primarily on the ways in which individuals create meaning through interaction with others and on how meanings vary by context.

This thesis adopts a pragmatic middle ground between these two traditions, in which aspects of sex are acknowledged as physical and natural facts which take on different social and individual meanings in different contexts. The philosopher John Searle distinguished between 'brute' facts and 'institutional' or social facts (Searle, 1995). For instance, the male erection is a natural or 'brute' fact and occurs regardless of the ways in which its meaning is interpreted. Similarly, male and female genitalia are natural facts, but both 'vagina' and 'penis' also carry socially constructed meanings. Some term this position 'weak constructionism', 'critical realism' (Bhaskar, 1989) or 'subtle realism' (Hammersley, 1992). This middle ground recognises that knowledge is always built on pre-existing ideas and values (whether this is made explicit or not) but that some accounts are more valid than others and science can be used to make judgments about their plausibility (Seale, 1999; pg26/27). It accepts empirical findings about the causes of sexual dysfunction whilst remaining alert to the ways in which alternative perspectives may have shaped the findings (Pilgrim & Bentall, 1999). This position enabled me to accept (albeit with healthy skepticism) that the concept of sexual dysfunction could be 'captured' and measured objectively as a useful public health indicator; and that the concept, once captured, would approximate to 'truth' for a broad range of study participants.

This study draws on methodological techniques from both interpretivist and positivist traditions. The fieldwork described in this thesis used semi-structured interviews in an attempt to build authentic accounts which would provide an understanding of the concepts of sexual function and dysfunction from the perspective of the participants (an inductive and interactionist approach to knowledge). However, the conceptual model built from these results will be tested using psychometric methods (albeit post this thesis) which rely on a positivist approach to knowledge. This pragmatic methodological approach is reflected in Seale's description of the middle ground which uses "philosophical and political debates as resources for achieving certain mental attitudes, rather than a set of underlying principles from which all else must flow, creating unnecessary obstacles to flexible and creative inquiry" (Seale, 1999; pg 26). Like Seale, I prefer to view the debate between these perspectives as "conversations stimulating methodological awareness among researchers, rather than laying foundations for truth" (Ibid, pg 26). In other words, I believe that methodology should be the servant and not the master of any research project; that it is possible to maintain scientific rigour without becoming enslaved to a particular epistemological framework. As Wright Mills states, "To have mastered 'theory' and 'method' in short, means to have become a self-conscious thinker, a man ready for work and aware of the assumptions and implications of every step he will take as he tries to find out the character and the meaning of the reality he is working on." (Wright Mills, 1959; cited in Seale, 2004; pg 20)

3.5 Reflections on the Interview Interaction

This middle ground requires a critical evaluation of the ways in which the research process may have influenced the results. Thus, in this section I reflect on my role as interviewer and on how the ways in which I was perceived may have shaped the data.

The assumptions that respondents may have made about me were potentially endless. My guess is that they included some of the following: that because I was white and heterosexual (I wear a wedding ring and was noticeably pregnant at the time of interview), my own sexual experience would be conventional and I would know little

about what it would be like to be an ethnic or sexual minority; that because of the setting (GP clinic and psychosexual clinic) and my affiliation to the London School of Hygiene and Tropical Medicine, I would be mostly interested in aspects of sex relevant to 'health'; that because of the way I initially explained the study, I must believe in wide variation in sexual practices and question the meaning of normal; that because I was researching sex I must hold reasonably liberal attitudes and perhaps be un-shockable; that because I was doing a PhD, I must be well-educated and they might have to 'impress' me by intellectualising their ideas.

Of course, I have no way of knowing for sure whether any participants held these assumptions but it is likely that at least some of them did and that having these thoughts about me may have led them to emphasise some aspects of their accounts over others. There were hints in the data. For instance, on more than one occasion a respondent broke off from his/her story in order to seek my opinion on a clinical matter: *Don't you think he should see the doctor more?* (F70). On other occasions, respondents demonstrated awareness of the underlying assumptions of the research, such as the questioning of normality: *That's why I was concerned at the beginning that you perhaps oughtn't to start with me because I haven't... not a... Well, I fell into your trap then: not a normal life – sexual. To which you say "what is normal?"* (M56). Although the likely assumptions about me and about the research ought to have biased accounts in a biomedical direction, I found that my respondents were actually more interested in talking about the interpersonal than issues of health. In the introduction to his book, 'The transformation of intimacy: Sexuality, love & eroticism in modern societies' Giddens remarks, "I set out to write on sex. I found myself writing as much about love; and about gender" (Giddens, 1992; pg 1). My experience felt similar.

Of course, respondents in any interview, consciously or unconsciously 'manage' the way they come across to the interviewer. Often this is a balance between being frank without inviting disapproval: *I try to be as frank as I can be without being over zealous about it or sounding callous – stuff like that* (M55). There were a few instances in which respondents appeared keen to demonstrate either their knowledge or experience, for example, the pronouncement: *because we've all read Masters and Johnson.....*, to which

I wondered, “all?”, since I’m not sure that any of my friends outside of the sexual health field have read Masters & Johnson! I viewed such impression management as influencing the edges of accounts rather than the central story. In general I felt strongly that respondents were frank in recounting their experiences. This feeling was confirmed by explicit statements, for instance:*somebody said to me yesterday, “are you going to tell any lies?” I said “no”. I didn’t see the point (F73).* Furthermore, I see these mild examples of impression management less as bias than as the inevitable and acceptable fact that ‘truth’ is always a product of the interaction between two people (see Charon, 2007).

Finally, I have been told by friends, colleagues and previous research participants that I am the sort of person in whom people find it easy to confide. I therefore have reasonable confidence that my demeanour as a researcher facilitated rather than hindered disclosure. Nonetheless, it appeared to me that, regardless of my demeanour, some respondents expected and wanted to tell their story. These respondents often began their stories during preliminary stages of the interview; taking broad ‘opener’ questions as a cue to begin:

IV: What does [the word sex] mean for you?

M65: Well it used to mean a lot but unfortunately what happened was

In addition, comments by respondents at the end of the interview, suggested that the experience of being interviewed had sometimes been useful and even cathartic; helping them to clarify and make sense of their story:

M52 It’s been good for me as well

IV: It’s been helpful?

M52: Because when you describe things to somebody else of course, it really focuses things in your own mind

3.6 Setting the Study Boundaries

Since one of the aims of this thesis was to investigate the meaning of sexual dysfunction one might argue that any sexual symptom could be potentially considered for inclusion. However, I set some boundaries from the outset. These boundaries were determined largely by the public health focus of the thesis; specifically the fact that I was aiming for a population prevalence measure for a public health orientated survey. This objective implied a need to stay reasonably generalised and focus on measurable and common symptoms. This led to a number of exclusions and limitations as detailed below:

Firstly, I followed conventional practice and did not consider the paraphilias (for example, Exhibitionism, Paedophilia, Fetishism etc.) as aspects of sexual dysfunction. Paraphilias are currently classified separately in the DSM (American Psychiatric Association, 1994) and are defined as “recurrent, intense sexually arousing fantasies, sexual urges or behaviours generally involving 1) non-human objects, 2) the suffering or humiliation of oneself or one’s partner, or 3) children or other nonconsenting persons” (pg 522-523). The debate about whether paraphilias constitute immorality or disease has been raging for centuries and was at the centre of much early sexological research from the mid 19th Century (see chapter two). But paraphilias primarily concern ‘appropriate’ objects of desire and arousal and affect a very small minority of the population. In this thesis, I assume that the object of desire/source of arousal is another consenting adult.

Secondly, there are some symptoms whose classification (and even existence) is contested. Sexual addiction, for instance, does not currently appear in the DSM (although ‘excessive sexual drive’ appears in ICD-10) but is said to be common and is often discussed, both by the medical profession and media. There is no consensus about whether it is a sexual dysfunction in its own right, or a manifestation of another mental health condition such as obsessive compulsive disorder. Sexual addiction did not arise specifically in my qualitative work but I did examine in detail problems of desire, and for the sake of simplicity have assumed that addiction may be examined under the broader heading of problems of desire; wanting sex too much, or hypersexual desire disorder.

Similarly, specific medical diagnoses such as Vulvar Vestibulitis are subsumed under broader headings such as pain/discomfort. I have excluded from discussion, rare conditions such as persistent genital arousal disorder (see Leiblum & Nathan, 2001) and priapism, whose symptoms are said to occur independent of wanted sexual feelings or activity.

Thirdly, I do not differentiate sexual dysfunctions according to sexual orientation. There is some debate about whether differences in experiences of sexual difficulties between sexual orientations are qualitative or merely quantitative. Sandfort and de Keizer argue that homosexual problems should not be studied from a heterosexual perspective (Sandfort & de Keizer, 2001). Specifically, they point to the obvious lack of vaginal penetration in gay male sex; and to the fact that sex roles can be reversed across couples (interestingly though, their overview of empirical research on sexual problems in gay men adopts a categorisation of problems identical to traditional heterosexual classifications). Certainly there are difficulties - such as experiencing pain during receptive anal intercourse (Rosser et al., 1997) and the so called 'lesbian bed death' (Bridges & Horne, 2007), as well as aetiological factors (anxiety about HIV; negative feelings about sexual orientation (Bhugra & Wright, 1995; Sandfort & de Keizer, 2001)) - that are particularly pertinent to homosexual men and women. And important correlates of satisfaction such as comfort with homosexual attraction and absence of internalised homophobia (Rosser, Metz & Bockting, 1997) are not relevant to heterosexuals. Whilst acknowledging these differences, in practical terms it was not possible to study heterosexual and homosexual problems separately, nor to devise separate measures for each group. Therefore my intention has been to adopt a neutral perspective; one that makes no assumptions about what activities occur and is broad enough to encompass both heterosexual and homosexual experiences and difficulties.

Finally, my review of the literature was focused on sexual dysfunction as experienced in Western countries, predominantly in the US and UK. This is because my ultimate aim is to develop a measure designed for use in a UK population.

3.7 Definition of Terms

A number of terms crop up regularly in this thesis, some of which may be understood differently by different readers and thus require clarification from the outset. Whilst I mention a few specifically here, it is worth noting that none of the key terms employed in this thesis are unproblematic; that is, their meanings may be contested according to one's perspective.

The meaning of sex or sexual activity was understood quite variably by respondents and many different definitions are employed in survey research (Schneidewind-Skibbe et al., 2008). I adopted a broad definition here, employing the term sex to refer to any sexual activity, including intercourse, oral sex, anal sex and masturbation. During semi-structured interviews, my preliminary question probed participant understanding of the term sex to ensure a shared definition from the outset.

I have adopted a narrow definition of sexual function as the flip-side or absence of sexual dysfunction. Thus to be sexually functional (or to have an absence of sexual dysfunction) does not necessarily imply sexual health, in the same way that an absence of depression does not imply joy. As I stated in the introduction, sexual health (as defined by WHO) encompasses much more than just function.

It is important to differentiate function from purpose. The latter is intentional, whilst the former is operational. I have discussed the purpose of sex in terms of individual and couple motivations and reasons for having it. On the other hand, the function of sex refers to its "mode of action or activity"⁵ that enables the purpose to be fulfilled.

As well as the terms sexual function and sexual dysfunction, I also refer to sexual function problems and sexual difficulties. I have used these terms more broadly, to refer to any physiological and/or psychosocial difficulty related to sex, regardless of whether it has reached a medically diagnosable threshold.

⁵ The Concise Oxford Dictionary, 1982

I did not use the terms function or dysfunction during interviews because of their biomedical connotations. Furthermore these terms are not well understood outside of the medical context and might encourage discussion framed by the medical paradigm. There was also a risk that 'function' and 'dysfunction' might be considered pejorative by some and irrelevant by others. Instead I used phrases such as 'OK for you' and 'good enough' or asked respondents to describe their ideal sex life, asking them to think in realistic terms rather than in terms of perfection. I used the notion of 'realistic ideal' as a proxy for the concept of function. I worked on the premise that there would be a reasonable fit between terms; what is described as good enough or OK in a lay context should mirror the concept of function as used in a medical context.

I particularly liked the term 'good enough' because it allowed for satisfaction without the pressure of expecting perfection. The term has been used in child protection studies to describe parenting ('good enough parenting': Swain & Cameron, 2003) and in development to describe governance (Grindle, 2007). It is also already in use in sexology (Metz & McCarthy, 2007). Whereas ideal represents a theoretical goal, 'good enough' represents an achievable goal.

At the end of the interview, I did sometimes ask respondents what they understood by the terms function and dysfunction. Respondents generally disliked the terms, describing them as *loaded*, *heavy-handed*, *miserable*, and stigmatised. They were understood quite variably but generally seen as problems *to do with the body*; medical and physical conditions. Dysfunctional was also a term associated with others rather than oneself. For instance, one respondent, on observing the cards in the card game⁶ (many of which described recognised sexual dysfunctions) said: ... *all these things can happen to all of us and it doesn't mean we're dysfunctional* (F35). The 'us' here appeared to imply 'normal' people, whereas dysfunctional people were 'other'; to label us normal people dysfunctional would be a misnomer. These observations confirmed that my decision to avoid these terms during interview had been the right one.

⁶ The card game was a device used in the interview to further explore the topic. See chapter four for details.

3.8 Notes on Style

- All quotes from participants are italicised; *like this*.
- Short participant quotes are contained within paragraphs; quotes longer than one sentence and dialogue between participant and interviewer begin on a new line. Everything *italicised* represents a respondent quote.
- Quotes from participants are preceded or followed by the sex and age of the participant, enclosed in brackets. For example, (M56) denotes a man aged 56, and (F54) denotes a woman aged 54.
- Where respondents quote others or report a conversation, double quotation marks are used; “*like this*”.
- All quotes from the literature are enclosed in double quotation marks but no italics; “like this”.
- Words whose meanings are contested, titles (of working groups, books, constructed or less known diseases etc.), labels, and colloquial phrases are indicated by single quotation marks; ‘like this’.
- Emphasis is indicated by underlining; like this.

3.9 Summary of Chapter

In this chapter I argued that classification and measurement matter, not only to advance aetiological and epidemiological knowledge, but also to diagnose accurately, treat effectively and plan adequately in terms of service provision. Despite standard definitions and classification systems from WHO (1994) and APA (2000) and despite a plethora of instruments purporting to measure sexual dysfunction, both concept and measurement continue to be contested. Of the instruments that exist, there is not one that is specifically designed to measure community prevalence, that incorporates patient perspectives into its design, that has male and female versions, and that is brief and acceptable enough to include in a public health survey. Thus the aim of this thesis was to undertake development work for a measure of sexual dysfunction with demonstrated acceptability, reliability and validity. It asked what sexual function meant to those who

have and have not experienced sexual difficulties, and then used these meanings to create a conceptual model and population prevalence measure of sexual dysfunction for use in UK community surveys. In answering the first question I undertook qualitative interviews which sought to understand how individuals define a satisfactory/acceptable sex life and how they perceive the severity and impact of problems that can affect their sex life and sexual relationships.

A number of theoretical assumptions underpinned my approach. For instance I assumed that sexual dysfunction could be reliably understood at the level of the individual and their reported relationship, and that because the sexual act is imbued with social and cultural meaning, an understanding of physiological processes could only ever provide part of the picture. In terms of my theoretical perspective, I adopted a pragmatic middle ground between essentialism and social constructionism. Known as critical realism or weak constructionism, this approach recognises that knowledge is always built on pre-existing ideas and values but that some accounts are more valid than others and can be judged on scientific merit. This position enabled me to posit that the concept of sexual dysfunction could be reliably 'captured' and measured objectively, whilst remaining alert to the ways in which social influences, such as the interaction between interviewer and interviewee, may have shaped the results. Reflecting on this interaction, I noted that I was seen by participants as a scientist and as having clinical expertise, yet despite this, respondent accounts tended to focus on the interpersonal rather than the clinical. For some, the experience of being interviewed was clearly cathartic and though there was some evidence of impression management, this influenced the edges of accounts rather than the central story.

Chapter 4

Study Methods

4.1 Introduction

In this chapter I outline the methods I used to answer the research questions outlined in chapter three. I describe three main methodological stages: development and preparation; fieldwork; and analysis. At each stage I outline the methods employed and consider any ethical or scientific issues arising from the use of that particular method.

4.2 Stage One: Preparation

This stage was primarily concerned with developing background knowledge of the topic and preparing for the qualitative fieldwork. The rationale, research questions and methodological approach were developed and refined during this stage. The development work comprised four activities: a literature review; observation of clinical consultations; design of data collection strategy and research tools; and application for ethical approval. Each activity is discussed in turn.

4.2.1 Activity one: Literature Review

The main literature review was conducted between November 2004 and March 2005. In undertaking this activity I sought to achieve the following:

1. To gain a broad understanding of biomedical and psychosocial approaches to classifying, measuring, diagnosing and treating sexual dysfunction;
2. To assess the current 'state of play' regarding the conceptualisation and measurement of sexual dysfunction and identify gaps in knowledge;

3. To inform the development of the research tools.

Based on these objectives, the literature review was structured into six broad themes.

These were:

1. **Foundations:** Overview studies; introductory medical texts
2. **Models and measurement:** Classification issues; conceptual models; measures; validation studies; measurement issues; reviews of measures
3. **Prevalence studies:** Community and clinic based samples; national studies and cross-cultural comparisons; reviews of prevalence studies
4. **Co-factors:** Aetiology; co-morbidity; impact of SD on individuals & partners
5. **Treatment:** pharmacological; other medical; therapy and counseling; treatment effectiveness studies
6. **Theoretical issues:** medicalisation of sexual function; feminist perspectives; sociological/cultural perspectives; social, historical and cultural construction of sexual dysfunction

The literature review began with a search of relevant databases (Pubmed; BIDS; Psychinfo, Medline and the Cochrane Database), using a wide range of search strings as well as MESH terms where applicable. The reference lists of papers retrieved during the database search were scanned for further relevant papers. The key search terms were as follows:

Sexual function terms: sexual function; sexual dysfunction; sexual satisfaction/dissatisfaction; sexual difficulties; human sexual response cycle; impotence; dyspareunia; vaginismus; sex disorder(s); psychosexual disorder(s); sexual function disturbances; anorgasm*; orgasm; premature ejaculation; vaginal dryness; psychosexual problem*; . erectile function; sexual desire; sexual interest; relationship; sexual distress

Related terms: classif*; measure*; model; prevalence; incidence; epidemiol*; psychometric; validity; reliability; specific measures (such as GRISS and FSFI);

aetiology; attribution; sexual schema; sexual script(s); discourse(s); homosexuality; intimacy; morbidity; quality of life; coping; depression; antidepressant; sexual adjustment; treatment; social construction*; symbolic interaction*; norms; historical; cross cultural; media; Viagra.

The collection and appraisal of relevant literature was not confined to the study development phase. Throughout the study period there was much serendipitous gathering of literature following discussions with peers, colleagues and my supervisors. In addition I undertook several small-scale searches whenever a gap in my knowledge became apparent or the research moved into new subject areas unforeseen at the outset. As an instance of the latter, my analysis of the ways in which respondents coped with their sexual difficulties (see chapter seven) required a detailed exploration of the psychological literature on coping. At the outset, the literature review focused on all six themes above with roughly equal emphasis. However, as the study progressively narrowed to focus on the research question, themes two, three and six took prominence. Under theme two a particular focus was on identifying other measures of sexual function. These are catalogued in chapter eight and appendix 15. Towards the end of the study period, a final 'sweep' of the major databases across all themes ensured that the most up to date research was included.

In addition to reading, I sought to expand my clinical knowledge base by attending the European Society for Sexual Medicine Annual Conference in December 2005.

4.2.2 Activity two: Clinical Observations

The second development activity, undertaken between March and May 2005, involved observing five clinical consultations at the Royal Free Sexual Problems clinic. The observations provided opportunity to listen to clinical patients describe and interpret their sexual function problems; to gain at first hand, an insight into the impact of these problems on patient lives; and to learn how such problems are diagnosed and managed in a therapeutic setting.

Like the trainee medical doctors attached to the clinic, I was allowed to sit in the back of the room during consultations with five first-time patients; three women and two men. The patients were asked by the doctor (and in my absence) whether they would be happy for a researcher attached to the clinic to sit in on the consultation. Where verbal consent was given, I was invited to join them. This was expressly not a data gathering exercise but a brief introduction to the ways in which sexual difficulties are presented in a clinical context.

4.2.3 Activity three: Development of Research Tools

I opted to use semi-structured interviews using a topic guide rather than a structured and detailed interview schedule. My aim was to have a “conversation with a purpose” (Mason, 1996; pg 45) with each interviewee and I felt that a topic guide with a small number of broad questions (with scope to probe or follow up on responses) would best facilitate this. I wanted to create space to enable respondents to tell their story. At the same time, I had a specific research question to answer and needed to identify themes and draw comparisons across respondents. Thus, the interviews had to cover roughly similar ground. Finding the right balance between structure and free-flowing conversation is an acknowledged challenge (Jones, 1985, reprinted in Seale, 2004; pg 258; Mason, 1996; pg 47).

The broad content of the guide was steered by the research question and objectives for the qualitative fieldwork (see chapter three). I was particularly interested in probing the boundary between pathology and normality; in finding out what people saw as sexual dysfunction, and what they viewed as problematic and non-problematic for themselves. For those who self-identified as having a sexual problem I wanted to understand the impact of that problem on their lives. Several specific areas were probed because the literature suggested they were of theoretical import. For instance, there is some debate as to whether women in particular, differentiate between desire and arousal (Graham et al., 2004; Janssen et al., 2008). I therefore added the question, ‘What do you understand by the terms sexual desire (wish for sex/sexual drive/libido) and sexual arousal (readiness

for sex)? Is arousal different from desire? In what way?', in order to ensure that my resulting model did not make any assumptions about a perceived distinction.

Respondents were first asked to describe what an ideal or good enough sex life would mean for them⁷. The ensuing discussion explored the origins of their views and looked at where they would place sex in relation to other priorities (such as work, social life, religion). Respondents were then asked to describe an unsatisfactory/unacceptable sex life and to think about why problems and concerns might arise. They were then probed for their experiences of such problems and the ensuing discussion focused on the impact of those problems on their relationships and lives in general.

The discussion was followed by a card game in which respondents were presented with 16 numbered cards each describing a different sexual difficulty, (for instance, 'Experiencing physical pain on intercourse' and 'Not feeling sexually satisfied'). Respondents were asked to place each card in one of four piles, according to their own view and/or experience. The four piles were called 'Just the way life is', 'A problem but not one that is big or worrying', 'A serious problem', and 'Don't know/depends' (see topic guide in appendix three). Respondents were encouraged to think aloud as they sorted the cards. After they had completed this exercise, we talked through their decisions, using probes such as, 'Would you seek professional help for any of these problems?' to guide the dialogue. This discussion occasionally led to one or more cards being transferred to a different pile. At the end of the game I recorded which cards had been put into which pile, noting any transfers. This ranking game served primarily as a discussion primer and was particularly useful in interviews where respondents had not encountered any difficulties themselves. It also served as a useful method of internal triangulation, enabling comparison of personal accounts with more abstract judgments about the severity of problems. Finally, I probed understanding and acceptability of key terms. Although I did not use the terms 'function' and 'dysfunction' during the interview, I did at the end, probe respondents for their comprehension of and reaction to those terms (see chapter three).

⁷ In chapter 3 I outlined the terms used during interviews

Question design was an iterative process, with input from advisory group members and in particular Kaye Wellings. With successive drafts, the question wording was tightened, details were added to probe questions and the overall structure improved. The fifth draft of the topic guide was approved by Camden and Islington Local Research Ethics Committee (LREC). As fieldwork progressed, the guide was modified slightly to address pertinent issues arising from previous interviews. This reflexive approach to interviewing is common to qualitative research (see for example, Charmaz, 2006). The final version is shown in appendix three.

4.2.4 Activity four: Application for Ethical and Management Approval

At the time I undertook my fieldwork (May to August 2005), the NHS required all studies using NHS patients to obtain ethical approval through the Central Office for Research Ethics Committees (COREC). Since our study comprised two research sites within a single domain (London Strategic Health Authority), we were permitted to apply directly to a Local Research Ethics Committee (LREC) within the domain. We opted to submit our application to Camden and Islington Community LREC because both our research sites were within the London boroughs of Camden and Islington. Following a meeting of the committee in January 2005 (which Kaye Wellings and I attended), we were awarded ethical approval provided that we slightly amend the patient information sheet to include information about the recording of interviews and storage of tapes. This amendment was duly made and the resubmitted information sheet approved.

We were also required to secure ethical approval from the LSHTM ethics committee. The application form was submitted at the end of January 2005 and approved by the committee in March. In granting approval, the committee made several helpful comments. Firstly, it was suggested that interviewing respondents in their own homes might present a risk to my safety. We agreed with this comment, and omitted 'respondent

home' from the choice of interview venue in the informed consent sheet⁸. Concern was also raised about our proposed reimbursement of travel costs at a flat rate of £8 per participant. It was pointed out that some participants would spend significantly less than that to reach the interview venue. We sought advice from the doctors whose patients we would be interviewing. Professor Nazareth advised us that it was not practice policy to reimburse patients participating in research, while Professor King advised us that patients taking part in interviews would be attending clinic for an appointment anyway. We therefore dropped plans for travel reimbursement at both sites. Finally, the chair of the LSHTM ethics committee pointed to the importance of maintaining confidentiality when presenting data with small numbers of interviewees. We assured him that we would take care to preserve anonymity by removing all identifying information from quotes.

Having secured ethical approval, we were then required to obtain management approval from the relevant NHS organisations, in this instance Camden and Islington Primary Care Trust and Camden and Islington Mental Health and Social Care Trust. We submitted our application through the Research and Development (R&D) Unit at St. Pancras Hospital. This was a lengthy process involving collation and submission of the following documents: project registration form; evidence of funding and external peer reviews for the project; CVs, references and occupational health forms for myself and Kaye Wellings (to obtain honorary contracts so that we could conduct the research); copies of the patient information sheet, informed consent form and topic guide; amended and signed version of the trust IP policy. In addition, we were required to secure local support from both the NHS trusts in which the research would be conducted. The study was duly approved by Kathy Hoffman (GP Medical Director, Camden and Islington PCT) and Colin Plant (Service Director, Camden and Islington Mental Health Trust). This was a drawn-out, time consuming and frustrating process, not helped by the fact that staff at the R&D unit were difficult to reach and often did not give consistent guidance on procedure and regulations.

⁸ Despite not explicitly offering this choice, three older women requested that the interview be held at their home. All were restricted in their movements by illness, disability or age. I judged that conducting interviews at their home would pose no risk to my safety and agreed to their requests.

The work involved in securing both ethical and governance approval was significant. I was dismayed by the sheer bureaucracy and duplication involved. In my particular case, there were several instances in which work was repeated unnecessarily. For instance, the Camden and Islington LREC could have opted to simply accept the already stated judgment of the MRC/ESRC regarding the scientific merit of my study, rather than requiring me to justify this again at length. Secondly, the LSHTM committee could have opted to quickly review my approved (and far weightier) COREC submission, rather than requiring me to complete a new set of LSHTM forms. Of course, I am firmly committed to protecting my research subjects and ensuring the highest ethical standards in my work. To this end, I was grateful for the comments I received during the ethical review process; they undoubtedly strengthened my proposal. The individuals I dealt with during the application process were also mostly friendly and efficient. However, from my perspective as a researcher, much of the process had less to do with ethical research than with institutional 'back watching'. In an ideal world I would liked to have undertaken true theoretical sampling (Charmaz, 2006; pg 96) and interviewed further respondents to verify my findings (in particular the typology described in chapter five) but the inflexibility of the ethical approval system proved to be an insurmountable barrier for a student with a limited fieldwork budget and time constraints. I felt troubled that what was essentially a bureaucratic process, held back good science.

4.3 Stage two: Fieldwork

The fieldwork phase comprised thirty two semi-structured interviews conducted with a purposive sample of men and women attending a GP surgery, an NHS Sexual Problems clinic (both in North London), and the Terrence Higgins Trust in Brighton. Here I describe the sampling strategy and recruitment method in detail.

4.3.1 Sampling Strategy

The sample comprised three groups of respondents:

Group 1: those who self-identified as having a problem related to sexual function;

Group 2: those with conditions associated with sexual function difficulties (specifically diabetes, depression or HIV);

Group 3: those who fitted into neither of the above groups but who, at the time of interview, were currently, or had been, sexually active (non-clinical group).

Broadly, these groupings were designed to capture a wide spectrum of experience in terms of sexual function. This is sometimes referred to as purposive sampling; “selecting groups or categories to study on the basis of their relevance to your research questions [...] and most importantly the explanation or account which you are developing” (Mason, 1996; pg 94). It was not a theoretical sample in the Grounded Theory sense (i.e. chosen to confirm, disconfirm or further explore a developing theory (see Charmaz, 2006, p102/103; Glaser & Strauss, 1967)). I was keen to ensure a wide age range, roughly equal numbers of men and women, to include representation from non-heterosexuals and ethnic minorities, to ensure that my sample was reasonably representative of a broader population in terms of demographic variables (see Mays & Pope, 2000). A provisional quota-sampling frame (based on 39 interviews) was created at the outset (see appendix four) and was followed as far as was practical given the logistics of recruitment. Although intended only as a proximate guide, the actual sample was broadly consistent with the original frame on most variables, except that it was older, more ethnically diverse and comprised more single people.

Following consultation with the advisory committee, I decided to exclude those under 18 from participation. Although above the legal age of sexual consent (currently 16 in UK law), people under 18 have had relatively little time to gain and assimilate views on their sexual experience. Their likely ‘added value’ to the research aims seemed unlikely to justify the extra difficulty often associated with their recruitment. I also decided to exclude anyone unable to understand and provide informed consent in English. This was because I lacked the resources to provide interpretation support to such individuals.

A provisional target of 39 interviews was set, with the intention that fieldwork would actually stop when no new issues or observations were being introduced by participants

(an approach known as sampling to redundancy or saturation (Glaser & Strauss, 1967; Charmaz, 1996)). After thirty-two interviews I felt I had arrived at saturation point in some areas of the topic guide but not others. However, because of the bureaucratic delay in beginning fieldwork (see above), we reached a fixed deadline (the imminent birth of my baby!) sooner than we had originally envisaged. Thus the decision to stop at thirty-two interviews was based on a mixture of scientific and pragmatic considerations.

4.3.2 Recruitment Methods

Potential participants were recruited from two main venues: a GP practice and a Sexual Problems clinic in North London. Access to patients attending these clinics was granted by Professor Irwin Nazareth and Professor Michael King respectively, both of whom were members of the advisory committee for this study. A third recruitment site, the Terrence Higgins Trust in Brighton, yielded a further three respondents, recruited through Chris Percy, a support worker at the Trust. A summary of the recruitment strategy is provided in table 4.1.

I originally attempted to recruit group one respondents (Sexual Problems clinic patients) by letter. In agreement with Michael King, the focus was on new patients on the basis that their accounts would be less 'contaminated' by a biomedical model implicitly transmitted during therapy sessions. During a specified period, the clinic administrator included a recruitment pack (letter of introduction, patient information sheet and consent form – see appendices five to seven) with clinic appointment letters sent to all new patients. The letter asked patients whether they would like to attend a research interview either immediately before or after their first appointment. When patients rang to confirm their appointment (as per clinic procedures), the administrator enquired whether they would also like to attend the research interview. There was typically a lag of several weeks between letters being sent out and the actual appointment. In addition, only a handful of new patients attended the clinic during any given week. According to doctors at the clinic, new patients were often nervous about their first appointment and it is

possible that an additional research interview was too much to consider at this time. Coupled with the aforementioned delays in securing ethical and governance approval from the relevant NHS bodies, this meant that with only eight weeks before I was due to go on maternity leave, no one had come forward for interview. After discussion with doctors at the clinic, it was decided to open the recruitment to repeat patients, as well as new ones and to live with the risk of 'contamination'. I recruited repeat patients through the clinic doctors, who handed patients an adapted version of the respondent information sheet at the end of their appointment. During one clinic session per week, I sat in the waiting room and the doctors introduced interested patients to me so that I could further explain the study and set up an interview. On one occasion an individual was able and willing to participate in an interview immediately. All the other interviews were conducted at an agreed later date. In the end, I recruited six patients during three recruitment sessions, all repeat attendees.

Group two respondents were recruited by letter from the GP surgery. Given the sensitive nature of the research, the fact that respondents were required to attend an interview of reasonable length, and the fact that these patients all had serious health conditions; I anticipated that the response rate would be significantly lower than the 20% achieved by previous research conducted at the surgery. This was not only due to the sensitive nature of the topic, but also the fact that the target population was selected because they were in poorer health (having either diabetes or depression) and the fact that involvement in the research was more onerous than filling in a brief questionnaire. We therefore sent out a total of 220 letters to ensure sufficient numbers of respondents. The practice research coordinator, using my sampling quotas for age and sex, drew up a random master list of around 250 patients from the practice diabetes and depression registers. The names on the list were checked for suitability by the practice doctors, to ensure that we would not be 'pestering' anyone who was seriously ill (or deceased). Recruitment packs, containing a letter of introduction from the surgery, a patient information sheet and a consent form, were posted to the remaining 220. Respondents with queries or who were interested in taking part were requested to ring me using a free-phone number. Thirteen individuals contacted me expressing an interest in taking part and all of them were

interviewed. As anticipated, our response rate was low. To an extent, this also reflected our decision to throw a single wide net (a single large mail shot), rather than a smaller mail shot with reminder letters, as is usually recommended (Dillman, 1978). This approach was adopted to save time, to reduce the burden on practice staff, and to avoid potentially 'pestering' un-well people with several reminders.

Group three respondents were approached by me in the waiting room of the same GP surgery as they were waiting for an appointment. I briefly introduced the study and asked whether they might be interested in participating. Anyone waiting alone who appeared to be over the age of 18 was approached. Men were more likely to agree to take the recruitment pack than women, but there were generally far more women than men in the waiting room (17 men approached versus 44 women). Parents with babies and non-speaking toddlers were approached although they were generally unavailable to participate due to childcare responsibilities. Parents with older children who might overhear the conversation and people attending as couples were not approached. I stopped approaching older people (appearing over 70) after several attempts when it became clear that the risk of causing offence outweighed the chance of recruiting someone willing and able to talk about their sexual life. Overall, the two most common reasons cited for not taking a recruitment pack were lack of interest and lack of time.

Although the waiting room was often quiet, it was generally possible to maintain a private conversation by keeping voices low. Those showing an interest were given a recruitment pack comprising a letter of introduction from the surgery, a patient information sheet, a consent form (shown in appendices five to seven) and a stamped addressed envelope. They were advised to take the information with them and consider whether to participate. They were given the option of ringing the free-phone number to arrange an appointment or completing the contact information section on the consent form and posting it back. Several respondents wanted to make an appointment there and then. A total of 61 people were approached, of whom 38 (62%) took a recruitment pack. Fifteen agreed to be interviewed (25% of those taking pack) and 10 interviews were actually held.

Due to administrative delays, both in securing ethical and governance approval and in logistical preparation at the clinic, recruitment at both these sites began later than anticipated. My timeframe for data collection was reasonably tight and so while waiting for recruitment at these venues to build momentum, I looked elsewhere for respondents. As a result, three additional respondents for group two were recruited via a sexual health advisor at the Terrence Higgins Trust (THT) in Brighton. The study was advertised on a notice board and interested individuals were given adapted versions of the recruitment materials by the THT advisor, Chris Percy. Table 4.1 summarises the recruitment strategy.

	Respondent Group	Method of recruitment
1	Self-identified as having sexual function problems (clinical)	<ul style="list-style-type: none"> Over three recruitment sessions at a London Sexual Problems clinic, the study was explained to repeat patients by Dr. at the end of their appointment. Those interested [n=6] were introduced to me in the waiting room and interviews were subsequently held with all 6.
2	Those with conditions associated with sexual function problems (associated clinical)	<ul style="list-style-type: none"> 220 letters sent to patients drawn randomly from diabetes and depression lists of a London GP practice. Interested individuals were requested to ring me (free-phone) to arrange an interview. 13 individuals responded and were interviewed HIV positive volunteers recruited via a staff member at an HIV charity [n=3]
3	Sexually active but not fitting into either of the above (non-clinical)	<ul style="list-style-type: none"> Over the course of 6 recruitment sessions (1 to 4 hrs duration), 61 patients were approached by me in the GP waiting room whilst waiting for their appointment. 38 individuals took a recruitment pack, 15 agreed to be interviewed and 10 interviews were held.

Table 4.1 Summary of recruitment strategy

Interviews lasted between 45 minutes and two hours. Thirty interviews were undertaken by myself and two by Kaye Wellings. Most interviews were held in a private room at the GP clinic or the Sexual Problems clinic. Additional venues were as follows: LSHTM (3 interviews); Terrence Higgins Trust in Brighton (3 interviews); respondent homes (3 female respondents with impaired mobility); one at a place of work, and finally one by telephone.

4.3.3 Ethical Considerations during Fieldwork

There are four main ethical considerations in research - informed consent; confidentiality; subject rights and welfare, and subject risk-potential ratio – although it has been argued that the ethical codes arising from these considerations are less applicable to qualitative research than biomedical research (Murphy, Dingwall & Greatbatch, 1998). For instance, qualitative research poses insignificant physical risk to participants compared with experimental biomedical research (Ibid, 1998). This debate notwithstanding, the principles of informed consent and subject rights and welfare were both important at this stage. Informed consent implies that participants understand what their participation involves and agree to participate of their own free will. This was ensured in the following ways:

- No one was ever pressed to take part in the study and those who agreed to take part were reassured that they could change their mind or terminate the interview at any point, even after the consent form had been signed.
- Apart from a few respondents who were keen to arrange an interview at the point of recruitment, all respondents had several days or more to think about their decision.
- Respondents were encouraged to use the free-phone number if they had any queries, although in the event, it was never actually used for this purpose.
- All those participating signed a written consent form either prior to, or at the start of, each interview.

- Both the consent form and introductory chat emphasised that the interview was strictly confidential and that the results of the study would be presented in an anonymous form.

As far as the rights and welfare of participants was concerned, the main ethical issue arose from the fact that the research involved a sensitive topic. There was a possibility that research participants would feel embarrassed or distressed talking about personal and private issues. I reasoned that those who were easily distressed talking about their sexual life would be unlikely to come forward for interview. I therefore anticipated that some degree of embarrassment would be likely, but that distress would be unlikely, and if felt, fairly mild in nature. On the other hand, I knew from previous research that many people welcome the opportunity to discuss personal and sexual matters with an empathic professional. Nonetheless, I prepared a list of contact details for relevant agencies such as Relate, Rape Crisis and the UK Council for Psychotherapists and handed it to respondents who made potentially distressing disclosures. In addition, the de-brief at the conclusion of each interview provided an opportunity for participants to reflect on the experience of being interviewed and enabled myself and Kaye Wellings to address any concerns that arose.

In line with ethical practice for non-therapeutic interventions, respondents were asked if they would like us to inform their GP of their participation. This was not mandatory, nor was declining deemed to be a reason for exclusion. It was felt that some individuals might be deterred from participating if their GP had to be informed, on the basis that their confidentiality would be compromised. In addition, participation in the study did not pose any health risk, nor did it interfere with treatment regimes or ongoing GP relationships. There did not, therefore, appear to be any risk attached to a GP not being informed. In the end, 11 respondents requested that I inform their GP of their participation.

As mentioned above, travel reimbursement was deemed inappropriate. Instead, respondents were given small (£5) shop tokens (Boots, WH Smith, Argos) and were provided with refreshments during the interview.

All participants were given the option of receiving a summary of the results. Twenty-eight requested and were duly sent, a four page summary at the end of the descriptive analysis phase (see appendix eight).

4.3.4 Fieldwork Caveats

Qualitative methods seek to provide “thick description” rather than generate law-like statements (Seale, 1999; pg 106/107). That is, they aim for validity rather than generalisability. However, where explanations generated by qualitative analysis are credible and persuasive, they can be used to develop general theoretical principles (see Mitchell, 1983). In using the theories and typologies I have generated to think about structural patterns in a broader population, three important caveats to my sampling strategy should be borne in mind. Firstly, I used purposive sampling to capture a wide range of sexual function experience. Secondly, for reasons explained above, the response rates were not high. Thirdly, the GP practice from which most participants were recruited was situated in a fairly well to do area. The implication of these caveats was that my sample was weighted towards older people, articulate people and individuals with a ‘story’ to tell and time to do so. In my view, the fact that many participants came to tell me their ‘story’ was a particular strength of the study; participant accounts were often reflective, insightful and characterised by self-awareness, giving rise to rich data.

In common with almost all fieldwork, my eventual design was not perfect but a compromise taking into account a range of constraints. For instance there were limits on what could be expected from participants in terms of their time; there were feasibility and ethical issues involved in seeking interviews with partners, including the risk of opening up sensitive and unresolved relationship issues; there were the usual time and resource constraints as well as limits imposed by the cumbersome process of ethical and

governance approval. To me, the perfect design, undertaken in a research utopia, would have involved repeat interviews with the same participants, as well as interviews with partners alone and with respondents and partners together. This design would also have permitted a return to fieldwork following initial analysis in order to explore emerging theories. Instead, my real-world compromise meant that I was only able to study accounts at one point in time, such that my understanding of how accounts change over time is derived from respondent perceptions of previous eras which are likely to have been 'moulded' to fit an emerging personal story. With my amended design I was obliged to accept the respondent account as a 'true' assessment of the couple dynamic and had no opportunity to triangulate respondent accounts with those of their partner. Finally, my compromised design meant that I was unable to go back and gather more data to test and solidify my emerging theories.

4.4 Stage Three: Data Analysis

Although described here as a discrete step following on from fieldwork, the process of analysis actually began simultaneously with the conduct of interviews. This early analysis consisted of observations and loosely structured memos jotted down immediately following interviews. In this section I describe the various techniques employed to build on these early notes in describing and analyzing the data.

In the end, I analysed my data twice! This obviously involved a lot of extra work (though in fact, not much duplication). On the other hand, testing out two different approaches to analysis on the same piece of data was an invaluable learning experience. Opportunity to experiment in this way is one of the many privileges associated with doing a PhD. Below I tell the story of this learning experience.

I have used the computer package NUD*IST to analyse data in the past and found it reasonably helpful as an 'electronic filing cabinet' for ordering data, particularly for applied and policy-focused projects. On this occasion I opted for low-technology paper and pencil plus an excel file for charting data (see below). I was mindful of the risk that

that computers can “alienate the researcher from the data” (Kelle, reprinted in Seale, 2004; pg 312) and their tendency to facilitate thin research with hastily drawn conclusions (see Murphy, Dingwall & Greatbatch 1998 for a good summary of the arguments). At the end of the day though, this choice was a matter of personal preference.

4.4.1 Preparation of Data

One interview was not tape-recorded (at the request of the respondent) but the rest (31) were tape-recorded and transcribed verbatim by an audio-typist (30) and by me (1). Both the audio-typist and I sought to accurately record the actual talk, omitting subtle nuances, such as rising and falling intonation, but noting significant pauses (more than two seconds), stuttering or stumbling between utterances and interruptions. I then listened to each interview and simultaneously read the corresponding transcript. Although laborious, this process fulfilled three important aims: familiarisation with the data set; tidying up of transcripts with respect to typing errors; and identification of missing or unclear speech. In general the quality of the recording and transcribing was good and there were few unclear speeches. As the fieldwork stage came to a close, I had 31 printed transcripts and one summarised interview, plus several ‘memos’ documenting my own observations and thoughts.

4.4.2 Analysis using the Framework Approach

I began by analysing the data using ‘Framework’ (Ritchie & Lewis, 2003), an approach to data analysis that had served me well during previous qualitative work. Framework offers a thematic approach to analysis, and involves five main steps: becoming familiar with the data; building a coding frame; indexing; charting; and mapping and interpretation. Each step is discussed in turn below:

Data familiarisation enables the analyst to obtain a handle on recurring themes relevant to the purpose of the study, and to appreciate the diversity (range and depth) of the data set (Ritchie and Lewis, 2003; pg 221). In this study, familiarisation was achieved through

the preliminary tasks described above: interviewing, listening to tapes, and reviewing and re-reading the transcripts. Of course familiarisation was an ongoing process, continuing right to the end of the study by which time I felt that I knew the each respondent like an old friend and could recite quotes in my sleep! However, I moved on to the second step – building a coding frame – once I felt that I had a good handle on the main themes arising from the data.

According to the Framework approach, the coding frame is developed by identifying the recurring themes, and sorting and grouping them under a smaller number of ‘higher order’ categories; in other words, by identifying all the categories of interest and working out how they are related to each other. Having developed this hierarchical framework, Ritchie and Lewis suggest moving swiftly to indexing (or tagging) the data using this coding frame, making refinements to the frame following preliminary application. This approach works well where the study is focused on an applied research question and the themes are immediately apparent. They state that the purpose of indexing is as “a first step in sorting the data for later retrieval” (Ritchie & Lewis, 2003, p225).

Aware that coding frames are seldom “analytically neutral” (Mason, 1996; pg 108), I wanted to avoid creating a coding frame that effectively established dimensions of functional sex at the outset, thereby forcing the analysis down a prescribed route. For instance, at this early stage it was not easy to categorise experiences as problematic and non-problematic; I felt these categories should emerge from later interpretative work, not from the initial sorting and organising of data. I also wanted to avoid making a priori assumptions about the ways in which categories may have been related to each other. For example, creating a code such as ‘satisfaction’ and positioning a sub-code such as ‘orgasm’ beneath it, would effectively impose my own assumptions about how orgasm relates to satisfactory sex. Given the complexity of the phenomenon under study I was also concerned about breaking the data into chunks which, taken in isolation, would no longer be meaningful (see Mason, 1996; pg 119). I therefore opted for a flat coding structure using very broad and accepted components of sex as codes, rather than a complex frame comprising layers of sub-categories.

I broadly followed Mason's guidance (1996) in devising a coding frame. I began by reviewing the topic guide and study aims and reading through several interviews. I created a draft coding frame and applied it provisionally to three interviews. Based on this trial I made some amendments, sought feedback from Kaye Wellings, and continued testing on a further two interviews, making minor amendments to the frame. Once the coding frame was finalised, I returned to the beginning, coding all the interviews using the final frame. The end result was an excel 'map' of the data summarising respondent accounts on broad themes, such as interest, orgasm, masturbation, pain, relationship, frequency, help seeking, gender differences and psychological history. The coding frame is shown in appendix nine.

Kaye Wellings and I identified five dimensions cutting across the themes and agreed that in the framework chart each theme should be sub-divided by these sub-categories as described below:

Perceptions: Beliefs about importance of an issue, norms, acceptability; preferences; opinions about what is good or problematic and why.

Definitions: Understanding of terms, activities, issues; what is included in a term; signs (e.g. of arousal); use of terms

Experience: Descriptions of actual experiences (own or others), whether positive or negative.

Determinants: Perceived factors underlying experiences; may be causal or influencing factors

Effects: Assessment of severity of difficulties; impact on self, sex, relationship and other areas of life; ways of coping with difficulties

Ritchie and Lewis then suggest using the main themes to order the material, allowing the analyst to "focus on each subject in turn so that the detail and distinctions that lie within can be unpacked" (Ritchie & Lewis, 2003; pg 229). The data are then placed onto a series of thematic charts or matrixes. The trick of charting is to reduce the data to

manageable and ordered 'chunks' without losing the context and language of the original interview (i.e. to establish a balance between 'over-condensed' and 'undigested' data). I opted to produce one large chart rather than a series of themed charts. Because of the complexity and circularity of the relationships between my categories (of which I was fully aware prior to coding) I decided it would be easier to move backwards and forwards within one chart rather than moving across different charts. I set up my chart on one excel spreadsheet and though it was un-printable (it would have covered my entire office wall), it was surprisingly easy to move around within it and locate relevant data on screen (the 'freeze panes' option being invaluable). In essence I created a large map of the data which adequately fulfilled my aims: to systematically view the data; to locate and retrieve data; to facilitate interpretative analysis; and to provide 'handles' on the data enabling me to develop the conceptual model. Excerpts from the chart are shown in appendix 10. Ritchie and Lewis advocate the use of a 'central chart' to record classifications and typologies emerging from the analysis. I adapted this idea by using different charts (excel sheets) to work on my classifications and summaries (using 'cut and paste' to transfer the original chunks and adding analytic memos or typologies in subsequent columns).

Alongside the mapping of data I created a set of questions that I wanted to ask of the data and 'puzzles' that I wanted to solve (Mason, 1996). These questions are summarised in appendix 11. I then set about exploring the data, using my analysis questions (or puzzles) to impose order on my investigation. Ritchie and Lewis (2003; pg 237) identify three steps in descriptive analysis:

- **Detection:** Identifying the range, or 'substantive content and dimensions of a phenomenon'.
- **Categorisation:** Identifying categories which can 'incorporate and discriminate between the different manifestations of the data'
- **Classification:** Assigning labels to groups of categories.

During this analysis phase I wrote memos which subsequently became two preliminary documents providing comprehensive but mostly descriptive accounts of the data; one explored components of function and the other looked at difficulties. Looking back on those documents later it was clear that although I had a good sense of the breadth of my data, I had nothing more than a common-sense thematic summary of my interviews. It was clear that my framework chart provided an excellent tool for navigating my way around the data. But at the same time, the analysis was being constrained by this framework. The problem was that, in trying to avoid a coding frame that was too analytical at an early stage, I had ended up with broad themes that followed widely accepted key aspects of function. I realised that to some extent I had simply “[labelled] data extracts as examples of themes [I] was interested in”, and thereby fallen into a trap common to much qualitative research (Green, 1998; pg 1064). It was clear that moving to a more interpretative level of analysis would require a more analytical approach to coding. It was at this point that I turned to Grounded Theory.

4.4.3 Analysis using Grounded Theory

Grounded theory (Glaser and Strauss 1967; Strauss 1987) seeks to provide theoretically dense accounts ‘grounded’ in empirical data (Green & Thorogood, 2004). The analyst moves backwards and forwards from data to theory (induction and deduction), using ‘constant comparison’ to test out emerging theories and hunt for confirmatory or deviant codes and cases (verification). The inductive-deductive approach explicitly recognises the validity of using ‘experiential data’ (technical knowledge plus the experience of the analyst) to guide the work, suggesting avenues for further exploring the data (Strauss, 1987; pg 11). Grounded Theory is perhaps one of the most “abused” phrases in qualitative research literature (Green & Thorogood, 2004, pg 183); many qualitative research articles blandly state that the data were analysed using Grounded Theory without explaining exactly what this meant practically (Green, 1998). In fact, the forefathers of Grounded Theory, Glaser and Strauss (1967), did not intend their approach as a set of rules to be rigidly followed; rather they developed a set of ‘rules of thumb’ to guide the researcher in making sense of dauntingly large datasets. Later Grounded

Theorists have continued to use the approach as “a set of principles and practices, not as prescriptions or packages” (Charmaz, 2006; pg 9).

Although I already knew the data well by this stage, I needed a fresh perspective. Thus I found it useful to engage in what is known as ‘open coding’. This intense ‘line-by-line’ analysis aims to fracture the data into a plethora of potential avenues for further investigation. I spent time asking questions of minute pieces of data in order to generate as many new concepts and codes as possible; some were integrated into emerging theory while others were discarded. Examples of codes that were discarded were ‘humour’ and ‘peer influence’. I initially included some in-vivo codes (for example, *being close*), however, the final labels used in the typologies presented in chapters five, six and seven generally represent my own interpretation of respondent terms and phrases (with the exception of *happy body feeling*, an in-vivo code so apt that it could not be bettered). Open-coding generated many codes representing respondent-identified aspects of functional sex (such as ‘feeling wanted’); codes relating to dysfunctional sex (such as ‘pain’); and codes relating to responses to sexual difficulties (such as ‘downgrading sex as a priority’). Having learned from my experience with Framework, I focused on conceptual rather than descriptive codes. Developing codes involved exploring their properties or key characteristics, for instance the code ‘changing goals to fit circumstances’ concerned attitudes and actions that resulted in a person shifting their view of ‘ideal’ sex as a direct result of experiencing a difficulty. I then explored the dimensions of the codes in detail. For instance, I identified three dimensions attached to the above code: ‘engage flexible stance towards the importance of sex’; ‘lower expectations’; and ‘engage flexible definition of sex’.

This process of identifying dimensions is often referred to as axial coding (Charmaz, 2006; pg 60). For each of these dimensions I thought about the conditions under which these strategies were employed (easier to do when single or with a partner?), the interactions between actors associated with each strategy (was the partner implicitly or explicitly involved in the strategy?); tactics associated (how did individuals actually manage to lower their expectations?) and consequences (what was the impact of the

strategy on the sexual relationship?) This battery of questions asked of each dimension (or category) is referred to by Strauss (1987) as the coding paradigm. Thus axial coding results in a set of categories with a corresponding 'coding paradigm' which describes the conditions, interactions among actors, strategies and tactics, and consequences associated with each category (Strauss, 1987; pg 27).

Open and axial coding typically generates a dense framework of inter-linked categories. During this process one or more 'core' categories are chosen which become pivotal in theory generation. Strauss (1987; pg 36) provides clear guidelines for the choice of core category; for instance, it must appear regularly in the data and be related to easily to other categories. In my data, two main categories emerged. The first 'orientations to sex' concerned the different ways in which respondents construed ideal or functional sex and encompassed all the various components of sex cited by respondents (see chapter five). The second, 'responses' concerned the ways in which individuals responded to a gap between their ideal and their lived reality and encompassed the factors that made their chosen coping strategy more or less likely to succeed (see chapter seven). Once these core categories had emerged, I used 'selective coding' to systematically search for these core categories plus codes that were related in significant ways. The analysis became increasingly focused and systematic. Further development and refinement of my coding structure was informed by the literature on sexual function and sex therapy (what Strauss terms 'experiential data'; Strauss, 1987; pg 11). A focus of the analysis was on several 'deviant' cases (whether whole accounts or extracts) that did not appear to fit with the emerging typology⁹. Often it was possible to intellectually resolve these 'deviant' cases and in this way, close analysis of these negative cases assisted in further refining the conceptual categories. Searching for negative cases is said to enhance the validity of qualitative research by providing additional support for conclusions or by indicating a need for refinement of emerging theories (Mays & Pope, 2000). Green (1998; pg 1065) refers to the search for negative cases as "the key to developing rigorous and valid theory". Whenever I felt 'stuck', or that aspects of the analysis required further detail, I returned to open coding

⁹ These are discussed in chapter five

Debate exists about the relevance of positivist criteria to judging quality in qualitative research, and whether there can be an alternative and universally accepted set of criteria specifically for qualitative research (Seale, 1999; Mays & Pope, 2000). There has recently been a proliferation of criteria sets and guidelines and although there is not one universally agreed set, many of them share similar principles. In assessing the quality of my results I adopted some of the criteria/questions suggested by Riessman (1993). Firstly, were my results convincing? Riessman argues that accounts are most persuasive when they are supported by evidence from data, consider alternative interpretations and are well written. As already described, an important component of my theory development was the focus on deviant or negative cases. I also sought to maximise validity by remaining close to actual accounts through the frequent use of verbatim quotes and by providing the reader with adequate contextual information about those quotes. Secondly, are these results relevant or of pragmatic use? For instance, how will sex therapists view my analysis of the ways in which individuals cope with sexual difficulties? And will public health researchers feel that my conceptual model contains the essential elements for measuring sexual difficulties at a population level? Establishing congruence and/or synergies with existing literature can also provide reassurance about the validity of findings. In my case I was reassured to discover that the existing literature often provided support for my results. I was also able to perform some specific reliability and validity checks. The first was a reliability check on my 'versions of functional sex' typology. Once the typology had been established, I sought to identify the dominant version of functional sex in each interview. Kaye Wellings then read a sample of three transcripts and independently identified the same dominant version for each. A second validity check involved seeking the opinion of clinical colleagues on the coherence and plausibility of the findings. Irwin Nazareth and Michael King (members of the advisory committee), both have significant clinical experience of treating patients with sexual function difficulties. They used their clinical perspective to comment on the written results, judging whether my interpretation was relevant to their clinical experience. Finally, I hope that this explicit and detailed account of my methodological approach will convince the reader to 'trust' my results (Riessman, 1993).

There were several validation strategies that I did not pursue. I did not triangulate my data, for instance using different respondents or an alternative methodology. This approach has been criticised on the basis that different methods are not strictly comparable, providing instead parallel datasets. Thus, while similar findings may be reassuring, the absence of similar findings does not necessarily imply refutation (LSHTM Qualitative research methods lecture notes, 2007). Mays & Pope (2000) suggest that triangulation is more usefully seen as a way of ensuring comprehensiveness rather than as a test of validity (Mays & Pope, 2000). I also did not engage in meaningful member validation. Reissman calls this correspondence; taking the analysed results back to those who have been studied. There are ethical reasons to do this (checking for instance that quotes do not identify individuals) and the responses of interviewees can be instructive leading to further refinements in theory. In my case I sent summaries to my respondents as a matter of professional courtesy. However, it is questionable whether this works well as a test of validity because the researcher has developed a perspective across a number of interviews whereas each individual respondent has only their own perspective. And if the respondent disagrees with the analysis, this does not necessarily imply that the analysis is wrong. It may be better to consider correspondence as a further process of error reduction (Mays & Pope, 2000). As Reissman states, "In the final analysis, the work is ours. We have to take responsibility for its truths." (Reissman, 1993; pg 67). Finally, some advocate making simple counts of key themes as a reliability check. Personally I am not in favour of this because it gives the reader a false security in numbers (which can generally never be shown to be statistically significant) and encourages the reader to think quantitatively about the data, with the risk that the data will be judged using inappropriate (i.e. quantitative) criteria. In addition, where interviews are semi-structured, a particular theme may be discussed in detail in some interviews and not touched upon at all in others; a simple count will be seriously affected by this.

As already indicated, the analysis described here did not set out as an explicitly Grounded Theory Study and did not adhere strictly to Grounded Theory doctrine, but

adopted the principles and approaches that fitted with my study aims, were feasible given practical constraints, and suited my instinctive approach to analysis. With regard to the latter, my own approach differed from that expounded in Grounded Theory text books in several ways. For instance, I did not write copious notes in the margins of transcripts (as is usual with open coding) but typed notes (or memos as they are often termed) directly into a word document. And asking questions of categories was not for me an explicit or formal task; it was my instinctive approach to reading transcripts and writing memos. I also drew many diagrams, on scraps of paper and in my notebook, and much of my understanding of how categories were related developed through sketches, mind maps and diagrams. Some academics view qualitative analysis as an “artistic endeavour” rather than method (Eisner 1981, cited by Kelle, and reprinted in Seale, 2004; pg 313). I prefer to view it as a craft, requiring a specific set of tools and guidelines but reliant also on the skill, experience and natural flair of the analyst. In other words, a good analyst does not just apply rules, but uses skills/abilities such as perception (of people and their motives and actions), interpretation, acuity, as well as an instinctive feel for exploring and understanding data. I believe it is because these skills are so important, that qualitative researchers have struggled to define their method in ways that can be straightforwardly replicated.

4.4.4 Refining the Analysis: Presentations and Peer Review

At the end of the descriptive (framework) analysis phase, I presented my findings to an ‘expert panel’ comprising advisory committee members as well as leading experts in the field such as John Bancroft and Cindy Graham. Professions represented at the meeting were: Academic research (social science, epidemiology and medical statistics); General Practice; Psychiatry; Clinical Psychology and Public Health medicine. In general the panel was supportive of my preliminary results, deeming them largely congruent with their own research and clinical practice. Later, I presented my results to a group of professionals in Brighton hosted by Terrence Higgins Trust, and to a GP practice group (five doctors and a practice nurse) in Bonny Bridge, Central Scotland. Both these

presentations were well received, and the latter was particularly useful in highlighting the aspects of my findings most relevant to a general practice setting.

I also presented my research at two academic conferences. In September 2006, I gave a '7 minute Paper' entitled 'Medicalising Female Sexual Experience: The case of the Female Orgasm' to the Second European Conference on Female Sexual Dysfunction in London (see appendix 12). In April 2007, I presented a paper entitled, 'Taking it personally: Understanding the variation in responses to sexual difficulties' to the World Association for Sexual Health 18th Congress in Sydney (see appendix 13). Following my presentation I had useful discussions with a range of delegates including the psychologist and sex therapist Sandra Pertot who shared my interest in the concept of 'good enough' sex.

Towards the end of the study period I presented a summary of my findings plus a draft conceptual model of sexual function at a lunch time seminar at LHSTM. During the discussion, a number of pertinent questions helped me to further develop the model. Preparing a brief yet informative presentation requires intellectual discipline and clarity and is therefore a useful process to undergo in refining analysis. The discussions I had during conferences and after presentations, both planned and serendipitous, were instrumental in crystallising ideas and temporarily reducing the loneliness that is the lot of the qualitative researcher and PhD student. A further process of refinement in analysis was via the writing up of papers (see appendices one, two and 14).

4.4.5 Ethical Concerns of the Analysis Stage

During the analysis stage, the primary ethical concern was the protection of respondent confidentiality and the anonymisation of the results. These concerns were of particular importance because the interviews contained personal information. Ensuring anonymity and confidentiality is particularly challenging in qualitative research where numbers are often small and the information given by participants is more detailed (Murphy, Dingwall & Greatbatch, 1998)

All names of individuals and places mentioned during interviews were removed from the transcripts. Transcripts and interview tapes were labeled with a study code (not names of individuals or recruitment site) which was not shared beyond my supervisors and the audio-typist. Participant biographical information alongside study codes were stored in a locked cupboard to which only I had access.

On completion of the study (successful viva examination plus papers accepted for publication), patient information (consent forms and study codes) will be destroyed, the tapes will be wiped and paper and electronic versions of the transcripts stored in secure archives at LSHTM, without personal identifiers and with no means of linking them to their source. LSHTM takes ongoing responsibility for the security of this data.

In presenting my data, both orally and in published work, I have been careful to omit identifying information from quotes and analysis. I am confident that there has been no breach of respondent confidentiality and anonymity arising from the study.

4.5 Sample Characteristics

Of the 32 interviewees, 15 were men and 17 women. The youngest interviewee was 23 at the time of interview and the oldest was 78. Over half the respondents were aged over 50 (n=17) and two were under thirty. Eighteen respondents were born in the UK (16 of whom had lived there all their lives) and 19 described themselves as white British. Two respondents had spent five years or less in the UK; the others had lived in UK either all their life or for significant periods (range 13 to 58 years). Educational experience ranged from pre O'Level to post-graduate qualifications, with half the respondents obtaining degrees. Twelve interviewees had children, of whom eight had grown-up children and the other four had children still living at home. Twenty respondents were in current partnerships, 16 of whom were married or co-habiting with their partner. Eight respondents were previously divorced. Three men described themselves as gay, one man as bi-sexual and one woman as lesbian; the other respondents described themselves as

heterosexual. Eight respondents had sought help for a sexual function problem; six of these were recruited from the sexual problems clinic and two were recruited by post from the GP practice but said they had previously attended a sexual problems clinic. I used attendance at a sexual problems clinic as the indicator for the group, 'self-identified as having sexual dysfunction'. Of the 13 respondents categorised as 'has condition associated with SD', several described sexual difficulties but had never attended a sexual problems clinic. These sample characteristics are summarised in table 4.2. overleaf.

In terms of gender and education, the sample was broadly representative of the London Borough of Camden from which it was drawn (Camden Council, 2007). It was of course older (6% under 30 compared with 44% in Camden as a whole) as a result of our purposive sampling for those experiencing sexual difficulties.

Characteristics of final sample (n=32)			
GENDER			PARTNERSHIP STATUS
Male	15		Single
Female	17		Co-habiting/married
			Partner, not cohabiting
			4
AGE			LEVEL OF EDUCATION
Under 30	2		Pre-O level/O level
30-49	13		A level
50 plus	17		Degree
			7
			9
			16
SEXUAL ORIENTATION			SEXUAL FUNCTION EXP.
Gay male	3		Self-identified as having dysfunction
Lesbian	1		Has condition associated with SD
Bi-sexual	1		Neither of the above applies
Heterosexual	27		8
			14
			10
ETHNICITY			
British Asian	2		
Black (non-British)	2		
Asian	1		
White British	19		
Other white	8		

Table 4.2 Sample Characteristics

During the early stages of the analysis, I realised that there were limitations to the above categorisation of respondents by sexual function experience. Until this point I had used

recruitment site as a proxy for sexual function experience, adapting this slightly to include two respondents who were recruited via the GP practice but recounted visiting a sexual problems clinic. The limitation was that several respondents outside of the 'self-identified' group during interview also identified themselves as having sexual function problems. Three respondents perceived that the 'problem' lay primarily with their partner, whilst four had sought help but not from a sexual problems clinic. Thus I re-grouped respondents according to their descriptions of their current sex life. This second classification is more subjective, relying on my own interpretation of respondent accounts (reduced reliability), but at the same time more accurately reflects actual experience of difficulties (enhanced validity). This second classification is shown in table 4.3 below.

Classification Criteria	Respondents
<p>Current sex life described as functional (n=7)</p> <p>Inclusion criteria:</p> <ul style="list-style-type: none"> • No significant frustrations expressed • No significant difficulties described 	<p>Female aged 23 Male aged 62 Female aged 35 Female aged 27 Female aged 38 Male aged 39 Female aged 47</p>
<p>Current sex life described as dissatisfactory but not problematic (n=9)</p> <p>Inclusion criteria:</p> <ul style="list-style-type: none"> ▪ Minor frustrations expressed ▪ Some difficulties described but respondent is not particularly concerned about them 	<p>Female aged 53 Female aged 54 Female aged 34 Female aged 42 Female aged 73 Male aged 78 Male aged 52 Male aged 52 Female aged 31</p>
<p>Current sex life described as problematic (n=16)</p> <p>Inclusion criteria:</p> <ul style="list-style-type: none"> ▪ Significant problem described ▪ Problem may relate to self (12) or partner (2 respondents) ▪ Describes some level of distress or dissatisfaction ▪ Clinical help sought or considered (Viagra or psychosexual counselling) 	<p>Female aged 64 (p has problem) Female aged 51 (p has problem) Male aged 61 Male aged 55 Female aged 60 Male aged 65 Male aged 33 Male aged 70 Male aged 48 Male aged 36 Male aged 36 Female aged 70 Male aged 60 Female aged 46 Female aged 33 Male aged 56</p>

Table 4.3 Participants Categorised by Degree of Sexual Function Problems

Using this categorisation, half the sample had sexual function problems, and less than a quarter had 'functional' sex lives. Men are slightly over-represented in the 'problematic' group. It may be that men are less likely to attend an interview on this topic unless they have a specific difficulty they wish to discuss.

4.6 Summary of Chapter

This chapter described the study methodology in three key stages. As part of the study development (stage one) I undertook a thorough review of the relevant literature; observed five clinical consultations; developed the topic guide; and secured ethical and management approval. In the second fieldwork stage, Kaye Wellings and I conducted 32 semi-structured interviews with individuals from 3 respondent groups: those who self-identified as having sexual function problems (recruited from a Sexual Problems Clinic); those who had conditions associated with sexual function problems (recruited from the diabetes and depression lists of a GP surgery and an HIV/AIDS charity); and those who were sexually active but did not fit into either of the above (recruited from a GP waiting room). The interviews were tape-recorded (all but one), lasted between 45 minutes and two hours, and were directed by the topic guide. In stage three I mapped out the data using 'Framework' but turned to Grounded Theory in order to develop a richer theoretical account.

Of the 32 interviewees, 15 were men and 17 women; their ages ranged from 23 to 78, with over half aged over 50. There was a broad mix of ethnicities as well as representation from key sexual orientations. In terms of gender and education, the sample was broadly representative of the London Borough of Camden from which it was drawn. There were several ways to categorise respondents according to sexual function experience. Using recruitment site as a proxy resulted in six individuals self-identified as dysfunctional; using reported help seeking as an indicator resulted in eight individuals classified in this way; finally my subjective assessment of a problematic sex life based on the account given during interview resulted in 16 individuals classified as having a problematic sex life.

Chapter 5

What is sexual function? Three versions of 'function' derived from lay perspectives

5.1 Introduction

As I outlined in chapter two, there has been widespread criticism of current classifications of sexual dysfunction, in particular the presumption of an underlying uniform and normative sexual response (Tiefer, 1996). In this chapter I set aside the existing classification of sexual dysfunction and explore instead how respondents themselves construed this concept. The results of this chapter have been written up as a paper (appendix 14) which is under review by the Archives of Sexual Behaviour.

I use the term 'version' to describe a coherent set of priorities and beliefs about what it means to have a functioning or 'good enough' sex life. My preferred term for what I have explored is 'orientation towards sex' but I avoided this term because of potential confusion with the term 'sexual orientation'.

It was possible to categorise the ways in which respondents evaluated their sexual experiences, and described their priorities, in terms of three distinct orientations towards or versions of sex (see table 5.1). I describe the dimensions of each version in turn, outlining the main purpose, motivations, criteria governing, and threats to, 'ideal sex'. In particular I explore discrepancies between versions adhered to by a respondent and their partner; and discrepancies between an individual's version of functional or ideal sex and their lived experience.

The versions I have identified are abstractions derived from accounts of lived experience. Respondent descriptions of their experiences and views of functional sex approximated to these versions, but seldom fitted completely with one type. In four of the 32 accounts,

the direction taken by the conversation did not furnish sufficient detail to discern a particular orientation. Of the 28 accounts in which versions were discernable, there were four in which two versions appeared to be equally prominent; in the remaining 24 accounts, one version appeared to dominate. The versions were less easy to discern in respondents with less sexual experience. On the other hand, they were more easily discernable in respondents who had experienced difficulties and had subsequently spent time and energy thinking about their priorities, using them to guide and evaluate their sexual activities.

	Interpersonal	Mechanistic	Erotic
Defining term	Relational	Physiological	Recreational
Focus	Emotion Intimacy Reciprocity	Genital	Sensation
Purpose	Bond between partners	Release Procreation	Pleasure Recreation
Motivation	Intimacy Shore up self-esteem	Physiological need Biological drive	Physical attraction 'Chemistry'
Criteria determining ideal sex	Balance between partners Emotional Security Emotional connection	Erection Penetration Achievement of orgasm	Variety Excitement Orgasm
Threats to ideal sex	Relationship/emotional difficulties	Physiological difficulties	Lack of novelty, boredom, over-familiarity Discordant sexual preferences
Sexual repertoires	Negotiable Usually penetrative sex Masturbation as consolation Non-penetrative sexual activities often as prelude to penetration Viagra permits reciprocity	Vaginal intercourse Penetrative sex crux of encounter Masturbation for physical release; as substitution Non-penetrative activities preludes to penetration Viagra assists erection	Broad-ranging Penetrative sex not essential Masturbation intrinsically enjoyable Non-penetrative sexual activities ends in themselves Viagra enhances physical pleasure

Table 5.1 Three Versions of Functional/Ideal Sex

5.2 *The Interpersonal Version of ideal*

The focus of the interpersonal version was on the relational context of sexual encounters. In other words, sex was given meaning and significance by the relationship in which it took place. Definitions centred on the interpersonal context, stipulating that some degree of intimacy and closeness should be involved:

Intimacy (M52)

The extension of the comfort zone - the height of being very close with someone (M61)

Exposing oneself on a physical and personal level (F31)

Intimacy between two people that you've got a chemical sexual

Attraction towards (F46)

All intimate aspects of a relationship (F47)

Trying to make your partner feel good in some way or another (F31)

Thus sex had less to do with a physical act and more to do with the relationship between two individuals. One respondent put it thus: *so much of sex has nothing to do with sex (F54)¹⁰*. Rather, sex was symbolised as the gift of yourself, given to another person: *you're giving someone the most special gift you can ever give (F31)*.

In this version, the main purpose of sex was construed as creating an emotional bond between partners (*a glue to the relationship (M61)*). According to one female respondent, women in particular seek sex to reiterate *that connection physically and then after, that closeness, because you shared something (F31)*. Sexual activity appeared to create this bond because it was an intimate act often requiring partners to make themselves vulnerable, *naked*, and *exposed*. As one respondent described, *it's the most intimate you would be with somebody (F35)*. Interestingly, for one male respondent, vulnerability itself was arousing:

¹⁰ Codes following quotes: M-male; F-female; numerical value refers to age of respondent.

M36: *For me, one of the things that I like with a woman is that she's putting her complete trust in me to let me sleep with her. She's made herself as vulnerable as she possibly could.....*

Perhaps because of this intimacy and vulnerability, premium was placed on the protection of self and partner's self-esteem. Thus, sexual satisfaction was closely tied to the feeling of being wanted and vice versa: *the uncertainty of...the other person really wanting you and showing that they want you...is probably the primary cause of sexual dissatisfaction* (M48). And shoring-up self-esteem was a recognised purpose of sex.

The focus on the interpersonal implied that sex was inextricable from its relational context. Those whose accounts centred on this version were often reluctant to separate the quality of a sex life from the quality of the sexual relationship. For instance, one female respondent described her current relationship as good because:

F35: *there's a real bond between us and we really love each other [...] but that's really more a relationship and the sex is part of that, a very fundamental part [...]. It's hard to separate it.*

On a purely physical level, the sex had *not been the best ever* for this respondent, but because it occurred within the context of a loving relationship, she described her sex life as good overall. In other words, sex for her was inextricably linked to its relational context and so she evaluated it as 'good', whilst recognising that the physical aspect was not ideal.

In this version, ideal sex was construed primarily as balanced, secure and emotionally connected. Similarity in levels of desire (for each other and for sex) was important: *I couldn't bear to have sex with somebody who I felt didn't really want to* (F35). This appeared to be primarily because of the impact on self-esteem: *[if my partner rarely initiated] I would find it hard to feel the confidence that they were sexually interested in me* (F34).

Similarly, reciprocity was important because *your partner doesn't believe in the depth of your feeling if you're not able to communicate it sexually* (M61). And furthermore: *you gain an enormous amount of pleasure by giving someone else pleasure* (M61).

Again, because of the recognition of the high level of vulnerability associated with the act, emotional security was emphasised within this version. According to respondents, emotional security was about feeling wanted, confident, comfortable and free from pressure. A range of factors were cited as contributing to this security including trust, communication and simple familiarity:

M61: *[pause]. It's...I don't want it to sound too chauvinistic – it's like a nice comfortable pair of shoes really that you can slip into and feel at home in ... a body you can feel comfortable with.*

The idea of emotional connection was clearly viewed as a component of ideal sex. It was described variously and somewhat nebulously as *a real sort of bond or love for that person* (F35), *that sort of good feeling* (F38), *rapport* (F23) and *an invisible chord that stays on there* (M48). In the absence of this connection, sex would become impersonal. A female respondent described a casual encounter devoid of connection thus:

F31: *It was almost like... if we were having sex he could have been with anyone. It wasn't like he cared about me.*

In this version of functional sex, physical pleasure was prioritised less than the sexual relationship, and there was a willingness to trade the former for the latter:

M61: *When your two bodies just fit together..[:...] and you enjoy giving pleasure to each other, there can be an enjoyment of the pure physical ability to do that, which doesn't necessarily have to be accompanied by an emotional love. Of course I think you're*

always looking for [love] though. You'll always sacrifice [physical pleasure] for somebody you love.

This trade off was considered acceptable because the relationship offers *a lot more* than sex.

F35: *... if I had better sex with somebody else it doesn't necessarily mean that I would want to split up with my current partner or leave him. It's got to be more than that act – a lot more.*

An older female, whose account fitted both the interpersonal and erotic, and whose partner had significant difficulties, believed that not only were women willing to trade pleasure for relationship, they were also capable of willingly deluding themselves about the actual pleasure they received:

F51: *I think the amount of sexual pleasure that most women get from men is very slight. I think we con ourselves in a rather sad way when we're really in love – that, that....that it's wonderful, it's wonderful to be in bed. And even if they are clumsy you... because it's the person you love and it's the centre of your universe – that relationship, which is strong and remarkable and wonderful. You're not going to say "I think you're useless" are you?*

In this version of sex, pleasure was defined in emotional or relational terms and the concept of *pure pleasure* was treated by some with disdain. This view was well articulated by a particular respondent who argued that, *sex for pure pleasure is very difficult for a woman* (F54). She later described feeling *sullied* and resentful following sex which was physically enjoyable but where the emotional connection had been lost:

F54: *... the person who's done a course on how to please a woman... I once had one boyfriend who had that. [...]* OK it was a holiday romance and then he came back to this country and we had a bit of a thing, and I suddenly became totally allergic to him –

hated and loathed him, which is unlike me. I really resented that he knew how to touch my body,

She was cynical and scathing of what she saw as a very *male* view of sex for pleasure, typified by the sixties generation. In her opinion this idea of *win-win* sex was a *fantasy that never came about*, and in reality implied the exploitation of women. However, she was both candid and lucid in acknowledging that underlying her inability to *detach the need for sex from being attracted to someone* was a reluctance to face the possibility that she might actually want *free floating sex in the same way that men might*.

For one male respondent whose account fitted well with this version, the benefit of Viagra was construed mainly as allowing the experience to feel mutual and reciprocal: ... *it's in a sense, more beneficial for your partner than it is for yourself, and you use it I think because you want to give satisfaction to your partner as much as to achieve successful sex yourself* (M61).

Some respondents whose descriptions mainly fitted this version saw masturbation primarily in terms of exploration and viewed it as *no bad thing* because it enabled an individual to perhaps become better prepared for 'the real thing'. However, particularly for women, masturbation was often viewed as devoid of interpersonal meaning and thus lacking *warmth* and *closeness*: [...] *It's a very cold thing a vibrator – there is no warmth. You're purely using it for the relief – to have an orgasm.*

Masturbation was also seen as potentially threatening to the relationship because it suggested that the sexual relationship was not sufficiently fulfilling for the masturbating partner. A prior feeling of security within the relationship militated against this threat:

F53: I feel secure enough in the relationship to be able to... I have a sexual masturbatory life for myself. So if for whatever reasons [climax] doesn't sometimes happen together, or one after the other, I can always work on it myself.

Whereas men (regardless of preferred version of sex) switched quite naturally to masturbation during periods of being single; women whose accounts approximated to the interpersonal were likely to *switch off* their desire for sex. Women seemed much less likely than men to view masturbation as an adequate substitute for sex:

F54: *I think masturbation is important actually. Maybe it's part of understanding your own body in a way. It's certainly not a substitute for sex at all.*

Often women, regardless of preferred version of sex, had 'discovered' masturbation later in life. Late discoveries appeared to stem from lack of exploration, lack of knowledge of one's body, and the perception that a woman's body is *difficult to work with*:

F51: *It wasn't 'till I was about 25. I had never done it in my life before. I had never masturbated. I was never aware of it.*

IV: *Why do you think you had never masturbated – at that stage...?*

F51: *Well I don't think I knew how to!*

In this version, emotional and relationship difficulties appeared to represent a more significant threat to ideal sex than physical functioning issues. The problem may begin as a relationship issue, and lead to a loss of intimacy and affection. Sex may become a metaphor for the relationship and as the relationship disintegrates, so the sex itself becomes 'dysfunctional':

M62: *...some of the touchy-feely stuff [...] that has nothing to do with the sexual act itself, goes. You're not any longer doing that with one another. [...] You're not as eager then to get physical and you just dissipate.*

The interpersonal was the most common version of functional sex in my data; the accounts of fifteen respondents were categorised as predominantly corresponding to it. Although this group comprised only five men compared with ten women, further quantitative work would be needed in order to establish a gender difference with any certainty. One might hypothesise that the interpersonal version would become more

prevalent as perspectives on sex change with age, particularly where individuals adapt to declining physical function by focusing more on the relationship. My numbers were too small to show a clear association but again, it would be worth exploring this quantitatively.

5.3 The Mechanistic Version of Ideal

In this version of ideal sex, the definition of sex was centred on the physical act, specifically *penetrative intercourse*. This was by far the most common response to the question, ‘what does sex mean for you?’ (10 respondents). However, use of a mechanistic definition by respondents when directly asked to define the term ‘sex’ did not necessarily imply subsequent reference to the mechanistic version in describing their own sexual lives.

The mechanistic version construed sex primarily as a biological or evolutionary act whose primary functions were procreation and the fulfilment of a biological need for sexual release. In this sense, it was primarily described as a natural function:

M65: You're not only a human being; you're an animal as well. [Sex is] an important thing.

Accounts which approximated to this version tended to include reference to sex as a need that had to be fulfilled; for instance one respondent talked about needing to be *charged* in order for your working life to go well (F38). Where such needs were not met, this was a source of concern:

M65: ...it worries me that she is not getting any [sex]. It's supposed to be a need.

The idea of sex as release was prioritised in the mechanistic version of sex but also appeared in accounts that were otherwise more consistent with the erotic and interpersonal. In the mechanistic discourse, release was narrowly construed in terms of

orgasm which was defined as: *the ultimate release of body fluids that causes pleasurable sensation* (M39), enabling one to feel *charged* (F38). Those endorsing other versions tended to talk in terms of the release of psychosocial 'substances' such as tension and emotions. For instance, a gay male respondent compared sex with crying and exercise, as a means by which emotions could be released in a *healthy* way (M48).

The procreative function of sex tended to be either irrelevant to participants (at least at the time of interview), undesired, or a source of stress (due to difficulties conceiving). Following the births of three children in quick succession, a male respondent described how *poor contraceptive advice* had led to *an unfortunate association between making love and having babies* (M78). This remark illustrated the general lack of conscious association between sex and conception until something goes 'wrong'. A female respondent (F33) also talked about how ideally she would like to have taken time to *heal* herself by remaining in an *asexual* state following a bad sexual experience, but because she was trying to get pregnant she had to keep having sex. Only one respondent mentioned procreation when asked to define sex. And only one respondent talked about a period in his life when he had construed sex primarily in terms of its procreative function: *I just thought it was the way that we were going to have our children* (M52). At the time he was married and not enjoying sex with his wife. Later he divorced and 'came out' as a gay man and from that point in his sexual career the procreative function was replaced by pleasure and intimacy functions. Thus, I do not argue here that mechanistic accounts prioritise procreation; only that this 'original' function of sex continued to indirectly shape the view of sex, primarily through the prioritisation of vaginal penetration as the *crux* (F34) of the (hetero) sexual encounter:

IVWR: *So penetration is one of the attractions of heterosexuality, or..?*

F34: *Yes. It's also the way you make babies. It's quite fundamental to procreation. [...] It's the act of creation. It's up there with birth and death.*

It should be noted that the importance attached to penetration was pervasive and not limited to the mechanistic version. Many of those subscribing primarily to other versions - such as that of the female respondent above - also valued penetrative intercourse as part

of their sexual repertoire. For example, one respondent gave an interpersonal 'rationale' for penetration:

F46: It's as near as you can get to being one.[....] If someone's inside you like that, it's as near as you can get to sharing everything.

However, within the mechanistic version, penetration tended to be seen as the only activity that mattered. Other sexual activities were seen merely as preludes to penetration and construed as meaningless unless the end point could be achieved: *..but then you see if you're good at the romantic side and you both know [that because of erectile difficulties] it's going to lead nowhere it all becomes a bit pointless...(M70).*

Given the focus on the biological, physiological function was a central component of ideal sex. Specifically, ideal sex was defined in terms of adequate arousal and maintenance of an erection until orgasm was achieved by both partners (after a not-too-long and not-too-short a time). In particular, orgasm was accorded high priority as the primary mechanism for sexual release: *... if you are not able to get an orgasm it's definitely a problem.....purely because physically there's no release (F54).*

Successful sex was defined by one respondent (M33) thus: *we both climaxed while penetrating.* Pleasure was also reduced to a button to be 'pressed':

M39: Of course ideally you would [have sex] every day, because the sensation is just so fantastic. We are lucky enough to be equipped physically with the sensation so, I suppose, in purely animalistic terms you would want to press the button as often as you can.....

In particular, for men in this version, 'giving' their female partner an orgasm was prized as an 'objective' indicator of a successful encounter. For one man, seeing a female partner *go through the roof* (M70) was about his power as a sexual partner:

M56: ... *maybe it gives me a feeling of power to be able to experience a member of the opposite sex physically out of control, or physically enjoying your power. I really don't know whether that's the case or not, but maybe it is.*

Later in the interview, the respondent above described how he felt that he lacked control in his relationships and that his female partners were *totally in charge*.. Thus experiencing a partner *out of control* may have been a way of wresting back some power for himself.

The respondent above (whose version of functional sex was both mechanistic and erotic), also subscribed to the idea that male 'abilities' as a *lover* can and should be judged by the extent of his partner's *ecstasy*.

Female respondents were often aware that their partner wanted to give them an orgasm: *I think he likes for me to [reach orgasm] as well. I think it makes him feel good if he knows he can satisfy me – that type of thing* (F31).

The role of Viagra was primarily construed in terms of facilitating successful sex by helping the male partner to achieve an erection. Viagra had not worked for one or two of the male respondents, and this failure was regarded as a signal that a functioning sex life was no longer possible: *I tried [Viagra] again; it didn't work so I didn't touch it again, so now I haven't got any sex life at all* (M65).

In this version, masturbation was seen primarily as an outlet for physical release where sex was not possible; it was seen in terms of meeting an important need for *cleansing [the] body of hormonal surges* (M55). The male respondent below, during his account of a period of low desire due to depression, conveys the idea of a body as a machine ensuring that its needs are met regardless of the mental state of the owner:

M39 *[masturbation] just required more effort because you really felt your body system is shutting down*

IV: *Did you give it more effort or?*

M39: *Yes, but in a way your body's telling you – somewhat ineloquently – that enough sperm has accumulated, you've got to get rid of it.*

Construing sex as a biological need engendered an understanding attitude by women towards the solo sexual activities of male partners such as reading pornography. The female respondent below saw her partner's porn magazines as unproblematic; fulfilling an understandable need:

F38: *[...] sometimes when he was working in G- and when he comes home he has these magazines with him. To me it doesn't bother me because he explained to me he needs them, so that's what he needs.*

In mechanistic terms, the inability to have penetrative intercourse posed the most significant threat to ideal sex:

M56: *[If I could not have penetrative sex] I'd regard myself as completely useless – or even more useless. I would be letting her down and that would be ...it's unspeakable and why would she stay with me? She would leave at any moment – it just wouldn't work. [She would think] I was no good.*

The respondent above assumed that his *horrendous fear* of not being able to *accomplish* an erection (M56) would be shared by all men. This goal orientated view of sex could give rise to significant pressure, exacerbating erectile difficulties, and in some instances 'causing' them:

M33: *[...] [Sex] was never something that I was enjoying; it was more something that we focused on achieving. So ... it never really got to the stage where I could lie back and enjoy what was happening.*

Five respondents were categorised as adhering primarily to the mechanistic version; one woman and four men. The numbers are too small to say with certainty, but it appears as

though this may be a version typifying men more than women. All the respondents were heterosexual, perhaps not surprisingly since taking on a non-heterosexual identity implies leaving behind beliefs in the centrality of vaginal intercourse. However, it may still be possible for the account of a gay man to reflect elements of this version, for instance, in believing that sex is not possible in the absence of an erection.

5.4 The Erotic Version of Ideal

In this version, sex was defined in broader, more flexible terms than purely penetrative intercourse. Several respondents gave definitions which embraced intercourse plus other 'peripheral' sexual activities such as oral sex, foreplay, touching genitalia; for others, sex revolved around broad-based descriptions of physical activity: *Both naked and stimulating each other* (M36).

In this version, sex was construed as a recreational act and the main focus was on giving and receiving pleasure. Since pleasure and not penetration was central, there appeared greater flexibility in what had to happen physically in order for the sex to be defined as 'successful'. For instance, for a gay respondent, an early ejaculation was not necessarily construed as an end to sex:

M52: A lot of men have a problem with premature ejaculation and it's always surprised me that for a lot of them that's it – "thank you very much, I'm off home now" sort of thing, whereas you think "hang on a minute, give it another 15 or 20 minutes and we'll see what can happen".

Characteristic of this version was the enjoyment of sex as a physical act that was uncomplicated by the interpersonal. That is not to say that personal relationships are unimportant here; only that they tend to be separated from the physical act of sex. For instance, a female respondent who subscribed primarily to this version described being excited by the element of surprise afforded by the unknown – the tall dark stranger – in an *unattached* encounter.

Given the greater variability in sexual activities, and the desire to separate sex from interpersonal 'baggage', premium was placed on compatibility between partners in terms of preferred activities. For instance, a male respondent described previous encounters in which a partner had been unwilling to engage in verbal fantasies with him. It meant he had to *shut up* and the *compromise* felt like *vanilla sex* (bland sex) to him (M55).

In this version, ideal sex was construed as exciting, varied and novel and Viagra was valued mostly for its role in enhancing this excitement: *[Viagra] is also prolonging it longer and more enjoyable, and nearly always a climax at the end so it's more satisfying and more pleasurable* (M55).

Masturbation was often seen as a satisfying alternative to sex. For a few male respondents, the preclusion of another person was an attraction of masturbation. Not always able to achieve pleasure and/or physical release through conventional intercourse, they found that masturbation could fulfil these purposes more easily. A male respondent with erectile difficulties highlighted one of the benefits: *there's nobody around, you're a free person, and you can do what you want, there's no one to disturb you on it* (M36).

This freedom, plus the fact that no one else knew exactly *where the pleasurable parts are* (M70), meant that masturbation was seen by such men as a more straightforward route to climax and physical satisfaction.

Individuals whose version of ideal reflected erotic priorities might seek novel encounters in order to maintain stimulation. As I discuss later, good sex (in erotic terms) could become difficult, if not impossible with someone loved and familiar. A male respondent subscribing to the erotic version was concerned that in his long term partnership, *it's hard to keep things exciting after all these years* (M36). For this respondent, the pressure to demonstrate his excitement to his partner had become a source of distress.

In accounts approximating to this version, the most significant threat to ideal sex stemmed from a loss of physical (or chemical) attraction to one's partner such that sex became dull and boring. The 'inevitable' dampening of sexual excitement within long term relationships was viewed as problematic: *that's always the thing with relationships at the beginning – they're very, very exciting and then over time it's less...*(M36).

If the excitement went, it was felt that sexual activity would inevitably wane:

M55: *There's only so many times you can make love to someone without it being stimulated by the eroticism of their body. This generally implied an end to the relationship: as the sex life diminishes or they've not wanted the sex life so much, the relationship's on its wane and on its way out.*

One gay male respondent felt that opportunities for novel and exciting encounters were less constrained for gay men where there was no expectation to 'settle down' and have children. As he put it: *You really go into a relationship thinking "I would like this to last but it may not", and it'll last while it's good, but when it's not it will end* (M52).

For one male respondent (whose account approximated both to the mechanistic and erotic) sexual pleasure was construed primarily in terms of the romance surrounding sexual encounters (M70). He talked at length about romance, seduction and conquest. He questioned the value of monogamy (*Why is it more adult and grown up to reserve yourself to one woman?*) and construed the giving of pleasure primarily in terms of achievement (*...you really feel quite an artist, that you've achieved something*). He prioritised romantic settings (*I think this is for me, the point: the heavenly bit about being with a woman is if it's in a heavenly place; it's the surrounding, it's the romance...*) and actually suspected that his *drive* for the physical act of sex was lower than average. His value set was, if you like, more 'old-fashioned'; he held to strictly demarcated gendered roles of male as seducer, protector and lover (*[men] are supposed to take the lead*) and female as seduced, protected and loved.

Although 'sex for pure pleasure' appeared to be difficult for some female respondents, this was by no means universal. For instance, a mid-years female, who elsewhere described feeling generally let down by men's lack of ability to give women pleasure, spoke enthusiastically of her only 'pure pleasure' relationship:

F51: He didn't love me and I didn't love him but it was... We were both in other relationships – he was married, I wasn't – but it was just magic because he just loved pleasing women.

Eight respondents (six men) appeared to adhere primarily to the erotic version. Four emphasised the erotic, while the other four gave accounts which blended the erotic with the interpersonal (two) and the mechanistic (two).

5.5 Categorisation of Participants by Version

	'Functional' sex life	Unsatisfactory but not problematic	Problematic sex life
Interpersonal	Female aged 35 Female aged 47	Female aged 31 Female aged 34 Female aged 42 Female aged 53 Female aged 54 Male aged 78 Male aged 52	Female aged 46 Female aged 64 Female aged 70 Male aged 36 Male aged 48 Male aged 61
Erotic		Male aged 52	Female aged 33 Male aged 36 Male aged 55
Mechanistic	Female aged 38 Male aged 39		Male aged 33 Male aged 56 Male aged 65
Interpersonal/ Erotic	Male aged 62		Female aged 51
Erotic/ Mechanistic			Male aged 60 Male aged 70

Table 5.2 Categorisation of Participants by Version and Experience of Sexual Problems

Table 5.2 above categorises respondents by dominant version and functional status (see chapter four for details of this latter categorisation).

The main point to note here is that there does not appear to be an association between adherence to a particular version and experience of sexual problems.

5.6 Incongruity between Version of Ideal and Lived Reality

Two accounts in particular illustrated the difficulties that can arise for individuals when a change in circumstance makes it no longer possible to achieve one's ideal. In both accounts, the individuals appeared torn between a conceptualisation of ideal sex in erotic terms and a desire for a steady and secure interpersonal context where this type of sex was difficult if not impossible. Their expectations of sex as varied, wild, exciting and novel were difficult to meet within the confines of their chosen interpersonal contexts which were characterised by familiarity and intimacy. For instance, a young man with erectile difficulties (M36) said that he was aroused by the idea of *forbidden fruit*, but because his wife was no longer 'forbidden', he did not feel aroused by her: *it's her naked body...I've seen it many, many times, so it doesn't turn me on as much as someone in the street that I'm seeing for the first time* (M36).

He also described himself as reserved, not particularly in touch with his own body and thus unable to relax and *let my body just kind of flow*. Having set up an ideal of sex in erotic terms he found he could not access this ideal within his long term relationship and the constraints of his reserved personality.

As one respondent suggested, for those construing sex as an interpersonal act, a hidden desire for erotic encounters devoid of the interpersonal might well be common - the quote below suggests a belief that we all have orgiastic fantasies – but because of the way that sex is constructed in the interpersonal version, the encounter would inevitably come with interpersonal *baggage*. The extent to which such fantasies give rise to inner conflict might be influenced by the extent to which present and past interpersonal-

orientated sexual encounters are experienced as sexually fulfilling and by the extent to which an individual is wedded to this conceptualisation of sex.

F54: [.....] *I think really, because somewhere in my fantasies, I'd love to be in an orgy – the whole orgiastic thing which we all have. It would be great if we could actually... heaven must be a place where you could do that without any of the baggage.*

5.7 Discontinuities between Partners

Since sex occurs in a relational context, the priorities of the sexual partner also come into play. Conflict can arise when the notions of ideal sex subscribed to by each partner are divergent. Three accounts in particular illustrated this tension, two of which I describe here. A young man with erectile difficulties (M33) described engaging in plenty of intimate activities such as oral sex with his wife and experienced *times when that is preferable to actually having intercourse*. However, he sensed that non-penetrative activities were *not enough for her* and thus felt: *uncomfortable just sticking with the oral sex but feeling that the mood was for going...further and actually going to intercourse* (M33).

In other words, he felt pressure to conform to what he perceived as her more mechanistic expectations of sex.

The second example was a female respondent (F64) who conceptualised sex in interpersonal terms, primarily focused on warmth. According to her account, her partner appeared to be uncomfortable with this interpersonal model. She described his rare attempts to initiate sex as follows:

F64: *I would go out to the theatre by myself and he'd get himself worked up somehow. When I came back I could hardly get my coat off. He was sort of at it [...]...but there was never any warm up or foreplay or just basic warmth. For him, I think – I don't think he realises this, but for him it was just a sexual function that he needed very, very rarely.*

Later she describes the fact that he didn't kiss her during intercourse, leading her to think, "*God, I might as well be a prostitute*". Thus, while she looked to sex for warmth and intimacy, he appeared to view sex in mechanistic terms; a function required occasionally to provide physical release.

5.8 Transitions through Life Stages

Throughout their sexual lives, individuals accumulate experience and may move in and out of different discourses over time depending what they experience and how they interpret it. The interview therefore captures a 'snapshot' of a dynamic process at one point in time. For instance, a male respondent with erectile difficulties was focused on mechanical aspects of sex at the time of interview. However, glimpses of interpersonal concerns within his account strongly hinted that had I interviewed him prior to the onset of his difficulties, his priorities may have leaned much more towards the interpersonal.

In my sample, many respondents described how their priorities for sex had changed and developed with time. Age appeared to influence sex-related priorities in four distinct ways: the biological process of ageing which often led to reduced desire and imposed limits on what might be achieved physically; cultural expectations about what is appropriate for older people; growing up in one cultural milieu (say the 1950s) as opposed to another (say the 1990s); the shift from one life stage to another and the accumulation of sexual experience with age. I look at these briefly in turn.

Several older respondents described how the physical limitations imposed by the ageing process tended to engender a greater sensitivity towards a partner's needs which greatly enhanced the experience of sex. In other words, with age, the focus of sex tended to shift towards the interpersonal. Faithfulness, appreciation, *cuddles and kisses* (F70) increased in importance, whilst physical functioning became less important.

Older respondents perceived a cultural expectation that affection and *kindness* (M70) were regarded as more appropriate for their age group. One older woman described how her expectation of a fulfilling sex life sat uncomfortably with her perceived norm of appropriate behaviour for her age:

F70: 70! God can you fancy that! You feel embarrassed to ask for it. You feel embarrassed to think about it but then if you're fit....

She related how she had got rid of her vibrator (despite enjoying it), because she did not want her children to find it after she died.

Related to age, was the shifting perspective associated with the move from one life stage to another. For heterosexual respondents, the most significant transition was viewed as the move to 'settle down' (buying a house; having children). According to a gay male respondent:

M52: For straight men there's the expectation a lot of the time that at a certain point in your life you'll settle down with a woman long term and you'll perhaps, or probably, have babies. Now for a lot of straight men once they've got that I think their sexual lives, by and large, are appalling. When I say appalling I'm talking about the frequency of sex and the quality of sex.

His view, which was echoed by several heterosexual respondents, was that 'settling down' involved compromising on one's sex life, at least for men. Living with that compromise successfully relied, to an extent, on a malleable sexual script or version.

The accumulation of personal experience appeared to significantly shape ideas and priorities:

M61: you have to learn your own individual pattern [for a satisfactory sex life]. I think there's a load of rubbish talked about sex.

In particular, one respondent reflected on how his past sexual encounters had enabled him to confront normative beliefs and re-categorise them as ‘myths’: *I have become more and more conscious of the myth of physical and emotional enjoyment being a function of each other* (M61).

The cultural milieu into which one was born or came of sexual age was also recognised as important: *One is very much a product of the time that you’re born in* (F54). For this particular respondent, the cultural milieu of her youth had engendered a belief in sex as inextricable from romantic love, and she had spent much of her sexually active life trying to manage this expectation against the disappointment of her actual experience. Being born into a particular milieu implies growing up within a cohort of people who share this cultural heritage. I found that for several respondents, peers were an important source of information and reference group: *You share ideas and experiences which make you understand your own* (F35). Where these friends are members of the same cohort, shared cultural values may be reinforced.

5.9 Discussion

I have highlighted three versions of functional or ideal sex to which individual accounts approximated in talking about their ideal and non-ideal sexual experiences. Each provides a distinct set of priorities and expectations for a fulfilling sex life, and criteria by which the quality of these experiences might be judged. To an extent, these versions can be viewed as operating rather like sexual scripts; serving as “storage devices for organising memories of past sexual experiences into coherent narratives” (Gagnon, Rosen & Leiblum 1982; pg 46; see also Simon & Gagnon, 1986).

The interpersonal version was most common in this study. This is likely to be due to the fact that my respondents were older (and I have argued that the interpersonal is more common among older people) but might also be because the interpersonal is somehow viewed as more appropriate or desirable within the context of a research setting.

5.9.1 Theoretical caveats

The three types of ideal sex are abstractions drawn from individual accounts of how sexual function is perceived and experienced. That is, they are not found in any pure form in the world, but instead can be used as a conceptual framework for understanding sexual priorities and expectations. In abstracting a set of characteristics from the accounts of individuals at one point in time one must be careful to avoid falling into the trap of imposing upon them immutable categories. There are two particular traps. The first trap involves treating individual versions as static when in fact, as I have shown, they are prone to vary over time with changing circumstances, and within and between partnerships. The interview therefore captures a 'snapshot' of a dynamic process at one point in time. The second trap involves assuming a perfect fit between a respondent account and a particular ideal type. Avoiding this trap implies recognising three caveats with respect to the versions. Firstly, one should be wary of treating them as if they exist materially in the minds of individuals (in other words, of reifying them). Secondly, one should avoid 'squeezing' behaviours, or patterns of sexual activity, into a specific version in cases where there is not actually a precise fit. Finally, one should regard the typology as a means rather than an end.

As with any typology derived from qualitative data, there were cases and particular observations that did not fit neatly. For instance, I struggled to understand how a sudden loss of sexual attraction to a partner might fit: was it more likely to be an issue in the erotic version or the interpersonal version? And how did the use of and desire for power fit with the typology? There were also a few accounts with stark inconsistencies, such as a woman who mostly subscribed to the interpersonal but, due to traumatic experiences in the past, tended during sex to disassociate her partner from the act of sex (in other words to give her partner anonymity). Often it was possible to explain these inconsistencies in terms of the versions. This woman, for instance, may have been separating her partner from the act precisely because she valued the interpersonal and therefore needed to wait until sufficient trust had been established before sex could become properly interpersonal.

The lack of perfect fit between a respondent account and a particular ideal type does not undermine the attempt to rigorously categorise them in this way. Categorising accounts helps to impose structure on their complexity and to understand how individuals and/or couples frame their sexual priorities. My aim was to shape an understanding of the meanings that actions have for men and women, and to understand life as it is lived.

5.9.2 Implications of the findings

5.9.2.1 Understanding the purpose of sex

In this chapter, I outlined a number of different purposes for sex and showed how these were prioritised differently in the three versions. The interpersonal emphasised the intimate bond between partners; the mechanistic emphasised physical release and reproductive functions; and the erotic emphasised pleasure and recreation. In some languages and cultures, these purposes are assigned different terms. For example, in the Malawian language, Chitumbuka, there is one term for procreative sex and another for recreational sex (Hemmings, 2007).

My findings concur well with those of Metz & McCarthy (2004) who posited five fundamental purposes of sex: reproduction; tension and anxiety reduction; sexual enjoyment and pleasure; self-esteem and confidence; and relationship closeness and satisfaction. A recent study also explored motives for sex (why people have sex) among a community sample (predominantly students) (Meston & Buss, 2007). The eight most frequently endorsed motives were exactly the same for each gender (though in slightly different order) and included: 'I was attracted to the person' (number one for both genders); 'I wanted to experience the physical pleasure'; 'It feels good'; 'It's fun'; 'I wanted to show my affection to the person'; 'I was "horny"'; 'I wanted to express my love for the person'; and 'I was sexually aroused and wanted the release'. Thus, in terms of proximate motives, interpersonal and erotic considerations appear to be most common. Taking into account all 237 motives identified, men were significantly more likely to endorse experience seeking and mere opportunity, whilst women more than men

endorsed emotional motivations. Meston & Buss (2007) identified four broad types of motive: physical, emotional, goal attainment and insecurity. The prominence of goal attainment (e.g. resources, social status, revenge, utilitarian), which did not particularly feature in my research, may reflect the difference between investigating a global purpose and a proximate motive.

5.9.2.2 Understanding differences in gender, age and orientation

There is a normative assumption that older people lose interest in sex. This has persisted despite a growing body of evidence to the contrary (Gott & Hinchliff, 2003b; Nicolosi et al., 2004; Bradford & Meston, 2007). Certainly, many of the older respondents in this study were keen to have an enjoyable sex life. I suggest that as people age, what is assumed by others to be a loss of interest in sex may sometimes be more accurately framed in terms of a change in version of functional sex; a shift in priorities towards intimacy and enjoyment rather than concerns with erectile performance, achieving orgasm and having frequent sex. This shift, together with a lowering of expectations, might enable individuals to successfully adjust to the physical limitations imposed by ageing (see also chapter seven). The fact that the prevalence of sexual dysfunction (defined as difficulties plus distress) remains constant with age even though sexual function declines (Hayes & Dennerstein, 2005) would appear to support the idea that many people are able to successfully adjust as they age.

I also hypothesise that women may have less fixed versions than men. This would be consistent with the greater variation in sexual expression among women (Bancroft, Graham & McCord, 2001; Baumeister, 2000). I suggest (albeit tentatively) that the interpersonal version may be more common among women, the mechanistic more common among heterosexual men, and the erotic more common among gay men. Current research supports my premise that women are more concerned with the psychological context of sexual encounters, prioritising relationship satisfaction, warmth and emotional security (Carroll, Volk & Hyde, 1985; Byers, 2001). And Masters & Johnson themselves noted that compared with heterosexual men, gay men tended to

emphasise pleasure without being orientated towards the ‘goal’ of orgasm (Masters & Johnson, 1979).

5.9.2.3 Implications for my measure of sexual function

My findings have implications for the measurement of sexual dysfunction. Self-report measures of sexual dysfunction have increasingly focused on biomedical aspects of function and on providing concise end points in clinical trials (Taylor, Rosen & Leiblum, 1994; Corona, Jannini & Maggi, 2006; see also chapter eight). Thus, the mechanistic version of functional sex is given primacy. Those whose versions of sex prioritise relational aspects and erotic experiences find themselves ‘judged’ against standards they do not value themselves.

To have wide applicability, all three perspectives or versions must be reflected in the measure. Practically speaking, this implies that there must be items in the measure relating to all three versions. If there were several items per version, an individual would then receive a ‘score’ on each version (or dimension), with the highest score signalling their ‘dominant’ version. However, the imperative of brevity for my particular model means that it will probably only be feasible to have two or so items for each version, probably not enough to permit identification of a dominant version (chapter nine describes the design of the actual model in detail).

5.9.2.4 Implications for Clinical and Therapy Settings

Although the versions were derived from respondent accounts, they also strike resonance with the scripts characteristic of different treatment settings. As a broad generalisation, the mechanistic version tends to predominate in clinical settings (the biomedical model); the erotic version is most commonly seen in self-help manuals (in titles such as ‘Sensational Sex: The Revolutionary Guide to Sexual Pleasure and Fulfillment’ by Dr. Sparr, 2006), and the interpersonal tends to dominate sex and relationship therapy settings. For instance, the latter fits well with the ‘Good-Enough Sex’ model designed for

couple therapy (Metz & McCarthy, 2007; see chapter two), which seeks to enhance pleasure, relationship intimacy and satisfaction, and views physical function as “necessary but not sufficient” (Ibid, pg 353).

Regardless of setting, my typology potentially provides a novel perspective for understanding and tackling sexual difficulties. Below I present some preliminary ideas that would benefit from further testing.

Medical histories typically focus on the presenting problem and its social and medical context (see Tomlinson, 1999). However, understanding what sexual function means to the patient and their partner may provide useful insights into possible psychological aetiologies and management. Whilst taking sexual histories, the versions typology may provide a useful framework for organising respondent beliefs and attitudes towards sex. Can a particular version of functional sex be clearly identified from a client’s account? How important is this version in structuring an individual’s priorities for an ideal sex life? Does their adherence to a particular version shed light on the ways in which they are responding to their difficulties?

Relationship factors – the sexual partner as well as the interaction between partners – are often fundamental to the experience of sexual difficulties (Byers, 2001; Candib, 2001; Clement, 2002; Fisher et al., 2005; Zilbergeld & Ellison, 1980). Where the source of sexual difficulty lies in conflict between partners about their needs and priorities for a fulfilling sex life, a therapist/clinician may help the couple to understand their different perspectives in terms of discontinuities between versions of functional sex. Respecting alternative versions may be a useful starting point to the therapeutic process. The therapist may then assist the couple in exploring options for individual adjustments such that these discontinuities are minimised. Alternatively, the therapist might assist the couple in coming to regard these discontinuities as a positive source of variety in their sexual relationship.

Similarly, where an individual patient complains of lack of sexual fulfilment, the therapist may be able to help them explore alternatives to their version that might engender greater fulfilment and that they might not have yet considered. The goal would be to create a perspective for the patient in which they felt most comfortable.

It may be that the lack of fulfilment stems from an inability to shift to a version that is more feasible within a specific life stage. For example, the mechanistic version would seem to fit less well for older couples where vaginal dryness or erection difficulties make penile/vaginal intercourse difficult or impossible. And, as I have shown, the erotic version may be more difficult to maintain once an individual has 'settled down' in a long term relationship, particularly during life stages where there are competing demands such as work and children. My results tie in with previous research suggesting that more flexible personal 'definitions' of sexual function enable individuals to cope better with a sexual difficulty (Barsky, Friedman & Rosen, 2006). I describe this in detail in chapter 7. The therapist can play a role here in helping an individual to adopt a more flexible set of priorities, although this process may be easier for women than men (Baumeister, 2004).

Understanding sexual preferences in terms of these versions may also be helpful to gay men coping with feelings of confusion, guilt and shame that are often associated with cruising behaviour (Lynch, 2002). It may be helpful to understand this distress as resulting from ambivalence or unresolved conflict about the primacy of the erotic versus interpersonal version. For instance, a man in a good interpersonal relationship that over time lacks excitement, may turn to cruising to fulfil his need for the erotic, but then feel guilty about engaging in sex devoid of the interpersonal.

Use of these versions may require clinicians to move away from assuming that the mechanistic version - the version most closely allied with biomedical conceptualisations of sex - is universally 'bought into' by their patients. Indeed, it is imperative that the clinician or therapist does not convey an implicit hierarchy of perspectives such that one version is seen as preferable to another. Patients themselves may bring with them a set of implicit hierarchies; part of the professional's role would be to sensitively challenge

them. This may be a difficult task since the experience of being medically examined or counselled may cause a patient to move towards a mechanistic perspective, implicitly transmitted via biomedical procedures. Explicit recognition of this tendency within clinical settings would help to avoid reinforcing messages of failure on those individuals whose sexual difficulties make it hard for them to have fulfilling sex as judged by purely mechanistic standards.

5.10 Conclusion

This chapter sought to explain the variation in individual priorities for a functional sex life in terms of three different 'scripts' or versions. I showed how most respondent accounts approximated to a particular version when framing their priorities and evaluating their experiences. In the interpersonal version, the focus was on intimacy, emotional security and reciprocity, and the main threats to functional sex were relationship or emotional difficulties. In the mechanistic version, the focus was on genital performance with physical release and procreation as key functions; the main threat to ideal sex was failure of the physiological responses (e.g. erectile difficulties or lack of lubrication). The erotic version was about recreation and the focus was on enjoying pleasurable sensations. The key threats to functional sex were lack of novelty, boredom, over-familiarity and discordant sexual preferences. These versions or scripts were abstractions and not immutable categories; individual accounts only approximated to these versions and were liable to change over time (dynamic rather than static).

My typology has several potential applications. Importantly, it provides a conceptual foundation for my measure of sexual dysfunction. For the measure to capture the observed variation in individual meanings of functional sex, it must include elements from all three versions. The typology may also prove useful in therapy, for instance, in exploring problematic discrepancies between versions adhered to by a respondent and their partner. Finally, it has potential to help explain differences in meanings of sexual function across age, gender and sexual orientation.

Chapter 6

Candidate Components of a Functional Sex Life

6.1 Introduction

In the previous chapter I introduced the three different versions of functional or ideal sex that appeared in respondent accounts. In this chapter I explore the components of these versions in more detail. At this stage I do not argue definitively for the inclusion of each component in a conceptual model of sexual function; that process occurs in chapter nine. Here, I merely present the evidence for each component from my data. I begin by raising some questions about what is being measured. Because it is sometimes easier to know what you want by defining what you don't want, I also examine what is seen as problematic as well as what is seen as ideal. The assumption is that if an experience is considered highly problematic, its absence must be integral to defining a sex life as ideal. Thus at the end I summarise the results of the card game and briefly present a vignette to demonstrate how sexual difficulties are inter-related. At the end of the chapter I return to the versions to examine how the components described here fit with these versions. I use the terms functional and good enough interchangeably throughout the chapter (see chapter three for a discussion of terms).

6.1.1 Explicit and Implicit Definitions of Ideal

There was a high level of congruence between definitions of good enough sex provided explicitly (in response to an early interview question asking participants to describe an 'OK' or 'good enough' sex life), and those implied in respondent accounts of their experiences. Preliminary and general questions such as my opening gambit ('how would you describe an OK sex life – what factors would you include?') often attract standard and normative answers, but this was not often the case here. Instead, most respondents provided candid answers that were specifically relevant to their own context, often citing

factors that were missing from their current sexual experience. Respondents who rated their sex life as not good enough, tended to conceptualise their ideal as 'other' than their own experience. For instance, a 46 year old woman who experienced pain on intercourse (F46) immediately described non-ideal sex as *being with someone that you care about and not being able to have sex in any sense because you know that it's going to hurt.*

The fit between explicit and implicit criteria for ideal sex was particularly good among individuals with a story to tell; typically, those with sexual difficulties. Where respondents had rehearsed their stories or reflected on their experiences (either alone or through counselling) they immediately supplied individually relevant rather than normative responses. Perhaps because they had a story to tell, many were eager to move away from abstract discussion towards more personally relevant detail. Answers to this opening question sometimes appeared to be constructed primarily to segue into dialogue about personal experience:

IV: What are the factors that would need to be there in order for you to describe the sex as good or as a positive....your sex life is good and positive?

M33: Being able to say "no" if [one of you doesn't want it] and taking some of the pressure which is my particular problem I suppose, of when you do have sex that actually you know that's what both of you want and therefore it flows from there.

However, there were times where respondents were necessarily required to think hypothetically (for instance in the card game). The difficulty of imagining life without something one has always taken for granted was highlighted by one respondent using career as a reference point:

F35: ...So I think [sex] is immeasurably important – much more important than my career in a way; but then I don't know because I've never not had a career

This difficulty was evident with respect to experiences such as orgasm. Those who experienced orgasm with ease tended to assume that it was mandatory to good sex while those who found orgasm difficult were less likely to view it as essential.

6.2 Candidate Components

The candidate components are summarised in table 6.1 and described below.

Criteria	Sub-criteria
Functional self	Happy body feeling Ability to give and receive pleasure Positive sexual identity Confidence to communicate needs Positive motivations to have sex Lack of anxiety
Conducive environment	Privacy Absence of stress and tiredness
Balanced partnership	Reciprocity Motive compatibility Sexual compatibility – roles and preferences
Psychological security	Trust Warmth Feeling wanted
Connection between partners	Interpersonal connection 'Chemistry'
Enjoyment and satisfaction	Enjoyment and satisfaction Novelty/Excitement
Orgasm	Regularity Quality Timing
Sexual desire	Mutual desire – balance in desire across couples Motivation to have sex Not avoiding sex
Arousal	Subjective Lubrication Erection function
Absence of pain	
Partner experience of problems	
Frequency	Relative frequency Absolute frequency

Table 6.1 Candidate Components of Sexual Function

6.2.1 Functional Self

The data presented in chapter five identified sex as a potentially vulnerable act with an attendant risk of rejection. Thus it was not surprising that key components of an ideal sexual self centred on feeling confident and comfortable. Several respondents described how they ran away from or avoided sexual encounters because they lacked sufficient confidence and comfort. As one woman put it:

F31: I think you have to feel comfortable with yourself and you have to have respect for your own body. You need a huge amount of self confidence [...] to have a healthy sexual experience.

I identified five factors that appeared to be associated with feeling comfortable and confident. The factors either contributed towards, or arose from, a feeling of comfort and confidence.

The first factor was described by one respondent as a *happy body feeling*. This implied knowing one's body well, respecting and accepting it, and believing that regardless of imperfections, it would appear physically attractive to a partner. According to many of the women's accounts, this was difficult to achieve. As an extreme example, one respondent recounted having blindfolded partners because she was embarrassed about a skin condition (F34). More usually, women worried about whether they looked *fat*, whether their partner would see their *wobbly bits*, and whether they would like what they saw. They felt that it took confidence not to worry about their body but also recognised that unless they were comfortable with their body they would not enjoy the encounter: *...if you're worried about what your bum looks like you're not actually going to enjoy yourself* (F31). This was predominantly but not exclusively a female preoccupation because men don't have *the same sort of insecurity that women seem to develop* (F34). That said, several men were self-conscious about specific areas of their body (such as scars) and one felt that he did not know his body very well (M36). There was also a

feeling, across both men and women that sex improved as you got to know your body better (F38).

A second factor associated with confidence and comfort was a positive sexual identity. This included feeling at ease with one's sexual orientation, and with one's identity as a sexual being. For instance, one man described a previous relationship with a partner who had enjoyed sex but had struggled with this fact because her strict religious upbringing had led her to associate sex with guilt (M56). Some of the gay respondents touched on complex issues around sexual orientation and self-esteem. According to their accounts, coming to a sexual encounter with self-esteem depended to an extent, on the degree to which one felt at ease with one's sexual identity. One gay man described a relationship in which his partner was always passive and:

M52: ...he got more and more unhappy with the fact that he was getting off on being fucked and it was really starting to affect his masculinity in terms of how he felt about himself.

The third factor related to giving and receiving pleasure. Being able to *please a partner* and being able to respond well to them were cited as key components of a functioning sexual self. One respondent explicitly linked his focus on pleasing his partners (rather than receiving pleasure himself) to his lack of self-worth (M48).

Fourthly, having the *confidence* and *vocabulary* to communicate sexual needs within a sexual relationship was mentioned as a key factor by a couple of female respondents. Sexual confidence appeared to be independent from confidence related to other spheres:

F54: You know you have been a powerful person, but that part of you – the sexual part – had gone right back to being a 12 year old wondering what the future will bring

Finally, three female respondents highlighted the importance of making a positive and autonomous decision to have sex. In order for the experience to feel comfortable it was

important to only have sex when you wanted it (F35). Negative motivations included having sex to *please* a partner; *to get him off my back* (F54); and feeling *obliged* (F54). The emotional aftermath of a sexual encounter undertaken for the ‘wrong’ reasons included feeling resentful and feeling *quite sort of empty afterwards* (F42). This latter respondent reflected on a period in her life in which she had wanted:

... a lot of sex with a lot of different people because it fulfilled a kind of need and it made me feel wanted [...] I thought if I went out and somebody wanted to have sex with me, they must like me and that would make me feel better about myself (F42)

At the time she believed that she was having sex because she enjoyed it but more recently, with the help of counselling, she had *worked out* that *wanting to be wanted* had been the primary motivating factor. She felt that for others, as well as for herself, the act of sex was quite ineffective at engendering a feeling of being wanted; the impact was momentary:

F42: *But it was short very lived.[.....] ...I would feel quite empty afterwards and worse really, than I felt before. It's a common thing*

Thus, where respondents looked to sex to shore up their self-esteem, something of a paradox emerged: sex perceived as ‘good’ was more likely to boost sexual self-worth (thereby creating a more ‘functional’ sexual self), but ‘good’ sex required a degree of pre-existing functioning in terms of comfort with body image, with sexual orientation, and with assertiveness. Sex was most likely to boost self-worth for those who already had some and less likely to serve this function for those lacking in self-esteem.

6.2.2 Lack of Anxiety

Anxiety was widely regarded as precluding good sex. It appeared to function both as an original source of difficulty and as a product of other difficulties such as pain.

Several respondents said they found it difficult to relax, let go and *be wild* (M36), and thus had difficulty receiving pleasure. This was seen as clearly detrimental to good sex because it precluded feelings of reciprocity (see section 6.2.4 on Balance below). There was one respondent in particular whose anxiety appeared to be the source of his difficulties (M33). He described himself as a *late starter* to sex and remembered that with his first partners he felt nervous about being *found out* as less experienced. Over time he became anxious about his ability to perform sexually and almost paradoxically, was distracted from enjoying it because he was concentrating too hard. He described how, through counselling, he was trying to avoid getting into this negative thought pattern:

M33: *[Pause]. Yes, because I think... again, it's just from personal circumstances, but actually it's almost been concentrating too hard which leads to the anxiousness. [...] and that mind set thing – “this must work, this has got to happen, I've got to be able to do this” – was part of the problem, and actually not coming into it from that mind set helped. [...] I need to have less goal orientated sexual thoughts.*

For some other respondents, anxiety arose from (and often subsequently reinforced) another problem. One respondent below described how feelings of apprehension and anxiety regarding his erectile difficulties ultimately became more of a concern than the erectile problems themselves. He put this down to fear of failure:

M61: *You're afraid of being a failure I suppose. There's a build up to sex. You build it up and then it falls back on its face.*

Other causes of anxiety included pain and fear of transmitting HIV. A male respondent described how the experience of burning pain on ejaculation had caused him to become apprehensive before sex because *you never know how it's going to go* (M60). And another described the fear of transmitting HIV as a *niggling at the back of your mind* (M52), taking the edge off his enjoyment.

6.2.3 Conducive environment

Respondents highlighted several factors related to the context of the sexual act that were not conducive to good enough sex including *feeling exhausted* (F47) and being preoccupied with work related stress (M39) or simply having a heavy workload: *the more work I have, the less I think about sex* (F34). In particular for those with children, privacy was highly prized. A woman with three children described being used to *that feeling of having to be a bit careful [when others are in the house]* (F47). However, when the house was empty, *the knowledge that nobody's going to come charging through the door is also quite liberating*. Consequently she experienced *some incredibly powerful sex when I was aware that nobody was in the house* (F47).

6.2.4 Balanced partnership

6.2.4.1 Reciprocity

According to the majority of respondents, a good enough sexual encounter (and relationship) implied giving and receiving in equal measure. Being responsive and reciprocating was viewed as important in communicating emotional commitment (see chapter five on the interpersonal version). If a partner did not respond and *enjoy you, there's no point in doing it* (M55), and feedback or reciprocation from a partner was important in creating a good feeling about oneself. Giving was also viewed as pleasurable. One respondent described a *flow through mechanism, because you get the warmth of [your partner's] satisfaction back which is nice for oneself* (M61).

At a broader level, reciprocity implied willingness *on both sides to work at the sex life* (F31), and a commitment to care for each other (*I look after him, he looks after me* (F38)). Maintaining feelings of reciprocity sometimes involved having sex when you would rather not. For instance, one man with erectile dysfunction said he was no longer interested but continued to have sex with his wife as a *kindness* because he knew she wanted it (M70). Descriptions of a good partner were also often construed in terms of reciprocity: *readiness to give of oneself; someone who is concerned with the other's*

needs (M78); someone who *allowed you to have an orgasm and they didn't rush it* (F73); *willing to give as well as receive* (F31).

Importantly, reciprocity appeared to be 'expected'; respondent accounts implied adherence to a normative set of 'rules' dictating an obligation to give as well as receive. These 'rules' were, for some, clearly demarcated by gender. For instance, a few respondents (both male and female) believed that initiating sexual activity was a male responsibility, but thereafter the woman had a responsibility to meet his needs: *once you know he appreciates your body then you can do anything for him* (F70). Both men and women talked about a male duty to satisfy their partner. Several female respondents recounted feeling *lucky* to have concerned and reciprocating partners, suggesting that this was not what they perceived to be the norm. Failure to reciprocate constituted an obvious breach of the implicit 'rules of fair play': *that's not fair if you have penetrative sex with a man and he comes and then he doesn't make any effort to [help you]* (F42)

Certainly, a *selfish* man in pursuit of his own pleasure or unwilling to engage in a shared agenda was described as unsatisfactory by several female respondents (F33; F27). Included under the rubric of *selfish* were men who 'gave' sexually, but for the wrong reasons/in bad faith. A female respondent recounted a previous relationship in which she perceived that her partner's 'giving' was actually intended to shore up *his* sense of achievement, rather than to genuinely give *her* pleasure:

F31: *he was happy that he could do that [make her experience pleasure]. It wasn't like he was happy he made me feel good.*

She described the relationship as *terribly unhealthy*, mainly because *everything was all about him*. Failure to reciprocate was not always about selfishness; sometimes psychological or physiological barriers made it difficult. This is illustrated by the account of a man whose first sexual encounters were with an older man, but who later described himself as heterosexual. Although he enjoyed receiving *blow jobs*, he felt repelled by the man's sexual *smell*. He was reluctant to reciprocate and felt *bad* about this:

M36: ... *because he kept on saying that we should do it for each other and I could never quite... I didn't fancy doing it.*

IV: *Do you remember how you felt at the time about the fact that you didn't fancy...?*

M36: ...*I felt bad because I knew that he's done something for me, I ought to do it for him. It's bit selfish really.*

Gendered expectations notwithstanding, failure to take turns at initiating sex was also seen as a breach of the rules of reciprocation. Always being the initiator was said to be a *drag* (F23); *tiring* (F31) and less than good enough: *I wouldn't want to feel that I was in a relationship where the initiation came from one side.* (F47)

Pleasing 'too much' might also result in a loss of balance, effectively encouraging selfish behaviour from a partner. One older woman recounted that her previous partners did not *bother to notice* whether she was OK. She blamed herself for trying to *please too much – I think I give too much and they don't notice it* (F70).

A less common breach of the rules was failure to receive pleasure. This appeared to be equally disruptive of the rules of fair exchange. One male respondent described his difficulty in allowing himself to receive pleasure from his partner:

M36: *Giving her pleasure – I think I'm reasonably good at that. It does depend a bit on how I'm feeling. I find it much more difficult to receive pleasure, to take pleasure and let my body just kind of flow*

Another male respondent (M78) described the despondency he felt that his wife *gave the impression of being bored in bed. She wasn't very encouraging.* She rarely initiated sex and when he initiated, she *behaved like a good wife.*

6.2.4.2 Compatibility

The term compatibility here refers to both dictionary definitions: a feeling of sympathetic understanding; and a capability of existing in harmonious or congenial combination¹¹.

Wanting sex for similar reasons was construed as important; motive incompatibility was thus problematic. Within a relationship, this was sometimes linked to broader differences in versions of ideal sex (see chapter five). For instance, a woman whose primary motive for sex appeared to focus on intimacy described a previous relationship as *harmful* despite the fact that her partner was both *respectful* and *affectionate* sexually (*a lovely partner in fact*). In contrast to hers, his motives appeared to centre on the erotic (the desire for pleasure) and he appeared to view her interpersonal notion of sex as naïve. Subsequently she felt that *what he wanted to destroy in me was my innocence in a way and that put me off men quite a bit* (F54). In first encounters, motive compatibility was described in terms of a simple dichotomy: *do they just want to shag you or do you want to have...or are they after a relationship* (F35). There was perceived to be a normative gender difference here (M61): women were more likely to be seeking a commitment from sex (interpersonal); whilst men were more likely to be just looking for sex (erotic).

In addition to motives, compatibility in terms of sexual identity and roles appeared to be important. This was discussed at length with some of the gay respondents. Perhaps the starkest imbalance occurred where one partner was 'out' (openly self-identified as gay) and the other was not. For instance, the lesbian respondent believed strongly that she would not want to engage in a sexual relationship with someone who was ambivalent about their sexuality; who was not willing to acknowledge and address those feelings within themselves and who was *afraid of being a lesbian*. She explained: *I haven't done all this work at trying to change myself to go [back] into the closet.* (F53). A gay man (M52) noted that homosexual partners had to work harder to define and negotiate roles within each relationship. He described a *healthy* homosexual relationship as one in which

¹¹ compatibility. (n.d.). *WordNet® 3.0*. Retrieved July 02, 2007, from Dictionary.com website: <http://dictionary.reference.com/browse/compatibility>

partners switched seamlessly from one role to another, achieving equality through a fluid division of roles. Where the roles (lover and loved; active and passive, for instance) were deeply entrenched, incompatibility might occur if one partner felt ill at ease with his particular role. Compatibility in sexual roles need not imply equality. For at least one respondent good sex involved being *domineered by a stronger person [...] there has to be a point of strength about that person* (M48). However, provided each partner was complicit in this 'imbalance' and content with their respective roles, such 'inequality' could be described as both balanced and compatible.

Compatibility in terms of preferences for sexual activities was mentioned by several respondents as a component of ideal sex. It implied being on the same wavelength insofar as any suggestion by a partner did not *come as a profound shock* (M62). As one respondent put it: *what I did to him and what he did to me, it seemed to work for each other* (F42). The versions described in chapter five shed some light on how preferences may be compatible or may collide with each other. For instance, a woman subscribing to an interpersonal view of sex described how she was put off a partner who appeared to have a wider sexual appetite than she did: *I quickly got images of him staying at home looking for porn* (F34). At the extreme end, an imbalance in sexual preferences may result in the less powerful partner feeling pressurised (and even coerced) into engaging in activities that made them feel uncomfortable. A younger female respondent explicitly described a not good enough sex life as one in which an individual felt *that they don't want to be doing a certain thing and the other person's pressurising them into doing it* (F27). Later, she felt sufficient comfort to relay her own story, in which a previous partner had pressurised her to take part in a threesome. When she resisted she felt that *she wasn't good enough* for him and worried that *he wasn't going to be satisfied* with her.

Even where vaginal intercourse is the preference of both partners, there remains wide scope for differences in what individuals want. One woman (F42) described her preference for *straightforward* and *gentle* sex but described many of her previous encounters as coming on *hell for leather and a bit stabby*. Incompatibility became

something of an issue for her because she often met partners in *hedonistic* contexts in which she presented a version of herself that was wild and uninhibited. Thus, she would often end up not having the kind of sex she really wanted because her partner had assumed a set of sexual preferences predicated on an incorrect notion of her 'true' sexual self. She felt that she lacked vocabulary and confidence to express her preferences without upsetting her partner and thus compatibility became mostly a matter of *luck*.

Factors such as HIV status had potential to create imbalance within sero-discordant couples. One HIV positive respondent (M52) related how he and his (negative) partner differed in what they considered to be 'safe' activities. Prior to his diagnosis they were on an *equal footing because I wasn't diagnosed with HIV, I wasn't taking the drugs, I wasn't ill*. His sero-conversion created an imbalance in sexual preferences: *he wants full sex and I don't always want full sex, so there is that gap between our relationship which wasn't there when we first got together*.

6.2.5 Psychological security

Psychological security was described as a *comfort zone* that had to be built within each relationship (M48). It is defined here as a characteristic of the partnership, although it is presumably most likely to exist where both members of the partnership are psychologically secure as individuals. Several inter-related components of this comfort zone were identified: trust; warmth; and feeling wanted. I discuss each in turn.

Trust (and feeling trusted) was talked about by several respondents (mostly female) in the context of a good enough relationship. From an interpersonal perspective, sex involved *giving someone the most special gift you can ever give* and therefore required a *huge amount of trust* (F31). A relationship without trust was said to be characterised by possessiveness and jealousy (F53).

Trust was of particular concern to those who had experienced a loss of trust in a previous relationship. Breaches of trust generally concerned infidelity, an act seen as creating a

block to a trusting relationship: *If I felt that...if he was sleeping with other people or had done. I think that might create a bit of a block* (F35). For a smaller (and notably male) group of respondents, the issue was less about fidelity than honesty. For instance, a gay male respondent explained that open relationships were possible with a *clear set of rules*, but even then, in practice it was difficult to continue to feel secure. He described his current open relationship as not good enough because lack of clarity regarding the *rules* left him feeling confused (M48).

A second aspect of psychological security was warmth. For some respondents, particularly those who construed sex as the ultimate expression of intimacy (interpersonal version), a warm, close, caring relationship was prerequisite to emotional security. In such a comfortable relationship it would be possible to *sit in a room [together] and do absolutely nothing, and feel happy and contented with that person* (M61). For some respondents warmth appeared to be generated more by physical affection than sex per se. For instance, a woman described feeling connected to her partner despite the fact that they had not had penetrative intercourse for years. Because there were lots of hugs and kisses she said, *oddly enough, we're extremely happy* (F51).

It is worth noting that some individuals find warmth and emotional closeness difficult; there was at least one story of a relationship breakdown because a partner *couldn't cope with the closeness that had developed between the two of us* (F42). As we have seen above, several respondents felt that it was possible to have enjoyable sex in the absence of warmth. One respondent recalled that some of the best sex she'd had was with people she had been breaking up with. Such encounters were still passionate but the passion was *fuelled by anger rather than lust* (F34).

Thirdly, feeling wanted by a partner appeared to be important for emotional security. Some of the male respondents appeared to equate feeling wanted with feeling desired: *I have to be with someone that is passionate for me* (M55). Women, by contrast, seemed to equate feeling wanted with a partner who showed sensitivity towards their needs and signified their commitment via, for instance, a willingness to engage in activities that

might be regarded normatively as undesirable (*only one person's been committed enough to go down the oral front!*) or difficult (such as enabling a female partner to reach orgasm).

6.2.6 Connection between partners

Connection between partners was commonly mentioned as an aspect of a good enough sex life. The term was used to convey a broad range of experience and was often nebulously defined. A second term, chemistry, appeared to imply a specific kind of physical/sexual connection.

Connection was implied in a range of descriptions of a good sex life: as *a real sort of bond or love for that person* (F35); *whether the person is with you or away, you still feel a sort of good feeling* (F38); *an invisible chord that stays on there* (M48); *an emotional identification* (M78); *feeling the other person's drawn to you* (F31); *mentally in tune* (F38); *constant looks, the constant real, real kisses... It's like you can almost sense that someone wants to be with you so to speak* (M48); *in love* (F23). Several respondents described experiencing the *strong bond* characteristic of early relationships in which *the outside world wasn't an issue* (M48). As far as sex itself was concerned, a connection was said to be a key determinant of sexual satisfaction and enabled [you to] *let yourself go with the way you express yourself* (F35). Respondents highlighted several benefits to a sexual connection with a partner who was known well: *[Known partners] start to know how to motivate you and excite you [...] to push the right buttons* (F46); *the rules of the game are known* (M56); *there is less worry about making the right impressions, not going about it the wrong way, not causing offence* (M56); and it was more conducive to achieving intimacy (M52). These factors engendered a more *interesting and fun* sex life (F31).

Indicators of loss of connection were construed as a distraction during sex when one partner is not *involved or engaged* (M62): *your heart isn't in it, your soul isn't in it, that you're not there to the same degree or level of engagement*. At a relationship level it

might imply a partner *closing down and being withdrawn* (F53) or a feeling that the couple has lost *rappport* and that the relationship is *not going to go anywhere* (F23). One woman described feeling she had lost connection with her partner during sex when he appeared to be *somewhere else in his head*. If he failed to maintain eye contact or appeared to be following his own agenda, this made her feel *empty* (F33).

There was some discussion about whether sex devoid of interpersonal connection (casual sex or masturbation for instance) could ever be good enough. Most commonly respondents (both male and female) believed good sex was possible without the warmth of an interpersonal connection, but only up to a point: *That's one of the things that rather surprised me, but yes, at the end of the day [casual sex] is not satisfactory but it can be good for quite some time before you think, "well, what am I doing?"* (M61). It was argued that much depended on *where you are in your life and what you're after* (F23), whether the partner knew *how to touch you and where to touch you* (F23) and whether you were able to *still [...] feel comfortable with the intimacy* (F35). However for some respondents (notably those whose accounts fitted the interpersonal version), sex was seen as inextricable from the relationship and a sexual encounter could not be 'complete' without an interpersonal connection. In this view, the relationship was seen as the real substance, and the sex component a decorative bonus: *[Sex is the] ...cherry on the cake..... but when you are hungry, the cake [relationship] is more important than the cherry* (F54). This analogy suggests that a cherry without cake (sex with no interpersonal connection) would be unsatisfying.

The term 'chemistry' appeared regularly in respondent accounts. In general it was used to indicate a particular type of erotic connection based purely on physical – or chemical – attraction: *like going from neutral to fifth; You know when somebody just walks in a room and you go "wow"; a wonderful animal spark* (M52). Chemistry was said to go beyond *liking what you see aesthetically* (F23) and in this sense the term was often used to fill an 'explanation gap' in understanding why sexual attraction occurred. One male respondent described chemistry thus: – *for whatever strange reason you are just very very attracted to someone – but for reasons you possibly can't explain, but that the*

genes, the chemistry is just right (M56). It was seen by some as independent from a personal or emotional connection and was most often used to describe new relationships. That said, a powerful connection was still possible within a long term relationship as this married woman attested: *I'm kind of amazed that two people who have made love thousands of times can still have these experiences sometimes and for no particular reason it seems. [...] ...sometimes it would just be so powerful* (F47).

Three respondents (two women and one man) described in detail the loss of chemistry or physical attraction within relationships that remained 'connected' on emotional and personal levels. One of them (F35) described a previous relationship in which she *stopped finding the person desirable or attractive and that, despite the fact that [she] loved him to bits. Eventually she lost [her] desire for him and it pretty much destroyed [their] relationship. The loss of desire appeared inexplicable: there was no explanation of why the desire stopped, which was very weird. I still don't know to this day what happened* (F35). Another woman described how she attempted to keep the relationship going despite the fact that the sex was *off-putting: I basically didn't fancy him but I was trying to convince myself that I did because [...] he was a good bloke and was brilliant for me* (F34). And in all cases the impact on the relationship was disastrous.

6.2.7 Enjoyment and Satisfaction

Around a third of respondents explicitly mentioned enjoyment, satisfaction, fulfilment or related terms (fun, excitement) when asked to describe ideal or functional sex. It was notable that for respondents encountering sexual difficulties, a key concern was that they had stopped enjoying sex. And in long term relationships, keeping things exciting was often regarded as the primary challenge.

The term 'excite' or 'excitement' was used often to describe different facets of sex: a state of arousal (*feeling excited; F42*), the experience of orgasm (*crescendo of sexual excitement; F33*), as well as a feeling of attraction (*they find you sexually exciting; M55*).

The term 'satisfaction' was used by respondents on three levels. In its narrowest sense it was used to infer an orgasm. At the next level, a specific encounter might be described as satisfying or otherwise: *I guess guys I've been with - a lot of them are quite caring and ask whether you are satisfied* (F23). At the broadest level, it might be used about a sex life: *For me, my own sexual satisfaction – or even my sexual functioning, as it were – was very much dependent on how I felt in the relationship emotionally* (F54). Various expressions were used to convey the idea of lack of satisfaction: *feeling empty; not getting what you wanted; no enjoyment; not feeling content and complete*.

There was of course, wide variation regarding the components considered essential to enjoyment and satisfaction. The variation could be understood in terms of the versions of sex to which individuals most closely adhered. As described in chapter five, the erotic version was most centred on enjoyment and satisfaction, emphasising physical components such as: *variety of activities; enthusiasm, perspiration; physical movement and abandonment* (M60); *talking about what you enjoy/fantasies; using all your senses* (M55); *fresh and fun* (F33). The antithesis of enjoyment was boredom: *you're bored with each other or you just don't know where to go now because you feel it's the "same old, same old"* (F23), or sex that was monotonous, *humdrum* (F34) and *bland* (M55). Within the mechanistic version of sex, orgasm was among the first of the components requisite for an enjoyable and satisfactory experience (see section 6.2.8 on orgasm). Finally, within the interpersonal version of sex, enjoyment and satisfaction were closely tied to aspects of the relationship already described (reciprocity, compatibility and psychological security); it also had to be mutual: *not just about his pleasure; it was our pleasure* (F60).

6.2.8 Orgasm

There was variation in the degree of importance attached to orgasm as a component of good sex. As described above, a few respondents (particularly those whose accounts fitted best with the mechanistic and erotic versions) equated orgasm with satisfaction or described it as an essential component of sex:

IVR: *When you say satisfactory sex, what factors need to be present for it to be satisfactory?*

M56: *[.....] The definition of a good satisfactory sexual experience – that both of you would mutually enjoy it equally; that both of you would therefore experience orgasms [...].*

From this perspective, sex without orgasm engendered a feeling that there was *something missing*. One woman likened sex without an orgasm to eating an appetising plate of roast beef but having your plate taken away before you had the chance to finish. For the majority of respondents orgasm was closely linked with satisfaction but not prerequisite. According to this perspective, an orgasm helped to *complete* sex but was still more a bonus than a necessity:

IV: *So are you defining it then that 'sexually satisfied' means that you've come?*

F42: *Quite a lot of the time but not always. It doesn't have to be, but it always... I'd feel like I've rounded it off quite nicely.*

Finally, a smaller number felt that it was not necessary to experience orgasm in order to feel satisfied. For instance, one female respondent described orgasms as important, but more for her partner than her. *On the whole I'm not bothered whether I do or do not. I'm not bothered – it doesn't detract greatly from whether it's satisfying or not (F47)*. Even so, this respondent believed the orgasm was *the clearest physical expression of satisfaction*.

Consistent with the section above on balance, many respondents were concerned as much about their partner's orgasm as their own. The ideal was that both partners should achieve orgasm. Thus, encounters in which only one partner achieved orgasm were ideally *the exception rather than the norm* (M65). Where mutual orgasm was prioritised but not achieved, there was potential for dissatisfaction:

F27: *I have been in relationships where the man has tried to satisfy but it's never happened. So they've tried to make me achieve orgasm, or whatever, and it's just not happened. So I suppose that makes it kind of unsatisfactory.*

In the context of the mechanistic version, lack of orgasm was considered *a real problem* because it precluded *the ultimate release of bodily fluids* (M39) and *release of all that tension*. One woman felt she would go *insane* if she was not able to achieve orgasms with some regularity. Several respondent accounts suggested a widespread belief that *something was wrong* (M65) with individuals who had difficulty achieving orgasm.

Interestingly, gender differences in the importance accorded to self or partner's orgasm were not marked. For both genders, an orgasm was said to span *a whole gradient of different sexual experiences* (F47), suggesting that the subjective experience of orgasm might be seen as a continuum with *lower order* at one end, and *cataclysmic* at the other. Although some descriptors were used in relation to both male and female orgasm (*muscle contraction; release of body fluids*), the experiences of men and women were seen as quite distinct and so are described separately below.

Female respondents described the experience of orgasm in a variety of ways: *feeling sensational; thrill up [your] leg; a great shove that sends you off into a place where your whole body is tingling and happy [...] it's a rocket (firework) because it goes 'chonk' and then you get all that crackling, tingling; explosion, tension and then release of tension*. However, some found it difficult to define:

IV: *Orgasm – what does that mean for you? How do you define...?*

F23: *I don't know, I don't know! I don't know. I don't know how to define it. It's like the feeling that you get when you... I don't know. I guess... like...[pause].*

It was generally believed that the female orgasm took *practice* and depended on knowing and controlling one's body. Several women described 'discovering' orgasms quite late on in their sex lives. Both male and female respondents noted that the female orgasm was more elusive (*like looking for a needle in a haystack*; M55). Perhaps because of this,

there was a feeling that women were more able than men to enjoy sex without climax and to be satisfied with achieving an orgasm only some of the time. For a few men, the very elusiveness of the female orgasm made it all the more important to ensure that it happened; they perceived it very much their responsibility and viewed it as an accomplishment. They also felt that the rarity of the experience had other compensations for women

M70: It seems to me that a male orgasm is virtually guaranteed every time, but it is of a very, very, very low order, whereas the female orgasm...the female pays for her orgasm as it were, by not having it every time, but when she does have it, it's cataclysmic – she goes through the ceiling, which I suppose you will say is me complimenting myself on being a good lover! [laughter][.....] Obviously with a good lover, or whatever, I just do think the height of female ecstasy is like Everest compared to a molehill. Again going back, that is partly why I think men go in for achievement, for notches on the bedpost as it were, precisely because [the male orgasm is] very repetitive and very dull – well not dull but...

Although the male orgasm was often conflated with ejaculation (*the release of body fluids*), several respondents distinguished between the release of sperm (ejaculation), and the *sensation before ejaculation [...] a lovely feeling; your whole body shakes.* (M61). Another respondent (self-defined as having sexual function problems) said that *orgasms are always wonderful but ejaculation itself can be draining* (M36). It was also defined in terms of *physical and mental release* (M33). Both male and female respondents believed that the male orgasm took *less effort* compared with the female orgasm. It was expected that the man would have an orgasm as a matter of course. As a result, when a man failed to achieve orgasm, or took a long time to achieve it, their female partners tended to feel *inadequate*, interpreting it either as their failure to provide sufficient stimulation, or as an indication that their partner was not sexually attracted to them.

Whether the timing of orgasm mattered appeared to depend on whether it was seen as the *end of [sex]* or not (M36). The gay respondents in particular did not view orgasm as

necessarily bringing pleasure to an end; rather they saw opportunities for further orgasm or for helping one's partner reach climax. Also, for those with an erotic focus, timing was more a matter of different needs for different occasions. For instance, one heterosexual respondent likened early orgasm to a shot, and delayed orgasm to a pint of beer; although a pint is more thirst-quenching, sometimes you just feel like a quick drink with an immediate impact (M55). However, among heterosexual respondents, the common view was that an orgasm completed sex or *rounded it off* and thus a sooner-than-desired orgasm might be construed as problematic.

6.2.9 Sexual desire/wanting sex

Sexual desire was construed as part of a *healthy, balanced relationship* (F31), with balance in desire between partners a key component of a good sexual relationship. Desire was talked about on two levels: a general ongoing sexual interest in another person (*seeing someone you fancy*), and a specific desire to engage in intercourse that is experienced proximate to sex taking place (*the impulse to kiss/hug someone and eventually have sex with them*). It is worth noting that feelings of desire appeared to be as much for intimacy and closeness as a desire for physical intercourse. Sexual fantasies were regarded as integral to desire and satisfaction for some men, but did not emerge in discussions with women. Although lack of desire per se can no doubt be problematic for the individual independent of relationship context, almost all the discussions about sexual desire in these data centred on its role within the relationship (see also chapter five on the interpersonal version of sex).

Several respondents recounted previous (and current) relationships in which an imbalance in desire had become a *huge issue* and even occasionally led to relationship break up. Balance in desire was recognised as a source of *arguments or difficulties in the relationship* (F27) but was also seen as difficult to achieve: *one always wants it more than the other* (F46). A gay man described a previous relationship in which such arguments were avoided by amicable compromise (M52). He and his partner would play backgammon; if he won they would not have sex and if his partner won they would. The

employment of rituals to avoid (or cover up?) potential conflict gave further credence to the idea that imbalance was perceived as potentially threatening to the relationship.

Several respondents referred to a normative assumption that where imbalance exists, it was typically the woman who desired sex less: *I think as a typical woman my main, if you like, problem with sex was [my] level of desire – how much [I] actually felt in the mood for sex ...* (F54). However, for four female respondents, this normative belief sat at odds with their lived experience, in which their male partners wanted sex far less than they did. Over the course of a long term relationship, the issue was not just about wanting sex in equal amounts, but also wanting it at the same time. For instance, (M61) described a not good enough relationship as *one where you don't feel that you both desire sex at the same time.*

Respondents noted several potential implications of an imbalance in desire. For the partner who desired sex less there was potential to feel pressurised into having sex when he/she would rather not. For example, a female respondent talked about a previous relationship in which she felt constantly under pressure to have sex. She would go to bed thinking, *“oh God, is he going to want sex?”* (F42). Another woman described having to run away to the house of a relative because of perceived pressure from her partner when she was pregnant (F38). Finally, a man who was seeking help for his low desire described the pressure involved in saying ‘no’ to sex:

IV: *What are the factors that would need to be there in order for you to describe your sex life as good and positive?*

M33: *[Long pause]. Both of us really feeling that we're wanting it.*

IV: *Both wanting it?*

M33: *Yes [long pause] Being able to say “no” if that's not there and taking some of the pressure which is my particular problem I suppose, of when you do have sex that actually you know that's what both of you want and therefore it flows from there.*

The partner who desired sex less also had to contend with the feeling of letting down their partner. For instance, an HIV positive gay male described the guilt he felt at saying 'no' to sex with his partner: *He's very understanding but I sometimes feel, especially if I'm adamant that there's no way we're having relations, a bit guilty afterwards I'm afraid, because I think that he thinks I'm still pushing him away and that's not the case* (M52). Finally, it was felt that the partner desiring sex less would have to live with the fear that their partner would go elsewhere to meet their sexual needs. Several respondents mentioned the *paranoia* that might stem from the fear that a partner *may well decide to go outside* (M56)

On the other hand, the partner who desired sex more had to contend with possible feelings of rejection and fear that all was not well with the relationship:

F23: If I was in this relationship and he didn't really like sex very often, well I'd be like "hmmm, what's going on, why aren't you... Is it because you're not attracted to me or" - whatever, whatever. I think there'd be a reason and then I think, probably because things weren't going well or...

Even where respondents recognised at a surface level the wide variation in innate sexual drive (*you've got to accept the person for who they are* (F23)), underneath, many said they would find it difficult not to interpret a partner's low desire as *rejection*. For instance, one woman said that if her partner rarely initiated: *I would find it hard to feel the confidence that they were sexually interested in me* (F34). They might also come to feel that their sexual needs were not being met. For those whose priorities fitted the mechanistic version, this was of particular concern.

Because masturbation was generally viewed as straightforward for men, they sometimes used it as an indicator of their level of sexual desire, such that a decline in frequency of masturbation was taken as a sign of dwindling desire. For instance, the respondent below, in talking about the impact of six monthly testosterone implants on his level of desire used masturbation as his primary indicator:

M36: *I'm totally in service if you like – subservient to the implants working. That's all. The sexual drive goes hand in hand with it.*

IV: *So it depends on how well the drugs are working sort of thing?*

M36: *At the peak of the 6 month period I'm masturbating every day. I want to masturbate more than that really, but at the end of it I don't masturbate at all – I've lost all sex drive and I hardly ever get an erection.*

Fluctuations in desire were widely regarded as commonplace and 'normal'; nearly all the respondents had experienced a loss of desire for sex at some point in their sexual career. For instance simple tiredness was said to *kill* desire. One respondent likened being tired to having a McDonald's before going out for a posh meal; it simply spoiled the appetite (F47). It appeared to be both expected and accepted that desire would diminish (or 'take a back seat') where circumstances necessitated. Examples of such circumstances included being single and unable to find a partner; a stressful period at work or a period of depression. It was expected that desire would return at the end of such episodes.

However, a loss of desire that turned into an avoidance of sexual activity was considered highly problematic. It was construed as a form of denial or *ignoring the problem* (F53). Avoidance suggested that an individual had given up trying to deal with the underlying problem and was simply running away: *from my own experience, it's running away from the problem I suppose and not confronting it* (M33). It might also be construed as a rejection of the relationship, leading the 'rejected' partner to question its foundations:

M52: *[avoidance] would be a real problem for me because I would feel that to be a rejection of the relationship and it would make me think that there was some deeply underlying problem there. It might well be that the person is finding sex somewhere else [...] or that the person has fallen out of love with me.*

This feeling of rejection could be very hurtful: *[Avoiding sex is a] slight on one of the people [.....] It's very bad when I'm [avoiding sex] and it's very, very hurtful when I've experienced it – very (M56).*

6.2.10 Feeling Aroused/excited

Respondents gave various definitions of arousal. Most centred on the idea of an altered physical state where sex was imminent. Phrases such as *turned on*, *awakening of the senses* and *horny* were used to describe this altered state. Often it was difficult to describe the exact feeling:

F51: you get this sort of urge. Sometimes you wake up in the middle of the night and think "ooh God". I'm sure all women feel like that

It is interesting that despite being able to provide only the vaguest description of this feeling, the respondent assured me that it is common to all women. It is conceivable that at least some women would know exactly what she is describing, regardless of the hazy description. The lack of an available script for such an apparently common feeling was striking.

Reaching a state of arousal was generally thought to require a degree of *touch* and *stoking interest*. Often respondents differentiated between desire as a thinking state and arousal as a *natural, physical state*. Several signs of arousal were mentioned by both men and women. In addition to lubrication and erection (described below), respondents mentioned physiological signals unrelated to genitalia, such as tingling, quickened heart rate, breathing faster, feeling excited, having a dry mouth and sweating. Both genders also mentioned the idea of *losing inhibition* and *loss of rational thought*.

While women tended to focus on erections as a sign of arousal in a male partner, male respondents seemed less clear about what to look for in a female partner, mentioning

vague signs such as *postures, attitudes and glances* as well as lubrication. There was a feeling among male and female respondents that women have a diverse range of *stimulatable areas (its like the Bermuda triangle down there (F31))*, whereas men have only one.

Arousal appeared to be an important component of good enough sex. A heightened physical state of excitement was believed to contribute to greater enjoyment as well as demonstrating mutual sexual attraction and wanted-ness. These functions seemed more important for erections than lubrication (see below). Difficulty becoming aroused was viewed as a *profound problem because everybody's spinning their wheels (M62)*.

Lubrication (*feeling wet; damp in the vagina; soaked*) appeared to be the primary sign among many signs of arousal in a woman. Despite this, it was not always so salient even for women themselves. One female respondent said she would notice lubrication only if she was particularly responsive or unresponsive (F47). Women also mentioned a diverse range of other physiological indicators (hard nipples, lips swell, sweating), although some were unsure about what happened:

IV: *Does anything happen physically in your body, that you think, 'I'm aroused'?*

F23: *Yes. I don't know what though! You have that feeling – I don't know. I probably feel satisfied.*

In my data, absence of lubrication (vaginal dryness) was not generally regarded as a significant problem. As well as being perceived as easy to fix, the lower awareness of lubrication (compared to an erection) meant that lack of lubrication was less likely to signify 'failure'. It could become a problem if externally-applied lubricant was not used or failed to work: *It's only a problem if I realise I'm more dry than other times and then not do anything about it, and just would have sex without lubricant (F53)*, thus leading to dry and painful sex.

For men, an erection appeared to be the only indication of arousal that mattered. It was seen as *a springing to life* and conveyed a sense of *urgency* and *crescendo*.

In the context of the mechanical version of sex, an erection was viewed necessary to achieve penetration. And where penetrative intercourse was regarded as the only 'proper' way, erectile failure was seen as precluding sex or at least making it *very very difficult* (M61). Some men, though by no means all, also considered an erection necessary in order to feel properly aroused.

Several men reported experiencing erectile difficulties and they were nearly always considered problematic. Men who had encountered erectile difficulties said they experienced feelings of inadequacy, failure and loss of self-esteem. This was partly because failure to get an erection implied inability to engage in penetrative intercourse which was *absolutely disastrous* (M56); and a sex life without penetration was *leading nowhere* (M70). It also meant that a man was unable to demonstrate to his partner firstly that he was able to receive pleasure and be responsive and secondly, that she was able to turn him on. Most women and gay men said they would interpret erectile failure as a loss of sexual attraction towards them and this would knock their confidence. As one woman put it, a male partner needed to get an erection so that *the woman doesn't feel like she's not good enough and can't turn her man on* (F27). This interpretation appeared to persist even in the face of other explanatory causes. For instance, several women said that although on one level they understood that their partner's lack of erection was nothing to do with them, they continued to see it as their fault, telling themselves, "*oh, I'm obviously rubbish then*" (F27). It was sometimes only with hindsight that women were able to consider alternative explanations: *I did take it quite upon myself that it was him not finding me attractive but with the benefit of a few years on, it might also be to do with how much he drank and smoked and all sorts of other things* (F34).

6.2.11 Frequency

Frequency of sexual intercourse was generally considered a component of a good enough sexual relationship. On occasion, it was used as a proxy indicator of the health of a

sexual relationship. Sex less than once a month was used to indicate a relationship that had become *humdrum*: *It felt like it was sort of going humdrum very fast. I wondered how long it was going to take before it was once a month and that sort of thing* (F34).

However, for at least one respondent, frequency of intimacy was more important than frequency of intercourse; whilst for others, quality and frequency were separate such that if the quality was good then the frequency was unimportant.

On an interpersonal level, sex was generally regarded as important in maintaining an emotional connection and keeping alive a degree of 'passion': *a few times a week there has to be a passion there to keep alive that feeling that that person is very interested in you sexually* (M55) even it's only *mediocre* sex. There were several respondent accounts of relationships in which a significant fall in frequency had led to an erosion of intimacy and feelings of affection:

F46: *'Cos me and my other partner – well I think that just got to the stage where we hadn't had sex for so long that we got to the stage that when we did have it, we didn't really feel that way about each other anymore.*

One respondent (F53) likened the absence of sex in a previous relationship to a *closed door* between partners, while another (M70) described how the *inhibitions* that arose after years of not having sex with his partner, became a barrier to attempting intercourse.

For one respondent experiencing sexual difficulty (M36), regular sex reduced the pressure for any single encounter to be 'successful'. On the other hand, another respondent experiencing low desire (M33) deliberately sought to reduce frequency in order to increase their level of desire (working on the principle that absence makes the heart grow fonder). Thus it appeared that frequency of sex could be manipulated in different ways by those attempting to solve their sexual difficulties.

In the mechanistic version, regular sex was felt to be necessary in order to meet a physiological need. The importance of having needs met has been discussed in chapter

five in discussion of the mechanistic version and so I merely highlight it here. There was some evidence of normative support for this belief. For instance, one respondent (F38) relayed how her work colleagues used to 'explain' aggressive female behaviour in the work place by saying "*Oh, they're not having sex*", implying that regular sex was required to keep unfeminine behaviours at bay.

There was some discussion about whether good enough frequency was relative only to the expectations of each couple, or whether there might be a widely agreed normative level. Several respondents said they would be concerned only about a drop in frequency relative to their 'normal' level: *... for me there is a normal amount of sex that we would have and if it's below that I kind of think there's something wrong...*(F35). A sudden decrease in frequency with no obvious and legitimate explanation would thus be problematic and threatening to the relationship.

Other respondents appeared more concerned about a level of frequency that was below what they perceived to be normal or expected given the relationship context. There was a sense that couples ought to achieve a given level: *We don't go at it as often as we should* (M60). Although the frequency of sex considered ideal or normal varied considerably, there appeared to be fairly good agreement that less than once a month was problematic. For many respondents, this equated to almost nothing and implied unhappiness for both partners: *We used to frankly have sex once a month or something like that, and neither of us could have possibly been happy about that* (M56). Certainly, couples who had no sex at all were considered *peculiar* (F47). There was also indications of a normative expectation that frequency would reduce both as a function of age and duration of the relationship.

6.2.12 Absence of Pain

Whenever pain was discussed, it was clearly felt to be at odds with a good enough sex life. Most respondents felt it would be *awful* and *distressing* to experience a level of pain that precluded sex or prevented enjoyment. Furthermore, it was noted by some

respondents that pain might signal deeper underlying physical problem in need of attention. However, it was also noted that where alternatives to vaginal penetration are seen as acceptable, as in for instance lesbian sex, pain is less problematic because there are other things that one can do. It was noted that *pleasure and pain are very close* (M55), so that for some individuals, and in certain sub-cultures, pain is seen as pleasurable and is deliberately sought as part of the sexual experience. The difference between 'pleasurable pain' and 'problematic pain' appeared to be about volition (whether the pain was within the control of the individual and his/her partner) and severity. As one respondent noted, extreme pain *takes it out of the sexual zone – it becomes a physical issue* (F34)

Three respondents described experiencing pain during intercourse and all had found it problematic, though to varying degrees, according to the severity of the problem. At the mildest end, one man (M55) reported sometimes experiencing non-sexual pain caused by knee problems. This was a source of distraction and exacerbated his difficulties reaching climax but not a major source of distress for him. More seriously, another man (M60) experienced burning pain on ejaculation which caused him to feel apprehensive prior to sex, contributed to difficulties getting an erection, and led him to attempt sex less often. He was seeking help for the problem. Most seriously, a female respondent (F46) with vestibulitis (inflammation of the vaginal wall) described how the constant pain had dominated her life leading directly to depression, unemployment and ultimately, the break up of her relationship.

6.2.13 Partner is Problem Free

It should be clear by now that a problem experienced by one partner impacts negatively on the other partner. In this chapter, I have already explored instances in which difficulties experienced by a partner impacted on the other's enjoyment of sex, for instance the loss of confidence experienced by women whose partners were unable to attain an erection; and the feelings of failure experienced by men whose female partners had difficulty reaching orgasm.

Nine respondents described instances in which the primary difficulty with their sex life lay with their partner. Five of these were briefly relating previous relationships in which their partner: had had erectile difficulties (2); been sexually abusive (3); had had serious issues with regard to sexual identity (1); and had not enjoyed sex (1). The other four (all women) were currently in relationships in which they perceived that their partner had sexual difficulties and their descriptions of, and reactions to, this problem was a major focus of the interview. I explore these reactions in detail in chapter seven. However, I focus here briefly on two particular accounts of women with partners who had declined to have sex with them for many years. On paper these women might appear to have poor sexual function: low frequency of sex, low frequency of arousal, excitement and orgasm, lack of satisfaction. But both respondents clearly perceived the problem to belong to their partner. One woman (F64) described her husband as asexual; they had not had sex for 30 years (although they had done sporadically for the first five years of marriage). She described how he lacked warmth and lacked the energy to *finish the act* although he could get an erection. She had stayed with him for family and social reasons and had coped sexually by having a couple of affairs and by masturbating. In the main, she missed warmth more than sexual activity. The second woman (F51) described how she had not had penetrative sex with her husband of 13 years. She believed that her husband avoided sex due to erectile difficulties stemming from a lack of confidence sexually. She embarked on an affair after 3 years and used masturbation to relieve sexual frustration but had gradually come to view the situation as less devastating. She described her husband as affectionate and their relationship as otherwise quite happy.

It was clear that both women had come to the interview for therapeutic reasons; they both embarked on their stories at the earliest possible moment in the interview and appeared keen to relay their experiences. Their accounts provided powerful testimony to the adage that a sexual problem for one partner implies a sexual problem for the other.

6.3 Components of Dysfunctional Sex: Results of the Card Game

Card	% rating card as major problem	Rank	% rating card - 'just the way life is'	Reverse Rank	Combined Rank	Overall rank
Deliberately avoiding sex	92	1	0	1	2	1
[man/partner] having difficulty getting and/or maintaining an erection on a regular basis (75% of the time)	69	2	4	2	4	2
Experiencing physical pain during intercourse	62	3	12	3	6	3
Not feeling much desire for sex/ not having any sexual thoughts or fantasies	46	7	12	3	10	4
[woman/partner] involuntary vaginal spasm so that intercourse is impossible or difficult	62	3	19	8	11	5
Not feeling sexually satisfied	50	6	15	6	12	6
Partner rarely initiates sex	35	9	12	3	12	6
A couple who have sex less than once a month	54	5	19	8	13	8
Feeling anxious just before having sex about your ability to perform sexually	31	10	19	8	18	9
Coming to a climax (Having an orgasm) less than 25% of the time	42	8	27	11	19	10
One partner in a couple wants to have sex much less often than the other	19	13	15	6	19	10
Coming to climax (having an orgasm) too quickly [at (or before) two minutes of intercourse on a regular basis]	31	10	27	11	21	12
Feeling distracted or unable to concentrate during sex	27	12	38	13	25	13
Having too many sexual thoughts or fantasies (excessive sexual drive)	15	14	50	15	29	14
Not feeling interested in sex but enjoying it once it gets going	8	15	58	16	31	15
[woman/partner] difficulty becoming lubricated	0	16	46	14	30	16

Table 6.2 Card game results: Cards ranked in order of perceived severity (n=26)

Twenty-six respondents completed the card game at the end of the interview¹². The rules and purpose of the card game are explained in detail in section 4.2.3. To reiterate, each

¹² In the remaining interviews we either ran out of time (4) or the respondent found it difficult to think hypothetically and felt that the game was unhelpful to the discussion (2)

respondent was given a pile of cards (each describing a specific sexual difficulty) and was asked to place each card on one of four piles: 'Just the way life is'; 'A minor problem'; 'A major problem' and 'Don't know/depends'. In the event, the 'Don't know' pile was only used by three respondents. Table 6.2 (previous page) shows each card, firstly ranked according to the percentage of respondents describing it as a major problem, and secondly ranked according to the percentage of respondents rating it as 'just the way life is' (the ranks shown in the table have been reversed). The ranks are then combined to give an overall rank. Although the neat ordering of difficulties is appealing, I am wary of concluding too much from this table because the numbers were small and my sample did not seek to be representative of a general population. With this caveat in mind, it is interesting to see that the rankings are broadly consistent with my qualitative findings, with avoidance and erectile difficulties at the top, and lubrication at the bottom. It appears less consistent with traditional models of sexual function, with cards relating to three traditional diagnoses (PE, vaginal dryness and anorgasmia) appearing in the bottom half of the table.

6.4 *Inter-relationship between Sexual Difficulties*

Where respondents described difficulties in their sexual lives, there was rarely a single clear problem. More usually, there were a number of inter-related difficulties. The complexity of the inter-relationship is illustrated in figure 6.1 overleaf, in a diagrammatic depiction the sexual life of one man (aged 60) as described to me during interview. It neatly demonstrates the inter-relationship between difficulties. Although he described the primary problem as burning pain on ejaculation, there were several other co-morbid symptoms such as erectile difficulties, unsatisfactory orgasm and apprehension before sex.

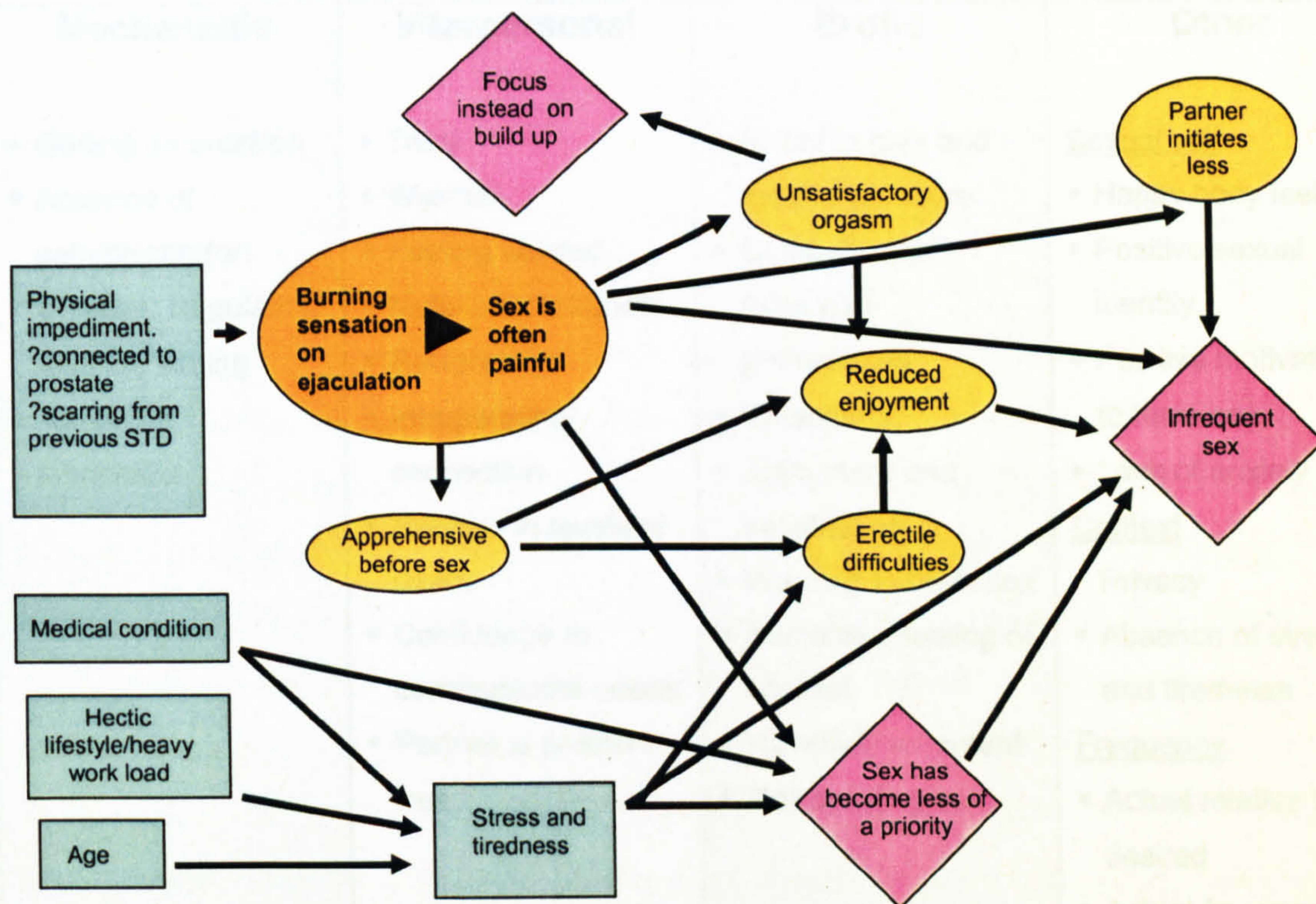


Figure 6.1 The Inter-relationship between Sexual Difficulties as Reported by a Male Respondent

6.5 Fit between Components and Versions of Sex

Many of the components described above were also highlighted in chapter five as priorities of particular version of sex. Thus it was possible to roughly categorise them according to the versions (see table 6.3 below). In this way, each version represented a different aspect of functional sex. Whilst recognising that individual priorities are likely to fit best with one particular version, a holistic model of functional sex would need to incorporate components from all three versions.

Mechanistic	Interpersonal	Erotic	Other
<ul style="list-style-type: none"> ▪ Getting an erection ▪ Absence of pain/discomfort ▪ Orgasm: Regularity, Quality, Timing ▪ Adequate lubrication 	<ul style="list-style-type: none"> ▪ Trust ▪ Warmth ▪ Feeling wanted ▪ Motive compatibility ▪ Reciprocity ▪ Interpersonal connection ▪ Balance in levels of desire ▪ Confidence to communicate needs ▪ Partner is problem free 	<ul style="list-style-type: none"> ▪ Ability to give and receive pleasure ▪ Compatibility in roles and preferences ▪ 'Chemistry' ▪ Enjoyment and satisfaction ▪ Wanting to have sex ▪ Subjective feeling of arousal ▪ Novelty/Excitement ▪ Not avoiding sex 	<p><u>Sexual self</u></p> <ul style="list-style-type: none"> ▪ Happy body feeling ▪ Positive sexual identity ▪ Positive motivations to have sex ▪ Lack of anxiety <p><u>Context</u></p> <ul style="list-style-type: none"> ▪ Privacy ▪ Absence of stress and tiredness <p><u>Frequency</u></p> <ul style="list-style-type: none"> ▪ Actual relative to desired ▪ Actual frequency

Table 6.3 Components of Functional Sex Categorised by Versions of Ideal Sex

6.6 Discussion

I have presented a large amount of data in this chapter. Here I focus on a few of the most striking findings; that is those that are particularly pertinent to the preceding literature review and design of the subsequent measure. In chapter nine I present evidence in support of each of these components as I consider which of them should be included in the final measure.

It has been suggested that neither women (Graham et al., 2004) nor men (Janssen et al., 2008) see a clear temporal distinction between the stages of desire and arousal. My data supported this suggestion and found that if any distinction was made, it was generally between desire as pertaining more to the mind, and arousal pertaining to the body. This

distinction has been noted elsewhere (see Regan & Berscheid, 1996 on men and women's concepts of sexual desire for instance).

I found that while men (and women) focused on the erection as the sign of arousal in men; women (and men) paid attention to a range of signs in women, of which lubrication was just one. However men as well as women were aware of signs such as a quickened heart rate as well as a general feeling of excitement; and men also described feeling aroused without necessarily having an erection. These data leave me unconvinced by the currently advocated split between genital, subjective and combined arousal among women (International Consultation on Erectile and Sexual Dysfunction, see Basson et al., 2004a; also see chapter two) and further sub-typing advocated by Basson (Basson, 2000). Firstly, given that it is rarely practical to measure actual levels of lubrication and engorgement in a patient, are these genital indicators any more 'objective' than other reported physiological indicators, such as a quickened heart rate, that go into an assessment of 'subjective' arousal? Secondly, the fact that a feeling of 'subjective' arousal bears little correlation to reported lubrication and genital congestion (Basson, 2002; Basson et al., 2005) does not imply that the two are therefore subtypes of the same disorder.

Instead, my results lean me more towards the ICD-10 approach, which is to categorise difficulties with erection and lubrication/engorgement simply as 'failure of genital response' (F52.2; WHO, 1994), rather than as arousal. In this way, they may be seen as physiological processes that enable sex to occur without pain/discomfort. The fact that many men experience nocturnal erections independently from feelings of arousal/desire (Godson, 2002) whilst levels of lubrication among women tend to vary according to phase of the menstrual cycle (Ibid, 2002) would seem to support the categorisation of erections/lubrication as physiological responses that are usually, but not always associated with arousal. The ICD-10 makes no mention of other 'subjective' physiological indications of sexual excitement/arousal, although it does have a category of 'Lack of sexual enjoyment', defined as 'Normal sexual response but lack of appropriate pleasure' (F52.11; WHO, 1994). I suggest instead that these subjective

indicators might usefully form an expanded category of sexual excitement which would encompass a range of events including desire to have sex, feelings of excitement prior to and/or during sex, fantasies, and physiological signs such as tingling and quickened heart rate. In other words, sexual excitement would comprise both desire and arousal, would not be restricted temporally and would include both cognitive and physiological processes. A number of observations from the literature support this suggested categorisation. Firstly, there is a strong evidence for an overlap between desire and arousal in women (Basson, 2006). Indeed, Segraves and colleagues recently noted that, “future research may indicate that the overlap between desire and arousal categories is so large that a separate category of arousal disorder may prove unnecessary” (Segraves, Balon & Clayton, 2007; pg 572). Furthermore, sole cases of arousal disorder appear to be rare; few women present with sexual arousal as the primary problem or as the only problem (Bancroft, Graham & McCord, 2001). Secondly, neither desire nor arousal categories appear straightforward to diagnose; concordance between clinical diagnosis and self rating of problem by women is lowest for sexual arousal disorder (38%) and loss of sexual desire (39%) (King, Holt & Nazareth, 2007) and the concept of desire is poorly understood (Levine, 2002). Current measurement approaches often conflate desire and arousal. For instance, self-report questions on arousal sometimes use terms such as ‘turned on’ which is just as easily interpreted as desire (for instance, the SFQ-Quirk et al., 2002; and the ASEX-McGahuey et al., 2000). This suggests that a broader category with a constellation of symptoms might be more useful. Many clinical conditions and illnesses are diagnosed by looking for a collection of symptoms, not all of which may be present, for example schizophrenia, alzheimers and systemic lupus erythematosus (Streiner & Norman, 1995). Recent proposals regarding the definition of premature ejaculation (PE) have suggested that it too might be most usefully viewed as a syndrome with several symptoms/complaints (Waldinger & Schweitzer, 2006). A potential criticism of this categorisation is that there would be high co-morbidity between the sexual response category and the sexual excitement category; however this could be avoided by positing that the sexual response failure is only diagnosed if erectile difficulties or insufficient lubrication occur *despite* feelings of excitement and desire.

This would mirror recent proposals to change the category of orgasmic disorder to lack of orgasm *despite* feelings of excitement and arousal (Basson et al., 2004a).

With respect to orgasm, the focus of the current classification systems (APA, 2000; WHO, 1994) is on whether or not orgasm is achieved and whether this occurs at the 'right' time. In contrast, my data suggested that some orgasms are better than others, and some individuals, particularly those who have struggled to experience orgasm, are able to enjoy sex without it, such that it might be better to 'judge' sex along a continuum of enjoyment/satisfaction, with orgasm representing a significant marker along this continuum rather than an all or nothing event. My data with regard to the female experience supported the existing literature in finding that women found it harder than men to achieve orgasm. This was often to do with lack of knowledge about one's body or inability to engage in anything other than narrow vaginal intercourse. This suggests caution in order to avoid labeling women as dysfunctional when in fact they are simply lacking practice or knowledge. As I suggested in chapter two, the same is true for premature ejaculation in men.

The findings of this chapter also provided strong support for the argument proposed in chapter two, that sexual (dys)function primarily concerns relationships. Firstly, several components described in this chapter specifically concerned aspects of the sexual relationship (reciprocity, motive compatibility, sexual compatibility, trust, warmth, feeling wanted and interpersonal connection). Secondly, threading through respondent accounts was the idea that which things matter depends greatly on the relationship and relationship context. For instance, I found that desire for sex within a relationship was often primarily a matter of balance across partners, and as Clement suggests, might be best construed at a systems level (the couple as a system) rather than at the level of the individual (Clement, 2002). This is of course not to say that single individuals cannot experience problems with desire, but where an individual is currently in a relationship that is the level at which difficulties are best understood.

I found that where respondents described difficulties in their sexual lives, there was rarely a single problem. For instance, anxiety was concomitant with erectile difficulties for one man, and the experience of pain led to infrequent sex for another woman. My diagram depicting the perceived causal pathways for one respondent who had presented to clinic with burning pain on ejaculation, aptly shows the complex picture often presented to practicing clinicians and therapists. This complexity supports existing literature suggesting high co-morbidity in diagnoses (Gregoire, 1999; Bancroft, Graham & McCord, 2001; First, 2005) and adds further weight to the argument I presented in chapter two that sexual dysfunction might be more usefully measured dimensionally rather than categorically (see Widiger, 2005; Widiger & Samuel, 2005).

My sample size for the card game was small but did augment my qualitative findings with some interesting insights. In both the interview and card game, avoiding sex, erectile difficulties and pain were regarded as the most problematic, and lubrication viewed as less problematic. Another interesting finding was that, although 'not feeling much desire for sex' was ranked as the fourth most problematic experience, 'not feeling interested in sex but enjoying it once it gets going' was almost the least problematic. In other words, an absence of sexual desire per se was viewed as problematic, but much less so if one enjoyed the encounter once it got going. It would be worth exploring this observation further. Current prevalence estimates of hypo-sexual desire disorder, particularly among women, are doubtfully high (see Laumann, Paik & Rosen, 1999; Nazareth, Boynton & King, 2003; Mercer et al., 2005), suggesting that low sexual desire is almost 'normal'. A focus instead on lack of desire which precludes enjoyment might provide a more realistic picture of the problem.

I have demonstrated in this chapter, high variability in what is regarded as important for functional sex, as well as what is seen as problematic (the latter to be explored further in chapter seven). This variability suggests that the inclusion of some measure of self-assessment is vital to properly gauge an individual's level of function. As I outlined in chapter two, the measure of 'marked distress and interpersonal difficulty' is currently highly contested, but I will consider the alternatives in chapter eight.

6.7 Conclusion

In this chapter I identified 31 candidate components of a functional sex life and showed how these factors may be organised according to the versions described in chapter five. A few components – absence of pain, ability to get and maintain an erection, and non-avoidance of sex – were regarded as important, if not essential, by almost all respondents. Others, such as lubrication and privacy were generally seen as less important or were raised by only one or two respondents. On the importance of the other components, there was little consensus.

I found that, in agreement with the existing literature, vaginal intercourse was widely regarded as the norm, and penetration was therefore regarded as both natural and essential, despite the fact that it was disappointing to many. My data also confirmed existing literature in finding that respondents did not generally see a clear temporal distinction between desire and arousal; instead a common distinction was between desire as pertaining to the mind and arousal pertaining to the body. I suggested that in classifying sexual function problems, a more useful distinction might be between genital responses (erection and lubrication) which enable sex to occur physiologically, and an 'excitement' response which would include feelings of desire, subjective arousal and excitement (without reference to any temporal sequence). Finally, it was striking that components relating to the sexual relationship featured so prominently. For instance, a balance in desire across couples appeared to be as important as desire per se.

Chapter 7:

Coping with Sexual Difficulties: The Gap between 'Good Enough' Sex and Lived Reality

7.1 Introduction

As described in chapter two, one of the key challenges in defining and measuring sexual dysfunction lies in identifying the boundary between normal and pathological. That chapter highlighted the variation in experiences that individuals consider to be problematic; plus the fact that only some of those with diagnosable dysfunction are distressed by it or see it as a problem. In order to understand what makes something problematic, I looked at the ways in which individuals coped with experiences that they appraised as not 'good enough'. My focus was on respondents who perceived a gap between their ideal and actual experience. I examined the coping strategies they employed and looked at the factors that made these strategies more or less likely to succeed. Specifically, I posed the question: Why do some individuals adapt to and feel happy with a sex life that falls short of their ideal while others do not?

Bury (1991) provides helpful definitions of the constructs I examine. He defines 'coping' as "the cognitive processes whereby the individual learns how to tolerate or put up with the effects of illness ... [which] involves maintaining a sense of value and meaning in life" (Bury, 1991: 460-1). He differentiates this from 'strategy', defined as "the actions people take, or what people do in the face of illness" (Bury, 1991: 461). Finally, he uses the term 'style' to mean "the way people respond to, and present, important features of their illnesses or treatment regimens" (Bury, 1991: 462). Although analytically distinct, in practice there is likely to be overlap between terms. The coping strategies I have defined incorporate cognitive, active and presentational elements.

As described in section 6.1.1 of the previous chapter, participants generally found it difficult to think in hypothetical terms because they felt that much would depend on the particular circumstances. Because of this limitation, I have focused as much as possible on respondent accounts of their actual reality. As discussed in chapters four and five, the interviews captured a snapshot of this process of coping and adaptation (or otherwise), but in reality the process was continuous, particularly for those whose circumstances were in a state of change.

7.2 Coping Strategies

Table 7.1 summarises the coping strategies identified from respondent accounts.

Coping category	Examples of strategies from the data
Changing circumstances to fit goals	
Seek to alter circumstances	<ul style="list-style-type: none"> ▪ Seek to fix the problem medically or psychologically, for example with Viagra ▪ Close down a relationship and begin a new one
Changing goals to fit circumstances	
Engage flexible stance towards the importance of sex	<ul style="list-style-type: none"> ▪ Downgrade sex as a priority ▪ Focus on other aspects of the relationship ▪ Focus on other priorities
Lower expectations	<ul style="list-style-type: none"> ▪ Accept a pay off between being with someone you love and having the perfect physical sexual experience ▪ Expect to have 'good' sex less often
Engage flexible definitions/version of sex	<ul style="list-style-type: none"> ▪ Shift from viewing excitement as most important to viewing intimacy as most important
Living with a gap between goal and circumstances	
Normalisation	<ul style="list-style-type: none"> ▪ Come to see your experience as normal ▪ Compare your experience favourably with others
Avoidance	<ul style="list-style-type: none"> ▪ Avoid sexual activity ▪ Avoid initiating sexual relationships ▪ Avoid thinking about the problem

Table 7.1 Strategies to Cope With Sexual Difficulties

Initial reactions to sexual difficulties included shock, confusion, worry and embarrassment. With time, many of the respondents whose sex life did not match their ideal adjusted to this situation by adopting one or more of the coping strategies described in table 7.1. I explore each strategy in detail below.

7.2.1 Changing Personal Circumstances in order to Achieve Goal

At least initially, most respondents responded to a sexual difficulty by seeking to fix it. Ten respondents relayed their experiences of seeking professional help for their problems. It was notable that in around half of the accounts, action was prompted or strongly supported by the sexual partner. In several instances, the partner was keen to find a fix but the individual perceived to have the main problem was reluctant to do so. Embarrassment and the belief that sexual matters are private were cited as deterrents to seeking formal help. One male respondent felt that seeking professional help was like failing as a man:

M65: I couldn't [seek help] straight away because it was that sort of subject. It was accepting defeat in a man so to speak.

In general, respondents felt they would be more likely to seek help for problems with a perceived physical, rather than psychological, aetiology. The former were generally perceived as easier to fix, whilst the latter were seen as more appropriately tackled within the relationship. During the card game, vaginal spasms and erectile difficulties were most frequently cited as problems for which individuals would seek help; both considered serious, physical and potentially fixable.

There were further accounts in which respondents said they had managed to 'fix' themselves, for instance, in the case of M56, by overcoming shyness and a physically repressed background, in order to become *concerned and loving* within his relationships. Sometimes this self-treatment was undertaken primarily for the benefit of a partner. For

instance a male respondent with erectile difficulties was asked by his partner to use a strap-on dildo. He felt it was...

... weird [...] you can see that it's making a fool of what little masculinity I have. It's demeaning for a man but if it gives my lady all the pleasure in the world then I'd better do it (M70)

Another approach to changing circumstances was to end a relationship perceived to be associated with the difficulty. There were several accounts of respondents ending problematic relationships over the course of their sexual career. One woman (F35) who had ended a relationship in which she had lost desire for her partner explained that at the time she *was much younger and it just didn't feel like worth pursuing*. She recognised that had she been married with children, the *stakes* would have been much higher and she may not have been able to change her circumstances.

Of course not all difficulties were straightforward to fix. PDE5 inhibitors had failed at least two respondents and penile injections were seen as inconvenient and intrusive by the one male respondent who was using them. Neither of the individuals experiencing sexual pain had found much relief for their symptoms. One of these respondents described feeling powerless, angry, and let down by medical profession as a result (F48). Thus, other coping strategies came into play.

7.2.2 Changing Goals to fit Personal Circumstances

7.2.2.1 Downgrading Sex as a Priority

Several respondents related how they had self-consciously or subconsciously sought to relegate sex compared with other concerns, as a means of coping with problematic sexual experiences. For instance, a female respondent whose husband avoided intercourse

recounted that sex had been *pushed* into less of priority for her because of the lack of it within her marriage:

IV: [.....] *Where does sex fit with your general list of priorities?*

F51: *Well not really because... My marriage has worked out... has pushed it into a... not into a priority.*

This was also clearly a strategy used by individuals experiencing iatrogenic sexual function problems, for example, whilst taking medication for a separate medical problem. A male respondent (M39) described experiencing loss of desire whilst taking anti-depressant medication during a period of depression. He described his *sex drive* at the time as of *absolutely secondary importance* compared with his wish to recover, and thus did not consider the loss of desire problematic. There were several other accounts in which sex was relegated and attention turned to *bigger concerns*:

F64: *you put the sexual thing away really and just get on with your life. At that point I decided that my main thing was to make sure that the children were secure and blah, blah, blah.*

Motivations to focus on other concerns were often multi-layered. For instance the female respondent above, in addition to prioritising the security of her children, also described being motivated partly by self-defence (protecting herself from possible hurt caused by the relationship); partly by circumstance (there were few opportunities in terms of other partners); and partly because of a change in priority with age (other aspects of relationships such as love and compassion had become more important).

Finally, it was not always easy to tease out cause and effect. In one example, a male respondent (M56), following the break up of an important relationship which *seriously affected* him, *dealt with the problem* by learning to *repress a certain sexual drive* and thus became very choosy about his partners; a strategy that resulted in a prolonged period of celibacy. He appeared to have been motivated by the desire to protect himself from

further emotional hurt. However, he also recognised some circularity in cause and effect when he acknowledged that had his desire been higher in the first place, he may have been *less selective* about his partners, thus avoiding the period of celibacy.

7.2.2.2 Lowering Expectations

The strategy of lowering expectations was summed up succinctly by one respondent: *You have to make do with the realities* (F54). Several participants described lowering their expectations as a result of their current circumstances. As one respondent put it:

F34: I've been predominantly single for quite a long time. That's enough for me really at this stage [.....][to] just have regular sex

For many respondents, reality involved a pay off. A commonly described pay off was between a good interpersonal relationship and physically good sex. For the respondent above, the scales were tipped in favour of a good interpersonal relationship: *If I had a strong relationship with someone, in terms of getting on with them and all various things, and sex wasn't that great it wouldn't bother me* (F34). The necessity for pay offs within relationships were recognised as a fact of life:

M56: You see it's a pay off between what you want and what you've got – what you can have. You're prepared to put up with certain things in life – not just sexually but.. ...[...]... so maybe I'm willing to put up with certain of those unsatisfactory things because there's certain other elements of my partner that I really, really appreciate; and I think it's like that for all of us isn't it, because none of us is perfect and we all have problems and therefore you will put up with certain things that are unsatisfactory.

Another pay off was construed in terms of a balance between competing needs. For example, an HIV positive respondent felt that the need to have sex without fear of

infecting a partner outweighed the need for physically ideal sex. Thus she was prepared to forgo the latter in order to have the former:

F42: He took away from me that fear of infecting somebody. So I was able, in some ways, to enjoy the sex even though it wasn't that good.

There was evidence of individuals compromising in the case of an imbalance of desire between partners. Four female respondents talked about partners whose desire for sex was lower than their own. For two women the imbalance was small and they described how they had 'chosen' to compromise by becoming more like their partner: *actually I've become more like him now because we've talked about it and we've realised that I probably have a more active libido than he does in a way* (F35). For the other two women, the disparity was stark and both sought compensations initially through affairs and masturbation, and later by 'switching off' their own desire for sex. (See chapter six for a longer discussion on imbalances in desire).

The need for compromise was felt to be particularly acute during the stage of life in which people looked to 'settle down' and perhaps raise a family. This sometimes required putting up with much less than the ideal in favour of other benefits. For instance, a bisexual man (M78) described how he had given up his sexual relationships with men in order to become faithfully married because what he wanted was stability and respectability. Within his marriage he prioritised the achievement of *common ends, with the establishment of a family*, such that although his sex life was not *satisfactory*, or 'good enough', *it wasn't the end of the world* because he had chosen to compromise his sexual satisfaction in order to have the other things that a stable relationship could offer him. A couple of gay men described a tendency they had observed among their heterosexual friends, to get 'stuck' in an unhealthy sexual relationship because of their need for relationship stability or material security and/or children. They believed that gay men felt the pressure to 'settle down' less often and therefore, their expectations for physically good sex remained high. In the mean time, among heterosexuals, there was

almost an expectation that physically enjoyable sex would be sacrificed on the altar of 'grown up' responsibilities (see also chapter five, section 5.8).

There was an awareness that expectations could rise again if circumstances improved. For instance, F34 above recognised the possibility that once she had met her expectation of a good relationship, her expectations for a good physical relationship might come to the fore once again.

Finally, at the level of the physical encounter, a recognised pay off was between the 'reward' of achieving the ideal physical experience and the effort required to achieve it. As one respondent described: *sometimes to reach a climax for me, there's too much effort put into it for the reward of a climax* (M55).

7.2.2.3 Shifting to a Different Version of Good Sex

Another coping strategy identified in the data centred on shifting one's view of ideal sex to fit one's circumstances. Previously (chapter five), I explored three distinct versions of ideal sex by which individuals framed their priorities for a functional sex life; the mechanistic, the erotic and the interpersonal. There was evidence that if required, some individuals were able to re-adjust their version where personal circumstances meant that their priorities could not be met. The participant quoted below had found a 'fix' for his erectile difficulties (PDE5 inhibitors) but not his difficulties with orgasm. He had thus learnt to enjoy sex by placing less emphasis on the importance of orgasm:

M61: Perhaps I'm wrong but I accept the fact that the diabetes reduces my libido and that I'm not going to come to orgasm as often as I would if I didn't have the diabetes; but that I can have sex and enjoy the physical sex without the orgasm if I take the medication. It's the situation I find myself in.

Being able to shift priorities depended on having a flexible version or discourse of sex. A highly flexible version was one which simply grew to fit one's experience: *Your own circumstances tend to mould. You develop your ideas towards the circumstances that*

you find yourself in (M61). There were several examples of pliable versions; that is, respondents re-ordering their priorities in the face of a difficulty. For instance, an HIV positive male respondent said that penetrative sex was *being pushed more and more out of the window* (M48) and he no longer enjoyed receiving oral sex because he feared infecting his partner. This fear had engendered a re-ordering of his preferences in terms of activities. Another respondent (M60) described having to *put more emphasis, if you like, or appreciation of the processes leading up to [intercourse]* because ejaculation had become painful. Whilst another described how the guilt associated with not being able to 'satisfy' his girlfriend via penetrative intercourse had led him to expend *much energy in making her happy and therefore I'm better at the romantic side*. (M70).

I suggested in chapter five that individuals tended to move towards the interpersonal version with increasing age. This appeared to be an adaptive shift, enabling them to continue to enjoy sex even where physical function was deteriorating. For instance, several respondents noted that their preoccupation with penetration had lessened with age. One male respondent (M62) said that in his twenties he would have been *adamant* that sex had to involve penetration, but with age, he had become more willing to contemplate the idea that non penetrative activities could also be fulfilling.

More often, respondents (especially younger ones) found it difficult to alter priorities, particularly when this required shifting from a penetrative to a non-penetrative focus (i.e. leaving behind a mechanistic version). For instance, although the man described above (M61) was able to adjust to having less regular orgasms, his attempts at trying alternatives to penetration only served to *reinforce [his] feelings of inadequacy*. In another example, a female respondent described a relationship with a lovely, rich but impotent man. Despite the benefits of the relationship, she described herself as *too young* to give up on her ideal of penetrative sex. It was also difficult for those focused on the interpersonal to adjust to a sex life devoid of this component. One respondent, who was in a difficult relationship at the time, described his sex life as limited to masturbation and internet chat rooms. He described these activities as *small compensation* (M48). Social values and norms may also deter a shift in version. A male respondent (M36) described

being fearful of the intimacy associated with sexual relationships. However, he did not feel able to switch to a more erotic focus involving casual partners because he felt such behaviour would meet with strong disapproval by the Christian church of which he was an active member. Finally, the desire to conceive may override a move to a different version. For instance, one man described how he and his partner had to continue with a sexual life focused on penetration despite their difficulties, because they wanted to conceive.

It is important to consider that while an individual may subscribe to a particular version, sex occurs in a relational context and so the version(s) of a partner come to play a significant part. In chapter five, I described the account a young man with erectile difficulties (M33) who felt pressure from his partner to move to intercourse, despite often feeling happier *sticking with oral sex*.

7.2.3 Living with a Gap between Ideal and Lived Reality

7.2.3.1 Normalising

In several accounts, respondents coped with sexual difficulties by re-conceptualising their experience as 'normal'. In fact, seeing oneself as normal appeared to be important to people, regardless of functional status and in spite of uncertainty about what constituted 'normality', as illustrated by the quote below:

IV: Do you think it is possible to say what a normal sex life is?

F23: No. Normal – I don't know what normal is now! Like when you say a normal family is Mum, Dad and three kids – it's not just... I guess it's whatever you... I think it's really hard to answer...

This uncertainty notwithstanding, a less than ideal sex life was regarded as 'normal':

F31: *Everyone has problems. I don't know if I know anybody that's ever said they have a perfect sex life... [...] ...If someone has I think they're lying!*

This view of normality as inherently less-than ideal, probably enabled individuals to view their own experience more positively. And for those with difficulties, this view enabled them to easily see their experience as normal. A female respondent, whose partner had sexual difficulties, described how she had come to view her situation as normal:

IVWR: *The fact that [you don't have sex], do you see that as a big problem?*

F51: *Well I used to but I don't now because I actually think it's quite normal. Which is almost quite ghastly. At first I thought I was abnormal and now I don't believe I am at all. I believe the state I'm in is absolutely quite normal.*

Normalising one's experience sometimes involved redefining dysfunctional as 'other' in relation to one's own experience. For instance, a female respondent (F46) with severe physical pain (due to vestibulitis) when asked to define 'dysfunction', construed it as a psychological rather than physical condition, thus positioning herself outside of the 'dysfunctional' camp. For another male respondent (M55) with delayed ejaculation, individuals with *impotency problem[s]* were construed as 'dysfunctional' and therefore 'other' to his experience. His concern with his own difficulty (delayed ejaculation) centred on the fear that he might find himself within this 'other' camp: *this is why sometimes I say, "it would be nice if I could climax quickly"; at least that way you don't feel that you have an impotency problem.*

The process of normalising was in evidence in the card game. Several respondents put cards that they had previously described as negatively impacting on their sexual life in the 'just the way life is' pile because they had come to see the difficulty as exactly that. For example, M56 said, *I'm putting [lack of satisfaction] there because that's sort of my life anyway, which is why it's "life's a bitch – deal with it"*. Conversely, it was

noteworthy that the only respondent not to use the 'just the way life is' category was a young woman who had not experienced any difficulties.

But there were exceptions to this tendency to normalise. One such man (M56) described his sex life as *peculiar* rather than *normal*, and thus made normative comparisons that highlighted this peculiarity: *everyone's doing it [sex] but me*. He viewed his sex life as 'not good enough' (*I absolutely don't have a satisfactory sex life*), despite the fact that he was not suffering from clinically diagnosable dysfunction. He appeared to have embraced a dysfunctional identity, regarding his situation as *penance – something that I just have to deal with*, and seeing himself as powerless to change things: *Despite being very open to change, I don't know if there's anything much I can do about it*. Another respondent (M65) with erectile difficulties, who was struggling to cope with his situation, described the intrusion of the 'abnormal' into his 'normality':

M65: *you never think it's going to happen to you, but it does happen in your normal life. An abnormal life then I can understand it – maybe you would end up drunk and spending the night with someone else. But I had a very steady life – it was going well.*

7.2.3.2 Avoiding the Problem

In a number of instances, respondents coped with a problem by simply avoiding it. Often this avoidance was benign; simply letting the problem be subsumed within the trials of daily life: *your daily life goes on and you forget that there is this major problem* (F64), or *letting things drift* (M56). There were also accounts of more active avoidance. For instance, a woman who was not able to achieve orgasm but who felt under pressure from her partner, avoided the issue by simply lying to her partner (telling him she had had an orgasm when in fact she had not) (F70).

A common strategy was to avoid sex, although in the long term, avoidance was seen as *storing up the problem for later on* (see also chapter 6, section 6.2.9). A male respondent (M33) described his various attempts to evade his sexual difficulties by avoiding sex. At

the time, the act of avoidance was hidden beneath more normatively acceptable rationalisation. For instance, during the early phase of his sexual career he claimed sex was simply not that important to him. However, in retrospect he recognised that this was a story he told himself in order to avoid confronting the fact that he did not actually enjoy sex. Similarly, in the early phases of his current relationship, he had used the fact that he and his partner were already long term friends as an 'excuse' to take the sexual side of the relationship very slowly. Again, in retrospect this was *a convenient guise...I didn't have to do very much to avoid having it*. Coming to recognise that he did actually have a sexual problem initially involved a feeling of failure but was essential to confronting his difficulties.

7.2.4 Non Adjustment

Around a third of the respondents were struggling to adjust to sexual lives they rated as 'not good enough'. Although many of them employed coping strategies to some degree, they continued to perceive a problematic gap between their ideal and their lived reality. A range of affective states were described in association with lack of adjustment, including feelings of rejection, defeat, depression, worry, frustration, apprehension and inadequacy. One respondent described how feelings of anxiety (the fear of *being a failure*) eventually became ingrained as a significant part of the problem, powerful enough to override attempts to fix the problem using Viagra (M61).

Occasionally, these negative feelings were contained within the sexual sphere; more often they spilled over into other aspects of the relationship and broader life. One respondent (M62) described the impact of difficulties using the pebble in the pond analogy; the relationship is affected most profoundly but the ripples can spread to other aspects of life. There were several accounts of unresolved sexual difficulties having a devastating impact on the relationship. For one respondent, his erectile failure...*was a very...an important point in the...disintegration of my marriage*. It caused a *virtual cessation* of the sexual side of the relationship (M61). Another man with erectile difficulties (M65) described his wife as very understanding but still anticipated, and lived

in fear of *the bombshell*: his wife leaving him. Another (M70) described the fear of discussing his erectile difficulties with this partner. In his view, it would be like saying: *I think I'm losing my powers.*

For one woman (F46), her experience of severe sexual pain eventually affected all spheres of life:

F46: it's become a life. In the end that became a life; there was nothing else. - that's all I could think about.

She described having to give up work, her relationship falling apart and being thrown out of her partner's home: *So overnight I had no home and no partner and no job and I was sick. She described it as absolute depression. [...] It's thrown my whole life upside down. Tore it to shreds really*

7.3 Correlates of Coping

In this section I examine the factors that influenced not only the choice of strategy, but also the likelihood that the strategy would result in successful adaptation and coping. Table 7.2 overleaf summarises these factors.

Factors	Factors facilitating adjustment	Factors impeding adjustment
Severity of the problem	<ul style="list-style-type: none"> • Difficulty perceived as mild and/or fixable • Onset of symptoms is gradual • Symptoms transient and/or occasional • Difficulty permits pain-free intercourse 	<ul style="list-style-type: none"> • Difficulty perceived as severe and/or unfixable • Onset is sudden and shocking • Symptoms experienced frequently and/or of long duration • Difficulty precludes sexual activity
Causal attributions	<ul style="list-style-type: none"> • Attribution located outside the relationship • Cause clearly understood and/or problem expected • No blame attached 	<ul style="list-style-type: none"> • Causes attributed to problems within the relationship • Cause not understood • Attribution implies blame of self or partner
Partnership context	<ul style="list-style-type: none"> • Strong and positive relationship • Partner reacts well to the problem • Partner has pliable version of ideal • No partner – no one to 'let down' 	<ul style="list-style-type: none"> • Weak relationship • Partner feels rejected or rejects individual because of the problem • Partner has fixed version of ideal

Table 7.2 Factors Affecting Choice of Coping Strategy and Likelihood of Success

7.3.1 Perceived Symptom Severity

The perceived severity of the problem appeared to be an important factor determining the level of adjustment. It makes intuitive sense that a problem perceived as severe will be more difficult to cope with than one perceived as mild. For instance, a mild difficulty is more easily reconstructed as 'normal'; and the required adjustment to expectations only slight. There was only moderate agreement across respondents as to which particular difficulties might be labelled mild and which might be labelled severe. However, the card game, in which respondents categorised a set of difficulties as either 'just the way life is',

'a minor problem' or 'a major problem' gave rise to a rough severity ranking (see table 6.2 in chapter six). From the data, I identified several dimensions of severity

Firstly, some of the variation in perceptions of severity could be explained by differences in versions of ideal sex (see chapter five): those whose priorities approximated to the interpersonal version tended to view emotional problems as most severe because they threatened the relationship; while those whose priorities fitted well with the mechanical version tended to view physical problems as most severe.

Secondly, where a difficulty was perceived as remediable, there was greater opportunity for changing personal circumstances so that the concept of ideal remained intact (see first strategy above). Lubrication was generally not viewed as serious because of the perception that it was straightforward to fix. On the other hand, for the woman with vestibulitis, after three years without a cure, there was a sense of powerlessness: *it's uncontrollable because it's nothing that I can do anything about and they can't say that it will ever go away* (F46). Concomitant with a problem perceived as unfixable was the fear that a sexual partner may give up and abandon the relationship.

A third dimension of severity was the duration and frequency of the symptoms. Transient and occasional difficulties were not generally regarded as problematic. There were several instances in which respondents described experiences that would have become problematic had they continued over a significant period of time. A problem whose onset was sudden (*some dramatic change in the baseline*; F34) was also construed in terms of greater severity. For instance, a male respondent (M70) described the shock he felt the first time he did not feel a *stirring in the crotch* on seeing a *really pretty girl: if you're used to it happening every single time it's absolutely amazing how earth shattering it is when it doesn't*.

Finally, as described in chapter 6, and as illustrated by the results of the card game (see table 6.2 in chapter 6), problems which caused pain or precluded intercourse were seen as the most severe.

7.3.2 Causal Attributions

All the respondents experiencing sexual difficulties had reflected to some extent, on the possible causes of their problem. In many cases, the ways in which causes were attributed appeared to influence both the perceived severity of the problem and the impact on the individual and their partner. Even those thinking hypothetically, for instance during the card game, appeared to think about difficulties in terms of their perceived aetiology; and at times, it appeared as important to individuals as the symptoms themselves. For instance, in describing the impact of sexual problems, one man (M62) below highlighted the 'why' factor as important:

M62: one or other, or both of you are suffering from it going bad, having gone bad. Your confidence is affected, your...[pause]... that may be both of you, it may be one of you, because it depends how that's... why it's happening. So...[pause].

Three dimensions of attributions appeared to determine the extent to which they were seen as problematic. The first dimension concerned whether the cause of the problem was located within or outside of the relationship. An example of the latter was reported by a woman whose previous boyfriend had had an accident which left him temporarily unable to have sex with her. She did not remember any detrimental impact on the relationship *because [the problem] was unrelated to the sex so, in a way you just accept it* (F35). Conversely, where causes were attributed to factors within the relationship, there was a risk that one partner would feel rejected. In particular, a problem attributed to loss of attraction to a partner was experienced as distressing. For instance, one woman (among many others) believed that if her husband suddenly did not want to have sex with her *it would impact on all aspects of our relationship [...] primarily because I would see it as such a fundamental rejection.*

Secondly, the amount of blame and culpability involved in the attribution appeared to be important. The experience of an older female respondent (F73) neatly illustrated this dimension. After 10 years of *satisfactory* sex, her first partner told her that he had

become impotent and they did not have sex for the next 10 years. She then discovered that, far from being impotent, he was *playing around with hundreds of women*. She became depressed and really quite ill (*everybody thought I was dying of cancer*) and her interest in sex *went into a dive and didn't emerge*. She divorced, remarried and once again enjoyed a good sex life that made her feel she could *live again*. Ten years into her second marriage, her partner had a prostate operation that left him unable to have penetrative sex, and once again her sex life ceased. This time, however, she was content with the situation, *because its fair do's*; he could not be blamed for his condition. This change in causal attribution was among the key factors enabling her to adjust easily to the cessation of her sex life second time around. Another respondent (M33) described how a change in attribution away from blame immediately ameliorated his difficulties. He described how his partner blamed herself for his erectile difficulties; she felt that she was not able to excite him sufficiently. This self-blame effectively exacerbated the problem by creating additional pressure on him to demonstrate that she could in fact excite him. They sought professional help which was partly focused on changing this attribution, with immediate positive effect:

M33: I think she's started to see now that [she's] not the root cause of [the problem] which obviously is very reassuring for me and takes some of that pressure off as a result because otherwise you think "I've got to be able to demonstrate to her that she is turning me on" and the more I kept thinking that the...it has the reverse effect.

One or two respondents blamed the medical profession for their predicament and as result felt significant anger and resentment: *I find it even more infuriating because the reason I'm impotent is because of the medical regime that was forced on me. I am impotent because I've been made to take lithium for the past 15 to 20 years and of course they don't tell you it'll make you impotent (M70).*

Finally, the extent to which the cause was clearly understood or expected appeared to be important. For instance, a couple of female respondents described how the changes to their sexual life while pregnant were unproblematic because they were expected and

understood. There had been a decline in frequency which *if I wasn't pregnant ...I'd really have [had] a question mark about our relationship*. However, *I suppose because we realise that it's the pregnancy, we're fine about it* (F35). On the other hand, the impact of pregnancy was experienced as problematic by another woman, whose partner did not understand that being pregnant was the cause of her change in desire for sex. He came to feel rejected and continued to pressurise her for sex (F38). And another woman recounted losing desire following the birth of her child. She did not realise that this was *normal* and as a consequence, the impact of her loss of desire *snowballed bigger*; the inability to confront the problem within the relationship was *yet another door closed in the communication with the partner*.

7.3.3 Interpersonal Context

Most of the problematic experiences recounted occurred within the context of a partnership. I identified two inter-related aspects of this context which appeared to influence the level of adjustment: firstly the strength and quality of the relationship; and secondly the reaction of the partner to the specific problem.

A strong relationship implied being able to talk openly about difficulties (*work it through*; F34); being able to confront problems rather than letting them drift (*If I was with a loving partner, I would not let the problem go on*; F64); being able to discuss problems in ways that avoided creating discord (*Depending on how close the couple is you can kind of laugh it off*; F27); and avoiding blame. Within a good relationship, a problem within the sexual sphere was felt to have less impact because there were other positive aspects on which to focus; this facilitated coping strategies such as downgrading sex (see 'downgrading strategy' above). A good relationship also provided a strong motive for confronting difficulties. One man described how solving his sexual difficulties became a priority once he was in a relationship that he really wanted to work: *Not having a good sex life would put that in danger* (M33).

The reaction of the partner to the problem was also important. A man with erectile difficulties described his wife's supportive attitude as one of the significant factors ameliorating his situation. He believed strongly that anyone else would *have said "rubbish", shut the door and gone out* (M65). Not all partners appeared so understanding however. A male respondent described his wife's anger at his erectile difficulties:

M61: *she felt she was being deprived of something for which she had a right to. She felt that she, as a woman, was being deprived of having sexual fulfilment, and she was very angry about that.*

Another woman (F33) who had lost her desire for sex felt that to a large extent her experience was problematic because her husband saw it as such. He accused her of not caring and she felt pressurised by him into seeking help. Similarly, a lesbian woman was only concerned about her low levels of desire because she believed that *people in the past ...have left because I wasn't good enough in the sexual department – what they consider good enough – whatever that is, I don't know* (F53). Often a negative partner reaction stemmed from feelings of rejection. As the partner of a man with erectile difficulties, one woman described feeling *pretty wretched* at first. She remembered thinking: *Well, why? Am I too plain, am I too fat, am I too ugly? why doesn't he desire me?* (F51).

Among couples with sexual difficulties (particularly erectile difficulties), the desire to conceive had potential to aggravate the situation. For instance, a male interviewee with erectile difficulties (M36) described how the desire to conceive had acted as a drive to seek help but also as a factor adding significantly to pressure to succeed in fixing the problem. He felt that his partner might *resent* it, if his difficulties meant that they were unable to have another baby. And she was getting impatient: as far as she was concerned, *"it's got to happen soonish"*.

There were several accounts of sexual difficulties experienced by individuals who were single at the time. In general, being outside of a relationship was easier because there was no one to let down. As one male respondent put it:

M78: If somebody is expecting things from you which you can't give, then of course you're upset. I've got nobody to expect it from me and therefore, I've nobody to worry about but myself.

However, for some single respondents, there was a nagging concern that their 'difficulties' would suddenly become more problematic should they want to embark on a relationship. For instance, a man who relied on testosterone implants to maintain his level of desire described his situation thus:

M36: I feel dead at the end of the implant usually, but sexually that doesn't make me feel depressed that I feel sexually dead. But it always makes me think that if I was in a relationship this would be very difficult – that's all.

7.3.4 Age, Gender and Sexual Orientation

It is likely that broad perspectives related to age, gender and sexual orientation will influence one's adjustment to sexual difficulties. I have already suggested that versions of functional sex may be less rigid among older and non-heterosexual individuals. I hypothesise that women, more than men, may find it easier to downgrade sex in importance and to adjust their version. However, given the small numbers of this sample, such patterns are at this stage, merely conjectures.

7.4 Vignettes

In this section I present two vignettes illustrating the coping strategies employed by respondents in adjusting (or otherwise) to sexual lives that were not ideal. It is important

to note that the story is told by one individual, thus we only have the respondent's perception of their partner's reactions.

7.4.1 Vignette 1

This 31 year old woman was married to her partner of eleven years. He rarely initiated sex and when they had sex, he regularly climaxed too early and did not often find orgasm enjoyable. The worry about whether he would climax early was stressful for him. The fact that he worried and did not always enjoy sex made her feel sad. Her concern about him made it difficult for her to relax during sex and as a result she did not achieve orgasm often. He, in turn, was concerned about the fact that he wanted sex far less often than her and that she found sex frustrating. She described a vicious circle in which *like two wounded birds* their respective concerns for each other intensified the significance of their difficulties and perhaps made everything seem worse than it actually was. She was clear that her sex life was less than ideal, but in the final analysis, described it as 'good enough'.

Her account revealed a number of coping strategies. Together she and her partner had looked at ways of changing their circumstances; they talked about their problems and had considered seeking professional help. However, it appeared that she was more interested in 'closing the gap' than he was so that whereas she was impatient for results, he wanted to take things slowly and sometimes seemed reluctant to talk (possibly, this reluctance was a way of avoiding the problem). They both sought to accommodate each other's needs. For her, this involved adjusting downwards her prioritisation of sex and lowering her expectations in terms of the frequency of intercourse (*I will just sort of switch off and go with the flow*). With her persuasion, he was able to shift his version a little away from its mechanistic focus; to realise that *there's other things you can do*, such that he was able to *relax* a little and not worry so much about climaxing early. She also clearly accepted a pay off between what she viewed as a very caring and loving relationship, and a not so good physical sex life. Comparisons made with her peer group helped to normalise her situation:

F31... *all my friends' relationships are the same – well my close friends where we actually talk about these sorts of things. I always find it's the women that are more interested in... over long periods of time I think, in initiating.*

Nearly all the correlates of coping were present in her account. Firstly, her version of sex was pliable; she appeared more concerned about making sure that they both felt relaxed and enjoyed the experience than 'achieving' a particular version of ideal. Secondly, in comparison with relationship issues they had confronted in the past, the problems appeared mild, potentially fixable and did not preclude satisfying sex on occasion. Primarily she attributed his sexual difficulties to his experience of invasive surgery at a young age, an event she also held responsible (among other factors) for the fact that he never masturbated and lacked sexual experience prior to their relationship. In other words, the causes were attributed to factors outside of their relationship and there was no blame attached to either individual. They clearly had a strong relationship: *I think we're actually quite good for each other though, because I just think we actually care a lot about each other and how each other feels.* They were also concerned to work through their relationship issues, sexual as well as non-sexual.

7.4.2 Vignette 2

This 65 year old man had had erectile difficulties for about ten years, and more recently had also lost the *urge* for sex. He was married with two teenage children. He described himself as having no sex life (*it's all barren now*) and the affection in his relationship was on the wane. The loss of a fulfilling sex life really bothered him; his primary concern being that he was no longer able to meet his wife's sexual needs (*it worries me that she is not getting any. It's supposed to be a need*).

He had made several attempts to change his lived reality. These included giving up on the medication that he perceived to be the cause of his problems and trying Viagra which he didn't like (*It felt as if my penis wasn't mine*) and which failed to work after the first

attempt. He had had some temporary success at rekindling his urge for sex by going away for a weekend in a hotel with his wife. But back in their *crowded* family home, the lack of desire again became an issue. There was little in his account to suggest that he had managed to lower his expectations, or focus more on other areas of his relationship, although it appeared that his wife had managed to do this. Despite adhering to a primarily mechanistic version of ideal sex he was willing to try other activities (such as oral sex) which enabled him to satisfy his wife and *sleep happier, because I'm a man and I've done my job so to speak*. However, his continued adherence to mechanistic priorities effectively implied an end to the affection in their relationship because *what's the point of being affectionate since you're not going to be able to do anything?*. At first he had seen his predicament as something that would occur only in an *abnormal life*, but with time he had begun to see his experience as normal: *I was reading the other day; apparently it's quite normal for men to be like that*.

Several factors appeared to militate against the success of this man's coping strategies. Firstly, as outlined above, he appeared unable to compromise on his view of ideal sex in mechanistic terms. Thus he construed his erectile difficulties as *defeat in a man*. For him the problem was severe because it precluded sex, narrowly defined as penetrative intercourse. Beyond a *miracle*, he did not see how the problem could be fixed. His account was heavy with blame and a sense of having been wronged and this causal attribution appeared to add to the perceived severity of his condition. For instance, he attributed the genesis of his difficulties to medical treatment he received for a heart condition. He also mentioned having diabetes, feeling stressed and getting older, but he felt that the *damage had been done* by these drugs. He was angry with the medical profession for not warning him about the side effects. He also blamed the *turbulence* of his teenage daughter's social life for his loss of desire. Although his wife appeared to have adjusted to their intermittent sex life and had not shown any overt negativity, he could not quite believe that she was fine, and his nagging doubts about her lack of fulfilment certainly added to the pressure.

7.5 Discussion

Many of my findings resonate with the established literature on coping in general, and coping with chronic illness/disability in particular. Although few of the respondents in this study would regard themselves as having an illness or disability, in most cases the difficulties they experienced might be viewed as chronic symptoms, and the ways in which they responded to those symptoms were, to some extent, similar to the coping strategies employed by individuals with chronic illness. And in the same way that chronic illness has been defined as a 'negotiated reality' (Strauss & Glaser, 1975), these respondents 'negotiated' the meaning and significance of their experience within themselves and in response to the reactions of external influences (notably their sexual partner, but also key influences such as clinicians and media portrayal of sexual difficulties).

My study identified a number of ways in which individuals responded to their difficulties, both cognitively and emotionally. Flexibility emerged as a key theme of the chapter. The concept of flexibility with respect to coping with sexual difficulties in the context of chronic illness has been examined in detail by Barsky and colleagues (Barsky, Friedman & Rosen, 2006). Theirs was the only paper I was able to find that examined coping strategies specifically in relation to sexual dysfunction. My data provided (much needed) empirical evidence for their theoretical argument. They too viewed flexibility as an important "determinant of successful coping" (Barsky, Friedman & Rosen, 2006; pg 237), defining it as "the ability to shift cognitive or behavioural focus in order to manage acute and chronic sexual dysfunction" (Ibid; pg 237). In agreement with my data, they also identified flexibility in the definition of sex (what I have termed 'version') and in the importance ascribed to sex, as two key components. However, I did not find much empirical support for the theoretical model they employed to conceptualise their ideas. Drawing on theories of self-regulation, they posited that holding flexible ideas about the definition of sex constitutes a 'bottom-up' coping strategy in which individuals attempt to manage or eradicate the problem, which then impacts on the (sexual) self concept. On the other hand, they argue, being flexible about the importance of sex, constitutes a top

down approach in which coping is achieved by shifting the “importance associated with sexual functioning among the aspects of life functioning that compose the self-concept and by redirecting one’s resources to other meaningful life domains” (Barsky, Friedman & Rosen, 2006; pg 239). My data did not support this neat top-down (flexible importance), bottom-up (flexible definition) distinction. Rather, the key distinction I found was between strategies that sought to change circumstances to fit goals, and strategies that sought to change goals to fit circumstances. I contend that both flexibility towards the importance of sex, and flexibility towards its definition/version are both examples of changing goals to fit circumstances.

I identified several different coping strategies employed by respondents in response to experiencing difficulties. In general, respondents adopted a range of different strategies which were dynamic over time. Coping strategies have been categorised in many different ways, and there exists a plethora of typologies (Skinner et al., 2003). The first two strategies in table 7.1 correspond well with Brandstadter’s distinction between accommodative and assimilative coping strategies (Brandstadter & Renner, 1990). Accommodative coping involves adjusting personal preferences to fit situational constraints (what I call changing goals to fit circumstances); whereas assimilative coping strategies seek to change circumstances to fit with personal preferences (what I call changing circumstances to fit goals). Assimilation and accommodation represent two independent categories; the opposite of assimilation is helplessness, whereas the opposite of accommodation is rigid adherence to an unattainable goal (Skinner et al., 2003). Thus they are not mutually exclusive; individuals may adopt both strategies simultaneously and both can lead to successful coping and adjustment (Ibid, 2003). Many researchers of coping behaviour believe that it is impossible to identify which coping strategies will be most successful. Depending on the problem and the context (what I call correlates of coping) any particular strategy may be adaptive or maladaptive (Ibid, 2003). Thus it is the opposites of these strategies, rigid adherence (for example, being unable to switch to a more interpersonal version of sex once the initial excitement of a long term relationship begins to wane) and helplessness (for example, feeling that one’s erectile difficulties cannot be cured) that are associated with less successful coping. However, where the

stressful event is irreversible (such as a stroke) and circumstances cannot be changed, accommodative strategies are associated with better quality of life for both patients and partners (Smout et al., 2001). Thus, it seems likely that as individuals age, accommodative strategies will become increasingly important where irreversible physiological difficulties increasingly impose constraints. Indeed, it has been shown that flexibility tends to increase with age whilst tenacity declines (Brandstadter & Renner, 1990). The situation is also complicated here by the fact that the coping response occurs in a dyad and therefore successful coping is not just about what works for the individual but about what is most adaptive for the couple.

A key finding of this chapter was that it is important for individuals to see their situation as normal. Those experiencing serious difficulties were required to employ greater cognitive effort in order to construct a story of life as normal. This cognitive effort involved re-defining sexual dysfunction so that it applied to others rather than oneself; it also involved seeking normative comparisons which enabled the affected individual to see their situation as normal. This process was in evidence in the card game when individuals put objectively serious difficulties in the 'just the way life is' pile because that was their experience of daily life. A similar process occurs among individuals (and their families) experiencing chronic illness and has been well documented (Robinson, 1993). At first patients describe their life as 'problem saturated' (White & Epston, 1990) and the shift to a 'life as normal' story is often precipitated by new information about the situation, either through personal experience or an external source. According to Robinson (1993), the 'life as normal' story evolves as individuals focus their attention (or lens) on aspects of their experience that enable them to feel normal; living and constructing the story are interactive processes. There was some evidence of this evolving 'life as normal' story in this study, for instance in the account of a female respondent whose husband had significant difficulties; at first she described her situation as 'abnormal' but with time, she came to see it as quite 'normal' (see section 7.2.3.1 above)

In the second half of the chapter I focused on factors that appeared to impact on the choice of coping strategies and the likelihood of successful and adaptive coping. The relationship between these factors and coping strategies is most probably bi-directional; coping style, for instance, has also been shown to impact on perceived disease severity (Constant et al., 2005). These factors – perceived severity of problem, attributed cause of the problem, and partnership context – have been shown to be important for coping responses with respect to other conditions. For instance, negative marital interaction surrounding the wife's illness has been shown to affect psychological adjustment for women with rheumatoid arthritis and their healthy husbands (Manne & Zautra, 1990). And attributional style (particularly the degree of blame) has been shown to be important in the management of various chronic conditions (Chalder, Power & Wessely, 1996; Benedict, 1995; Pakenham, 2007). With respect to sexual dysfunction it has been suggested that regardless of the type of problem, couples tend to blame the patient rather than the circumstances or the partner (Fichten, Spector & Libman, 1988)

In particular, my data pointed clearly to the importance of causal attributions in facilitating a coping response. I noted that identifying a cause, or aetiological agent, was important in resolving 'why?' or 'why me?' questions, and in finding meaning to the experience. The meaning of malaise to those experiencing it has been studied by various authors (Charmaz, 2000; Sanders, Donovan & Dieppe, 2002). With respect to the impact of chronic illness, Bury distinguished between two types of meaning: 'meaning as consequence' refers to effects on everyday life such as the disruption to domestic routine; and 'meaning as significance' refers to symbolic connotations which impact on the sense of self and on the reactions of others (Bury, 1988; Bury 1991). The causal attributions made by respondents in this study might be construed as part of an attempt to find 'meaning as significance'. My data clearly demonstrated that causal attributions directly impacted on the significance and meaning attached to the experience, and to the subsequent sense of self. For instance, where loss of function was construed as part of the normal ageing process, the meaning of the experience was downplayed and the impact on one's sense of self was less detrimental. I also found evidence to support the idea of 'meaning as consequence'. For instance, the consequence of the difficulty on the

sexual relationship and in particular the reaction of the partner appeared to play an important role in ascribing meaning to the experience. Specifically, where an individual was not in a relationship, the meaning of the experience could be downplayed. On the other hand, if a partner reacted very negatively to a difficulty, its significance intensified. Bury also identified a third type of meaning called 'meanings at risk' (Bury, 1988; Bury, 1991). This relates to the risk that the same definition of the situation does not exist between the individual with the malaise and those around them. Again, there was evidence of 'meanings at risk' in my data, for instance, where men with erectile difficulties interpreted their symptoms as physiological in origin, but their partners interpreted the same symptom as emotional in origin, specifically as a loss of desire for them.

My data also highlighted aspects of the difficulty itself that impacted on coping strategies, including the nature of its onset, the extent to which symptoms were seen as mild, fixable or transient, and the impact on sexual activity. Aspects of illness that impact on illness behaviour have been studied by widely. Mechanic and Volkart (1960) identified 4 dimensions; commonality of those symptoms in the population; familiarity of the symptoms; predictability of the outcome of the illness; the amount of threat and loss that is likely to result from the illness. And later Mechanic (1978) identified factors related to the type of illness that influence help-seeking, in particular: visibility or salience of the symptoms; perceived present and future seriousness of the symptoms; extent to which symptoms disrupt social activities; frequency of symptoms; interpretations of the cause of symptoms and availability of treatment. I suggest an additional dimension: the extent to which the onset of symptoms is sudden and 'shocking'.

The findings of this chapter will be of particular interest to professionals in therapeutic settings tasked with helping individuals to respond to their difficulties in constructive and healthy ways. The message of assimilative versus accommodative coping strikes resonance with a traditional Christian prayer, originally penned by Reinhold Niebuhr in

1934¹³: “God, give us grace to accept with serenity the things that cannot be changed, courage to change the things which should be changed and the wisdom to distinguish the one from the other”. Therapists then, play an important role in helping respondents identify what can be changed and work out ways of adapting to those that cannot. Adaptation in this latter case will be much more likely where patients are encouraged towards more flexible definition/versions of sex and flexible prioritisation of sex.

7.6 Conclusion

In this chapter I explored the ways in which participants responded to experiences that fell short of their ideal sex life. I identified three main coping strategies. The first strategy was to change circumstances to fit goals, for instance by seeking a medical fix or closing down a relationship (this is also known as assimilative coping). The second strategy was to change goals to fit circumstances, for instance by downgrading sex as a priority or by being flexible about one’s version of ideal (this is known as accommodative coping). And the final strategy was to live with the gap between goal and circumstances, either by normalising one’s experience or by avoiding the problem. Often respondents engaged a range of strategies simultaneously and the mix of strategies employed varied over time. Choice of strategy, as well as the likelihood of successful adjustment was influenced by several ‘correlates of coping’. These included the severity of the problem (in terms of frequency of symptoms, intensity of symptoms and perceived fixability); the causal attributions made about the problem (whether the perceived cause was located inside or outside of the relationship and whether blame was implied); and the partnership context (how the partner reacted to the problem and whether the relationship was strong enough to cope with the problem). I found that flexibility, in terms of one’s definition or version of ideal sex and the importance assigned it, was a key determinant of successful accommodative coping. In addition, the attribution of a cause was important in establishing the meaning of the experience (what Bury terms ‘meaning as significance’). In the longer term, even those dealing with severe and disruptive difficulties were often keen to construct a story of life as normal; a cognitive process observed in other chronic

¹³ http://en.wikipedia.org/wiki/Reinhold_Niebuhr. Accessed June 2008

health conditions. The fact that the coping response occurs in a dyad adds a further layer of complexity; successful coping is not just about what works for the individual but about what is most adaptive for the couple.

In conclusion, this typology represents a novel, holistic and empirically driven approach to understanding coping that will be useful in assisting those coming to terms with their sexual difficulties.

Chapter 8

Measuring the Population Prevalence of Sexual Dysfunction

Literature review II

8.1 Introduction

In this second review of the literature I examine key issues concerning the measurement of sexual dysfunction at community level. Firstly, I outline current methods for measuring sexual dysfunction, in both clinical and community settings, including an extensive review of self-report measures. Secondly, I look at methodological challenges specific to the design of community based (prevalence) measures. The purpose of this second literature review is to provide an evidence base for subsequent decisions regarding the design of the conceptual model and measure (see chapter nine).

8.2 Sexual Dysfunction Questionnaires

Sexual dysfunction is measured in a range of contexts including laboratory research, clinical consultations, treatment evaluation studies and clinical trials. Various techniques have been developed to measure physiological arousal mechanisms such as penile tumescence and rigidity in men and vaginal vasocongestion (vaginal blood flow) in women (Rosen, 2001). However, most commonly, measurement of sexual dysfunction requires subjects or patients to report their sexual experiences via structured questionnaires, diaries or event logs. Questionnaires are either administered by the clinician/researcher or completed by research subjects/patients (self-report questionnaires). I look at each type in turn, but focus on self-report questionnaires because these are most relevant to epidemiological research.

8.2.1 Clinician Administered Questionnaires

Structured interviews, conducted by a trained clinician or researcher, provide detailed and accurate data that may be used for research or clinical purposes. Structured interviews provide opportunity for the administering clinician to explain any technical terms and clear up misunderstandings. Discomfort and embarrassment regarding particular questions can be identified and addressed by the clinician (perhaps by rephrasing), potentially avoiding non-response and desirability bias. Interviewees can provide detailed answers rather than being constrained by set response formats. Such interviews can also help to facilitate an open and intimate relationship between patient and clinician (Corona, Jannini & Maggi, 2006). The drawbacks to this type of assessment include the resources required and the potential reluctance to disclose sensitive information face-to-face. Furthermore, in research settings inter-rater reliability can be a potential problem (Rosen & Barsky, 2005). In most cases, interviews are conducted using un-validated questionnaires or screening tools, though there are several validated structured tools for clinicians. Table 8.1 lists some prominent tools, together with details of their psychometric properties. Some measures, such as the HSDD screener (see table 8.1) contain self-report as well as physician directed items; others, such as the SIDI-F are designed for clinician use but may be self-completed if the respondent feels too embarrassed to answer questions face to face.

Title and source	Domains and Items	Size (time to Complete)	Purpose of measure/ Reliability and validity
Female Sexual Interest and Desire Inventory (SIDI-F) Clayton et al., 2006	No domains. Items concern: relationship, receptivity, initiation, desire, thoughts-positive, erotica, arousal, orgasm. Plus a further 5 items on context of symptoms such as mood.	13 items	Designed by expert panel to quantify the severity of symptoms in women with HSDD. Internal consistency $\alpha = 0.9$. Discriminates between women with and without HSDD. Correlates highly with FSFI.
Structured Interview on Erectile Dysfunction for men (SIEDY) Petrone et al., 2003	3 domains: organic component of ED, relationship component of ED, intra-psychic component of ED	13 items (5-10 mins)	Designed for use by clinicians treating individuals with ED. Sensitivity 68%; Specificity 68% for scale 1 plus score > 3.5 is predictive of ED of organic origin
Centre for Marital and Sexual Health - Sexual Functioning Questionnaire (CMSH-SFQ) Glick, McCarron & Althof, 1997	4 domains: frequency, quality of erection, incidence of orgasm, patient and partner satisfaction	21 items	Focused on ED. Designed as self-report but recommended that a clinician go over responses with the respondent afterwards. Most items demonstrate acceptable levels of reliability and validity.
The Derogatis Interview of Sexual Functioning (DISF) Derogatis, 1997	sexual cognition/fantasy; arousal; sexual behaviour/experience; orgasm; sexual drive/relationship	26 items (15-20 mins)	Also has self-report version (see table 8.2). Designed for use in clinical trials. Male and female norms developed.
Changes in Sexual Functioning Questionnaire (CSFQ) Clayton et al., 1997b	5 domains: sexual pleasure, sexual desire/frequency, sexual desire/interest, sexual arousal and sexual orgasm	35 items (W) 36 (M) (20 mins)	Designed to assess sexual function associated with psychiatric illness and medication effects. Aims to differentiate lifelong from acquired dysfunction. Demonstrated reliability, concurrent validity with the DISF-SR, and ability to discriminate between clinical and non-clinical samples.
HSDD Screener Leiblum et al., 2006	Sexual desire only	5 SR items plus 5 iw Qs	A screening tool to assist clinicians in identifying HSDD in postmenopausal women. Moderate convergent validity demonstrated with a structured diagnostic method. For cut off score of 7, sensitivity = 0.82% and specificity = 0.99

Table 8.1: Clinician Administered Tools

8.2.2 Self-report Questionnaires

There are two main types of self-report measure: event logs/daily diaries, and self-administered questionnaires (SAQ). Both types collect subjective data, relying heavily on respondent comprehension, recall and truthfulness. Biomedically trained researchers and clinicians are sometimes skeptical about the veracity of subjective indicators, perceiving them to be unreliable. Sometimes this skepticism results from a failure to distinguish between variable type and measurement strategy, for instance, where medical records (a measurement strategy) are viewed as intrinsically more objective than questionnaires, even though some of the 'variables' on medical records include 'subjective' clinician assessments (Cleary, 1997).

Event logs and diaries usually collect information on intercourse frequency and satisfaction, quality of erection and medication use (Rosen, 2001) and are typically used in clinical trials. Diaries generally require daily recordings while sexual event logs are updated only when sexual activity occurs. Diary information can be clinically useful, for instance during trials investigating the temporal relationship between drug dosing and 'successful' or otherwise sexual events (Althof et al., 2005b). Event logs and diaries can also provide detailed quantitative information about an individual context over a sustained period, but this information tends to be limited in scope and does not necessarily reflect the respondent's self-assessment overall, nor capture all the specific components of interest to a clinical trial. This was demonstrated in a recent study (Rellini & Meston, 2006) in which frequency of satisfying sexual events, as measured by an event log failed to predict change in clinical sexual arousal disorder post treatment, whereas the arousal domain of an SAQ (FSFI: Rosen et al., 2000) was able to detect change. Furthermore, event logs and diaries tend to generate dichotomous response sets ('Was the encounter satisfactory?' Yes/No) and are therefore considered less sophisticated than SAQs which typically use ordinal or interval scales (Althof et al., 2005b). Event logs and diaries can also be a burden to respondents, leading to lack of compliance, particularly with traditional pen and paper methods (Stone et al., 2003). Despite their apparent inferiority, current guidelines (Food & Drugs Authority, 2000)

recommend them as primary endpoints in clinical trials, with SAQs as secondary endpoints (Althof, Rosen & Derogatis, 2005).

Self assessment questionnaires (SAQs) rely on subjective individual reports. Providing that questions are direct and response alternatives clearly specified, meaningful data are usually generated (Rorer, 1965). This meaningfulness or validity is greatly enhanced where SAQs are grounded in theory or empirical evidence, and subjected to psychometric testing. SAQs designed and tested in this way are appealing to clinical trial investigators because of their reliability, validity and sensitivity to treatment interventions (Rosen, 2002). In addition SAQs provide standardisation and transferability to other settings, and can generate normative values in clinical and non clinical populations (Taylor, Rosen & Lieblum, 1994; Rosen, 2002). From a logistical point of view, they are easy to administer and score, fairly unobtrusive, and not generally burdensome to respondents (Rosen 2001; Rosen 2002). There are of course drawbacks. It is difficult for a brief measure to avoid over-simplification of the issues at hand; there may be differences in semantic perceptions; there is potential for response bias (particularly desirability bias); and validity may be compromised by differences in demographic and cultural factors between respondents (Conte, 1983; Corona, Jannini & Maggi, 2006).

An earlier review of self-report measures of sexual function (Conte, 1983) suggested few available measures, and these were often beset by weaknesses such as poor readability, development in only one gender and predominantly on college populations, omission of key information such as degree of satisfaction with present function, and lack of validity data and cross-validation. A more recent review of self-report measures (Daker-White, 2002) identified twenty-three measures (published between 1980 and 1999), of which 14 met minimum standards for reliability, internal consistency and validity¹⁴. Many of the measures were designed only for respondents in current heterosexual relationships and

¹⁴ Following Streiner & Norman (1995) the minimum standards applied by Daker-White were as follows:

- 1) Explicit statement concerning face or content validity based on views of expert panel
- 2) Mean reliability of > 0.70 for reported subscales (tested using Cronbach's alpha)
- 3) Measure is reproducible in test-retest with reliability coefficients >0.50 on all scales.

ten were designed only for sexually dysfunctional individuals. The majority of measures were tested primarily on white, middle class Americans. Only two of the 17 studies described a development process which involved creating items based on patient perspectives.

Arrington and colleagues (Arrington, Cofrancesco & Wu, 2004) unearthed 45 sexual function measures (published between 1957 and 2001) and identified six common domains: interest and desire, satisfaction/quality of experience (including pain/discomfort), excitement/arousal, performance (ability to maintain erection sufficient to reach orgasm), attitude/behaviour (including feelings of avoidance, embarrassment and change in frequency of intercourse) and relationship. Only one measure involved patient perspectives in its development, and only eight were deemed adequately reliable and valid. Not one measure could be universally applied across gender, sexual preference and health status. The study concluded that current measures often omit key domains, are lengthy and intrusive, take insufficient account of gender and sexual preference groups and lack validity testing in key populations.

The recent trend in measure design has been towards self-report measures focused on biomedical aspects of function and specifically designed to provide concise end points in clinical trials (Taylor, Rosen & Leiblum, 1994; Corona, Jannini & Maggi, 2006). Increasingly, SAQs are expected to demonstrate good psychometric properties; that is good reliability and validity. Reliability relates to the consistency or repeatability of the measure and may be viewed as the inverse of measurement error (Loewenthal, 2001). A reliability co-efficient (r) of 1 indicates perfect reliability or a measure without error. There are two types of reliability relevant to SAQs: test-retest reliability which involves repeated administration to the same population 2-4 weeks later and indicates the stability of the measure over time ($r > 0.5$ is usually considered acceptable); and internal consistency which measures the homogeneity of an item within a scale or domain (Cronbach's alpha > 0.7 is usually considered acceptable). An alpha value greater than 0.9 might suggest that a scale is too homogenous and that some of the items may be redundant (Streiner & Norman, 1995), although where a measure is designed for clinical

purposes (i.e. measurement at the individual level), higher alpha values (0.90 upwards) may be desirable (Bland & Altman, 1997). Validity indicates the extent to which the questionnaire measures what it is intended to measure. Evidence for the validity of a measure is established over time through an ongoing series of studies that test and extend the generalisability of the results (Meston & Derogatis, 2002). Validation studies might measure whether test scores correlate closely with a similar measure of sexual function (concurrent or criterion validity); whether the scores are associated with a related but different construct such as depression (convergent validity); and might ensure that the measure is not correlated with unrelated concepts such as left-handedness (discriminant validity) (Streiner & Norman, 1995). For a measure of prevalence, sensitivity is important; the ability to differentiate between individuals with and without sexual dysfunction. This differentiation is made easier where published norms are available for the measure. Other considerations when assessing the suitability of a measure include: test brevity; ease of administration and scoring; cost efficiency; computer compatibility and availability of language translations (Meston & Derogatis, 2002). Further detail on psychometric testing is provided in chapter 10.

Table 8.2 below, details the most common current self-report measures of sexual function that meet minimum published standards of reliability and validity¹⁵. These are measures that could be used to test concurrent validity with my measure (see chapter 10). A second table (see appendix 15) catalogues 37 measures that focus on specific aspects of sexual function (such as distress or sexuality related quality of life) or are designed for use with specific populations. I refer to these as para-measures. They could be used to test convergent validity with my measure. This table is not exhaustive but includes recognised measures that have undergone scientific testing and that purport to measure aspects relevant to sexual function.

There are clearly many measures available. However, only 17 measures have acceptable standards of reliability and focus on the concept of sexual function wholly and exclusively (see table 8.2). Only one of these measures was specifically designed to

¹⁵ Using the same standards applied by Daker-White (2002). See previous footnote

measure population prevalence (the EMAS-SFQ) but this has only a male version; the rest are designed for use in clinical trials or to measure treatment efficacy. Six of the measures were designed for men and women (or had male and female versions). Five of these consist of more than 20 items and two of the five (DSFI and SII) are extremely long. The remaining measure, the 5-item ASEX (McGahuey et al., 2000) is the only psychometric measure that could possibly be used for my intended purpose. In chapter nine, I examine whether the ASEX would suffice.

Title		Domains							Further domains		Size		Purpose of measure/ Reliability and validity information	
		Desire/drive/interest	Arousal/Excitement	Orgasm	Satisfaction/Quality	Relationship	Sex behav & exp			# of items				
Male and female measures														
Golombok Rust Inventory of Sexual Satisfaction (GRISS) Rust & Golombok, 1985 & 1986				* W	*				Others: erectile function (M), premature ejaculation (M), vaginismus (W), communication, frequency, nonsensuality, avoidance	28		Designed by expert panel for couples or individuals in current heterosexual relationship undergoing therapy. Provides subscale scores and total score of quality of sex relationship functioning. Internal consistency for subscales- range $\alpha=0.61-0.83$. Test-retest $r=0.52-0.84$ for subscales. Sensitive to improvement following therapy and can differentiate between patients and controls. Validated in 10 languages. Considered a gold standard.		
Derogatis Sexual Functioning Inventory (DSFI) Derogatis, 1998	*				*		*		Others: General information, attitudes, psychological symptoms, affects, gender role definitions, fantasy, body image,	254		Estimates the quality of an individual's current psychosexual functioning. Internal consistency $\alpha=0.60-0.97$ for subscales; test-retest $r=0.7-0.9$. Scores can be summed to provide a 'Sexual Functioning Index' and a 'Global Sexual Satisfaction Index'. Long and difficult to use but widely validated. Gender-specific versions.		
Derogatis Interview for Sexual Functioning – Self Report (DISF-SR) Derogatis, 1997			*	*			*		Others: Sexual cognition and fantasy, sexual desire and relationship	25		Simplification of the DSFI. Self-report version of the DISF, a semi-structured interview. Designed for use in clinical trials. Male and female norms developed. Internal consistency $\alpha=0.74-0.80$ for subscales; and test re-test $r=0.86$ for total scale		
Sexual Interaction Inventory (SII) LoPiccolo & Steger, 1974									Others: Frequency dissatisfaction, self-acceptance, sexual pleasure, knowledge of partner's preferred activities, acceptance of partner, perceptual accuracy	102		Assesses current satisfaction and level of functioning within a couple's relationship. Answers across both members of couple are summed to derive joint profile. Good internal consistency ($\alpha=0.88$) and test-retest ($r=0.82$). Cut off score >70 indicates large degree of pathology. Some evidence for convergent and discriminant validity		
Sexual History Form (SHF) Nowinski & LoPiccolo 1979									Others: frequency of sexual activity, sexual functioning and overall satisfaction	28/ 46		Used in studies of sex therapy outcome. Also provides Global Sexual Functioning Score (Creti et al., 1998) with test re-test $r=0.98$ and good ability to distinguish clinical from non-clinical populations, good divergent validity, and sensitivity to change.		

Arizona Sexual Experiences Scale (ASEX) McGahuey et al., 2000	*	*	*	*	*	*	*								5	Derived from lit review. Designed to evaluate impact of psychotropic drug-induced sexual dysfunction though relevant to other groups. $\alpha=0.9$ for total scale; $r=0.8$ for patients and $r=0.89$ for controls. Sensitivity - 82% and specificity 90%; PPV-88%; NPV-85%	
Male measures																	
International Index of Erectile Function (IIEF) Rosen et al. 1997	*	*	*	*	*	*	*								15	Originally developed for use in clinical trials of sildenafil. Shown to be highly sensitive in treatment trials. Good internal consistency ($\alpha=0.91-0.96$) and test-retest $r=0.82$. Adequate discriminant and concurrent validity. Easy to use. Severity algorithms available for clinical interpretation. Considered a gold standard.	
Male Sexual Health Questionnaire (MSHQ) Rosen et al., 2004b		*	*	*	*	*	*								25	Designed to assess key domains of sexual function and satisfaction in aging men with uro-genital health concerns. Designed to address weaknesses in IIEF such as heterosexual bias. Good internal consistency ($\alpha=0.81-0.9$) and re-test reliability $r=0.86-0.88$ for subscales. Good criterion validity	
Brief Sexual Function Questionnaire for Men (BSFQ) Reynolds et al., 1988	*														21	Emphasis on psychological etiologies. Does not assume that respondent has sexual partner. Reliable and valid but no data on sensitivity to treatment	
Brief Male Sexual Function Inventory (BSFI) O'Leary et al., 1995	*	*	*	*	*	*	*								11	Designed for use in urology. Easy to use but lacks evidence on sensitivity and treatment responsiveness. Internal consistency ($\alpha=0.62-0.95$) and test-retest ($r=0.79-0.89$) for subscales.	
European Male Ageing Study Sexual Function Questionnaire (EMAS-SFQ) O'connor et al., 2008															16	Designed to measure sexual function in population surveys of ageing men. Internal consistency ($\alpha=0.80$ to 0.88) and test-retest ($r=0.74$ to 0.93) for subscales. Two of the four sub-scales able to discriminate between men with high and low testosterone levels. Sensitive to age differences. Shows good convergent and divergent validity.	

Female Measures	Desire	Arousal/Excite	Orgasm	Satisfaction/Quality	Relationship	Sex behave & Exp.	Others: frequency of activity, receptivity/initiation, sexual problems	22	Modified from the BSFQ for men. Relatively low internal consistency ($\alpha=0.39$ to 0.83 for subscales) Test re-test $0.68-0.78$; concurrent validity with DSFI; able to discriminate between oophorectomised women and controls. Norms for composite and domain scores available.
Brief Index of Sexual Functioning for Women (BSFI-W) : Taylor, Rosen & Leiblum 1994	*	*	*	*	*		Others: frequency of activity, receptivity/initiation, sexual problems	22	Modified from the BSFQ for men. Relatively low internal consistency ($\alpha=0.39$ to 0.83 for subscales) Test re-test $0.68-0.78$; concurrent validity with DSFI; able to discriminate between oophorectomised women and controls. Norms for composite and domain scores available.
Female Sexual Function Index (FSFI) Rosen et al. 2000	*	*	*	*			Other domains: lubrication, and pain/discomfort	19	Designed by expert panel to assess sexual functioning in clinical trials. High internal consistency ($\alpha=0.82$ and higher); High test-retest ($r=0.79$ to 0.86 for subscales). Demonstrated to discriminate between clinical and non clinical women. Divergent validity established. Emphasis on arousal. Based on activity in past 4 weeks. Norms available.
Sexual Function Questionnaire (SFQ) Quirk et al. 2002	*	*	*				Others: lubrication, enjoyment, pain, partner satisfaction	31	Originally designed for clinical trials of sildenafil in women with sexual arousal disorders. Short-item version available. Strong internal consistency and test-retest reliability. Treatment responsiveness demonstrated.
McCoy Female Sexuality Questionnaire (MFSQ) McCoy & Matyas, 1998	*	*	*	*			Others: satisfaction with partner, feelings of attractiveness, vaginal lubrication	19	Assesses a woman's general level of sexual interest and response. Good evidence for changes across time and with treatment. Good construct, content and convergent validity. Internal consistency, $\alpha=0.77$ and re-test $r=0.83$ Only evaluated on women of menopausal age. Option to increase measure to 33 items by adding an additional 14 items
Short form of the Personal Experience Questionnaire (SPEQ) Dennerstein, Leheret & Dudley 2001	*	*					Others: pain, partner's sexual problems	9	Adapted from the MFSQ above and represents a reduced version of the 22 item PEQ (Dennerstein, Hopper & Burger, 1997). Designed for clinical use and to measure prevalence among women during the menopausal transition. Test-re-test $r=0.71$ to 0.95 for sub scales. Normative scores and cut-off scores available. Sensitivity and specificity both 79%
Profile of Female Sexual Function (PFSF) McHorney et al., 2004	*	*					Others: pleasure, responsiveness, self-image, concerns & disinterest (arousal domain includes orgasm)	37	Items developed via focus groups. Designed for clinical trials to measure therapeutic change in postmenopausal women with HSDD experiencing distress. Good internal consistency ($\alpha=0.79-0.96$) for women with low desire and re-test reliability $0.66-0.92$. Proven discrimination between women with low desire and age-matched controls.

Table 8.2 Reliable, valid and widely used measures of sexual function

8.3 Measuring Prevalence: Design Challenges

This section explores the challenges of measuring sexual dysfunction at population level and provides the methodological groundwork for chapter nine in which I introduce my conceptual model and draft measure.

8.3.1 The Impact of Measure Design on Prevalence Estimates

As mentioned in chapter two, a study by Laumann and colleagues in 1999 (Laumann, Paik & Rosen, 1999) estimated the prevalence of sexual dysfunction in the US at 43% for women and 31% for men. These figures have been widely cited¹⁶ and continue to hold authority as definitive evidence of the scale of the public health burden. But even the most cursory look at the study methodology suggests that these figures over-estimated the true problem. They derive from a reliable enough source; the 1992 US National Health and Social Life Survey of 1410 men and 1749 women aged 18-59 years. Measurement of sexual dysfunction was based on answers to 7 dichotomous response items, each measuring a different component of sexual dysfunction. Individuals were classified as sexually dysfunctional if they answered 'yes' to any one of the seven questions. The questions themselves were fine; a pragmatic solution to the need for brevity, acceptability and ease of comprehension within a broader survey. But essentially they measured sexual difficulties and in no way equated to a diagnosis of sexual dysfunction. Despite this, the resulting figures were presented by the authors (albeit with caveats) and in subsequent citations as estimates of dysfunction. This interpretation rightly drew criticism (Tiefer 2001d; Moynihan 2003; Bancroft 2002; Graham & Bancroft, 2005).

The story of the Laumann study illustrates some of the challenges inherent in epidemiological research in this field. In this particular instance, the authors failed to explicitly define what they were measuring, and failed to differentiate actual function problems from transient or adaptive changes in behaviour. These weaknesses are by no means unique to this study. Indeed, several reviewers have lamented the large number of prevalence studies failing to report any definition and/or assessment

¹⁶ 991 citations according to ISI Web of Knowledge, accessed on 30th April 08

criteria or failing to use a psychometrically validated instrument (Spector & Carey 1990; Simons & Carey 2001; Hayes & Dennerstein, 2005).

Despite decades of research, there is still neither a standardised measure for community prevalence studies nor an established methodology (Hayes & Dennerstein, 2005; Balon 2007). Working in this theoretical and methodological void, researchers are required to find their own solutions to the numerous measurement challenges. The inevitable lack of standardisation limits the potential for generalising across studies and has resulted in widely varying prevalence estimates. Reviewers of prevalence studies (Spector & Carey 1990; Simons & Carey 2001; Dunn et al., 2002; Hayes et al., 2008) point to the profound effect that differences in diagnostic criteria/case definition can have on prevalence estimates and lament the limited possibilities for comparison across studies. As an illustration, comparison of 11 recent prevalence studies for women, showed that on average 64% of women reporting any sexual difficulty experienced problems with desire. But across the 11 studies, that figure ranged from 16% to 75% (Hayes et al., 2006). Hayes and colleagues (Hayes et al., 2008) clearly demonstrated the impact on prevalence estimates of using different self-report instruments by comparing them directly within the same questionnaire to a community sample of women. Not surprisingly, the four different measurement strategies used, each produced a different estimate of dysfunction.

8.3.2 Design Parameters Associated with Epidemiological Measurement

Obtaining accurate estimates of the prevalence of sexual difficulties is challenging. This is partly because the parameters set by the research context are demanding. They include the need to minimise respondent burden; the need for acceptability (Dunn et al., 2002); and the need for relevance to diverse sections of the population. The need to be brief and yet comprehensive raises the obvious challenge of trying to 'capture' the construct in only a few questions. Often sexual dysfunction is measured within a larger questionnaire survey on aspects of health and/or sexuality such as sexual risk behaviours (Hayes & Dennerstein, 2005). Where this is the case, brevity is of great

importance and there is often only space for a single question per difficulty (Hayes & Dennerstein, 2005). Asking questions about sexual matters requires sensitivity (Mitchell et al., 2007) but particularly where they may appear 'out of the blue' as in a more general survey. Because the risk of offence and surprise is greater, even more careful attention than usual must be paid to item wording. The challenge is to find a balance between accuracy and acceptability. And where the survey is administered to a general population, somehow the measure must have relevance to the wide array of sexual practices within that community. Prevalence measures should also have public health utility; in other words, they should provide useful information on the likely burden of ill health and give an indication of how many and who might require professional help. This implies that, as far as possible, they should avoid including those with transient difficulties and those whose sexual difficulties represent an adaptive response to their particular situation.

8.3.3 Design Decisions

8.3.3.1 Underlying definition and classification

An operational definition is the logical starting point for question design. Surprisingly, many studies omit this step or fail to report it (Spector & Carey, 1990; Simons & Carey, 2001; Hayes & Dennerstein, 2005).

The debate surrounding the definition and classification of sexual dysfunction has already been described in chapter two. The pertinent question here is whether prevalence studies can purport to measure clinically diagnosable dysfunction or whether, in reality, they can only measure aspects of it. Some argue that it is rarely practical or feasible to measure sexual dysfunction as clinically defined on a population level (Graham & Bancroft, 2005) because of the difficulty of obtaining reliable diagnoses. Öberg and colleagues note that "a clinically sufficient questionnaire highlighting the background of different sexual dysfunctions is probably too elephantine for epidemiological surveys" (Öberg, Fugl-Meyer & Fugl-Meyer, 2004; pg 268). Despite these caveats, in reporting their results, prevalence studies often confuse self-reported problems with medically diagnosable disorder (Basson & Leiblum, 2003).

8.3.3.2 Construct Primacy

Overlapping with decisions about which definition of sexual dysfunction to employ, are decisions about which constructs or domains to measure. There are a large number of constructs that could potentially be included in a measure but it is generally only feasible to focus on a few. This implies the need for a rigorous and evidence-based set of inclusion and exclusion criteria to differentiate the construct itself from its correlates. As I stated in the rationale for this study and, as is evident in table 8.2 above, most current measures use the existing literature and professional opinion as their evidence base for this process. The measure under development in this study is unusual in using respondent reported experiences as a significant part of the evidence base.

The impact of the continuing dominance of the DSM and ICD-10 criteria in determining construct primacy is that measures or questions enquiring about aspects of function beyond the traditional DSM criteria tend to be viewed as measuring different constructs. For instance, the recent (Pfizer funded) Global Study of Sexual Attitudes and Behaviours (Laumann et al., 2006) measured 'subjective sexual well-being', defined as the 'cognitive and emotional evaluation of an individual's sexuality' (Öberg, Fugl-Meyer & Fugl-Meyer, 2002). The domains measured under this concept included satisfaction with emotional and physical aspects of relationships, satisfaction with sexual functioning and the relative importance of sexuality in one's overall life. Depending on one's perspective, the distinction between these domains and the concept of a functional sex life is somewhat blurred. If one is prepared to leave behind traditional biomedical notions of sexual function, then the inclusion of such domains, within rather than concomitant to, sexual dysfunction is a matter of perspective, preference and interpretation of the evidence.

And even if one does adhere to DSM-IV and ICD-10 criteria, there is uncertainty about which constructs, or diagnoses, rightfully belong. For instance, there are ongoing calls for dyspareunia to be re-classified as genital pain syndrome rather than a sexual dysfunction (Binik et al., 2001) and some empirical work supports this suggestion (Meana et al., 1997). Others have called for vaginismus to be removed as

a diagnostic term because it is actually only a description “akin to bronchoconstriction or colon muscle contraction” (Basson, 2001b; pg 109). And many others have questioned whether low desire among women actually constitutes dysfunction, or whether it is only lack of responsive desire that really matters (Davis 2001; Basson, 2001b, Goldmeier, 2001). Even the diagnosis of women’s orgasmic disorder has been called into question (Bean, 2002; Tiefer, 2001d).

The inclusion/exclusion criteria are driven to some extent by the purpose of the measure. As stated above, community prevalence studies are interested in public health utility whereas many existing measures of sexual dysfunction are designed to assess the impact of pharmacological agents under clinical investigations. For such measures, physiological and biochemical domains take precedence.

8.3.3.3 Selection of Items or Measures

Thus far, there has been a failure to select or invent a small number of standard sexual dysfunction measures (Balon, 2007). This reluctance no doubt relates to the ongoing debate about what sexual dysfunction means and how it should be classified (see chapter two). Concern about the lack of epidemiological studies adopting standard DSM criteria (Nathan 1986; Simons & Carey, 2001), only stand if one accepts the DSM as clinically useful and relevant to individual concerns. Many argue that this is not the case, particularly for women (Graham & Bancroft, 2005; Tiefer 2001d; see also chapter two).

As far as prevalence studies are concerned, the common practice is to borrow, adapt or design from scratch a series of single questions rather than utilise psychometrically validated measures (Graham & Bancroft 2005; Hayes & Dennerstein, 2005). For instance, following the Laumann study in 1999, half of the ensuing eight studies of female sexual dysfunction selected for review by Hayes (2006) adopted or modified the questions used by Laumann’s study team. Whilst appearing acceptable and comprehensible, these questions have not been subjected to scientific testing. Choice of items is made harder because objective parameters such as the frequency of sex

suffer from recall bias with long reporting periods (Catania et al., 1990) and may vary independently of dysfunction/dissatisfaction (Rust & Golombok, 1986).

Regardless of whether a measure or set of questions is utilised, sensitive question wording is of critical importance. In a prevalence study by Dunn (1998), the researchers discovered that up to a third of the respondents had not answered certain questions; a problem not unique to their own study (Dunn, Croft & Hackett, 1998). In addition, response formats must be considered carefully; dichotomous 'yes/no' responses, for instance, are likely to yield less clinically useful information than more specific likert scales (Nathan 1986; Althof, Rosen & Derogatis, 2005). For these reasons, pre-testing and piloting of questions is clearly essential.

8.3.3.4 Choice of Self-rating Indicators

Providing an indication of the severity of the reported difficulties and the extent to which they are perceived as problematic assists in providing a better approximation to dysfunction and helps to differentiate transient and adaptive responses from clinical disorder. I review several indicators of severity here.

- **Duration of symptoms**

Within the DSM, there is no consensus on how long a difficulty should last before it becomes diagnosable dysfunction (Balon 2007). Uncertainty about the 'right' duration is reflected in epidemiological studies, which employ widely varying timeframes. Analysis of the NATSAL 2000 data (Mercer et al., 2005) showed that increasing the reported duration of symptoms from 'at least one month in the last year' to 'at least 6 months in the last year' led to a reduction in prevalence of reporting any sexual function problems from 53.8% to 15.6% among women and 34.8% to 6.2% among men. A recent review of prevalence studies confirmed that even differences of a few months could significantly alter estimates (Hayes et al., 2006). Hayes and colleagues also demonstrated that asking respondents to report symptoms in the past month resulted in significantly lower prevalence estimates than asking respondents to report symptoms lasting for longer than one month in the past year (32% versus 58% for Hypoactive Desire Disorder) (Hayes et al., 2008). What

then, is the optimum duration? The balance appears to be between a period long enough to avoid capturing transient difficulties, and short enough to avoid missing severe but relatively short-lived episodes. Going back to the figures from Mercer and colleagues, it seems highly unlikely that the burden of ill health incorporates over half of British women and over a third of British men (the proportion reporting difficulties lasting one month+), whereas the '6 months+' estimates appear reasonable, taking into account the proportion who seek help (21% of women and 10.5% of men who reported any difficulties, regardless of duration) and taking into account those who avoid sex because of their difficulties (62.4% of women and 32.5% of men reporting any sexual difficulties, regardless of duration) (Mercer et al., 2003). However, before opting for the longer duration, it would be important to know whether problems of shorter duration differ in severity and aetiology from those of longer duration.

It is worth noting that if one is considering the timeframe for reporting, as opposed to the duration of symptoms, the opposite may be true; that is, shorter reporting time spans may result in lower prevalence estimates (Öberg, Fugl-Meyer & Fugl-Meyer, 2004).

- **Intensity of symptoms**

Professional consensus since DSM-IV has emphasised that for a diagnosis of dysfunction, symptoms should be reported as persistent and recurrent (Basson et al., 2000). Few epidemiological studies have collected these data however. In a notable exception, Öberg and colleagues provided empirical support for this emphasis, demonstrating that differentiation of sexual function experience according to whether it is manifest (occurs quite often, nearly all the time, and all the time) or mild (occurs hardly ever or quite rarely) provided a useful epidemiological distinction (Öberg, Fugl-Meyer & Fugl-Meyer, 2004). They demonstrated that reporting of mild symptoms among Swedish women was much more common than reporting manifest symptoms (with the exception of vaginismus). Furthermore only 1-2% of those reporting mild symptoms also reported manifest distress. This would suggest that for most individuals, experiencing mild symptoms of dysfunction might be reasonably considered normal variation. Interestingly, the authors did not agree with this interpretation, on the basis that reporting mild symptoms was also significantly

associated with low sexual well-being (defined as responding 'rather dissatisfied, dissatisfied or very dissatisfied' to the questions, 'How satisfying is your sex life?').

- **Distress**

I introduced the debate about the use of distress as an indicator of dysfunction in chapter two. To recap briefly here, the distress criterion is considered to have clinical relevance to the extent that those who are distressed are more likely to seek help (Öberg, Fugl-Meyer & Fugl-Meyer, 2004; Graham & Bancroft, 2005). It also assists in understanding what types of problems worry people, and in differentiating between those with transitory and/or adaptive problems, and those with clinically significant dysfunction. Those opposing the distress criteria argue that it is particularly difficult to define and measure objectively (Rosen et al., 2000; O'Donohue, 2001; Althof, 2001; Balon, 2008), although the development of validated instruments to measure distress, such as the Female Sexual Distress Scale (FSDS) (Derogatis et al 2002) has provided options for more reliable measurement. There is also not always a clear association between the severity of a problem and the level of stress experienced (O'Donohue, 2001; Sugrue & Whipple, 2001) but since we lack normative data, we are on shaky ground if we insist that an individual who is not distressed by their symptoms is still abnormal or dysfunctional.

- **Perception of a problem**

King and colleagues recently examined concordance between an ICD-10 diagnosis (using the BISF-W; see table 8.2) and women's perception of a problem. Of the 401 female GP attendees completing their survey, 38% were assigned at least one ICD-10 clinical diagnosis, but this prevalence fell to 18% if one included only those women who felt that they had a sexual problem, and to 6% if one included only those who viewed the problem as distressing (King, Holt & Nazareth, 2007). Thus the inclusion of both these self-rating indicators had rather a dramatic impact on prevalence estimates. Furthermore, there was only moderate agreement between standard and self-rated indicators: 18% of women were given a diagnosis and agreed they had a problem; 20% were given a diagnosis but did not think they had a problem; 19% were not given a diagnosis but did think they had a problem; and 42% were not given a diagnosis and did not think they had a problem. Thus standard and self-rated

indicators were in agreement in only 60% of cases. Concordance between standard and self ratings was lowest for sexual arousal disorder (38%) and loss of sexual desire (39%). It was highest for non-organic dyspareunia (74%) and non-organic vaginismus (77%), presumably because the descriptions attached to these diagnoses are more specific. Overall, the data suggest that standard diagnostic criteria provide only part of the picture; a more accurate assessment is attained if self-perceptions of a problem are included. This finding is supported by an earlier review of community based studies among women (Bancroft, Loftus & Long, 2003). Bancroft and colleagues found limited correspondence between women who self-defined as having a sexual problem and women 'assigned' a problem by one of the study-defined categories. They also found a strong association between the presence of a sexual difficulty and current problems in the women's lives such as relationship difficulties, suggesting that many of the 'problems' may have been what Bancroft termed 'adaptive responses' to negative situations. It would be interesting to conduct both these studies with men to see whether a similar pattern emerged.

- **Perception that partner has a problem**

In chapter six we saw that some of the respondents experiencing difficulties also talked about problems experienced by their partners. In four instances, the account given by the respondent suggested that it was their partner who had the primary problem and in all three cases co-morbidity between partners was high. Previous research has suggested that in up to a third of patients with sexual problems, the partner also has a sexual dysfunction (Gregoire, 1999). This suggests that if one takes an interpersonal perspective, information about the partner may provide an important piece of the picture. As Graham and Bancroft argue, it is also important to ensure that an individual is receiving appropriate stimulation, otherwise their 'score' may partly reflect the sexual inadequacies of their partner (Graham & Bancroft, 2005).

- **Overall rating of satisfaction**

One option for assessing severity is simply to ask respondents to provide an overall assessment of their sexual health. Perceived health is regarded by some as one of the most subjective concepts in health measurement. And yet, as an indicator it has a

surprising amount of predictive power (Cleary, 1997). For example, one study suggested that older people who perceived themselves to be in poor health were six times more likely to die in a 4-year period than those perceiving their health to be excellent (Idler & Kasl, 1991). Among the suggested explanations for the power of this variable is the idea that, in answering this question, individuals mentally synthesise a whole range of information (family history, genetics, recent health, attitudes to health, signs and symptoms) that researchers could otherwise access only through a large number of specific variables (Cleary, 1997).

It would be interesting to explore whether a standard question, such as 'Overall, how would you rate your health?' (Very poor, poor, OK, good, very good), translated to the field of sexual dysfunction, could have the same epidemiological usefulness. One foreseeable drawback to an item like this would be the lack of appropriate terminology to replace the term 'health'. A term such as 'sexual function' is not well understood outside of the medical context, and terms such as 'sex life' and 'sexual health' are open to variable interpretation. For instance, the latter might be interpreted as asking about the presence or otherwise, of sexually transmitted infections.

Probably the closest corollary to an indicator of perceived health, within the field of sexual dysfunction, is the measurement of sexual satisfaction. This indicator has already been used widely in prevalence studies and has also shown to be strongly correlated with sexual dysfunction. For instance, women reporting frequent sexual difficulties, accompanied by personal distress, also report low levels of sexual satisfaction (Fugl-Meyer & Fugl-Meyer, 1999). King and colleagues found that sexual satisfaction was lowest among women externally (using ICD-10 criteria) and self defined as having problems, and highest in women neither externally nor self-defined as having problems (King, Holt & Nazareth, 2007). And Laumann and colleagues found that experience of sexual difficulties significantly predicted reporting low physical satisfaction, low emotional satisfaction and low general happiness for both men and women (Laumann, Paik & Rosen, 1999). It is clear that a global rating of sexual satisfaction is useful. The key question is whether satisfaction is concomitant to dysfunction or is more reliably construed as part of the construct itself. Some measure satisfaction as a construct, distinct but related to, dysfunction

(Dunn, Croft & Hackett 2000; Öberg, Fugl-Meyer & Fugl-Meyer, 2004), while others see it as part of the construct (see for instance the MSFQ in table 8.2 above).

- **Help seeking**

Help seeking can be a useful proxy for measuring severity. It is an indicator with public health utility because it suggests the likely burden on health services. There are two separate indicators here: expressing a desire for help, and actually seeking help. The latter is perhaps more objective (individuals either go for help or they do not) but does not necessarily capture all those who view their symptoms as severe.

Data from NATSAL suggest that while 32.5% of men and 62.4% of women avoided sex because of their problems, only 10.5% of men and 21% of women sought help (Mercer, Fenton & Johnson, 2003). Clearly, only a proportion of individuals with difficulties seek help, and this varies according to the type of difficulty. Studies suggest that very few men with PE seek help, partly from embarrassment and partly due to a belief that there is no cure (Rosen & Althof, 2008). I explored the difference between reporting low sexual desire per se and seeking help for the problem, in terms of key variables such as age and marital status in my paper on sexual interest (see appendix two)

There are a number of cognitive steps that individuals must take before they arrive at the doctor's door. Firstly they must perceive that they have a symptom and that this symptom is a problem to them. Next, they must believe that their symptom is of relevance to the medical profession and that therefore, the doctor is an appropriate person to see. Finally they must be keen enough for the symptom to be sorted that they are prepared to do whatever the doctor might suggest (Ogden, 2003). Whether or not a person perceives that they have a symptom requiring help depends to an extent on the severity of the symptom but is also affected by factors such as the version of 'good' sex to which they adhere; the perceived cause of the problem; and the partnership context (see chapter seven).

Seeking help may also be confounded by a range of factors unrelated to the individual context such as the availability of effective treatment (Spector & Carey, 1990). For instance, the number of recorded diagnoses of erectile dysfunction more than doubled

after the introduction of sildenafil in the UK (Kaye & Jick, 2003), most likely an artifact of the availability of treatment. Other barriers to help seeking may include perceived attitudes of the health professional (Gott & Hinchcliff, 2003a) and difficulty communicating about sexual matters in general, both by the patient and practitioner (Stead et al., 2001).

8.3.3.5 Inclusion of Descriptive and Diagnostic Information

Where the measure is embedded in a larger survey exploring a broad range of issues, space constraints may limit opportunities for collecting descriptive information in addition to the sexual function measure. However, such information is often vital in understanding the results; increasing the sensitivity and specificity of the measure; and providing avenues for exploring aetiological agents.

One reason for collecting additional descriptive information is to approximate, as near as possible, a DSM-IV diagnosis for disorder. Studies based on DSM-IV criteria should ideally obtain further information, such as whether the symptoms are generalised or situational; whether they are life-long or acquired; and whether the dysfunction is not better accounted for by another Axis I disorder, or medical condition or substance use. Many studies adopting DSM criteria fail to collect this necessary information (Simons & Carey, 2001). Other variables such as frequency, while not actually required for a DSM diagnosis, can help to build a more detailed picture of the experience of difficulties.

Another reason for collecting additional information is to differentiate between transient difficulties and dysfunction. Where low sexual function coincides with life event factors such as a relationship break up, work related stress, marital stress, presence of young children in the house, or a recent birth, one might hypothesise that such events confound the experience, and that for a proportion of respondents, their difficulties represent a transitory and adaptive response to those factors. Finally, extraneous information assists in exploring aetiological agents. For instance, information such as poor communication about sex with a partner, attitudes towards the importance of sex, and sexual competence at first sex can provide useful detail about risk factors for low sexual desire (see appendix two).

8.3.3.6 Relevance with Respect to Gender and Orientation

Historically, much of what is conjectured about female sexuality has been based on research and understanding of male sexual behaviour. This has led to some fundamental errors with significant consequences, including Freud's somewhat notorious assertion that women who derived sexual satisfaction from clitoral stimulation were immature and phallically oriented (Christopher 1987; McLaren, 1999).

Although Masters and Johnson proposed the Human Response Cycle as basically applying equally to men and women (Masters & Johnson, 1966), they later categorised female dysfunction quite differently to men, recognising socio-cultural influences as a major cause of female sexual dysfunction (Masters & Johnson, 1970). However, it was the Human Response Cycle that became the foundation for sexological research and practice, giving rise to a classification system that is conceptually similar for men and women. To an extent, this blurring of distinction between male and female dysfunctions was an attempt to redress the societal view of female sexuality as fundamentally different to male; this distinction being a central tenet of the historical repression of female sexuality (Graham & Bancroft, 2005).

More recently, there has been recognition of differences in male and female sexuality, and it has been acknowledged that women's accounts fail to fit neatly with the DSM classification (Potts & Bhugra, 1995). Women, for instance, do not generally differentiate between desire and arousal, a finding supported by clinical observation and research (Basson, 2000). They are also generally less concerned about the physiological factors emphasised by DSM (lubrication, frequency of orgasm) and more concerned about subjective and contextual factors such as mood and relationship with the sexual partner (Tiefer, 2001a; Bancroft, Loftus & Long, 2003). Indeed objective measurements of sexual response in women, such as vascular pulse amplitude (VPA) in the vagina correlate poorly with women's reported subjective experience (Laan & Everaerd, 1998). The failure of Pfizer, following eight years of research, to adapt Viagra for use with women, provides further testimony to

fundamental gender differences in sexuality and the pharmaceutical industry has belatedly acknowledged that these differences exist (Graham & Bancroft, 2005).

A similar debate exists about whether it is possible to study homosexual problems using the framework of the Human Sexual Response Cycle (Sandfort & de Keizer, 2001; Boyle, 1993; Bhugra & Wright, 1995). This debate has already been explored briefly in chapter three.

In my study, I avoided making strong assumptions about the variation in function by gender and orientation because of my small sample. However, if pushed to state an opinion, my impression was that, if one stayed away from assumptions of vaginal penetration, and focused on priorities rather than activities, there did not appear to be major qualitative differences between the sub-groups. Based on my data, I believe that differences across gender and orientation in terms of priorities for a functional sex life are quantitative rather than qualitative.

The observation of variation across gender and orientation has to be weighed against the practical value of an epidemiological measure that is applicable to all groups and therefore permits comparison of variation across groups. Provided questions can be answered by any individual, regardless of gender and orientation (or for that matter, cultural and socioeconomic group), then the measure can be made relevant to sub-groups by establishing separate cut-off scores for each.

8.3.3.7 Scoring Systems

Decisions regarding the scoring of the measure are particularly important. Ultimately, scores and cut-off points are used to discriminate between those with and without dysfunction (Dennerstein, Anderson-Hunt & Dudley, 2002), and the summary score or numerical estimate is often the single piece of information carried into a policy arena. As the Laumann story illustrated, the subtleties of the methodology are left behind and the final figures may be re-interpreted or used to paint a different picture. Thus it is essential that the scoring system yields good specificity, sensitivity, positive predictive value, and negative predictive value. However, a complex scoring system, though desirable in these terms, may be off-putting to potential users if too unwieldy.

For epidemiological studies adopting a brief set of questions, there is debate about whether single questions can provide useful information about a specific difficulty, or whether the questions should be used only to provide a single summary score. This question ties in with the broader debate about whether sexual function may be construed as a single dimensional entity, or as a set of discrete diagnostic categories. The observed overlap and co-morbidity across DSM-IV diagnostic categories (see chapter two) supports the idea of a single entity. This overlap has also been found in prevalence studies of female sexual dysfunction (Segraves & Segraves, 1991; Read, King & Watson, 1997). For instance, in the study of GP attendees by King and colleagues, 25% of women assigned an ICD-10 category received more than one diagnosis (King, Holt & Nazareth, 2007). Given this overlap, the splitting of sexual dysfunction into discrete diagnoses, risks “reifying as separate entities components of a single complex syndrome” (Pincus et al., 1992; pg 113). Some researchers have tentatively suggested that a composite score of dysfunction may be useful (Dennerstein, 2001; Basson et al., 2001), particularly in research (Conte, 1983). Others are critical of the idea of a composite score, suggesting that dysfunctions that do not coincide with others would be omitted for the sake of internal consistency (Vroege, Gijs & Hengeveld, 2001) and that an overall measure, with only one or two question per symptom/dysfunction would not be sufficient to tap into each symptom/dysfunction (Conaglen, 2001).

Even where the results of an epidemiological study are presented as a composite or summary score, there is likely to be strong demand for additional analysis broken down by individual difficulty. That said, the ‘total’ scores of 43% and 31% offered by Laumann and colleagues were widely used and accepted, suggesting that summary scores are also perceived as useful.

8.4 Conclusion

The purpose of this chapter was to provide an evidence base for decisions regarding the design of my conceptual model and measure (see chapter nine). I reviewed 54 existing self-report measures of sexual dysfunction (see table 8.2 and appendix 15), concluding that there is only one measure (the ASEX) that might be suited to

measuring prevalence at population level. Of the others, 37 focused only on specific aspects of sexual function, on related constructs, or on specific populations; 11 did not have both male and female versions and 5 were too long for a public health survey.

I demonstrated that in community based surveys, the questions asked impact greatly on the prevalence rates produced and so question design is fundamentally important. But designing a good measure is challenging, particularly in the context of a public health survey, which has a number of constraints on design, including brevity and acceptability. My review of the evidence in this chapter provided support for a number of decisions regarding the theoretical and methodological parameters of the measure. I begin the next chapter by summarising these decisions. I conclude this chapter by suggesting that although it is easy to criticise existing measures and prevalence studies, it is much harder to identify ways of overcoming their weaknesses.

Chapter 9

Designing the Conceptual Model and Measure

9.1 *Purpose of the Conceptual Model*

The design of the conceptual model is dependent on its purpose and parameters. These were described in detail in chapters three and eight (section 8.3.2) and are briefly summarised again here.

The model is designed to provide the conceptual basis for a measure of sexual dysfunction. The purpose of the measure is to determine the prevalence of sexual dysfunction within a UK community sample. It is envisaged that the measure will be embedded within larger surveys of health or sexual health, such as NATSAL (Johnson et al., 2001), rather than a stand-alone questionnaire (although this latter use will of course be possible). Given this purpose, the measure should be:

- Of public Health Utility (accurately captures the public health burden);
- Comprehensive (includes key dimensions of the construct of sexual dysfunction);
- Brief (no longer than 15 items);
- Acceptable (should not cause offence or appear too intrusive or surprising);
- Easy to understand (simple language and avoidance of 'expert' terminology).

9.2 *Evidence-based Design Parameters*

In the preceding chapters, I presented evidence, both from my fieldwork and from the literature, to support a range of decisions regarding the design of the model. Here I summarise my decisions with regard to the methodological issues raised in chapter eight (please refer back as necessary). These were difficult decisions because the evidence was sometimes sketchy or contradictory, and there were often equally strong arguments both for and against a particular decision. Thus the decisions were arrived at through a careful weighing of evidence and analysis of the debate. Clearly, my own

inter-disciplinary perspective infused this process (see chapter three). Each decision is summarised as a design parameter below:

- **Operational definition and underlying Classification.** As stated previously, this study and the resulting measure are premised on the definition of sexual dysfunction offered by WHO (see below). This definition was chosen in preference to the APA definition because it is not tied to the Sexual Response Cycle and therefore to heterosexual vaginal intercourse. Given the difficulties of accurately measuring clinically diagnosable dysfunction at a population level (see chapter eight), the measure will ask about and report on a range of sexual difficulties, but will aim to provide a composite score of sexual function, with scores below a designated threshold approximating to sexual dysfunction. For reasons outlined in chapter two, I decided not to use the DSM-IV (American Psychiatric Association, 2000) or the ICD-10 (World Health Organisation, 1994) diagnostic criteria as a classificatory basis for the model.
- **Construct Primacy.** I adopted a biopsychosocial perspective and used respondent priorities to determine construct primacy. As suggested by the literature and demonstrated by my data, there is wide variability in sexual expression and priorities and the three versions of ideal sex identified in chapter five (interpersonal, erotic and mechanistic) provide a useful basis for capturing this variation. Based on my results, the model does not assume vaginal intercourse as a norm but does assume that subjective experience is as valid as physiological. The model is also premised on the idea of 'good enough' sexual health, rather than notions of ideal/perfect and thus seeks to measure health and avoid measuring performance. Finally, it views the sexual relationship as integral to sexual function.
- **Conceptual (dis)similarity.** From a public health perspective, a measure applicable to all genders and orientations is useful because it permits comparison across groups. In chapter eight I presented evidence against assuming conceptual similarity across gender/orientation in terms of functional experience. But if the underlying perspective is broad enough (see construct primacy above), applicability need not imply conceptual similarity.
- **Dimensionality.** Whilst bearing in mind the need for brevity, my fieldwork, as well as the existing literature, overwhelmingly point to the multi-dimensionality

of the concept. Although several dimensions are proposed (erotic, mechanistic and interpersonal), later psychometric testing (beyond the scope of this thesis) will confirm or deny the validity of these dimensions.

- **Unit of evaluation.** The basic evaluative unit will be the individual but respondents will be required to assess the relationship dimension of their sexual experience (where applicable).
- **Self-assessment indicators.** A key consideration of the model is to differentiate between transitory or adaptive difficulties and those that have public health/clinical importance. Since there is not one fail-proof indicator (see chapter eight), the model will initially try out a range of self-rating indicators, including duration and intensity of symptoms.
- **Norms and cut-off scores.** The measure will seek to avoid pathologising normal variation primarily by establishing cut off scores that maximise specificity. Psychometric development work (post this thesis) will produce normative data (from NATSAL 2010) which can be used to assist in identifying population relevant cut-off points, separating function from dysfunction. To avoid unfair comparison there may be four separate cut-off points: for single men; single women; co-habiting men; and co-habiting women. Analysis of the NATSAL 2010 data will explore whether there is also need for specific cut off points for different sexual orientations.

9.3 *Building the Model*

9.3.1 Selection of Factors

In chapters five, six and seven, I explored, using evidence from my fieldwork, the ways in which individuals framed their priorities for a 'good enough' sexual life, the components that might comprise such a sex life, and the coping strategies respondents employ when their criteria for 'good enough sex' cannot be met. In looking at the components of functional sex (chapter six), I made no attempt to disentangle the relative importance of the factors, nor their inter-relationship. In this chapter I return to these components to impose some order and select those that should go into the model. I select factors from the candidate components outlined in chapter six, using

evidence from the preceding results chapters (five, six, seven and eight) as well as the literature. To recap, table 9.1 lists the sub-factors identified in chapter six:

Mechanistic	Interpersonal	Erotic	Other
<ul style="list-style-type: none"> ▪ Getting an erection ▪ Absence of pain/discomfort ▪ Orgasm: Regularity, Quality, Timing ▪ Adequate lubrication 	<ul style="list-style-type: none"> ▪ Trust ▪ Warmth ▪ Feeling wanted ▪ Motive compatibility ▪ Reciprocity ▪ Interpersonal connection ▪ Balance in levels of desire ▪ Confidence to communicate needs ▪ Partner is problem free 	<ul style="list-style-type: none"> ▪ Ability to give and receive pleasure ▪ Compatibility in roles and preferences ▪ 'Chemistry' ▪ Enjoyment and satisfaction ▪ Wanting to have sex ▪ Subjective feeling of arousal ▪ Novelty/Excitement ▪ Not avoiding sex 	<p><u>Sexual self</u></p> <ul style="list-style-type: none"> ▪ Happy body feeling ▪ Positive sexual identity ▪ Positive motivations to have sex ▪ Lack of anxiety <p><u>Context</u></p> <ul style="list-style-type: none"> ▪ Privacy ▪ Absence of stress and tiredness <p><u>Frequency</u></p> <ul style="list-style-type: none"> ▪ Actual relative to desired ▪ Actual frequency

Table 9.1 Items Identified as Components of Sexual Function

Having identified the items, the first step was to establish criteria by which they might be included or excluded from the model. On the basis of the parameters described in the section above, and following a brainstorming session (myself and Kaye Wellings), the following inclusion and exclusion criteria were established:

Criteria for inclusion:

1. Items represent 'appropriate activities'¹⁷ with regard to the functions of sex: creating a bond between partners, release, procreation, pleasure and recreation

¹⁷ Chambers English Dictionary. Definition of 'Function'.

Criteria for exclusion:

1. Items that are correlates of the construct (predisposing factors, precipitating factors, maintaining factors, contextual factors and outcomes (see Althof et al., 2005a), or items that are “a degree or so removed from explicit sexual behaviour” (Derogatis, 1997; pg 293).
2. Items that do not indicate a public health burden. In other words, items for which individuals are unlikely to seek professional help or items which are desirable/ideal rather than ‘good enough’ (appearing to measure performance).
3. Items that appear to overlap with another item.

Criteria one was the most difficult to interpret. There are a range of factors that are considered part of the construct in some models/measures, and considered co-factors in others. The question of whether an item belongs within the construct or outside depends entirely on the concept of sexual (dys)function underlying the measure. This question is somewhat circular since the conceptual model is essentially determined by the factors put into it and yet the choice of factor is determined by the underlying concept of sexual function. I defined correlates as any factors that could be construed as antecedent to or an outcome of, a functioning sex life. In other words, these factors represented the context of the sex life (whether personal, relational or physical), and some might also be viewed as aetiological agents. Some correlates may also be useful as indicators of severity. Construct factors were those viewed as central to defining functional sex. Delineating constructs from correlates involved a combination of data, logic and perspective. However, because of the imperatives of brevity and public health utility, I erred towards excluding rather than including factors from the construct.

Kaye Wellings and I considered the items above in turn and excluded 14. Table 9.2 below summarises the rationale and decision for each item. Decisions about whether to include or exclude an item were guided firstly by my data (see chapters five, six and seven), and secondly, by evidence from the previous literature reviews (chapters two and eight) as well as additional evidence specific to each item (see table 9.2 below). For the sake of brevity, existing measures and para-measures of sexual dysfunction referred to in the table are listed only by acronym. Please refer to table 8.2 in chapter eight or appendix 15 for full details.

Evidence and Decision

**'Happy body feeling'; Ability to give and receive pleasure; Positive sexual identity;
Confidence to communicate needs; Positive motivations to have sex**

In my data, these factors were described as contributing towards, or arising from, a feeling of comfort and confidence during sexual encounters. In other words, they were antecedent to as well as outcomes of, a functional sex life. To this extent, they may be viewed as correlates of the construct.

The existing literature generally also regards these items as co-factors (whether predisposing, maintaining or outcomes), rather than integral to the concept of function. See for instance, Sanchez & Kiefer (2007) on body concerns and sexual dysfunction (SD); Graham et al. (2004) on inhibitors/enhancers of sexual arousal; Cyranowski, Aarestad & Andersen (1999) on sexual self-schema; Meston, Heiman & Trapnell (1999) on early sexual abuse and later sexual difficulties; Nazareth, Boynton & King (2003) on psychological morbidity. Also, see Rosen & Althof (2008) for review of studies re. PE and its impact on confidence and self-esteem and see Sandfort and de Keizer (2001) for review of impact of homosexual identity and self-esteem issues on sexual problems. The New View (The Working Group, 2001) – a categorisation of causes of problems - includes 'anxiety or shame about one's body, sexual attractiveness or sexual responses' and 'confusion or shame about one's sexual orientation or identity or about sexual fantasies and desires' as part of its classification system. Long inventories such as DSFI and SII and several of the shorter female measures, (BISF-W, PFSF) as well as several para-measures (SSS-W) cover these aspects briefly. In addition, several para-measures focus on sexual esteem and self-efficacy (SSES-F; SSES-E; the Sexuality Scale).

DECISION: Exclude on the basis of criterion (1)

Anxious about performance

Items above concerning body image and communication skills etc. were important because of their association with feeling confident and comfortable. Anxiety implied an absence of confidence and comfort. It was seen as a problem in itself, leading to distracting thoughts and precluding enjoyment. It was an original source of difficulty but was also tied up with other difficulties such as pain and fear of transmitting HIV.

Kaplan (1977) argued that anxiety was the basic cause of all sexual dysfunctions but a more recent review of the evidence concluded that anxiety is "not universally disruptive"; much depends on the

level and nature of the anxiety as well as its origins (Althof et al., 2005a; pg 795). The effects of anxiety appear to be mediated through attentional processes (distraction) (Cranston-Cuebas & Barlow, 1990), suggesting that it is not anxiety per se, that is important but the changes it causes in perception and attention (Rosen & Leiblum, 1995). Greater non-sexual thought frequency and greater anxiety over thoughts are associated with poorer sexual functioning for both men and women, and also lower sexual satisfaction for women (Purdon & Holdaway, 2006). Sexually dysfunctional individuals appear more prone to performance related cognitive distractions and feelings of anxiety (Barlow, 1986). Several studies have suggested a link between anxiety and PE (see Rosen & Althof, 2008). Anxiety reduction is a common focus for cognitive behavioural therapy, for instance in treating anorgasmia (Meston et al., 2004). In particular, reduction of pressure to perform sexually is important (Apfelbaum, 1988). The Dual Control Model emphasises the important role of inhibitory mechanisms in sexual dysfunction (Bancroft & Janssen, 2000). The SAI measures perceived arousability and anxiety in response to various sexual experiences. In view of the evidence described here, the item should focus both on anxiety and on distracting thoughts

DECISION: Include

Privacy; Absence of (non-sexual) stress and tiredness

In my data, these items were mentioned by several respondents as contributing to a conducive environment. They are clearly correlates rather than part of the construct.

In the literature, factors such as stress and tiredness are recognised as potentially contributing to sexual dysfunction. For instance, the NHSLS survey found that stress related problems were associated with experiencing sexual difficulties (Laumann, Paik & Rosen, 1999). The New View (The Working Group, 2001) categorises 'lack of interest, fatigue or lack of time due to family and work obligations' under 1D (socio-cultural, political or economic causes). These items are rarely included in self-report measures.

DECISION: Exclude on the basis of criterion (1)

Reciprocity

Within the context of a sexual relationship, reciprocity indicated a balance in giving and receiving pleasure across partners. This was considered particularly important within the interpersonal model of sex. This does not imply that partners always give and receive in equal amounts, but that each individual is content with the way that giving and receiving of pleasure is shared across the couple. Achieving this balance required many of the factors above (e.g. ability to give and receive pleasure)

and the outcomes of lack of reciprocity were expressed in terms of lack of relationship and sexual satisfaction.

There is little discussion of reciprocity as a component of sexual function although equality of sexual rewards and costs across partners, and a balance of sexual rewards and costs in the relationship are both said to affect sexual satisfaction (Byers & MacNeil, 2006). An older study found that a partner's failure to respond to sexual requests was the problem most commonly cited by gay men (Bell & Weinberg, 1978) and because being penetrated and penetrating carry symbolic meanings (in terms of submission and dominance) reciprocation can be particularly important for gay men (Sandfort & de Keizer, 2001). Measures of sexual function occasionally assess willingness to reciprocate but these items are often designed to assess individual receptivity, rather than reciprocation as a function of the couple. The New View classification mentions loss of reciprocity as a cause of dysfunction (The Working Group, 2000).

Conceptually, this factor overlaps to some extent with ability to give and receive pleasure (above) and balance in desire (see below). The latter has a greater weight of evidence and is therefore a better choice for inclusion.

DECISION: Exclude on the basis of (3)

Compatibility in motive for sex across partners; Compatibility in roles/identities across partners

Compatibility in motive implied wanting sex for the same reasons, whilst compatibility in terms of roles/identities implied each individual feeling satisfied with the roles played both by themselves and their partner. The latter was particularly important to gay respondents who had to work harder to define and negotiate their roles within the relationship. Although important to several respondents, these items might be most accurately viewed as factors predisposing or precipitating difficulties within a couple.

Plenty has been written about the influence of identity, perceived sexual role and motives for sex on experience of SD (see first box in this table). There has also been research on compatibility across the sexes in terms of preferred characteristics of a sexual partner (McGuirl & Wiederman, 2000). However, I could not find any research specifically relating compatibility in motives or roles to sexual function problems. There is a measure – the HISC – that is focused specifically on compatibility, but it does not contain items relating to either sexual motive or roles. Compatibility in motive may be of greater importance in casual encounters and at the beginning of relationships, than in established relationships. Compatibility in roles/identities overlaps to some extent with compatibility in sexual preferences (see below) to the extent that agreement about what to do sexually probably requires prior agreement about individual roles and identities.

DECISION: Exclude on the basis of criterion (1) and (3)

Compatibility in preferences for sexual activities across partners

Compatibility in terms of preferred activity or sexual preference was regarded as important in my study. Discordant sexual preferences were particularly problematic to the erotic version of good sex. Compatibility does not necessarily imply that both partners should want to do the same things, but that each individual is comfortable with each other's preferred activities. In other words, that the relationship permits the desired sexual expression of each individual. To an extent, compatibility in motive and role (above) may be viewed as antecedent to compatibility in sexual preference. A lack of this type of compatibility - partners unable to find mutually enjoyable activities – was expressed as a source of sexual dissatisfaction.

Compatibility in preferences or libido types has been the focus of self-help guides (see Pertot, 2007). The New View classification includes it as a problem relating to the partnership (The Working Group, 2000). Compatibility is not generally assessed in measures of sexual dysfunction, although para-measures focused on sexual relationships, such as the HISC (see above) and IDHP focus specifically on this construct. The SSS-W also contains several good items on compatibility

DECISION: Include

Trust between partners; Warmth; Feeling wanted

Trust, warmth and feeling wanted were all construed in my data as aspects of psychological security within a relationship. They were all considered important, particularly within a long term relationship, and particularly within the interpersonal model of sex. However, they are all factors that are generally antecedent to, and sometimes outcomes of, sexual activity. Warmth in particular appeared desirable rather than essential; 'good enough sex' in certain contexts, was felt to be possible without it. Feeling wanted during a sexual encounter also overlaps to an extent with balance in desire between partners (mutually desiring each other) and can be excluded primarily on that basis.

The literature suggests that relationship difficulties (implying an absence of these constructs) are important sources of dysfunction and distress (King, Holt & Nazareth, 2007; Bancroft, Loftus & Long, 2003; Wise 1999; Rosen & Leiblum, 1995) (i.e. they are seen as causes rather than part of the construct). Conversely: Intimacy is associated with sexual function (see McCabe, 1997); Relationship quality is consistently related to orgasm frequency and sexual satisfaction (Mah & Binik, 2001; Lawrence & Byers, 1995); Trust has an important influence on sex within a relationship (Crowe, 1995); Marital adjustment is associated with sexual function (Rust, Golombok & Collier, 1988; Hawton, Gath & Day, 1994); Marital satisfaction mediates the effect of sexual difficulties

(Morokoff & Gilliland, 1993); and loving care between partner is cited as necessary for successful treatment (Althof et al., 2005a). These constructs are not assessed in measures of sexual function, and rarely addressed in para-measures, even those focused on relationships

DECISION: Exclude on the basis of criteria (1) (and (2) and (3) for feeling wanted)

Interpersonal connection; 'Chemistry' between partners

The idea of an emotional connection and /or 'chemistry' (sexual/physical connection) between partners was raised by the majority of respondents and was important to those subscribing to an interpersonal model of sex (emotional connection/intimacy) and those prioritising the erotic (chemistry). Definitions employed to describe these terms varied widely across respondents; the former was described in terms of a bond, being mentally in tune and in love; the latter was described as an animal spark and occurred suddenly and often inexplicably. Chemistry would be a difficult term to operationalise; it also overlaps a little with arousal (see below).

Bancroft has shown that for women, relationship factors such as feeling connected are closely linked to satisfaction (Bancroft, Loftus & Long, 2003). Tiefer views these relational aspects as integral to female sexuality (Tiefer, 2001a). Loss of 'chemistry' or 'spark' within a relationship is a common reason for seeking help from a sex therapist (Perel, 2007). Connection, in terms of emotional closeness is assessed in several para-measures such as the SSS-W and the SFQoSL. Measures of sexual dysfunction (the IIEF, GRISS and EMAS-SFQ) tend to focus on more general relationship factors such as love, affection and relationship satisfaction.

DECISION: Include emotional connection. **Exclude** chemistry on the basis of (3)

Subjective enjoyment; Novelty, excitement and satisfaction

Enjoyment was almost taken for granted as an aspect of sexual function. Within the erotic version of sex it was the whole point. Many of the items described above as correlates (for example, psychological security), were said to impact on enjoyment. As a term, satisfaction might simply imply orgasm, or it might be used to describe a specific encounter, or to describe an ongoing sexual relationship. Overall satisfaction was regarded by respondents as integral to a functional sex life. Feeling excited was used to describe a state of arousal, as well as being used in connection with orgasm and attraction to a partner (see arousal section below). Novelty and variety were valued but recognised as difficult to achieve within a long term relationship.

Various studies have explored the importance of innovative sexual play and fantasy and conversely the impact of sexual boredom on intimacy (Granvold, 2001; Tunariu, 2003). In particular, the 'Good-Enough Sex' model promotes pleasure, variability and playfulness (Metz & McCarthy, 2007).

Correlations have been established between greater sexual repertoire and experience of orgasm (Öberg, Fugl-Meyer & Fugl-Meyer, 2007). However, novelty and excitement are more commonly addressed in therapy (see Perel, 2007). There is a sense in which this more 'positive' aspect of function is regarded as beyond the remit of medicine.

Sexual dissatisfaction is significantly correlated with aspects of physical dysfunction (Öberg, Fugl-Meyer & Fugl-Meyer, 2004; Dunn, Croft & Hackett, 2000) but is generally viewed as a correlate. It is entirely possible for individuals to report satisfaction with their sexual relationship at the same time as reporting sexual difficulties (Read, King & Watson, 1997). Factors predicting satisfaction differ by gender (Dunn, Croft & Hackett, 2000). Among women, markers of subjective pleasure have been shown to be more important in predicting levels of sexual distress than traditional DSM categories (Bancroft, Loftus & Long, 2003). The current diagnostic nosology has been criticised for ignoring subjective ratings of satisfaction or pleasure (Rosen & Leiblum, 1995). Though it has been suggested that satisfaction ratings may not be that stable over time (Corty, Althof & Kurit, 1996). Nine of the 14 measures of sexual function included questions about enjoyment and/or satisfaction. In addition, there are several para-measures focused specifically on satisfaction (SSS-W; ISL; SQL; ISS). The Global Study of Sexual Attitudes and Behaviours (Nicolosi et al., 2004) included non-pleasurable sex as a dysfunction.

DECISION: Include enjoyment as part of function and overall satisfaction as part of the self-rating of function. Exclude novelty and variety on the basis of (2) but use excitement to describe arousal (see below).

Orgasm: Regularity, Quality, Timing

Orgasm was considered important, though to varying degrees. For some it was considered the height of physical sensation and release (mechanistic) or the ultimate indicator of pleasure (erotic) and essential to satisfaction. For women more than men it was a bonus rather than a necessity. It was recognised that the female orgasm was more difficult to achieve but was often of a much higher quality. Both men and women appeared concerned as much about their partner's orgasm as their own. Timing of orgasm appeared to be less of a concern to the gay respondents compared with the heterosexuals. Several men pointed to the difference between the experience of orgasm and that of ejaculation. There are several dimensions of orgasmic experiences (ease of achieving climax, timing, control and quality of experience) and due to space constraints it may not be possible to include all four. Quality represents less of a public health problem compared with the other three and overlaps a little with enjoyment.

In the literature, experiencing orgasm is widely regarded as a component of functional sex. Orgasm frequency and sexual satisfaction are consistently correlated (Mah & Binik, 2001). However, experiencing orgasm may be less important to women compared with men (Nicholson & Burr, 2003). Even so, anorgasmia is the second most frequently reported female problem (Meston, Hull

& Levin, 2004). The latest revised definition of orgasmic dysfunction for women states that orgasm is absent despite sexual arousal/excitement (Basson et al., 2004b). Premature ejaculation (PE) is considered by many clinicians to be the most common problem affecting men (Wylie & Ralph, 2005; Barnes & Eardley, 2007). Within a couple, there is often only moderate partner agreement regarding the perception of a PE problem, with women less likely to perceive a problem than their male partner (Byers & Grenier, 2003). There is no universally agreed definition of PE (Broderick, 2006; Segraves, 2006) though lack of control over ejaculation, ejaculatory latency time (IELT) and marked distress, have been proposed as key indicators (Rosen & Althof, 2008). Perceived control shows stronger effect on distress and satisfaction than IELT (Patrick, Rowland & Rothman, 2007). There are those who view PE as an invented disorder (Jeffreys, 1990) and there remains the question, 'premature for what?' Twelve of the 14 measures of sexual function included questions on orgasm and/or PE.

DECISION: Include items on regularity, timing and control

Exclude items on quality of orgasmic experience, on the basis of (2) and (3)

Balance in desire for sex across couples

A balance in the level that each individual in the couple desires or wants each other sexually was considered important, particularly within the interpersonal model of sex. The partner who desired sex less often felt they had let down their partner and felt under pressure whereas the partner who desired sex more felt frustrated and rejected. This ties in with 'feeling wanted' above but is more proximate to the sexual encounter.

Several researchers have posited that balance in levels of desire is key (Davies, Katz & Jackson, 1999; Levine, 2003; Clement, 2002; King, 2007), with some suggesting that sexual desire ought to be re-conceptualised as a primarily relational problem (Zilbergeld & Ellison 1980; Clement 2002). Among gay men it has been suggested that low sexual desire may be less common than instances of desire discrepancy within couples (Coleman & Reece, 1988). Problematic sexual desire discrepancies can adversely affect sexual satisfaction, and perception of a desire discrepancy is associated with relationship non-adjustment in both heterosexual and homosexual couples (Davies, Katz & Jackson, 1999; Bridges & Horne, 2007). Despite this, desire discrepancy is not usually classified as a sexual dysfunction, though it is specifically mentioned in the New View classification (The Working Group, 2000). It is not generally assessed in measures of sexual function, but has been asked in some para-measures (the HISC) and in community surveys (the SEI).

DECISION: Include

Wanting to have sex/Sexual desire

Desire (whether before or during sexual activity) was regarded as important, both as a factor itself and in relation to other factors such as enjoyment. It was construed as much as a desire for sexual intimacy as activity. Absence of desire was ranked fourth in the card game in terms of severity.

Estimates of low desire range between 21-43% (Segraves & Woodward, 2006). In the current DSM, lack of desire is classified as Hyposexual Desire Disorder, and is widely regarded as a common sexual dysfunction. However, in reality, the concept of desire is 'slippery' (Levine, 2002), complex and poorly understood (Davies, Katz & Jackson, 1999). Importantly, there is the question of whether desire is purely the initiation stage of sexual intercourse (Kaplan, 1974) or a psychological process in its own right. The former suggests a focus on quantity; the latter on quality (Clement, 2002). Levine (2002; 2003) differentiates between biological *drive*, psychological *motivation* to have sex and *wish* (culturally influenced values and rules about sexual expression). Historically HSDD was construed as a psychiatric, not organic disorder, and many continue to view desire as a subjective, psychological construct rather than a behavioural pattern or physiological event (Regan & Berscheid, 1996). It may be unfair to compare male and female levels of desire; there is substantial evidence of gender differences in the occurrence of sexual fantasies, thoughts, and desire motivation to initiate sex (Baumeister, Catanese & Vohs, 2001; Baldwin & Baldwin, 1997). In addition, women are more likely than men to see love and emotional intimacy as the goal of sexual desire, and less likely than men to see sexual activity as the goal (Regan & Berscheid, 1996). Women, may lack spontaneous desire but may still have responsive desire (Goldmeier, 2001; Basson, 2001a). It has also been shown that lack of desire does not necessarily preclude arousal and enjoyment of sexual activity when a partner initiates (Butcher, 1999). Women are less likely to seek help for low desire than complaints such as dyspareunia, suggesting that low desire for women is not always problematic (Nazareth, Boynton & King, 2003). Fluctuations in desire are said to be normal (Levine, 2002) and temporary losses of desire may be adaptations to stressful life situations (Bancroft, Loftus & Long, 2003). Desire is strongly influenced by age, gender, social situation and health (Levine, 2003). Distress associated with lack of desire tends to be inversely associated with age (Graziottin, 2007; Hayes et al., 2006). This evidence put together, suggests a need to focus on desire that precludes participation in and enjoyment of sexual activity. There are questions pertaining to lack of desire in 10 of the 14 sexual function measures, including all 5 of the female measures. There are also measures (such as the SDI) which focus exclusively on desire.

DECISION: Include desire as a feeling proximate to, or during sex rather than a general feeling of interest in sex (e.g. fantasies) occurring at any time

Avoiding sex

Avoiding sex was considered highly problematic. It was seen as running away from the problem and hurtful to a partner. In the card game it was ranked as the most serious difficulty. However, the

data suggested that avoidance was not usually a dysfunction itself, but a reaction to other difficulties (for instance, experiencing pain). Although this would initially suggest exclusion based on criteria (1), avoidance is a useful indicator of the severity of the problem (in the same way that satisfaction provides a useful overall indicator)

In the current DSM-IV, Sexual Aversion Disorder is recognised as a distinct diagnostic category. But data on this disorder is scarce and the diagnostic criteria overlap with HSDD (Balon, 2008); i.e. it is the extreme negative end point on a continuum of desire (Levine, 2003). There have thus been calls for its removal from DSM (Balon, 2008). Specific questions about avoiding sex can be found in several para-measures (SQOL-F; HISC, PFSF) and it has been included in prevalence studies such as NATSAL (Mercer et al., 2005)

DECISION: Include as indicator of severity

Subjective feeling of arousal; Adequate lubrication; Getting an erection

Arousal, whether before or during sexual activity, was regarded as an important component of a sexual experience. It was defined as an urge, a loss of inhibition and awakening of the senses. In my data arousal was construed as a physical state, whereas desire was viewed as a mental state. Both for men, and for their female partners, being able to get and maintain an erection (a springing to life) was considered important, particularly by those subscribing to a mechanistic model of sex. Various physiological indicators of arousal were mentioned for men and women, including quickened heart rate, sweating and tingling. Among women, lubrication was consistently mentioned although lack of lubrication was not necessarily seen as problematic. For women, the various subjective feelings of arousal appeared more salient.

Currently the DSM-IV TR does not include subjective assessment of arousal. Indeed much of the focus on female arousal remains on lubrication despite only weak association with subjective feelings of excitement/arousal. In older women, pain caused by lack of lubrication is a primary cause of loss of desire (Meston, 1997) i.e. lubrication may be more important for its impact on desire than on arousal. There have been recent calls to sub-type female arousal into genital, subjective and combined subtypes (Basson et al., 2004b). Elsewhere (see section 6.6 in chapter 6) I argue that this split is unnecessary and unhelpful. It is uncommon for female patients to present with arousal disorder as the sole or primary problem (Bancroft, Graham & McCord, 2001). Indeed, the literature suggests a complex and overlapping relationship between desire and arousal among women (Rosen et al., 2000; Levine, 2002; Basson, 2002; Graham et al., 2004) and recently, even men (Janssen et al., 2008). According to Basson, women often experience desire following arousal and intimacy is key in determining responsiveness (Basson et al., 2003); arousal and responsive desire become virtually indistinguishable (Segraves & Woodward, 2006). Among men, the focus is on erections. Difficulties with erections are common. The Massachusetts Male Ageing study

suggests that 9.6% of men have complete erectile dysfunction (5% at age 40 and 15% at age 70) (Feldman et al., 1994). Erectile difficulties are one of the most common reasons for seeking professional help (NIH, 1993).

Nine of the 14 sexual function measures included questions on aspects of arousal. Questions about lubrication and erectile function are most common. Indeed, most male measures centre heavily on erectile function. Several para-measures focus exclusively on this (MFP/IQ; QOL-MED; PAIRS, SHIM, FSHQ, EQS). There are also a number of para-measures focused on broader aspects of arousal (SIS/SES; SESII-W; SAI)

DECISION: Include getting an erection and lubrication as indicators of functional genital response; **Include** subjective feelings of arousal and excitement.

Pain/Discomfort

Experiencing pain was ranked as the third most serious difficulty in the card game. Pain was said to preclude enjoyment and perhaps signal a deeper underlying physical problem. Two respondents who had experienced pain related to sexual activity described the significant and detrimental impact on their sexual function.

In the DSM, pain is classified as dyspareunia, or genital pain. Far more is known about dyspareunia in women compared with men and there is some uncertainty as to whether it is the same phenomenon (Binik, 2005). Painful receptive anal intercourse is commonly reported among gay men (Rosser et al., 1997). Questions have been raised about the separation of dyspareunia and vaginismus in current nosologies (Basson & Riley, 1994; Reissing et al 2004). Indeed, there is debate about whether dyspareunia would be more accurately classified as urogenital pain disorder rather than a sexual dysfunction (Binik, 2005; First, 2005; Carpenter & Anderson, 2005). Sexual pain disorders present a "formidable therapeutic challenge" (Bancroft, Graham & McCord, 2001; pg 99). However these controversies in classification do not preclude the inclusion of pain in my model, given the evidence that pain can detract from all three aspects of sexual function; physical, erotic and relational. Pain and discomfort are assessed in several of the sexual function measures (BISF-W; FSFI; SPEQ, SHF) as well as many para-measures (SAQ; SFQoSL). It is frequently assessed in prevalence surveys

DECISION: Include Pain/discomfort. As an indicator it should also cover specific painful conditions such as vaginismus and vulvar vestibulitis

Partner experience of problems

In my data, where a partner experienced a problem, the impact on the individual included feelings

of rejection, loss of confidence, frustration and a gradual erosion of desire. I explored the accounts of two women in particular to show how a respondent might appear in a survey to have a problem, when actually their 'low score' simply reflected the fact that their partner had a problem. This suggests that whether or not a partner is perceived to have a problem ought to be included as part of an assessment of function.

Co-morbidity between partners is common. In up to a third of patients with sexual problems the partner also has a sexual dysfunction (Gregoire, 1999). Erectile difficulties, for instance, have been shown to adversely affect the sexual well-being of the female partner (Rosen, Eardley, Sand & Goldstein, 2005; Cayan et al., 2004; Conaglen & Conaglen, 2008). Several studies of PE in men have suggested a negative impact on the partner's experience of sex (such as less frequent orgasm) and an association of PE with interpersonal difficulties suggesting that PE should be regarded as a couple's problem (Rosen & Althof, 2008). In one survey of women, several of the experiences seen as most problematic related to difficulties affecting the respondent's partner rather than the respondent (Ellison, 2001). Of the sexual function measures, two (SPEQ and SHF) ask about partner experiences of problems and whether or not these difficulties interfere with intercourse.

DECISION: Include

Frequency

In my data, frequency of intercourse was construed as an indicator of the health of the relationship. Regular intercourse was regarded as important and sex less than once a month was generally construed as problematic.

A recent (industry funded) international study (Laumann et al., 2006) linked frequency of intercourse to subjective sexual well being, although the direction of the association is not clear. Reporting no intercourse in previous 4 weeks is associated with reporting sexual dissatisfaction (Nazareth, Boynton & King, 2003). Frequency is commonly assessed in measures of sexual function. It may be expressed in terms of number of sexual encounters per month or number of orgasms per sexual encounter, for example.

In general, frequency is used as an indicator of the overall sexual health of the relationship, but it is imprecise because it can be affected by factors unrelated to this such as young children in the house (Mercer et al., 2005), duration of the relationship, fertility intentions and contraception (Schneidewind-Skibbe et al., 2008). It is also highly variable across countries (Ibid, 2008) though some of the variability is doubtless due to differences in study design. Frequency may be more appropriately construed as an outcome or correlate of a functional sex life.

The NATSAL questionnaire already contains detailed questions about frequency and so this item is

not required in this instance.

DECISION: Exclude on the basis of (1)

Table 9.2 Summary of Evidence in Support of Including or Excluding Items from the Model

The decisions made above are summarised in table 9.3 summarised thus:

Assign as co-factors	Include as construct	Exclude completely from model
<ul style="list-style-type: none"> • Happy body feeling • Able to give and receive pleasure • Positive sexual Identity • Confidence to communicate needs • Positive motives to have sex • Stress and tiredness • Privacy • Trust, warmth, feeling wanted • Compatibility across couples in terms of motive for sex and sexual roles/identities 	<ul style="list-style-type: none"> • Anxiety • Compatibility in sexual preferences • Emotional connection • Enjoyment • Orgasm – timing • Orgasm – control • Balance in levels of desire across couple • Individual desire for sex • Lubrication/Erection • Feeling aroused/excited • Pain • Partner has problem 	<ul style="list-style-type: none"> • Reciprocity • Chemistry • Novelty/excitement • Quality of orgasm • Frequency

Table 9.3 Summary of Items Included and Excluded from the Model

9.3.2 Transforming the List of Items into a Conceptual Model

Having identified the items to be included in the conceptual model, the next task was to collate them into a smaller number of domains (groups of related items). In chapter five I identified three different versions of functional sex – mechanistic, erotic and interpersonal – and argued that any model of sexual function ought to reflect each of these versions in order to capture the variability in individual priorities for functional sex. Thus my model should contain items relating to each of the three versions. I decided that in order to ensure this happened; each version should represent a domain of the model. Later statistical testing (post this thesis) would then confirm whether the items in each domain hang together as a sub-scale.

The conceptual model is presented in figure 9.1 below. Several items potentially applied to more than one domain, thus the construct is presented as three overlapping spheres. By placing anxiety in the middle, I do not seek to imply that anxiety is the central item, only that it is relevant to all three versions. In other words, the anxiety may be about feeling pressure to perform functionally (mechanistic); relationship anxiety (interpersonal) or anxiety about one's ability to give and receive pleasure (erotic).

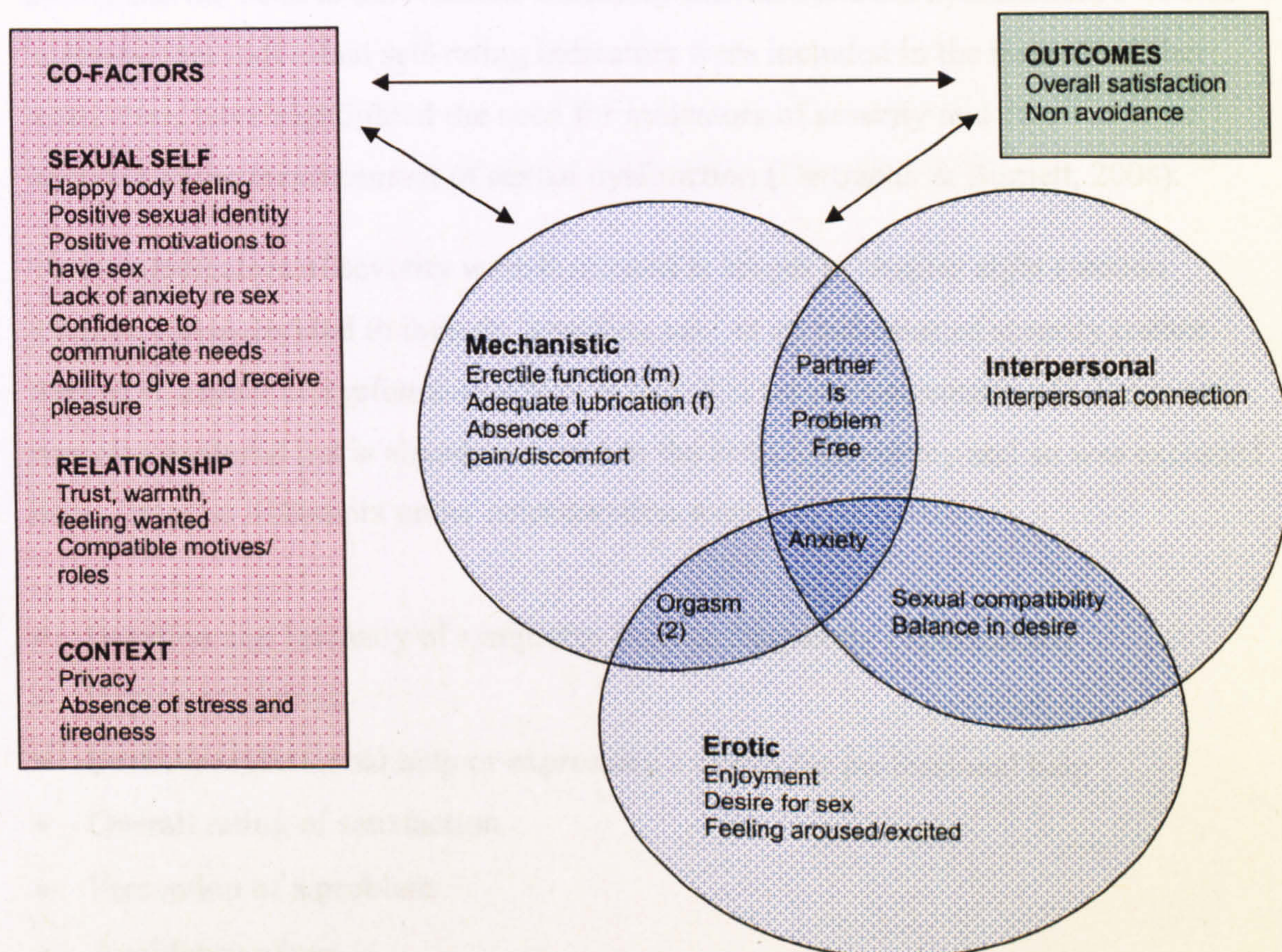


Figure 9.1 Conceptual Model of Sexual Function

Going back to the operational definition, it is important that (the absence of) these 12 factors should represent “the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish” (World Health Organisation, 1994). It is immediately clear that all factors fit well within this definition. Furthermore, (the absence of) these factors should interfere with the identified purposes of sexual activity: creating a bond between partners, physical

release, procreation, pleasure and recreation. Again, all 12 can be viewed as important in enabling these purposes to be fulfilled.

9.3.3 Adding Indicators of Severity

Given the evidence that standard diagnoses correlate only moderately with individual assessment of their situation, particularly for women (King, Holt and Nazareth, 2007), and the need to differentiate transitory difficulties from dysfunction, I wanted to ensure that individual self-rating indicators were included in the measure. Other researchers have highlighted the need for indicators of severity and duration to be included in the measurement of sexual dysfunction (Derogatis & Burnett, 2008).

Various indicators of severity were discussed at length in chapter eight (section 8.3.3.4). I also decided to include 'avoiding sex' as an indicator of severity (rather than as an aspect of dysfunction which is how it is sometimes construed). Frequency was also explored but is already covered in the NATSAL survey and so was excluded here. Thus the indicators under consideration were:

- Duration and Intensity of symptoms (rare to frequently experienced)
- Degree of distress
- Seeking professional help or expressing a desire for professional help
- Overall rating of satisfaction
- Perception of a problem
- Avoidance of sex

I decided to leave all these indicators in the model for the time being and decide which ones to exclude on the basis of their scientific performance (post this thesis, see chapter 10). It is anticipated that not all will remain in the final measure.

9.4 From Model to Measure

In chapter eight, I identified one brief measure that might be suitable for my purpose of measuring population prevalence. The Arizona Sexual Experience Scale (ASEX –

McGahuey et al., 2000) was originally designed to measure the impact of psychotropic drug-induced sexual dysfunction among depressed patients but is broad enough to be used in other populations. It has demonstrated reliability, sensitivity and specificity and there are male and female versions, each with only 5 items. Before designing a measure of my own, it is worth considering whether this measure would suffice. A brief appraisal of the measure identified the following limitations: choice of items was not based on patient experiences; there is no relationship component; no items on pain/discomfort, anxiety, or enjoyment; no self-rating of function; timeframe for reporting is restricted to the past week; the wording for items on desire and arousal are vague; and there is an item on orgasm quality, a component that has been excluded from my model. In summary, this measure would not adequately capture my conceptual model and so I must proceed to designing my own

In order to move from conceptual model to the measure, I assigned each item to a single 'best fit' domain, excluded the co-factors, and added the indicators of severity. The items for the measure came together as shown in figure 9.2:

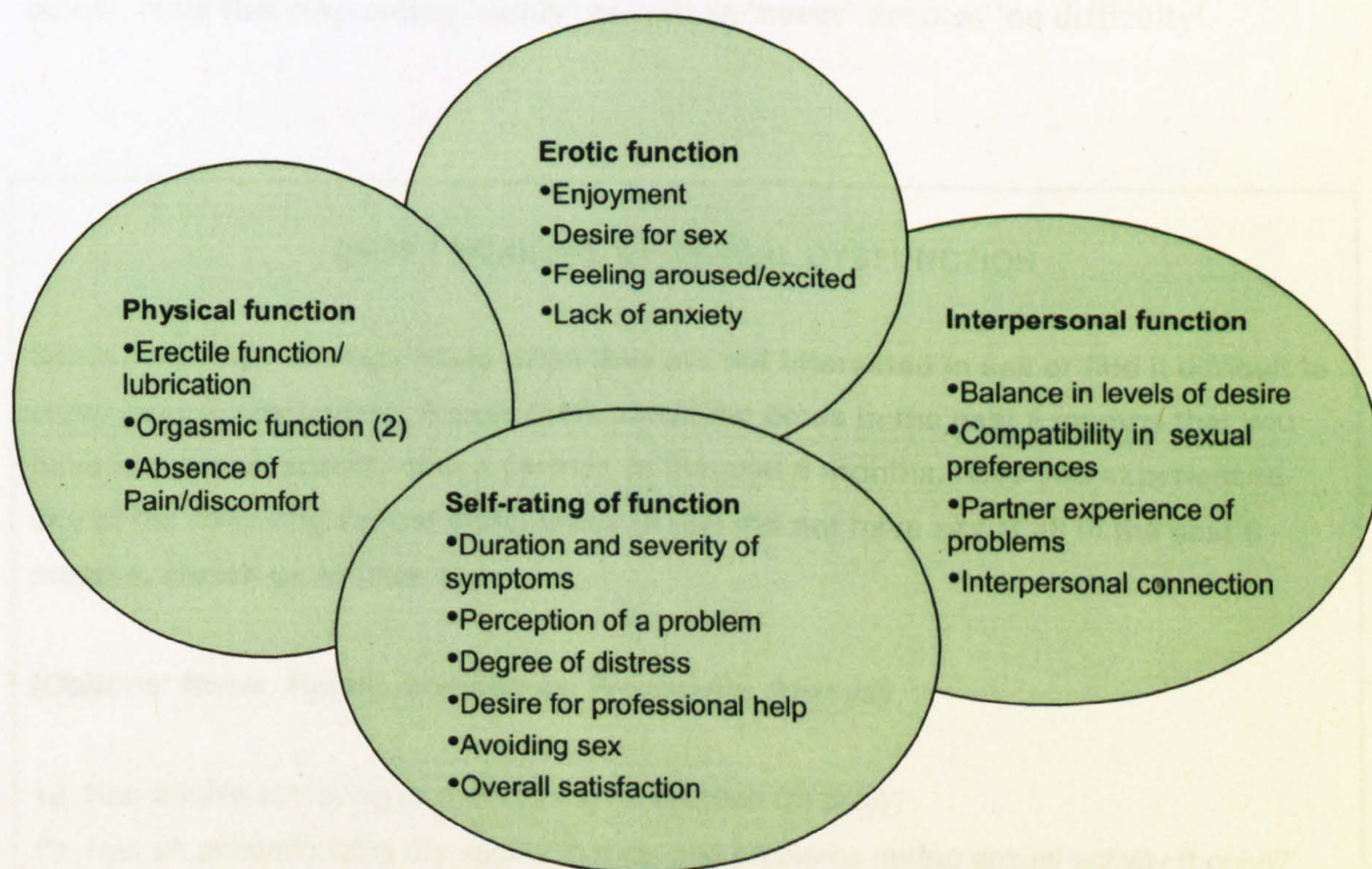


Figure 9.2 Measure of Sexual Function

9.4.1 Designing Items and Putting the Model Together

Assuming one question per factor above (apart from orgasmic function which includes both occurrence and timing), and three questions selected under the self-rating domain, this model translates into a 15 item measure (11 items for those not in a current partnership). Rather than creating items from scratch, I searched existing measures for 'good fit' questions that had already been tried and tested. Appendix 16 contains this inventory. In general I created new items, borrowing phrasing from the 'best fit' questions listed in the inventory. Where possible I adopted NATSAL phrasing in order to maximise comparability with the previous NATSAL survey. The next step was to standardise questions (as far as possible) in terms of response categories and reporting timeframes. I added the final item (question 19) on the understanding that it would not remain in the final measure but might provide useful information during psychometric testing that might help refine the measure. Although I only offer here one question per item, during testing alternative questions may be added in order to compare different wordings. The draft measure is shown in table 9.4 below. Note that responding 'rarely' as well as 'never' denotes 'no difficulty'.

DRAFT MEASURE OF SEXUAL DYSFUNCTION

Some people go through times when they are not interested in sex or find it difficult to enjoy sexual intercourse. Please think about the times in the past 6 months that you have had sexual activity with a partner. In the past 6 months, have you experienced any of the following sexual difficulties? [If you did not have sex at all in the past 6 months, please go to filter 1]

[Options: Never, Rarely, Sometimes, Frequently, Always]

- 1a. Had trouble achieving or maintaining an erection (m only)?
- 1b. Had an uncomfortably dry vagina that caused problems during sexual activity (f only)?
2. Were unable to come to a climax (experience an orgasm) despite feeling excited?
- 3a. Came to a climax (experienced an orgasm) more quickly than either you or your partner would prefer?
- 3b. Felt unable to control ejaculation sufficiently to enjoy sexual activity? (m only)

4. Experienced pain or discomfort as a result of sexual activity?
5. Felt a lack of desire which stopped you from having sex or prevented you from enjoying it?
6. Found it difficult to feel physically excited or aroused during sexual activity? (Feeling aroused means experiencing physical sensations such as increased heartbeat, tingling, breathing more quickly)
7. Felt anxious or distracted during sexual activity?
8. Did not enjoy sexual activity?

FILTER 1: If you have had one main sexual relationship over the past 6 months, please answer the following questions about that relationship. If you have not been in a sexual relationship that has lasted for the past 6 months or longer, please go to FILTER 2

Thinking about your main sexual relationship over the past 6 months, please read the following statements and say whether you strongly disagree, disagree a little, neither agree or disagree, agree a little or strongly agree:

9. My sexual partner and I share about the same level of interest in having sex.
10. My sexual partner and I share the same sexual likes and dislikes.
11. My sexual partner has not experienced any sexual difficulties in the past 6 months
12. My sexual partner and I feel emotionally close when we have sex together.

FILTER 2: If respondent has answered 'Never' or 'Rarely' to all questions 1 to 9 and 'Strongly agree' or 'Agree' to all questions 10 to 13, then go to question 19. Otherwise proceed to question 14:

Thinking about the difficulties you have experienced in your sex life over the past 6 months please read the following statements and say whether you strongly disagree, disagree a little, neither agree or disagree, agree a little, or strongly agree:

13. I feel dissatisfied with my sex life
14. My sex life is a big problem for me
15. I feel distressed or worried about my sex life
16. I have avoided sex because of my difficulties

Please answer the following three questions:

17. For how long have you experienced sexual difficulties? a) less than one month; b) between 1 month and 6 months; c) Between 6 months and 2 years; and d) more than 2 years

18. During the last year, have you contacted any of the following for help with your difficulty(s)? Options: GP, VD/STD/Sexual health clinic, Psychiatrist or psychologist, Marriage counsellor, Other type of clinic or doctor and Contacted a helpline.
19. In the past 6 months have you experienced any sexual difficulties not mentioned above?

[END]

Table 9.4 Draft Measure of Sexual Dysfunction

9.5 Conclusion

This chapter began with a set of 31 components, derived from qualitative analysis, which represented a functional sex life. I showed how these components corresponded with the versions of sex identified in chapter five, and these versions became domains for the model. Using evidence both from my fieldwork and the existing literature, plus a set of inclusion and exclusion criteria, I reduced these to a list of 12 items (8 items for those not in a relationship). To these I added 6 items measuring self-rating of function (plus an exploratory open-ended question). Selecting and adapting items from an inventory of existing psychometrically tested questions, I designed a draft questionnaire. Post this thesis, psychometric testing will be used to identify the items with the best psychometric properties, and in doing so reduce this 19 item questionnaire into a 15 item measure (or less). For the moment it is possible to conclude that this draft measure fulfils the design attributes (such as brevity and acceptability) and parameters (such as a biopsychosocial perspective) outlined at the beginning of the chapter.

Chapter 10

Protocol for Psychometric testing of the measure

10.1 Introduction

In chapter nine I produced a conceptual model and draft measure of sexual dysfunction derived from participant accounts and incorporating psychosocial and biomedical perspectives. The measure is the final outcome of this thesis but also the starting point for a second psychometric evaluation study. Funding for this work has already been secured. In this chapter I present a brief protocol for this next study¹⁸.

The desired attributes of the measure were described in detail in chapter nine. The measure is primarily intended for inclusion in the forthcoming third National Survey of Sexual Attitudes and Lifestyles (NATSAL 2010). We hope that the measure will be subsequently adopted elsewhere as a standard measure for estimating community prevalence of sexual dysfunction and in questionnaires investigating the impact of diseases/conditions on sexual quality of life.

10.2 Methodology

10.2.1 Summary of Methodology

Our methodology will follow internationally recognised guidelines for the development and validation of health outcome measures (Scientific Advisory Committee of the Medical Outcomes Trust, 2002). This gold standard methodology comprises three stages:

Stage one (Item generation): Generate a pool of questions (items) based on the dimensions of our conceptual model (see chapter nine).

¹⁸ I use 'we' rather than 'I' in this chapter because the work will be undertaken by a team of which I will be a member

Stage two (Scale formation): Field test the pool of items with a general population sample (via postal survey to GP practice populations) and clinical sample (via questionnaires to psycho-sexual clinic attendees) to identify items with the best scientific performance.

Stage three (Scale evaluation): Evaluate the measurement properties of the new measure by 'hitching' the item-reduced measure onto the NATSAL 2010 general population pilot survey.

Detailed advice on statistical testing will be sought from key textbooks (Streiner & Norman, 1995; Loewenthal, 2001) as well as from the project statistician. Ethical approval for the field work will be sought from the London School of Hygiene and Tropical Medicine ethics committee and from the National Research Ethics Service (NRES).

10.2.2 Stage one: item generation

The aim of this stage is to generate a pool of items which adequately reflects the domains of our conceptual model of sexual function.

10.2.2.1 Constructing items

I have already compiled a comprehensive list of existing questions, ordered under relevant domain (see appendix 16) and have suggested an initial list of items for the measure (see chapter nine). The draft measure presented in chapter nine is the starting point but we may want to try out several different options for each item in terms of wording and phrasing. Where appropriate we may 'borrow' from items presented in appendix 16. The benefit of including existing questions is that they have already been tested for their comprehensibility and acceptability. However they would need to be assessed for suitability to this particular measure. As well as finalising question wording, we will need to agree on aspects of design such as layout, question order, definitions of key terms and the use of filters. We will test the readability of the questions using the Flesch Reading Ease Score and the Flesch-Kincaid Grade Level Score, both available in MS word.

10.2.2.2 Piloting the items

We will undertake a pre-pilot, using a small number of individuals (about 5). The purpose is to iron out any obvious and major problems with language and meaning prior to piloting. The item pool will then be piloted with a small sample of people who represent a spectrum of experience regarding sexual difficulties (general population, those with associated conditions and those presenting with sexual difficulties) to address any ambiguities in language and/or issues with acceptability. Piloting will continue until no further changes are suggested by respondents. We envisage that around 20 participants will be required. Those who took part in the qualitative interviews will be asked (by postal letter) whether they would be interested in continuing to participate in the study by taking part in this pilot stage. If required, further participants will be recruited from the waiting room of a North London GP practice¹⁹ and interviewed at a time and place convenient to them (probably a private room within the clinic). After completing the questionnaire without interruption, respondents will be asked to discuss each item with the interviewer, to determine how questions were understood and answered. The pilot phase should result in a set of items that are comprehensible and acceptable to the target population.

10.2.3 Stage two: Scale formation

The aim of this stage is to construct a scientifically valid measure of sexual dysfunction by selecting from the item pool those items with the strongest scientific properties.

10.2.3.1 Sampling frame

The questionnaire developed during stage one will be administered by post to registered patients from GP surgeries and psycho-sexual clinics. Our sampling strategy will be determined by the need to achieve a sample that reflects, as near as possible, the population for which the measure is designed (Nunnally, 1970; Kline,

¹⁹ This is the same GP practice from which participants in the prior qualitative study phase were recruited.

1986). Thus we will aim to achieve a sample that is representative of the general population in terms of sex, age, socio-economic status, ethnicity and sexual orientation. However, in order to ensure that we include sufficient numbers of people who have experienced difficulties, the sample will be weighted towards this group by sampling from psycho-sexual clinics. We will meet the need for range (of the construct) and representativeness (of the general population), by selecting 3 GP practices and 3 psycho-sexual clinics²⁰ in rural and urban settings and in a range of socio-economic catchment areas. The final sample will reflect a balance between the imperative of representativeness, and the cost and time associated with involving a number of primary care trusts.

10.2.3.2 Sample Size and Recruitment

There is little guidance available on recommended sample size for psychometric analysis. In general, a sample size of around 300 is widely recommended for item analysis (Nunnally, 1978; Ware et al., 1997). Due to the sensitive nature of the research and the difficulty recruiting from GP clinics, we estimate that the response rate may be around 50-60%. We also need to develop a male and female measures, thus we may need to initially send out roughly 550 questionnaires to men and 550 to women. In GP clinics, respondents will be drawn at random from practice/clinic lists. Names will be identified and letters dispatched by a member of the study team or practice staff, depending on the preference of clinics involved. In the psycho-sexual and GUM clinics, consecutive patients will be given questionnaires by clinic staff (on entry to the clinic or following their appointment). The detailed logistics of recruitment will be agreed with each clinic depending on their preferences and what is feasible. Standard techniques, such as personalised letters, standardised instructions and follow up reminder letters (Dillman, 1978), will be employed to ensure as high a response rate as possible. Questionnaires will be given to English speaking patients, excluding the terminally ill and those under 18 on ethical grounds.

²⁰ Numbers attending psycho-sexual clinics are small, hence the need to recruit three sites even though the number of questionnaires required is far less than those from GP practices.

10.2.3.3 Psychometric Testing of the Questionnaire

Items will be evaluated using standard guidelines for psychometric testing (Scientific Advisory Committee of the Medical Outcome Trust, 2002) and we will adopt a strategy of item reduction based on the work of Lamping and colleagues (Lamping et al., 2002; Lamping et al., 2003). Data will be entered and analysed in SPSS. The first step involves identifying 'weak' or uninformative items for possible elimination using a range of psychometric criteria (test one in table 10.1). For example, if over 5% of respondents do not answer an item, this suggests that the item may be confusing or unacceptable. If an item correlates with the total score by less than 0.30, we would then need to consider whether it is tapping into a different dimension of sexual dysfunction or another construct altogether. Alternatively, if an item correlates with another item by more than 0.70, it suggests that those two items are measuring more or less the same thing and so only one item will suffice. If over 80% of respondents tick the same response category, the item may not discriminate sufficiently between groups of respondents. This is also a risk if responses are spread very unevenly across response categories (aggregate adjacent endorsement frequencies). Having eliminated the weakest items, we will then test our item-reduced measure for content validity and face validity, internal consistency and scaling assumptions, (see table 10.1). We will begin by using factor analysis to identify the existence of sub-scales (if any) within the measure. We will then assess the extent to which all items measure the same construct (internal consistency) by ensuring that Cronbach's alpha for summary scores are greater than 0.70 and item-total correlations are greater than 0.30. Tests of scaling assumptions (intercorrelations between scales, $0.30 < r < 0.70$; item-own scale correlations higher than item-other scale correlations) will be conducted to ensure that sub-scales (if they exist) measure distinct but related constructs and that items can be combined to provide a summary score. Content and face validity will be assessed qualitatively (see table 10.1). Given that our underlying conceptual model has been based on detailed qualitative analysis, we can reasonably assume strong content validity, though we will need to ensure that this is not lost during translation from draft into final measure. It will be important to establish face validity; the extent to which the measure appears relevant to those completing it. This will essentially be a matter of our own judgment, based on a superficial assessment of the overall measure.

In adopting these criteria, it is worth noting that a balance has to be found between maintaining content validity and ensuring reasonable internal consistency. Although internal consistency can be improved by removing items that are not highly correlated with other items or with the total score, if we do so, our measure may no longer adequately cover the construct of sexual dysfunction; that is content validity may be reduced. Streiner and Norman recommend that “it is better to sacrifice internal consistency for content validity”. This is because, “the ultimate aim of the scale is inferential, which depends more on content validity than internal consistency” (Streiner & Norman, 1995; pg 147).

By the end of this stage we would hope to have an item-reduced measure, with face and content validity, and comprising only items with strong psychometric properties.

10.2.4 Stage three: Scale Evaluation

The purpose of stage three is test whether the measure developed at stage two provides rigorous measurement of sexual dysfunction.

10.2.4.1 Sampling and recruitment

At this stage we will validate our measure on a general population sample. We are fortunate to be able to ‘hitch’ our item-reduced measure onto the NATSAL 2010 pilot study (n=200) scheduled for implementation in 2009. The sampling and recruitment for this study are described elsewhere²¹. Respondents taking part in this survey will be asked whether they would be willing to complete a subsequent questionnaire, and a sub-sample of willing respondents, will be sent an identical questionnaire around two weeks later in order to examine test-retest reproducibility (table 10.1, test 3.2). A two week period has been used previously (Cano et al. 2004, among others); it is considered long enough to prevent recollection of previous answers but short enough to make actual changes in individual situations unlikely. This second questionnaire will also contain other measures of sexual dysfunction such as the ASEX (McGahuey

²¹ NATSAL 2010 proposal submitted to the MRC/Wellcome Trust

et al., 2000) and the GRISS (Rust & Golombok, 1986), as well as measures tapping into related constructs such as the Beck Depression Inventory (Beck & Steer, 1987), and questions tapping into an unrelated construct such as left/right handedness²².

Finally, we will also send the measure to a small sub-sample of psycho-sexual clinic attendees in order to compare scores between those with and without clinically diagnosed dysfunction (known group differences testing; see table 10.1).

10.2.4.2 Psychometric Testing of the Questionnaire

We will again test for acceptability and reliability, applying the same criteria described above (see sections 2 and 3 in table 10.1 below). Test-retest reproducibility, which assesses the stability of the scale over time (essentially a measure of random error), will be deemed to be sufficient if intraclass correlations (ICC) exceed 0.70. It is worth noting here that reliability is partly a function of the number of test items; one of the simplest ways to increase reliability is simply to increase the number of items on the test (Streiner & Norman, 1995). This being a brief measure, it will be more difficult to achieve a high reliability co-efficient.

A range of approaches will be employed to assess construct validity. If the measure has sub-scales, we will look at the extent to which these sub-scales appear to be measuring distinct but related concepts (within scale analyses). This can be done by assessing whether Cronbach's alpha co-efficients for summary scores are over 0.70; by assessing whether item-total correlations are greater than 0.30; by testing whether inter-correlations between scales are between 0.30 and 0.70; and by testing whether items within scales correlate more with each other than with items in different scales (scaling successes). The second approach to construct validity will be to analyse our measure against external criteria. Convergent validity gives an indication of the extent to which our measure correlates with other measures of sexual function (such as the ASEX). We would expect our measure to correlate highly with measures of sexual function which are based on similar conceptual approaches to our own; on the other hand we would expect more moderate correlations with measures designed to evaluate related but less similar constructs (such as the Beck Depression Inventory).

²² It is not feasible to include these measures within the first NATSAL 2010 pilot survey because of the risk of over-burdening the respondent.

Our measure should not correlate with measures of unrelated constructs, such as left/right handedness (discriminant validity). Finally, we will set up a range of hypotheses to test the ability of the measure to differentiate between known groups. Importantly the measure should be able to differentiate between clinical and non-clinical populations. We would also expect higher scores among people with conditions known to be associated with sexual function such as depression and diabetes.

We will seek to design a scoring system for the measure that is simple (avoiding weightings where possible) and easy to interpret. By comparing scores on our measure with respondents scores on a gold standard (for instance, the GRISS), we will be able to identify specificity and sensitivity estimates for each score and thereby determine cut-off scores that maximise specificity (i.e. low number of false positives), without compromising too much on sensitivity (i.e. low number of false negatives). Receiver Operating Characteristic (ROC curve) analysis can be used to help determine the optimum cut off point (Leiblum et al 2006). This curve depicts the pay-off between sensitivity and specificity for each test score; and the larger the area under the curve, the better the discriminatory power of the test (See Streiner & Norman, 1995). Later, following the main NATSAL 2010 survey, it may be possible to establish UK based norms (cut-off scores) for gender and age categories.

At the end of this stage we will have established whether our scale provides a reliable and valid measure of sexual dysfunction among the general population of the UK. And we will have a validated prevalence measure of sexual dysfunction ready for inclusion NATSAL 2010.

Psychometric Property	Definition / test	Criteria for acceptability
1. Item reduction	Identify items for possible elimination due to weak psychometric properties; assessed on the basis of item analysis, factor analysis and tests of scaling assumptions.	Apply criteria to all items: <ul style="list-style-type: none"> • Missing data < 5% • Item redundancy: inter-item correlations < 0.70 • Maximum endorsement frequencies < 80% (i.e. the percentage of respondents who endorse each response category). • Aggregate adjacent endorsement frequencies > 10% • Item-total correlations > 0.30

2. Acceptability	Data quality; assessed by completeness of data and score distributions.	Applied to all items: <ul style="list-style-type: none"> • Missing data < 5% • Maximum endorsement frequencies < 80%
3. Reliability		
3.1 Internal consistency	The extent to which items in a scale measure the same construct; assessed by Cronbach's alpha and item-total correlations	Cronbach's alpha coefficients for summary scores > 0.70 Item-total correlations > 0.30
3.2 Test-retest reproducibility	The stability of a scale over time; assessed on the basis of correlations between repeat administrations of the scale on two occasions	Intraclass correlations (ICC) > 0.70 between test and re-test scores (2 weeks between tests)
4. Validity		
4.1 Content validity	The extent to which the content of the scale is representative of the conceptual domain it is intended to cover; assessed qualitatively during questionnaire development	Qualitative evidence from semi-structured interviews, literature review, expert panel and piloting of questionnaire that items are representative of all domains relevant to sexual function
4.2 Face validity	The extent to which the scale appears to measure what it is supposed to measure and thus seems relevant to lay respondents	Qualitative evidence from expert opinion and piloting
4.3 Construct validity		
4.3.1 Within scale analysis	Evidence that the scale measures a single construct, that items can be combined to form a summary score, and that sub-scales measure distinct but related constructs; assessed on the basis of internal consistency, item-total correlations, intercorrelations between scales and tests of scaling assumptions.	<ul style="list-style-type: none"> • Cronbach's alpha coefficients for summary scores > 0.70 • Item-total correlations > 0.30 • Intercorrelations between scales $r = 0.30$ to 0.70 • Scaling successes (i.e. higher item-own scale correlations than item-other scale correlations).
4.3.2 Analysis against external criteria		
4.3.2.1 Convergent validity	Evidence that the scale is correlated with other measures of the same or similar constructs; assessed on the basis of correlations between the new scale and measures of similar constructs	Hypothesis based on degree of conceptual similarity between measures. Choice of comparison measures will depend on our conceptual model, but it will be possible to select measures that should be highly correlated (e.g. BSF-Q; BISF-W) and moderately correlated (e.g. Beck Inventory for depression) with our own measure.
4.3.2.2 Discriminant validity	Evidence that the scale is not correlated with measures of different constructs.	Low correlations with an unrelated construct such as left/right handedness

4.3.2.3 Known group differences/ hypothesis testing	The ability of the scale to differentiate known groups; assessed by comparing scores between groups whose scores on the scale are expected to differ	Scores on our measure should be significantly higher for those who self-identify as having sexual function problems (attendees at a psycho-sexual clinic) than those from the general population. Scores should also be higher for people with diabetes and depression
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Table 10.1 Psychometric tests and criteria (adapted from Lamping et al., 2002, 2003)

10.3 Summary

This chapter has described a well established and widely accepted methodology to turn a draft set of questions into a psychometric scale. The procedure entails a series of statistical tests to ensure that the scale is reliable (reproducible or free from random error) and valid (measures what it purports to measure). We will undertake two waves of data collection; the first survey will be used to build a final scale from the original draft, and the second (tacked onto the NATSAL pilot survey) will be used to validate the final scale and test its psychometric properties. At the end of this process we will have a measure ready for inclusion in the upcoming NATSAL 2010 survey.

Chapter 11

Summary and Conclusions

11.1 Summary of Thesis

This study has comprehensively explored the conceptualisation and measurement of sexual dysfunction. In doing so, it has produced detailed development work for a community prevalence measure. The research arose in response to a request from the NATSAL survey team for a brief measure of sexual dysfunction suitable for inclusion in the forthcoming 3rd National Survey of Sexual Attitudes and Lifestyles. A preliminary review of the literature failed to identify any measures of sexual dysfunction based on lay perspectives, driven by holistic understanding of sexual dysfunction, and specifically designed to give accurate population prevalence estimates. It was established that this gap existed partly because of the lack of consensus regarding the definition of sexual dysfunction, and partly because of the current emphasis of the field on designing end point measurements for clinical trials.

Having identified this gap, I thus set out to answer two specific research questions. **Firstly, what does sexual function mean to those who have and have not experienced sexual difficulties? And secondly, how can this concept of sexual function be accurately captured in a population prevalence measure?**

I sought to answer these questions via qualitative fieldwork and through an extensive review of the literature. My fieldwork involved 32 semi-structured interviews with individuals who had and had not experienced sexual difficulties. Respondents were recruited from a GP practice, Sexual Problems clinic and HIV/AIDS charity. The interviews explored how respondents defined a good or ideal sex life; what they felt was normal and not normal for themselves; how they perceived the severity and impact of sexual difficulties; and what terms and language they used to describe their sexual lives. Analysis of the interviews using Grounded Theory identified 31 potential components of good/ideal sex reported by respondents. I then set out the

empirical evidence (my data plus evidence from existing literature) to support the inclusion or exclusion of each component in a model of sexual function. I employed three logical criteria to exclude components: Firstly I excluded items that were correlates of the construct (predisposing factors, precipitating factors, maintaining factors, contextual factors and outcomes), or were “a degree or so removed from explicit sexual behaviour” (Derogatis, 1997; pg 293). Secondly I excluded components that did not indicate a public health burden. In other words, components for which individuals were unlikely to seek professional help or components which were desirable/ideal rather than ‘good enough’ (appearing to measure performance). Finally I excluded components that appeared to overlap conceptually with other components. At the end of this reduction process I was left with 12 components which formed the basis of my conceptual model (eight components for those not in current relationships). My research had highlighted the importance of incorporating an individual self-rating of function and so six items were added to capture this aspect. To turn this model into a draft measure I compiled an inventory of items from existing measures and borrowed phrasing from ‘best fit’ measures to design my questions. Post this thesis, psychometric testing will be used to identify the items with the best psychometric properties, and in doing so reduce this 19 item measure into a 15 item (or less) measure.

The hypothesis underlying this study was that an approach grounded in the perceptions of respondents in clinical and non-clinical settings and incorporating both biomedical and psychosocial perspectives would generate a conceptual model and subsequent measure of sexual dysfunction that would most comprehensively capture the phenomenon. I also assumed that it would be feasible to design a measure that adequately captured the concept and was still practical for measuring population estimates. The true test of this second assumption will occur post this thesis, during psychometric testing. The task was challenging because the purpose of the measure (to provide population prevalence estimates) meant that it would most likely be included in a large public health survey and therefore had to have public health utility, be brief, acceptable, easy to understand and user-friendly. Yet there appeared to be a large number of components that could be potentially included in the measure. In general I felt confident that my particular methodological approach led to a model

and measure that captured the key dimensions as comprehensively as possible given the purpose of the measure.

11.2 Original Contributions to Knowledge

In undertaking this work I made a number of original contributions to the conceptualisation, classification and measurement of sexual dysfunction.

As described above, the main contribution was a draft model and measure of sexual dysfunction, ready for psychometric testing. The measure is novel in that it is genuinely grounded in respondent perceptions; can be completed by individuals of any sexual orientation, gender and age; allows respondents to self-rate their function; and incorporates relational, psychological and physiological dimensions. Later psychometric testing will ensure that the final measure is also short and user-friendly; differentiates those with dysfunction from those with adaptive and temporary problems; and provides an accurate assessment of community prevalence. To my knowledge, the final measure will be the first psychometrically validated measure designed specifically to measure the prevalence of sexual dysfunction among men and women in community settings.

The second contribution was to introduce a new typology to understand the variation in individual priorities for good/ideal sex. I identified three distinct perspectives or scripts, each comprising a coherent set of beliefs about what it means to have a functioning or 'good enough' sex life; these were termed 'versions of good sex'. I showed that in framing their priorities and evaluating their experiences, most respondent accounts approximated to a particular version. In the interpersonal version, the focus was on emotion, intimacy and reciprocity, and the ultimate purpose was to create/strengthen bonds between partners. Ideal sex was characterised by balance between partners (e.g. in terms of desire), emotional security and emotional connection. Relationship or emotional difficulties constituted the main threat to ideal sex. In the mechanistic version, the focus was on the genitals with physical release and procreation as key functions. Ideal sex was construed in terms of achieving and maintaining an erection and achieving orgasm at about the right time. The main threat

to ideal sex was failure of the physiological responses (e.g. erectile difficulties or lack of lubrication). The erotic version was focused on enjoying pleasurable sensations, and sex was about recreation. Ideal sex was construed in terms of excitement, variety and orgasm (the height of pleasure), while the key threats to sex were lack of novelty, boredom, over-familiarity and discordant sexual preferences.

These versions or scripts were abstractions and not immutable categories; individual accounts only approximated to these versions and were liable to change over time (dynamic rather than static). There were thus three important caveats: firstly, the versions should not be assumed to exist materially in the minds of individuals (in other words, they should not be reified); secondly, behaviours or patterns of sexual activity should not be squeezed into a specific version in cases where there is not actually a precise fit; thirdly, the typology should be regarded as a means rather than an end.

My typology has several potential applications. It may be used in a therapeutic context, for instance, to explore problematic discrepancies between versions adhered to by a respondent and their partner; and discrepancies between an individual's version of ideal sex and their lived experience. The typology may also be helpful in explaining age and gender differences. For example, 'successful sexual ageing' may be construed in terms of ability to shift away from the mechanistic version (with its focus on physiological function) towards the interpersonal/erotic versions.

Importantly for this thesis, these versions became the foundations of the subsequent model of sexual dysfunction. They became the means by which the model could ensure that variation in individual meanings of sexual function was adequately captured.

Thirdly, I made a unique contribution to understanding the ways in which individuals respond to and cope with, sexual difficulties. Although there is a broad literature on adapting and coping with chronic illness, and on coping strategies in general, there has been little work on coping specifically with sexual difficulties. I identified three main categories of coping: changing circumstances to fit goals; changing goals to fit circumstances; and living with the gap between goals and circumstances. In my data I identified several different coping strategies under each category. Changing circumstances to fit goals (also known as assimilative coping) included strategies

such as fixing the problem medically or ending a relationship; changing goals to fit circumstances (also known as accommodative coping) included strategies such as focusing on other priorities, lowering expectations, and shifting to a different version of good sex; and living with a gap included strategies such as normalising one's experience and avoiding thinking about the problem. I showed that the severity of the problem, causal attributions made about the problem, and the partnership context (strength of the relationship and the partner response to the difficulty) all impacted on the choice of coping strategies employed, and whether those strategies led to successful adjustment. I found that flexibility, in terms of one's definition or version of ideal sex and the importance assigned it, was a key determinant of successful accommodative coping. In addition, the attribution of a cause was important in establishing the meaning of the experience to the individual and/or their partner. The fact that the coping response occurs in a dyad adds a further layer of complexity; successful coping is not just about what works for the individual but about what is most adaptive for the couple.

My final contribution was to add my voice to current debates concerning the classification of sexual dysfunction. This contribution was timely because committees are currently convening to prepare for the fifth edition of the DSM. In the first literature review, as well as in a paper co-authored with Cindy Graham, I argued that future classifications of sexual dysfunction should consider the relationship dimension of sexual function and should consider moving from a categorical to a dimensional system of measurement. Later in the thesis, I highlighted the need to integrate some measure of patient self-appraisal into the diagnosis. The distress criterion is deeply contested but I examined other options, such as whether a patient (and if appropriate, their partner) sees the reported symptoms as problematic.

I also suggested in this thesis that recent calls to divide female sexual arousal into genital, subjective and combined subtypes was not particularly helpful. I suggested that it might be more helpful to adopt the ICD-10 approach; that is to categorise difficulties with erection and lubrication/engorgement simply as 'failure of genital response' (F52.2; World Health Organisation, 1994), rather than as arousal. In this way, they may be seen as physiological processes that enable sex to occur without pain/discomfort. I suggested that the other 'subjective' physiological indications of

sexual arousal might usefully form an expanded category of sexual excitement which would encompass a range of criteria including desire to have sex (before and during sex), feelings of excitement prior to and/or during sex, fantasies, and physiological signs such as tingling and quickened heart rate. In other words, desire and arousal would no longer be restricted temporally, and would include both cognitive and physiological processes. This suggestion would circumvent many of the current difficulties with the categorisation of desire and arousal such as the reported overlap between the two (Basson, 2006; Segraves, Balon & Clayton, 2007); the fact that few women present with sexual arousal as the primary or only problem (Bancroft, Graham & McCord, 2001); the fact that concordance between clinical diagnosis and self rating of problem by women is lowest for sexual arousal disorder (38%) and loss of sexual desire (39%) (King, Holt & Nazareth, 2007); and the fact both erections and high levels of lubrication can occur independently from subjective feelings of arousal/desire (Godson, 2002).

11.3 Methodological and Conceptual Caveats

This was a multi-disciplinary PhD which drew on several disciplines (notably sexual medicine, psychology and social science) to define and tackle a problem. However, my own perspective as a public health orientated social scientist certainly infused my handling of the data and appraisal of the literature. It was the lens through which the data presented by different disciplines were understood. The results I presented were shaped by my assumption that sex is connected in fundamental ways to individual self-identity and to relationships between individuals, and that it is imbued with powerful social meanings. Because of this, it cannot be simplified or reduced to a mere physical act. I adopted a 'critical realist' approach which viewed sex as comprising both natural (biological) and social (constructed) 'facts' (Searle, 1995); I accepted empirical findings about the nature of sexual dysfunction whilst remaining alert to the ways in which alternative perspectives may have shaped these findings (Pilgrim & Bentall, 1999). This position enabled me to accept (albeit with healthy skepticism) that the concept of sexual dysfunction could be 'captured' and measured objectively; and would approximate to 'truth' for a broad range of study participants.

There are several methodological and theoretical caveats to this study that should be made explicit. Firstly, my sampling strategy sought to include individuals who had experienced difficulties as well as those who had not. The implication is that my sample is weighted towards older people and those who have spent time reflecting on their sexual experiences. Qualitative methods do not aim for generalisability but do seek to identify theories and patterns with relevance to broader populations (Seale, 1999). In judging the relevance of my findings to a general population, my particular sampling strategy should nonetheless be borne in mind. My decision to collect data via semi-structured interviews with individual participants also implied several caveats: firstly the 'lens' into the experiences of the couple was provided by only one-half of that couple; secondly the interviews could provide only a 'snap-shot' of a dynamic process at one point in time; thirdly, the data generated by the interviews was the product of an interaction between myself and the interviewee and therefore approximated rather than represented the 'truth' as internalised by the respondents themselves. In addition, although my eventual analytical approach adopted the principles of Grounded Theory, I was not able to undertake true theoretical sampling due to logistical constraints. Thus I was unable to pursue emerging theory through further interviews; in other words to engage a truly cyclical, iterative and inductive-deductive approach. Instead, I was restricted to movement between theory and data within the confines of my already collected data.

Finally, the typologies produced by my analysis are preliminary and would be strengthened by further quantitative work to test whether they reliably exist in broader populations. For instance, I refrained from making strong assertions about differences across gender and sexual orientation. My work would benefit from quantitative testing to explore these differences in detail.

There are also a number of limitations to my proposed draft measure. Sex therapists might point out that it contains nothing about relationship intimacy; experts on PE and orgasmic dysfunction (see Waldinger & Schweitzer, 2006a&b; Broderick, 2006) would probably consider the questions on orgasm/ejaculation imprecise and incomplete; those who advocate on behalf of rare and specific conditions such as persistent sexual arousal disorder (Leiblum & Nathan, 2001) might point out that these have been omitted; some might feel that 'sexual activity' is too broad a basis for

reporting symptoms compared with intercourse; and various individuals (notably The Working Group for a New View of Women's Sexual Problems, see The Working Group, 2001) would criticise my attempt to put forward a 'normative' list of difficulties. Whilst some will feel that I have strayed too far from the current classification; others will feel that I have not strayed far enough. In my defence I would highlight the fact that most limitations of the measure stem directly from the imperatives of brevity, user acceptability, relevance to all population sub-groups and public health utility. Furthermore, I hope this thesis has convincingly demonstrated that there is little agreement concerning the conceptualisation and measurement of sexual dysfunction (Balon, Segraves & Clayton, 2007; Balon, 2008; Mitchell & Graham, 2008). In contrast to many existing measures, I based my decisions on empirical evidence collected specifically for the purpose, thus giving my measure a strong claim to validity. And until we have further empirical evidence of this nature, the judgment of whether this measure has adequate face and content validity must be primarily a matter of perspective.

11.4 Lessons Learned

Throughout the thesis I attempted to be as candid and transparent as possible about the way in which the study evolved. A PhD is first and foremost a learning experience and for me this learning was as much about myself as a researcher as it was about the techniques of research.

In terms of myself, this was the first time I had interviewed older people and I found the experience incredibly rewarding. Older people have a wealth of accumulated lifetime experience; they have had opportunity to 'digest' and reflect on this experience (though not all take this opportunity). They are able to provide life-story narratives which chart dynamic processes (such as an evolving sexual identity) and they can use hindsight to re-examine motives for actions and behaviours during their youth. This study also confirmed my natural preference towards in-depth analysis of qualitative data; but though I survived and even enjoyed the experience, I hope I will never again have to lead such a solitary existence. I much prefer to be part of research team, particularly working in conjunction with quantitatively-minded colleagues.

In terms of research techniques, perhaps the greatest lesson concerned qualitative analysis. Effectively, I analysed my data twice. In some ways this was of great benefit since by the end I was extremely familiar with the data and was able to use my 'Framework' map to move around the data very quickly. But in future I will not have the same luxury of time and will have to be far more careful in ensuring that my choice of analytical approach fits well with the purpose of the study. Secondly, I learnt for myself that asking people to rate experiences/difficulties hypothetically is far less useful than asking them to describe their actual experiences. This is because it is difficult to realistically imagine what it is like to lose something (one's sight, for example) until it is actually taken away. Although the card game was useful for those few respondents who had limited experiences of difficulty, and although it provided useful quantitative comparison, the frustration expressed by respondents in being 'forced' to allocate each problem to a category, increased my existing scepticism about this type of quantitative approach.

11.5 Future Research Ideas

In addition to the proposed psychometric measure, other results from this study might be usefully applied in clinical and public health contexts. The Versions of Sex typology could itself be developed into a psychometric measure with public health utility, for instance, in helping to 'explain' or understand sexual attitudes and practices such as risky sexual behaviour. Secondly, the results of this study could be used to design guidelines for discussing and diagnosing sexual difficulties within a GP setting. Based on my conceptual model plus review of the literature, the guidelines could provide a step-by-step protocol for arriving at a patient-centred definition of the problem and its cause, and jointly agreeing a treatment plan.

11.6 Conclusions

This was a thesis with a well defined end product (a draft measure of sexual dysfunction) but the work leading to this end product generated many interesting findings. The research supported my underlying hypothesis that sex is best

understood as a relational, psychological and physiological phenomenon. I also confirmed previous research in finding the meaning of functional sex highly variable across individuals. This study has brought me to a number of conclusions. Firstly, I conclude that expectations of perfect physical function, perfect pleasure and perfect relationship are detrimental to sexual health; a focus on measuring, diagnosing and treating according to the notion of 'good enough' sex is much preferable. Yet 'good enough' will always be relative; what is 'good enough' for one may not be 'good enough' for another. Furthermore, individuals are capable of adjusting to a gap between their ideal sex life and their lived reality, such that 'sexual satisfaction' can co-exist with function difficulties. And the existing literature, plus the high level of variation across respondents in this study, suggests that identifying norms will continue to be challenging. For all these reasons, it seems prudent to incorporate self-rating indicators as a key component of measurement. Secondly, I conclude that the current classification and measurement of sexual dysfunction, driven by pharmaceutical interest in end points for clinical trials, promotes a version or model of ideal sex to which only some individuals subscribe; those whose priorities are focused on the erotic and the interpersonal, rather than the mechanistic, find themselves judged by an 'irrelevant' standard. To redress this, the current reliance on expert opinion and expert consensus needs to be supported by genuine attempts to understand variation in sexual function from the perspective of individual and couple experience; only then will we arrive at a valid and meaningful classification. Thirdly, from my data as well as the existing literature, I conclude that sex is an inherently relational act; and unless the relational dimension can be incorporated, efforts at conceptualising and measuring will continue to falter. Finally, I conclude that a dimensional approach to measurement offers a potential solution to the current challenges of classification, such as the overlap between diagnostic categories, the lack of consensus regarding diagnostic criteria, and lack of clinical utility.

APPENDICES

Two Challenges for the Classification of Sexual Dysfunction

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ABSTRACT

Introduction. The current classification of sexual function (in particular, the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV) has lately attracted significant criticism at both research and clinical levels. Despite this, there has been a reluctance to return to the drawing board. Instead, attempts to improve the system have been marginal, constrained by the need to secure professional consensus, the desire for continuity with traditional categories, and the emphasis on diagnostic agreement (reliability).

Aim. In this article, we examine two key challenges currently faced by the DSM: how to effectively acknowledge the relational context of sexual problems and how to avoid pathologizing normal variation.

Results. We raise some possible new directions, such as ways in which relational processes could be integrated into the current system, and possibilities for introducing a dimensional rather than a categorical model of sexual function.

Conclusions. We argue that if the next version of DSM (version V) is to avoid the weaknesses inherent in the present system, then a return to the drawing board is precisely what is required. Mitchell K, and Graham CA. Two challenges for the classification of sexual dysfunction. *J Sex Med* **;**:**-**.

Key Words. History of Sexual Dysfunction; Epidemiology; Psychological Assessment

Introduction

Classification systems impose meaning and structure upon complex phenomena, and where officially sanctioned, create a common language for the advancement of knowledge. Since 1952, sexual function problems have been classified under the rubric of mental health, in which the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD) prevail as officially sanctioned classification systems [1,2]. The purposes of these diagnostic systems are to facilitate communication among professionals, help clinicians determine which particular disorder is present, and guide treatment decisions and research; in the United States, the DSM also provides the basis for reimbursements to insurance companies. Many authors have argued that current classification systems fall far short of the abovementioned goals. Indeed, it has been suggested that the DSM criteria have

hampered research into the etiology, pathophysiology, and treatment of mental disorders [3-5]. The DSM system for classifying sexual disorders has not escaped these criticisms, particularly in recent years [6,7].

The concept of "psychosexual dysfunction" first appeared in the third edition of the DSM (DSM-III) [8]. Grounded in the work of Masters and Johnson, Lief, and Kaplan, the classification is based on a biomedical model of sex comprising three temporal stages: desire, arousal, and orgasm [9-11]. Since 1980, several revisions of the DSM have reflected advances in research coupled with ongoing debate concerning the nature of sexual difficulties. Also, since the latest version [1], various panels have met to suggest further revisions: the National Institutes of Health Consensus Development Conference on Impotence, the International Consensus Development Conference on Female Sexual Dysfunction, and the second International Consultation on Sexual Medicine [12-14]. However, there have been no

paradigm shifts and most of the suggested revisions have been minor [15], what Carson earlier described as "... more tinkering on a superficial level with operational diagnostic criteria that tend over time to approach the status of revealed truths" ([3] p. 304).

A particular barrier to substantive change has been the requirement that there be substantial empirical data before modifications can be considered [16]. Attempts to ground the DSM in empirical research date back to DSM-III [3]; however, in practice, it seems that maintaining "continuity" with the classification system in place may sometimes take precedence over research evidence. Segraves and colleagues provided an example of this in the work leading up to DSM-IV [16]. A literature review suggested that the subjective criteria for female arousal disorder be retained. The DSM-IV work group overruled this in order that the DSM-IV diagnosis be similar to the ICD-9 criteria and "to maintain male-female similarity in diagnostic categories" ([16] p. 569), a key feature of the DSM-IV nosology. The process by which the DSM is compiled may also present barriers to substantive change; in particular, the selection of DSM working group and task force members, and the need for consensus. For example, lack of "satisfactory consensus" was one of the key reasons that "sexual satisfaction disorder" failed to be introduced as a new category following deliberations of the International Consensus Development Conference on Female Sexual Dysfunction. This occurred despite a majority in favor and despite the relevance of the category to a significant proportion of women seeking help for sexual problems [13]. It is noticeable that much of the "tinkering" has been toward increasingly precise operational criteria designed to provide quantitative end points for clinical trials and clear-cut delineations for insurance companies. This is not surprising, given the lack of nonclinical representation on consensus panels, and pervasive links between panelists and the pharmaceutical industry [15,17-19].

As preparations for DSM-V step-up, suggestions for improving the system are being brought to the table. Segraves and colleagues [16] recently proposed that DSM-V include specific criteria related to duration and severity of symptoms, in order to avoid labeling transient (and possibly adaptive) alterations in sexual function as "sexual dysfunction" [20]. These seem reasonable suggestions and ones that have some empirical support [21,22]. However, in our view, there are also a

number of more fundamental issues that need to be addressed in the next revision.

Working from this premise, we examine two challenges that have been the source of much debate: (i) how do we effectively acknowledge the relational context of sexual problems; and (ii) how do we best avoid pathologizing normal variation? In the context of this debate, we aim to provide some possible directions for a revised classification system of sexual problems.

How Do We Effectively Acknowledge the Relational Context?

Relationship factors—the sexual partner as well as the interaction between partners—are often fundamental to the etiology and experience of sexual difficulties [23]. This fact is well supported by empirical evidence [20,24,25]. A recent British study showed that between half and two-thirds of women thought that difficulties with their partner lay at the base of their sexual problems [26]. We also know that comorbidity of sexual problems in partners is common, and that when one partner receives individual therapy for a sexual problem, there is often also improvement in sexual functioning for the other partner [27-29]. There is increasing recognition that medications, such as phosphodiesterase type 5 inhibitors, may prove ineffective if significant relationship issues are not also dealt with, and there has been a related interest in combining medical and sex therapy approaches to treatment [30,31]. In practice, the relational context is almost always a central focus of clinical therapy for problems [32].

Given this evidence and the realities of clinical management, it is puzzling that the possibility of formally acknowledging relational components within the classification system does not appear to have been seriously considered [33]. In fact, recent proposals to revise the DSM have, if anything, placed even more emphasis on the individual rather than on the couple. For instance, the International Consensus Group on Female Sexual Dysfunction recommended replacing the DSM criterion of "marked distress and interpersonal difficulty" with "personal distress" [13]. More recently, Segraves et al. recommended, "decrease in desire related to... discrepancies in sexual desire between sexual partners, should not be diagnosed as desire disorders" ([16] p. 576). The ostensible rationale for both of these recommendations was that the system should not pathologize individuals on the basis of their relationship context.

To an extent, the case made by Segraves and colleagues is persuasive: discrepancies in desire should not result in the partner with the lower level being labeled as "dysfunctional." But the mismatch itself can be seen, at a systems level, as a problem belonging to the "interactional dynamics of the couple" ([34] p. 243). In fact, it has long been recognized that within couples, the assessment of desire is relative; individuals make judgments about their level of desire primarily in comparison with the level of their partner [35]. If we are interested in a classification that is *clinically meaningful*, then this couple-level dysfunction is important because it is such a common problem for which individuals seek help. Clement questioned whether sexual desire might be more usefully construed as an "emergent function of the structural matching of partners" than as an individual trait ([34] p. 243). Relevant here is the large body of literature on "relational disorders," defined as "persistent and painful patterns of feelings, behavior, and perceptions involving two or more partners in an important personal relationship" ([36] p. 161). Work is being carried out to develop diagnostic criteria for relational disorders such as marital conflict disorder and marital abuse disorder [37]. In a similar vein, it may be worth exploring the possibility of an additional subcategory of sexual disorder where the focus is primarily relational.

Incorporating relational processes need not imply as radical a step as the creation of new categories. Although the DSM highlights relational processes in the V codes and in some of the supplemental materials, "currently relational problems are poorly described . . . and not very useful for clinical or research purposes" ([38] p. 360). In response to this, various authors have discussed the possibilities for integrating relational issues into the DSM [36-40]. For instance, Beach and colleagues suggested that reference to the presence or absence of specific relational processes associated with a sexual disorder could be made via "relationship specifiers" ([38] p. 364). Specifiers are usually used to "describe the course of the disorder or to highlight prominent symptoms" or to "indicate associated behavioral patterns of clinical interest" ([38] p. 364). Alternatively, relationship patterns of relevance could be elaborated as part of the symptom criteria for the disorder.

A third approach to acknowledging the relational and cultural contexts of sexual problems is to develop a classification system that is based on etiology of sexual difficulties rather than on dis-

crete categories of symptoms. Such an approach has been put forward by the "New View of Women's Sexual Problems" developed by an independent group of clinicians and social scientists [41]. This classification system incorporates a woman-centered definition of sexual problems (as "discontent or dissatisfaction with any emotional, physical, or relational aspects of sexual experience") and provides four categories of causes including sociocultural, political, or economic factors, partner and relationship factors, psychological factors, and medical factors.

All of these approaches would require further research and elaboration, but in our view, they have the potential to rectify DSM's problematic "erasure of the relational context of sexuality" ([41] p. 3). Without such fundamental shifts in thinking, we will continue to get tied up in knots trying to classify an inherently relational act in purely individual terms.

What Is the Best Way to Avoid Pathologizing Normal Variation?

Establishing the boundary between normal and pathological has always been a key issue and is still being raised with respect to the next edition of the DSM [42]. This is a similar challenge to that faced by mental health practitioners in deciding when "sad" becomes "depressed."

Some argue that more reliable cutoff points could be established if there was sufficient normative data. This lack is frequently bemoaned, but what little data we have actually suggest substantial variability in sexual interest and behavior across age, gender, cultural context, and sexual orientation [43-45]. For instance, the variability with which women experience desire and arousal (and indeed whether these constructs are separable) has posed an ongoing headache for the classification of female desire and arousal disorders [7,46-48]. Given this variation and the fact that what counts as normal is so culturally dependent, attempts to define "normal" need to be met with extreme caution [43].

Against this background, at least three strategies have been proposed to avoid pathologizing this normal variation. We discuss each in turn.

One option that is increasingly fashionable is to aim for precise and evidence-based cutoff points using what normative data are available. An example is the recently proposed cutoff point of 1.5 minutes of intravaginal ejaculation latency time in the diagnosis of premature ejaculation (PE)

[49]. Thus, ejaculations deemed "too quick" by men themselves (or their partners) but that occur longer than 1.5 minutes after penetration are construed as normal variation. The difficulty with precise cutoff criteria is that it feeds an unhelpful obsession with a particular criterion of "health" (in this instance, time to ejaculate) and might risk measuring "performance" according to this indicator. If we accept that some men are "designed" to come sooner than others (in the same way that some men are better at sprinting, and others at long-distance running), then it is harder for some men to "achieve" the cutoff point than others. Given the association between performance anxiety and PE, do we want to (further) encourage men to think about their sexual life as governed by a stopwatch? On a more practical level, it is questionable how feasible it would be to use such precise criteria in clinical settings.

A second option is to specify distress as a necessary, but not sufficient, criterion for diagnosing dysfunction. "Marked distress or interpersonal difficulty" is currently an essential criterion for any DSM diagnosis of sexual dysfunction, and distress or disability is a necessary condition for the diagnosis of all psychiatric disorders [1]. But this criterion was apparently added in haste, and with insufficient consultation, to DSM-IV and has been the source of controversy ever since [16].

The issue of whether distress should be a criterion for classification, unless it is contributing to the problem (e.g., "performance anxiety" contributing to erection difficulties), is a difficult one. On the one hand, if we accept that sex is an inherently psychosocial act, essentially variable, primarily relational, and influenced as much by culture as by biology, then it would seem to follow that if individuals do not see themselves as having a problem, they cannot be deemed by others to do so. The problem is that the distress itself is influenced by sociocultural factors such as the expectations of a partner or messages from the media.

Furthermore, we know that some individuals with sexual dysfunction are not distressed by it. Studies that have measured distress have found that only a proportion of women with sexual difficulties (up to two-thirds) also report distress [50]. In one national survey of women that examined distress about sexual relationships, the best predictors of distress were general emotional well-being and emotional relationship with partners [20]. In contrast, DSM-related physical aspects of sexual functioning, such as lubrication and orgasm, were poor predictors, suggesting that distress may be

more closely associated with relationship quality than with physical function. A recent qualitative study suggested that the degree of distress might be affected by a wide range of factors including the perceived cause of the problem and the reaction of the partner [51].

A study by Oberg and colleagues demonstrated that from an epidemiological standpoint, measuring dysfunction *per se* vs. dysfunction plus distress (i.e., comparing the A and B categories to differentiate dysfunction from its emotional impact) results in similar patterns of reporting across age and type of difficulty but with lower prevalence rates for the latter [22]. Alternatively, they suggested that the distinction between the reporting of mild (defined as "hardly ever" or "quite rarely") vs. manifest ("quite often"; "nearly all the time"; and "all the time") symptoms alone can provide epidemiologically useful information. The importance of specifying duration and intensity of symptoms has been discussed earlier [16].

Clearly, anyone who is not distressed or troubled is unlikely to seek treatment, and clinically, it is important to assess the degree of distress engendered by a problem. However, logically, it seems that lack of distress should not exclude a problem from a diagnostic category, even if it means that the nondistressed individual does not wish treatment. It would also seem important that research into the etiology, course, and prognosis of individuals with sexual dysfunction includes individuals in this latter group as well as those who are motivated to seek help for a problem.

We would agree with the views of Althof [52], and Segraves and colleagues [16] that personal or interpersonal distress should not be a requirement for the diagnosis of sexual dysfunction. One possibility, suggested by Althof [52], is that distress be included as a "specifier" rather than an essential criterion for diagnosis. Other specifiers might indicate developmental or biological features of a disorder.

A third option is to use a dimensional model of classification of sexual disorder rather than a categorical one. The former views sexual dysfunction as "arbitrary distinctions along dimensions of functioning," while the latter views them as "discrete clinical conditions" ([53] p. 211). In a categorical system, a "case" is an individual who meets the criteria for the attribute; using a dimensional model, "caseness" is a matter of degree, and a "cutoff" point may be imposed, depending on circumstance [54]. A dimensional system avoids the need to claim distinct boundaries between

normal and pathological, and gets around the problem of overlap between diagnostic categories.

The question of whether a dimensional model should supplant the categorical perspective used in the DSM is a long-standing issue but one that seems to be gaining momentum [3,36,53,55]. At the 2007 Annual Meeting of the American Psychiatric Association, a symposium was held on the feasibility of adding dimensions as well as categories of mental disorders to DSM-V. It was noted that the purpose of a diagnostic system, such as the DSM, is not to say what is "normal" or "acceptable," but to describe the presentation of an individual who comes to get clinical help [56]. The debate around a categorical vs. dimensional classification system seems highly relevant to the debate around medicalization of sexual problems [15]. However, it is interesting that, again, there have been no proposals for using a dimensional model of sexual functioning as a possible basis of classification of sexual disorders in the DSM.

Part of the reluctance to consider a dimensional classification stems from a fear that it is less clinically useful [53]. Yet the current categorical system has been criticized for its weak clinical utility, both in predicting the best form of treatment or the prognosis [15,43,57]. It has been described as "a list of symptoms not necessarily synonymous with diagnoses" ([58] p. 131). As Carson argued, "the notion that the patient may simultaneously harbour a plurality of separate diagnoses with considerable feature overlap seems on its face to involve enormous classificatory difficulties" ([3] p. 303).

Finally, a strong argument in favor of a dimensional rather than a categorical model is the fallacy of the "one model fits all" idea. This was amply demonstrated in a recent study by Sand and Fisher [59] in which a community sample of women, when asked which best represented their own sexual experience, was equally likely to endorse each of the three different current models of sexual response—those of Masters and Johnson [9], Kaplan [11], and Basson [47]. The findings underline the heterogeneity of women's sexual response, and highlight the need for more research into how women (and men) themselves actually experience sexual problems. The presumption that the current DSM categorical system represents an underlying "model" of sexual response that is uniform across and within individuals is a likely source of many of its shortcomings and lack of clinical utility. Although the Sand and Fisher study had limitations, e.g., the descriptions of the models

were fairly brief, it is one of the few studies that has employed such a "bottom-up" approach and is a refreshing alternative to the "consensus" conferences that have required expert members to reach agreement about recommendations for diagnostic criteria.

Conclusions

In summary, there has been a lack of progress in refining and improving the criteria for diagnosing sexual dysfunction, which we would argue has less to do with a lack of empirical data and more with a deep-seated reluctance to "go back to the drawing board." It is interesting that although there are some fairly radical suggestions for changes in classifying other psychiatric disorders (e.g., [37,39]), most of the suggestions for revising the classification of sexual disorders have been comparatively modest.

In the introduction, we stated that the purposes of the DSM are to facilitate communication among professionals, help clinicians determine which particular disorder is present, guide treatment decisions and research, and, in the United States, provide the basis for reimbursements to insurance companies. We suggest that a dimensional classification system, which includes relational aspects as one dimension, may facilitate a valid conceptualization, enabling clinicians to understand, treat, and research difficulties holistically and in context. It would also facilitate a dialogue across disciplines by formally requiring clinicians to consider dimensions beyond their immediate clinical focus and by avoiding the unhelpful split between psychosocial and biomedical perspectives. It may also simplify reimbursement procedures by avoiding plural and overlapping diagnoses.

Our aim in this article was neither to present a new classification scheme nor to suggest new diagnostic criteria for the DSM-V categories of sexual dysfunction. Instead, we wanted to raise some possible "new directions" for conceptualizing sexual problems (e.g., as relational disorders, or using a dimensional model) that warrant serious consideration. Although much work would need to be carried out to develop the possibilities we have raised (in particular, much further research) and there is bound to be a reluctance to consider such changes, the outcome might be a classification system of sexual problems that would be useful for both clinical practice and research.

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References

- American Psychiatric Association. Diagnostic and statistical manual of mental disorders, (4th edition (DSM-IV-TR). Washington, DC: American Psychiatric Association; 2000.
- World Health Organization. ICD-10: International statistical classification of diseases and related health problems. 10th edition. Geneva: World Health Organisation; 1992.
- Carson RC. Dilemmas in the pathway of the DSM-IV. *J Abnorm Psychol* 1991;100:302-7.
- Kendell R, Jablensky A. Distinguishing between the validity and utility of psychiatric diagnoses. *Am J Psychiatry* 2003;160:4-12.
- Hyman S. Forward. In: Phillips K, First M, Pincus H, eds. *Advancing DSM: Dilemmas in psychiatric diagnosis*. Arlington, VA: American Psychiatric Association; 2003:xi-xix.
- Tiefer L. Historical, scientific, clinical and feminist criticisms of "the human sexual response cycle" model. *Annu Rev Sex Res* 1991;2:1-23.
- Tiefer L. A new view of women's sexual problems: Why new? Why now? *J Sex Res* 2001;38:89-96.
- American Psychiatric Association. Diagnostic and statistical manual of mental disorders (3rd edition (DSM-III). Washington, DC: American Psychiatric Association; 1980.
- Masters WH, Johnson VE. *Human sexual response*. Boston, MA: Little, Brown, & Co.; 1966.
- Lief HI. Inhibited sexual desire. *Mod Asp Hum Sex* 1977;7:94-5.
- Kaplan HS. *The new sex therapy*. New York, NY: Brunner/Mazel; 1974.
- NIH Consensus Development Panel on Impotence. Impotence. *JAMA* 1993;270:83-90.
- Basson R, Berman J, Burnett A, Derogatis L, Ferguson D, Fourcroy J, Goldstein I, Graziottin A, Heiman J, Laan E, Leiblum S, Padma-Nathan H, Rosen R, Segraves K, Segraves RT, Shabsalgh R, Sipski M, Wagner G, Whipple B. Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and classifications. *J Urol* 2000;163:888-93.
- Lue T, Basson R, Rosen R, Giuliano F, Khoury S, Montorsi F, eds. *Sexual medicine: Sexual dysfunction in men and women*. Paris: Health Publications; 2004.
- Bancroft J, Graham CA, McCord C. Conceptualizing sexual problems in women. *J Sex Marital Ther* 2001;27:95-103.
- Segraves R, Balon R, Clayton A. Proposal for changes in diagnostic criteria for sexual dysfunctions. *J Sex Med* 2007;4:567-80.
- Hall M. Small print and conspicuous omissions: Commentary on the "FSD" classification report. *J Sex Marital Ther* 2001;27:149-50.
- Shaw J. Another procrustean bed for female sexual functioning. *J Sex Marital Ther* 2001;27:211-4.
- Tiefer L. The "consensus" conference on female sexual dysfunction: Conflicts of interest and hidden agendas. *J Sex Marital Ther* 2001;27:227-36.
- Bancroft J, Loftus J, Long JS. Distress about sex: A national survey of women in heterosexual relationships. *Arch Sex Behav* 2003;32:193-208.
- Mercer CH, Fenton KA, Johnson AM, Wellings K, MacDowell W, McManus S, Nanchahal K, Erens B. Sexual function problems and help seeking behaviour in Britain: National probability sample survey. *BMJ* 2003;327:426-7.
- Oberg K, Fugl-Meyer A, Fugl-Meyer K. On categorization and quantification of women's sexual dysfunctions: An epidemiological approach. *Int J Impot Res* 2004;16:261-9.
- Fisher WA, Rosen RC, Eardley I, Sand M, Goldstein I. Sexual experience of female partners of men with erectile dysfunction: The female experience of men's attitudes to life events and sexuality (FEMALES) study. *J Sex Med* 2005;2:675-84.
- Dennerstein L, Leher P, Burger H, Dudley E. Factors affecting sexual functioning of women in the midlife years. *Climacteric* 1999;2:254-62.
- Ellison C. *Women's sexualities*. Oakland, CA: New Harbinger; 2000.
- Kling M, Holt V, Nazareh L. Women's views of their sexual difficulties: Agreement and disagreement with clinical diagnoses. *Arch Sex Behav* 2007;36:281-8.
- Gregoire A. Assessing and managing male sexual problems. In: J. Tomlinson J, ed. *ABC of sexual health*. London: BMJ Books; 1999:35-7.
- Cayan S, Bozlu M, Canpolat B, Akbay E. The assessment of sexual function in women with male partners complaining of erectile dysfunction: does treatment of male sexual dysfunction improve female partner's sexual functions? *J Sex Marital Ther* 2004;30:333-41.
- Heiman J, Talley D, Bailen J, Oskin T, Rosenberg S, Pace C, Creanga D, Bavendam T. Sexual function and satisfaction in heterosexual couples when men are administered sildenafil citrate (Viagra®) for erectile dysfunction: A multicentre, randomised, double-blind, placebo-controlled trial. *BJOG* 2007;114:437-47.

J Sex Med **,**,**--**

- 30 Rosen RC. Erectile dysfunction: Integration of medical and psychological approaches. In: Leiblum SR, ed. *Principles and practice of sex therapy*. 4th edition. New York, NY: Guilford Press; 2007:277-312.
- 31 Riley A. Commentary on Rowland's article. *J Sex Marital Ther* 2007;33:461-6.
- 32 Graham CA, Bancroft J. The sexual dysfunctions. In: Gelder M, Lopez-Ibor J, Andreasen N, Geddes J, eds. *New Oxford textbook of psychiatry*. 2nd edition. Oxford: Oxford University Press; 2008:472-83.
- 33 Tiefer L. The medicalization of sexuality: Conceptual, normative, and professional issues. *Annu Rev Sex Res* 1996;7:252-82.
- 34 Clement U. Sex in long-term relationships: A systemic approach to sexual desire problems. *Arch Sex Behav* 2002;31:241-6.
- 35 Zilbergeld B, Ellison CR. Desire discrepancies and arousal problems in sex therapy. In: Leiblum SR, Pervin LA, eds. *Principles and practice of sex therapy*. New York, NY: Guilford Press; 1980:66-104.
- 36 First MB, Bell CC, Cuthbert B, Krystal JH, Malison R, Offord DR, Reiss D, Shea MT, Widiger T, Wisner KL. Personality and relational disorders: A research agenda for addressing crucial gaps in DSM. In: Kupfer DJ, First MB, Regier DA, eds. *A research agenda for DSM-V*. Washington, DC: American Psychiatric Association; 2002:123-99.
- 37 First M. Relational processes in the DSM-V revision process: Comment on the special section. *J Fam Psychol* 2006;20:356-8.
- 38 Beach SRH, Wamboldt MZ, Kaslow NJ, Heyman RE, Reiss D. Describing relationship problems in DSM-V: Toward better guidance for research and clinical practice. *J Fam Psychol* 2006;20:359-68.
- 39 Denton WH. Issues for DSM-V: Relational diagnosis: An essential component of biopsychosocial assessment. *Am J Psychiatry* 2007;164:1146-7.
- 40 Kaslow FW. History, rationale, and philosophic overview of issues and assumptions. In: Kaslow FW, ed. *Handbook of relational diagnosis and dysfunctional family patterns*. New York, NY: John Wiley; 1996:3-18.
- 41 The Working Group for a New View of Women's Sexual Problems. A new view of women's sexual problems. In: Kaschak E, Tiefer L, eds. *A new view of women's sexual problems*. New York, NY: The Haworth Press; 2001:1-8.
- 42 Balon R, Segraves RT, Clayton A. Issues for DSM-V: Sexual dysfunction, disorder, or variation along normal distribution: Toward rethinking DSM criteria of sexual dysfunctions. *Am J Psychiatry* 2007;164:198-200.
- 43 Potts A, Bhugra D. Classification of sexual disorders. *Int Rev Psychiatry* 1995;7:167-74.
- 44 Laumann EO, Nicolosi A, Glasser DB, Paik A, Gingell C, Moreira E, Wang T. Sexual problems among women and men aged 40-80 years: Prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. *Int J Impot Res* 2005;17:39-57.
- 45 Lippa RA. The relation between sex drive and sexual attraction to men and women: A cross-national study of heterosexual, bisexual, and homosexual men and women. *Arch Sex Behav* 2007;36:209-22.
- 46 Rosen R, Brown C, Heiman J, Leiblum S, Meston C, Shabigh D, Ferguson D, D'Agostino R Jr. The Female Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *J Sex Marital Ther* 2000;26:191-208.
- 47 Basson R. The female sexual response: A different model. *J Sex Marital Ther* 2000;26:51-64.
- 48 Graham CA, Sanders SA, Milhausen R, McBride K. Turning on and turning off: A focus group study of the factors that affect women's sexual arousal. *Arch Sex Behav* 2004;33:527-38.
- 49 Waldinger MD, Schweitzer DH. Changing paradigms from a historical DSM-III and DSM-IV view toward an evidence-based definition of premature ejaculation. Part II. Proposals for DSM-V and ICD-11. *J Sex Med* 2006;3:693-705.
- 50 Hayes RD, Bennett C, Fairley CK, Dennerstein L. What can prevalence studies tell us about female sex difficulties and dysfunction? *J Sex Med* 2006;3:589-95.
- 51 Mitchell K, Wellings K, King M, Nazareth I, Johnson A. Taking it personally: Understanding the variation in responses to sexual difficulties. World Association for Sexual Health 18th Congress. Sydney, 2007; Abstract 034-7.
- 52 Althof S. My personal distress over the inclusion of personal distress. *J Sex Marital Ther* 2001;27:123-5.
- 53 Widiger TA. A dimensional model of psychopathology. *Psychopathology* 2005;38:211-14.
- 54 Scriver DL, Norman GR. *Health measurement scales: a practical guide to their development and use*. 2nd edition. New York: Oxford University Press; 1995:4-14.
- 55 Widiger TA, Samuel DB. Diagnostic categories or dimensions? A question for the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition. *J Abnorm Psychol* 2005;114:494-504.
- 56 Busko M. Why dimensional as well as categorical diagnoses are needed in DSM-V. *Medscape Medical News*. 2007. Available at: <http://www.medscape.com/viewarticle/558395> (accessed June 27, 2007).
- 57 Bancroft J. *Human sexuality and its problems*. Oxford, U.K.: Elsevier (in press).
- 58 Davis S. An external perspective on the report of the International Consensus Development Conference on Female Sexual Dysfunction: More work to be done. *J Sex Marital Ther* 2001;27:131-3.
- 59 Sand M, Fisher WA. Women's endorsement of models of female sexual response: The nurses' sexuality study. *J Sex Med* 2007;4:708-19.

Prevalence of low sexual desire in Britain: Is there a problem?

Running Head: Prevalence of low sexual desire in Britain

Abstract

We examine two measures of lacking interest in sex: (1) reporting a persistent lack of interest in sex (≥ 6 months in the past year) and (2) reporting seeking help for a persistent lack of interest in sex, in terms of their prevalence and association with key variables. Our data come from a probability survey of 12,110 men and women aged 16-44 years resident in Britain between 1999 and 2001. Computer-assisted personal interviewing was used to collect sociodemographic, behavioural and attitudinal data. We found that 2.3% (95% CI 1.8%-2.8%) of men and 10.7% (95% CI 9.9%-11.6%) of women reported lacking interest in sex for a period of 6 months or longer ($p < 0.0001$ for gender difference) and similar proportions of men and women sought help for this 'problem' (26.2%, (95% CI 18.1%-36.2%), and 27.9%, (95% CI 24.3%-31.8%)). Persistent lack of interest was reported as the only 'problem' by 69.4% (95% CI 65.8%-72.8%) of respondents. For women, reporting persistent low desire *per se* (outcome one) and reporting seeking help for low desire (outcome two) were associated with not enjoying sex, wanting sex more often, not being competent at first intercourse, poor communication about sex with partner, frequency of sex and attitudes according sex low priority. Increasing age, reporting a birth in the last year, having children under 5 in the house, and reporting no sexual partner in the past year were associated with outcome one only. Being married and self-perceived health status were associated with outcome two only. We discuss these patterns and highlight their relevance to clinical practice.

Key words: Sexual desire; sex survey; help seeking; prevalence; women

Introduction

Persistent lack of interest in, or desire for, sex is classified as a disorder of sexual function both by ICD-10 (World Health Organisation, 1992) and the DSM-IV-TR (American Psychiatric Association, 2000). It is the most common sexual difficulty among women (Graziottin, 2007; Nazareth, Boynton & King, 2003; Mercer et al., 2003; Hayes, Bennett, Fairley & Dennerstein, 2006), and the most frequent presenting problem by couples attending psycho-sexual therapy (Rosen & Leiblum, 1989).

Estimates of the prevalence of lack of sexual desire are variable and there is a lack of data that are generalisable to the general population. In a recent UK study of General Practice (GP) clinic attendees (Nazareth, Boynton & King, 2003), 6.7% of men and 16.8% of women reported lack or loss of sexual desire. In the most widely cited US prevalence study, roughly 30% of women and 15% of men reported lacking sexual interest in the previous 12 months (Laumann, Paik & Rosen, 1999). A recent pan-European epidemiological study of women (Graziottin, 2007) showed substantial inter-country variation, with lack of sexual interest/desire ranging from 21% (France) to 36% (Germany). Across all countries lack of desire increased with age and experience of the menopause.

The measurement of sexual interest/desire at a population level is not straightforward. Ongoing attempts to accurately delineate and define diagnostic criteria for sexual desire disorders are far from reaching conclusion (Basson, et al., 2003) and there are repeated calls for greater clarity (Heiman, 2001). One of the challenges lies in the fact that desire often co-exists and overlaps with arousal (Regan & Berscheid, 1999), particularly among women (Basson, 2006). There is also debate about whether there is a clinically significant split between spontaneous and responsive desire (desire occurring simultaneously with arousal) (Basson, 2000; Goldmeier, 2001). Traditional indicators of desire such as the presence of fantasies are now regarded as far more valid for men than women (Basson & Schultz, 2007).

There is also wide variation in the measures and methodological design adopted in prevalence studies (Dunn, Jordan, Croft & Assendelft 2002; Hayes, et al., 2006). Design criteria such as the time period for reported difficulties, the inclusion (or not) of individuals with no sexual partner, and the inclusion (or not) of a distress criteria have a substantial impact on the resulting prevalence estimates (Hayes et al., 2006). This partly explains why estimates of low sexual desire among women vary widely between 7.2% (Bancroft, Loftus & Long, 2003) and 54.8% (Richters et al., 2003). Although community prevalence studies rarely adopt DSM-IV criteria, they are often subsequently (mis)quoted as providing estimates of clinical dysfunction rather than difficulties. Inflated estimates run the risk of pathologising normal variation in desire and play into the hands of those who argue that low sexual desire is to a large extent, a socially constructed disease (Moynihan, 2003).

To our knowledge, there are no recent prevalence estimates of sexual interest/desire from a British probability sample of men and women. In view of the difficulties described above, there is a need to continue to improve understanding of normative patterns of low sexual desire in the general population. This paper attempts to meet this need for a British population estimate, in addition to contributing to the debate about measurement approaches. We explore factors associated with reporting low desire (first outcome variable) as well as seeking help for low desire (second outcome variable). We were particularly interested in the differences in factors associated with these two measures. We have previously reported on sexual function problems within a British national probability sample (Mercer et al., 2003; Mercer et al., 2005) but in this paper we explore in greater detail data from the same survey that specifically relate to the problem of lacking interest in sex. Given the relatively small prevalence among men, (Mercer et al., 2003) especially of the second outcome (reporting seeking help for a persistent lack of interest in sex) the analysis of factors associated with each variable is limited to women.

Methods

The 2000 National Survey of Sexual Attitudes and Lifestyles ('Natsal 2000') is a stratified probability sample survey of the general population aged 16 to 44 years, resident in Britain. Details of the methodology and question wording are published elsewhere (Erens, McManus & Field, 2001; Johnson et al., 2001; Fenton et al., 2005). The survey was undertaken between May 1999 and February 2001. A sample of 40,523 addresses was selected from the small-user postcode address file for Britain using a multistage probability cluster design with over-sampling in London. Additional sampling was conducted in the last six months of the main survey to increase the number of respondents from Britain's four largest ethnic minorities (Indians, black Caribbeans, Pakistanis, and black Africans) in the overall sample (949 interviews in addition to the main survey's 11,161 interviews). Trained interviewers visited selected addresses and recorded the number of residents aged 16–44 years. One randomly selected resident from each household was then invited to participate in the study. Natsal 2000 achieved response rates of 65.4% and 63.0% for the main survey and ethnic boost sample, respectively (Erens et al., 2001; Johnson et al., 2001; Fenton et al., 2005), which is in line with other major surveys conducted in Britain (Department of Work and Pensions, 2001; Lynn & Clarke, 2002).

Respondents were asked a range of questions about their sexual lifestyles and attitudes including, in a computer-assisted self-interview (CASI) component, questions about their experience of sexual problems. The questions were based on those used in the United States' National Health and Social Lifestyle Survey (Laumann, Paik & Rosen, 1999) which measured the main dimensions of sexual dysfunction as defined in the ICD-10 (International Classification of Diseases tenth revision). Respondents were asked "*In the last year, have you experienced any of the following for one month or longer?*" and the first item was "*Lacked interest in having sex*", followed by six further sexual problems. Respondents were asked about problems lasting at least one month, as well as 'persistent' problems; those lasting 6 months or longer. Those reporting problems were then asked, "*During the last year, have you contacted any of the following for help with [reported problem]?*" Options included the "*GP*", "*VD/STD/Sexual health clinic*", "*Psychiatrist or psychologist*", "*Marriage counsellor*", "*Other type of clinic or doctor*" and "*Contacted a helpline*".

The analysis was performed using STATA 8.0 and the data were weighted to correct for unequal selection probabilities, including over-sampling in Greater London, and to match Britain's age/sex population profile (Erens et al., 2001; Johnson et al., 2001). As in previous publications (Fenton, et al., 2005; Johnson et al., 2001; Wellings et al., 2001), we used binary logistic regression to obtain odds ratios (OR) to compare estimates for respondents who did and did not report lacking interest in sex for 6 months or longer. We then ran a second analysis using 'reported lacking interest in sex for 6 months or longer *and* sought help for problem' as the outcome variable, in order to examine whether those who sought help (a proxy for viewing lack of interest as problematic) differed in any way from those who merely reported lack of interest. Unlike in previous publications, (Mercer et al., 2003; Mercer et al., 2005) here the denominator includes all respondents, irrespective of whether they reported ever having a sexual partner, since our interest was in individuals' perceived level of sexual desire, regardless of partnership status. The prevalence estimates therefore

vary very slightly to those previously published. We focus on those reporting a 'persistent' lack of interest (6 months or longer) because we want to exclude, as far as possible, those experiencing temporary difficulties specific to a transitional context (for instance work stress or a relationship break down). We also focus our detailed analysis on women; prevalence figures for men were too small to demonstrate significant associations. We use the terms 'sexual interest' and 'sexual desire' interchangeably.

We present ORs adjusting for age, marital status and reported number of partners (opposite and same-sex partners) in the past year. Statistical significance is considered as $p < 0.05$ for all analyses.

The study was approved by the University College Hospital and North Thames Multi-Centre Research Ethics Committee and all the Local Research Ethics Committees in Britain.

Results

Overall, 2.3% (95% CI 1.8%-2.8%) of men and 10.7% (95% CI 9.9%-11.6%) of women reported lacking interest in sex for a period of 6 months or longer in the year prior to interview ($p < 0.0001$ for gender difference). Those reporting persistent lack of interest in sex (for 6 months or longer) comprised 12.9% (men) and 27.5% (women) of all those reporting *any* lack of interest (defined as lasting one month or longer).

Of those reporting a persistent lack of interest, similar proportions of men and women sought help for this: 26.2% (95% CI 18.1%-36.2%) and 27.9% (95% CI 24.3%-31.8%), respectively ($p = 0.7391$ for gender difference), with the majority turning to their GP for help (72.3%, (95% CI 52.4%-86.1%) of men and 69.2% (95% CI 60.9%-76.4%) of women, $p = 0.7473$). A persistent lack of interest was reported as the only 'problem' by 69.4% (95% CI 65.8%-72.8%) of respondents; 18.5% (95% CI 15.8%-21.6%) reported one other sexual problem, while 12.1% (95% CI 9.7%-15.0%) reported three or more problems²³. Among men, the most common 'problem' experienced alongside lack of interest was 'feeling anxious just before having sex about their ability to perform sexually', and among women the most common co-existing problem was being 'unable to come to a climax'.

Among women, reporting a persistent lack of interest in sex was significantly associated with increasing age, with reporting a birth in the last year, and with having children under 5 at home (see table one). However none of these factors were associated with reporting low desire *and* seeking help (second outcome variable). Married women were significantly more likely than those who had never married to report seeking help for their low desire (AOR 0.36, Table 1), but this factor was not associated with simply reporting a persistent lack of interest. Women's self-perceived health status was also associated with seeking help, but not simply reporting persistent lack of interest, with 9.1% of women who reported their health as 'bad' or 'very bad' reporting this, in contrast to 2.8% of women who reported their health as 'very good', 'good', or 'fair' (AOR 3.62). Ethnicity and educational status were not related to either outcome variable.

²³ There was no significant gender difference for reporting other sexual problems.

In contrast to Table 1, Table 2 shows greater similarity in the direction and magnitude of the AORs for the two outcomes with respect to the sexual behaviour factors considered. The circumstances of sexual debut appear to be important, with both outcomes more likely if women were considered *not* to have been competent at first sex (defined as an absence of duress and regret, autonomy of decision, and use of a reliable method of contraception (Wellings et al., 2001)). Ease of communication about sexual matters with partner(s) also seems to be important, with women who reported finding it "difficult to talk about sex with any partner" more likely to report both a persistent lack of interest and to seek help for this problem (AORs of 3.02 and 3.36, respectively). It is also worth noting that while competence at first sex and ease of communication about sex are correlated with each other, these factors are independently associated with both measures of lack of interest.

The frequency of sex was highly significant, with women reporting more than the average number of occasions (four in the four weeks prior to interview) less likely to report both a persistent lack of interest *and* seeking help for this problem. Reporting a greater number of sexual partners (in the past year) was also found to significantly reduce the probability of reporting a persistent lack of interest in sex *per se*, but there was no association between number of partners and reporting seeking help for low interest. Almost one in five women reporting no sexual partners in the past year also reported persistent lack of interest (18.2%) in contrast to 7.9% of women with multiple partners in the past year.

Women who reported that they did not always or, mostly do not enjoy sex were more likely to report both a persistent lack of interest and seeking help for this problem, than women who said that they mostly enjoyed sex (29.3% vs. 8.3% and 6.7% vs. 2.5%, both $p < 0.0001$, Table 3). Women who reported that they "would like sex much, or a bit more often" were significantly more likely to report both the outcomes (AORs of 1.77 and 1.92, respectively). Attitudes regarding the importance of sex appeared to be associated with interest and with help seeking. Women who believed that a happy sexual relationship was not very, or not at all, important for a successful long-term relationship/marriage had increased odds of reporting a persistent lack of interest, and reporting seeking help for this (AORs of 3.86 and 3.07, respectively). Disagreeing with the statement that "sex is the most important part of any marriage or relationship" was similarly associated (both AORs of 2.12).

We investigated, but do not report in the tables, a number of factors that were not significantly associated with either variable for women: education, body mass index; alcohol consumption; masturbation; STI diagnosis in the past 5 years; and the beliefs that 'sex without an orgasm is not satisfying for men' and 'sex without an orgasm is not satisfying for women'.

Discussion

In summary, we found that lacking interest in sex appeared to be most often a 'problem' in its own right, unrelated to other sexual function problems. Married women and those in (self-perceived) poor health were more likely to seek help for persistent lack of interest but no more likely to report a lack of interest *per se*, than

those who had never married and those in good health. Older women, and those reporting no partners in past year, a birth in the last year, or children under 5 in the household were more likely to report persistent lack of interest, but this association disappeared for the outcome variable persistent lack of interest *plus* seeking help. First experience of sex, ease of communication about sexual matters, enjoyment of sex, frequency of sex, wanting sex more often, and attitudes which accord low priority to sex within a relationship were all associated with both outcome variables (reporting persistent low desire and seeking help for the problem).

There are some limitations to this study. Firstly, our sample is young. Our prevalence estimates for reporting lack of interest are therefore likely to be underestimates with respect to the whole sexually active population. Merely reporting a persistent lack of interest in sex does not imply a problem, let alone sexual dysfunction. However we can be reasonably confident that those who seek help must view their lack of interest as problematic to some degree. Even so, this does not equate to a diagnosis of HSDD, which is more accurately measured epidemiologically via specifically validated scales such as the Sexual Interest and Desire Inventory-Female (SIDI-F) (Clayton, et al., 2006). Therefore, we are reporting here on sexual difficulty rather than dysfunction. Finally, this is a cross-sectional survey; so that we cannot be certain about the causal direction of the associations we have identified. For instance, having no partners in the past year may give rise to a persistent lack of interest, but equally lacking interest in sex may lead an individual to avoid new sexual partnerships.

We have assumed that women who sought help for their reported lack of interest in sex saw this lack as problematic and we used help seeking here as a proxy indicator of distress. On the other hand, individuals who report a lack of interest in sex but who did not seek help, may or may not have seen their lack of interest as problematic. We found that for women, age, frequency of sex in the past four weeks, no sexual partners in past year, having had a birth in the past year and/or children under 5 in the home were associated with reporting lack of interest, but not with seeking help. It may well be here that this lack of interest represents an adaptive response to life circumstances. Parents of young children may be responding to stress and fatigue; and single women, consciously or otherwise, may be 'switching off' their interest or compartmentalising it, in order to avoid the frustration of thwarted desire. For women experiencing these life circumstances, six months may still be too short a time-frame to capture persistent rather than transient symptoms. In other words, duration is an inadequate marker of severity for these women. A similar pattern is found for age. We have shown that although older women are more likely to report a lack of interest in sex, they are no more likely than young women to seek help for this problem. This concurs with many previous studies showing an increase in sexual difficulties concomitant with a decrease in distress with age (Graziottin, 2007, Bancroft, Loftus & Long, 2003; Hayes & Dennerstein, 2005). A likely explanation is that changes in expectations through the life stage mean that women adapt and adjust to lower levels of interest, viewing them as 'normal' for their particular life stage.

We found that women's attitudes towards the importance of sex matter, with those who believed that "a happy sexual relationship was not very, or not at all, important for a successful long-term relationship/marriage" significantly more likely to report persistent lack of interest. We might argue that lacking interest for some women is part of a coherent and benign set of beliefs concerning the importance of sex against

other priorities. However, women with 'problematic' desire (i.e. those who have sought help) are also significantly more likely to view sex as less important. If sex matters less to them, why do they seek help for their lack of desire? A potential explanation is that these women perceive that their attitudes are not affirmed by their partners and/or by prevalent norms. Thus distress is caused by the disjuncture between their own attitudes and those of significant others around them. It is also possible that feelings of low desire led to a downgrading of the importance of sex, rather than the other way round.

For the majority of respondents (69%), lacking interest in sex was reported in the absence of any other problem. This concurs with previous research suggesting that around 60% of subjects with a primary diagnosis of Hypo-Sexual Desire Disorder (HSDD) have no co-morbid diagnosis (Segraves & Segraves, 1991). Where low desire occurs in spite of a physically functioning sex life, the underlying cause, for at least some individuals, may be medical or may be found instead in broader relationship difficulties, other psychosocial problems or may represent an adaptation to personal circumstances. Evidence from elsewhere suggests that some of the reported lack of interest may be either adaptive or at least unproblematic for the individual (Bancroft & Janssen 2000). Nazareth and colleagues (2003) for instance showed that only 18% of women and 16% of men with low interest had sought advice from their GP on sexual matters compared with 35% of women and 27% of men who sought advice for other single diagnoses. Furthermore, Öberg and colleagues (2004) showed that the prevalence of manifest decreased sexual interest falls by half (29% to 15%) if the criterion of personal distress is employed.

From a public health perspective, it is important to differentiate between this adaptive or benign disinterest and problematic lack of desire. Those with benign (or unproblematic) lack of desire do not require treatment or services; that is, they are of no clinical relevance. We should avoid including them in our estimates.

Conversely, circumstances or normative expectations may turn benign lack of interest into something more pernicious. It is interesting that among women, reporting lack of interest *per se* showed no association with marital status, but seeking help for the 'problem' was more common among married women. One hypothesis is that the male partner or the couple dynamic generates pressure to have greater interest in sex such that the woman comes to feel that she has a problem requiring help. A growing weight of evidence points to the importance of the couple context and dynamic in both the aetiology and treatment of difficulties (Davies, Katz & Jackson, 1999; Clement, 2002; Rosen, 2007). Goldmeier (2001) suggested that the majority of women presenting to his clinic with low sexual desire actually had functioning 'responsive sexual desire'; that is, they felt desire in response to partner-initiated activity but felt as though they ought to experience more 'spontaneous' desire. Explaining that responsive desire is 'normal' may come as a great relief to these patients.

The pattern of reporting with regard to frequency of sex is puzzling. It makes sense that women who lack interest in sex also have less sex. It is less obvious why lack of interest should be associated with wanting sex a bit or much more often, particularly since lacking interest is significantly associated with not enjoying sex. Of course, some individuals are distressed by their lack of desire and would like to *want* sex

more often. Others, for instance single respondents, may have 'switched off' their interest (as described above) but would still ideally like more sex should the opportunity arise. Finally, other individuals might feel they *ought* to have sex more often, perhaps because they are influenced by their partner or wider cultural norms.

Competence at first intercourse (that is the extent to which first intercourse is planned, wanted, protected and enjoyed (Wellings et al., 2001)) appears to impact on later interest in sex. Because of the temporal sequence we know that the experience of first intercourse is a risk marker for lack of desire and not the other way round. Elsewhere, our survey has demonstrated a link between sexual competence and other sexual difficulties beyond desire (Mercer et al., 2003). We have also shown a clear association between difficulty communicating about sexual matters and lack of interest. The links between communication about sexual matters, competence at first intercourse and later interest in sex are important. Most interventions targeting first sexual encounters do so for reasons of pregnancy and STI prevention. We suggest a separate but equally important motivation; that low competence at first encounter predicts poor sexual health in later life.

Our data provide some useful pointers for the clinical management of lack of desire. We have shown elsewhere that the majority of those seeking help for persistent lack of interest turn to their GP. Previous research has shown that the majority of GP attendees (75%) consider their GP an appropriate person with whom to discuss sexual difficulties (Spence, 1992). Yet previous research also suggests that many GPs feel ill at ease talking about sexual matters with their patients (Humphrey & Nazareth 2001; Sack, Drabant & Perrin, 2002). Our findings suggest some useful conversation topic areas that may facilitate the discussion with female patients. For instance, it may be useful to discuss confidence around communication of sexual matters, enjoyment of sex and actual versus desired frequency. In particular for women, GPs may find it useful to discuss attitudes towards the importance of sex, and to examine possible conflict of interest between those of the patient and those of significant others around them.

Conclusion

Persistent lack of interest in sex affects a significant minority of Britain's population but we should not be overhasty in concluding that this represents a burden of ill health. Unpacking the factors associated with reporting low desire suggests that some of this lack of desire is benign and even adaptive and should not necessarily be viewed as problematic.

References

American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders, (4th ed., text rev.). Washington, D.C: American Psychiatric Press.

Bancroft, J., & Janssen, E. (2000) The dual control model of male sexual response: A theoretical approach to centrally mediated erectile dysfunction. *Neuroscience Biobehaviour Review*, 2000, 24, 571-579.

Bancroft, J., Loftus, J., & Long, J.S. (2003) Distress about sex: A national survey of women in heterosexual relationships, *Archives of Sexual Behaviour*, 32, 193-208.

Basson, R. (2000) The female sexual response: A different model. *Journal of Sex and Marital Therapy*, 26, 51-64.

Basson, R., Leiblum, S., Brotto, L., Derogatis, L., Fourcroy, J., Fugl-Meyer, K., Graziottin, A., Heiman, J.R., Laan, E., Meston, C., Schover, L., van Lankveld, J., Weijmar Schultz, W. (2003). Definitions of women's sexual dysfunction reconsidered: advocating expansion and revision. *Journal of Psychosomatic Obstetrics & Gynaecology*, 24(4), 221-9.

Basson, R. (2006) Sexual desire and arousal disorders in women. *New England Journal of Medicine*, 354, 1497-506.

Basson, R., & Schultz, W. (2007) Sexual sequelae of general medical disorders. *The Lancet*, 369, 409-424.

Clayton, A., Segraves, R.T., Leiblum, S., Basson, R., Pyke, R., Cotton, D., Lewis-D'agostino, D., Evans, K., Sills, T., Wunderlich, G. (2006) Reliability and validity of the Sexual Interest and Desire Inventory-Female (SIDI-F), a scale designed to measure severity of female hypoactive sexual desire disorder. *Journal of Sex and Marital Therapy*, 32, 115-135

Clement, U. (2002) Sex in Long-Term Relationships: A Systemic Approach to Sexual Desire Problems. *Archives of Sexual Behaviour*, 31, 241-246.

Davies, S., Katz, J. & Jackson, J.L. (1999) Sexual desire discrepancies: Effects on sexual and relationship satisfaction in heterosexual dating couples. *Archives of Sexual Behaviour*, 28, 553-567

Dept. for Work and Pensions (2006)
www.dwp.gov.uk/asd/frs/2000_01/methodology/response.asp (last accessed: 27 January 2008).

Dunn, K.M., Jordan, K., Croft, P.R. Assendelft, W.J. (2002) Systematic review of sexual problems: epidemiology and methodology. *Journal of Sex and Marital Therapy*, 28(5), 399-422.

Erens, B., McManus, S. & Field, J. (2001) National survey of sexual attitudes and lifestyles II: Technical report. London: National Centre for Social Research.

Fenton, K.A., Mercer, C.H., McManus, S., *et al.* (2005) Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: a probability survey. *Lancet*, 365,1246-1255

Goldmeier, D. (2001) 'Responsive' sexual desire in women – managing the normal? *Sex and Relationship Therapy*, 16(4), 381-387

Graziottin, A. (2007) Prevalence and evaluation of sexual health problems – HSDD in Europe. *Journal of Sexual Medicine*, 4(suppl.3), 211-219

Hayes, R.D., Bennett, C.M., Fairley, C.K., Dennerstein, L. (2006) What can prevalence studies tell us about female sexual difficulty and dysfunction? *Journal of Sexual Medicine*, 3, 589-595

Hayes, R. & Dennerstein, L. (2005) The impact of aging on sexual function and sexual dysfunction in women: A review of population-based studies. *Journal of Sexual Medicine*, 2, 317-330

Heiman, J. (2001). Sexual desire in human relationships. In Everaerd, W., Laan, E., Both, S. (Eds.) *Sexual appetite, desire and motivation: Energetics of the sexual system* (pp117-134). Amsterdam: Royal Netherlands Academy

Humphrey, S., & Nazareth, I. (2001) GPs' views on their management of sexual dysfunction. *Family Practice*, 18(5), 516-8.

Johnson, A., Mercer, C. H., Erens, B., Copas, A. J., McManus, S., Wellings, K., Fenton, K., Korovessis, C., Macdowall, W., Nanchahal, K., Purdon, S. and Field, J. (2001) Sexual behaviour in Britain: partnerships, practices and HIV risk behaviours. *Lancet*, 358,1835-1842

Laumann, E.O., Paik, A. & Rosen, R.C. (1999) Sexual dysfunction in the United States: prevalence and predictors. *Journal of the American Medical Association*, 281(6), 537-544.

Lynn, P. & Clarke, P. (2002) Separating refusal bias and non-contact bias: Evidence from UK national surveys. *The Statistician*, 51, 319-33

Mercer, C.H., Fenton, K.A., Johnson, A.M., Copas, A.J., Macdowall, W., Erens, B., Wellings, K. (2000) Who reports sexual function problems? Empirical evidence from Britain's 2000 National Survey of Sexual Attitudes and Lifestyles. *Sexually Transmitted Infections*, 81, 394-399

Mercer, C.H., Fenton, K.A., Johnson, A.M., Wellings, K., Macdowall, W., McManus, S., Nanchahal, K., Erens, B. (2003) Sexual function problems and help seeking behaviour in Britain: National probability sample survey. *British Medical Journal*, 327, 426-427.

Moynihan, R. (2003). The making of a disease: female sexual dysfunction. *British Medical Journal*, 326, 45-47.

Nazareth, I.P., Boynton, P. & King, M. (2003) Problems with sexual function in people attending London general practitioners: a cross sectional study. *British Medical Journal*, 327, 423-426

Öberg, K., Fugl-Meyer, A. & Fugl-Meyer, K. (2004) On categorization and quantification of women's sexual dysfunctions: An epidemiological approach. *International Journal of Impotence Research*, 16, 261-269

Regan, P. & Berscheid, E. (1999). *Lust: What we know about human sexual desire*. Thousand Oaks, CA: Sage

Richters, J., Grulich, A.E., de Visser R.O., Smith, A.M.A. & Rissel, C.E. (2003) Sex in Australia: Sexual difficulties in a representative sample of adults. *Australian and New Zealand Journal of Public Health*, 27, 164-170

Rosen, R.C. and Leiblum, S.R. (1989) Assessment and treatment of desire disorders. In Leiblum, S.R. & Rosen R.C. (Eds.) *Principles and Practice of Sex Therapy; Update for the 1990s* (pp.19-47). New York: Guilford Press.

Rosen, R.C. (2007) Sexual dysfunction in the context of the couple's relationship: Current findings and theory. *Journal of Sexual Medicine*, 4 (suppl 1), 38

Sack, S., Drabant, E., Perrin, E. (2002) Communicating about sexuality: An initiative across the core clerkships. *Academic Medicine*, 77, 1159-60.

Segraves, K., Segraves, R.T. (1991) Hypoactive sexual desire disorder: Prevalence and comorbidity in 906 subjects. *Journal of Sex and Marital Therapy*, 17, 55-8

Spence, S.J.A. (1992) Problems that patients feel are appropriate to discuss with their GPs. *Journal of the Royal Society of Medicine*, 85, 669-673

StataCorp (2003) *Stata statistical software: Release 8.0*. Texas: Stata Corporation.

Wellings, K., Nanchahal, K., Macdowall W., McManus, S., Erens, B., Mercer, C., Johnson, A., Copas, A., Korovessis, C., Fenton, K., Field, J. (2001) Sexual behaviour in Britain: early heterosexual experience. *Lancet*, 358, 1843-1850

World Health Organization. (1992) *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*. Geneva: World Health Organisation

Table 1: Significant variations in the prevalence of two measures of lacking interest in sex by selected sociodemographic characteristics and self-perceived health status.

	Reporting lacking interest for 6+ months:			Reporting lacking interest for 6+ months AND seeking help:			Denominator (weighted/unweighted)
	% (95% CI)	Crude OR ¹ (95% CI)	Adjusted ^{1,2} OR (95% CI)	% (95% CI)	Crude OR ¹ (95% CI)	Adjusted ^{1,2} OR (95% CI)	
All	10.7 (9.87, 11.6)	-	-	2.96 (2.52-3.48)	-	-	5724,6655
Age							
16-24	4.91 (3.69, 6.51)	$P < 0.001$ 1.00	$P < 0.001$ 1.00	1.62 (1.04, 2.54)	$P = 0.010$ 1.00	$P = 0.779$ 1.00	1346,1338
25-34	11.6 (10.3, 13.1)	2.55 (1.84, 3.53)	2.02 (1.40-2.91)	3.27 (2.58, 4.13)	2.05 (1.21, 3.46)	1.23 (0.69, 2.2)	2216,2712
35-44	13.36 (11.9, 14.9)	2.98 (2.16, 4.14)	2.25 (1.54-3.29)	3.48 (2.69, 4.49)	2.18 (1.3, 3.66)	1.2 (0.66, 2.17)	2162,2605
Marital status							
Married	12.7 (11.4, 14.1)	$P < 0.001$ 1.00	$P = 0.093$ 1.00	4.07 (3.27, 5.05)	$P < 0.001$ 1.00	$P = 0.002$ 1.00	2630,2694
Cohabiting	10.9 (9.06, 13.1)	0.84 (0.67, 1.07)	1.05 (0.82-1.34)	2.72 (1.9, 3.88)	0.66 (0.43, 1.02)	0.71 (0.45, 1.14)	1078,1036
Previously married ³	14.3 (11.7, 17.3)	1.15 (0.89, 1.48)	1.17 (0.90-1.52)	2.66 (1.55, 4.55)	0.64 (0.35, 1.18)	0.64 (0.35, 1.18)	454,776
Single, never married	6.15 (5.13, 7.34)	0.45 (0.36, 0.57)	0.77 (0.58-1.02)	1.26 (0.83, 1.91)	0.30 (0.18, 0.49)	0.36 (0.21, 0.61)	1549,2132
Ethnicity							
White	10.8 (9.91, 11.8)	$P = 0.246$ 1.00	$P = 0.342$ 1.00	3.03 (2.56, 3.59)	$P = 0.058$ 1.00	$P = 0.068$ 1.00	5262,5536
Black Caribbean	12.9 (9.06, 18.0)	1.22 (0.81, 1.84)	1.19 (0.78-1.83)	2.12 (0.91, 4.85)	0.69 (0.29, 1.66)	0.84 (0.35, 2.00)	111,339
Black African	13.6 (7.73, 23.6)	1.33 (0.69, 2.57)	1.19 (0.60-2.34)	0.17 (0.00, 1.17)	0.05 (0.01, 0.38)	0.05 (0.01, 0.38)	61,253
Indian	5.9 (3.08, 11.0)	0.52 (0.26, 1.03)	0.53 (0.26-1.07)	2.95 (0.96, 8.69)	0.97 (0.30, 3.09)	0.93 (0.29, 3)	102,195
Pakistani	5.9 (2.87, 11.8)	0.52 (0.24, 1.10)	0.57 (0.27-1.21)	1.42 (0.51, 3.89)	0.46 (0.16, 1.31)	0.44 (0.16, 1.28)	40,138
Other	10.74 (6.79, 16.58)	0.99 (0.6, 1.66)	1.15 (0.67-1.97)	3.07 (1.33, 6.91)	1.01 (0.42, 2.43)	1.09 (0.45, 2.65)	127,170
Child(ren) aged under 5 in household							
No	8.89 (8, 9.87)	$P < 0.001$ 1.00	$P < 0.001$ 1.00	2.64 (2.13, 3.25)	$P = 0.033$ 1.00	$P = 0.209$ 1.00	4015,4660
Yes	15.1 (13.34, 17.05)	1.82 (1.51, 2.19)	1.90 (1.55-2.33)	3.75 (2.92, 4.81)	1.44 (1.02, 2.02)	1.27 (0.88, 1.83)	1695,1971

Table 1 (CONTINUED): Significant variations in the prevalence of two measures of lacking interest in sex by selected sociodemographic characteristics and self-perceived health status.

	Reporting lacking interest for 6+ months:			Reporting lacking interest for 6+ months AND seeking help:			Denominator (weighted/unweighted)
	% (95% CI)	Crude OR ¹ (95% CI)	Adjusted ^{1,2} OR (95% CI)	% (95% CI)	Crude OR ¹ (95% CI)	Adjusted ^{1,2} OR (95% CI)	
All	10.7 (9.87, 11.6)	-	-	2.96 (2.52-3.48)	-	-	5724,6655
Had a birth, past year		<i>p</i> =0.018	<i>p</i> =0.008		<i>p</i> =0.267	<i>p</i> =0.174	
No	10.42 (9.58, 11.34)	1.00	1.00	3.03 (2.56, 3.58)	1.00	1.00	5309,6189
Yes	14.33 (11.13, 18.26)	1.44 (1.06, 1.94)	1.53 (1.12-2.10)	2.05 (1.04, 3.99)	0.67 (0.33, 1.36)	0.6 (0.29, 1.25)	414,461
Self-perceived health status		<i>p</i> =0.217	<i>p</i> =0.352		<i>p</i> <0.001	<i>p</i> <0.001	
Good/very good/fair	10.63 (9.79, 11.54)	1.00	1.00	2.82 (2.38, 3.35)	1.00	1.00	5598,6477
Bad/very bad	13.96 (9.09, 20.85)	1.36 (0.83, 2.2)	1.28 (0.76-2.14)	9.11 (5.12, 15.68)	3.45 (1.8, 6.62)	3.62 (1.85, 7.08)	126,178

Notes for Table 1:

1. Odds ratio (OR)
2. OR adjusted for age, marital status and partner numbers in the past year.
3. Separated, divorced or widowed

DRAFT

Table 2: Significant variations in the prevalence of lacking interest in sex by selected sexual behavioural factors.

	Reporting lacking interest for 6+ months:			Reporting lacking interest for 6+ months AND seeking help:			Denominator (weighted/unweighted) 5724,6655
	% (95% CI)	Crude OR ¹ (95% CI)	Adjusted ^{1,2} OR (95% CI)	% (95% CI)	Crude OR ¹ (95% CI)	Adjusted ^{1,2} OR (95% CI)	
All	10.7 (9.87, 11.6)	-	-	2.96 (2.52-3.48)	-	-	
Sexually competent at 1 st sex ³							
Competent	8.64 (7.54, 9.87)	p<0.001 1.00	p<0.001 1.00	2 (1.44, 2.77)	p=0.001 1.00	p=0.002 1.00	2298, 2524
Not competent	12.51 (11.31, 13.82)	1.51 (1.26, 1.82)	1.48 (1.23-1.80)	3.72 (3.08, 4.5)	1.9 (1.28, 2.8)	1.88 (1.27, 2.78)	3217, 3855
Find it difficult to talk about sex with any partner							
No	9.39 (8.59, 10.26)	p<0.001 1.00	p<0.001 1.00	2.51 (2.09, 3.02)	p<0.001 1.00	p<0.001 1.00	5263, 6081
Yes	25.7 (21.93, 29.88)	3.34 (2.67, 4.17)	3.02 (2.39-3.82)	8.08 (5.85, 11.05)	3.41 (2.32, 5.02)	3.36 (2.25, 5.02)	462, 574
Number of occasions of sex, last 4 weeks ⁴							
Less than four	16.57 (15.14, 18.12)	p<0.001 1.00	p<0.001 1.00	3.91 (3.18, 4.8)	p=0.001 1.00	p<0.001 1.00	2454, 3130
At least four	6 (5.14, 6.99)	0.32 (0.27, 0.39)	0.28 (0.23-0.35)	2.18 (1.65, 2.86)	0.55 (0.38, 0.78)	0.46 (0.31, 0.67)	3062, 3257
Numbers of partners, last year							
None	18.16 (14.88, 21.98)	p<0.001 1.00	p<0.001 1.00	2.88 (1.57, 5.24)	p=0.824 1.00	p=0.193 1.00	369, 574
One	10.7 (9.76, 11.72)	0.54 (0.42, 0.7)	0.34 (0.25-0.48)	3.08 (2.55, 3.71)	1.07 (0.56, 2.05)	0.51 (0.22, 1.17)	4366, 4836
More than one	7.87 (6.11, 10.87)	0.39 (0.27, 0.55)	0.40 (0.28-0.57)	2.64 (1.69, 4.12)	0.91 (0.43, 1.94)	0.8 (0.36, 1.76)	781, 975

Notes for Table 2:

1. Odds ratio (OR)
2. OR adjusted for age, marital status and partner numbers in the past year.
3. This composite measure is defined as an absence of duress and regret, autonomy of decision, and use of a reliable method of contraception at first heterosexual sexual intercourse. (Wellings et al, 2001)
4. Corresponds to the median number of occasions of sex in the last four weeks estimated as four. (Johnson et al 2001)

Table 3: Significant variations in prevalence of lacking interest in sex by selected attitudinal factors.

	Reporting lacking interest for 6+ months:		Reporting lacking interest for 6+ months AND seeking help:		Denominator (weighted/unweighted)
	% (95% CI)	Crude OR ¹ (95% CI)	% (95% CI)	Adjusted ^{1,2} OR (95% CI)	
All	10.7 (9.87, 11.6)	-	2.96 (2.52-3.48)	-	5724,6655
Don't always/mostly enjoy sex					
No	8.3 (7.49,9.19)	$P < 0.001$ 1.00	2.49 (2.07,2.99)	$P < 0.001$ 1.00	5036,5646
Yes	29.32 (25.92,32.96)	4.58 (3.75,5.6)	6.68 (4.79,9.25)	3.07 (1.78,5.33)	660,960
'Would like sex much/bit more often'					
Disagree	8.4 (7.47,9.43)	$P < 0.001$ 1.00	1.23 (1.74,2.85)	$P < 0.001$ 1.00	3390,3835
Agree	14.22 (12.75,15.82)	1.81 (1.5,2.16)	4.09 (3.29,5.07)	1.92 (1.36,2.72)	2295,2752
"Sex is the most important part of any marriage or relationship"					
Agree/strongly agree	6.64 (5.11,8.59)	$P = 0.0001$ 1.00	1.72 (1.01,2.93)	$P = 0.0183$ 1.00	7641026
Neither agree/disagree	9.71 (8.11,7.4)	1.51 (1.08,2.12)	2.18 (1.41,3.38)	1.33 (0.64,2.75)	1032,1203
Disagree/strongly disagree	11.8 (10.73,12.96)	1.88 (1.39,2.54)	3.43 (2.84,4.13)	2.12 (1.16,3.86)	3905,4388
"A happy sexual relationship is important for a successful marriage/long-term relationship"					
Very important / quite important / don't know	9.99 (9.16,10.88)	$P < 0.001$ 1.00	2.77 (2.34,3.27)	$P < 0.001$ 1.00	5490,6381
Not very important / not at all important	29.26 (23.31,36.03)	3.73 (2.7,5.15)	7.86 (4.78,12.66)	3.07 (1.77-5.33)	221,253

Notes for Table 3:

- Odds ratio (OR)
- OR adjusted for age, marital status and partner numbers in the past year.

'Understanding sexual difficulties' Study

Topic Guide

- Introduce study
- Give respondent option to change their mind about participating
- Assure respondent about confidentiality and anonymity of disseminated results
- Acknowledge that topic may be embarrassing. Alleviate worry about embarrassment.
- Emphasise that respondent can skip any questions he/she does not feel comfortable answering
- Emphasise that there are no right or wrong answers – all experiences and opinions are valid.
- Request permission to tape record interview.
- Ensure CONSENT FORM completed and signed

Background information. [Please tell me about yourself]

Age; Level of education; employment status; Ethnic status; Length of time in UK;
Current partnership status; children/family; Sexual orientation

Describing a satisfactory/OK/acceptable sex life and an unsatisfactory sex life

[Suggested terms for sections 1 and 2: OK, acceptable, what you want, matching expectations, realistic ideal – use respondent preferred]

- **What does the word sex mean for you? [Is there a term that you would prefer us to use during this interview?]**
- **How would you describe the ideal sexual relationship? How would you describe the ideal sexual act/sexual activity? [ideal in realistic terms]**
Probe: Think about physical factors, psychological factors, relationship factors, personal factors, medical factors?
Which factors are most important to you? What would others say (men and women)?
- **How would you describe an unsatisfactory/not OK/unacceptable sexual relationship? How would you describe unsatisfactory sex?**
Probe: Think about physical factors, psychological factors, relationship factors, personal factors, medical factors?
Which factors are most important to you? What would others say (men and women)?

- **How important is having a satisfactory/OK/acceptable sex life to you, compared with other aspects of your relationship? And other aspects of your life? (compare with e.g. work, social life, leisure pursuits, financial security, spiritual/religious beliefs)**
- **Where do you think your ideas about a satisfactory/OK/acceptable sex life come from?**

Probe: How have these experiences affected your views? what do you take as your 'standard' or comparison? What are your sources of information? Which are the most important sources and why?

Problems and difficulties [5 mins]

- **What kinds of problems or difficulties can affect someone's sexual relationships? What kinds of problems can affect sexual activity?**

*Probe: Functional, psychological, medical and relationship difficulties
What problems particularly affect women? Men? Older people? Younger people?
Which problems do you think would be most difficult to cope with?*

- **Why do you think these problems arise? [what causes these problems?]**

SEE PROBE CARD. Which are the most important factors?

- **Have you experienced any difficulties like this recently or in the past?**

*Probe: Can you tell me a little more about these experiences? Consider duration; severity; impact on respondent and partner Why do you think these problems arose for you?
What terms would you use to describe these problems?*

Types of sexual activity [5 mins]

- **When you think about your sex life, what activities do you generally include?**

*Probe: kissing; cuddling; caressing; sexual intercourse –various types
What are your reasons for including/excluding these activities?*

- **How important is penetrative sex for you? For others?**

Probe: If you were unable to have penetrative sex, how would this affect your sex life?

Exploring severity and impact [25 minutes]

Card Game

Show respondent the set of cards [see box below]. Ask them to read through and think about them for a minute [probe to see if further explanations are required].

- Firstly, please sort each card into one of four piles according to what each of these would mean for you: 'just the way life is'; 'a problem, but not one that is big or worrying'; 'a serious problem' and; 'don't know/depends'.
- **Which experiences would have the biggest effect on your general wellbeing/quality of life? Or which of these experiences would cause you the most distress?**

Probe: In what ways would these experiences affect your wellbeing? What would be the signs that your wellbeing was affected? ? [Think about affect on sex life; on relationship; on other areas of life]

- **For how long might you experience something before you would consider moving it to a more severe category?** [From non-serious problem to serious problem for example]

Probes: a few weeks; a few months; a year or more? Consider moves from first to second and from second to third card piles.

- **For which of these cards would you want to seek professional help?** [Please explain your choice]

Probe: How long would you wait before seeking help? Where would you go for professional help? What would you expect to happen/what kind of treatment would you expect to receive?

- **Which of these experiences do you think are most common? How common do you think they are?**
- **Have you, or any of your sexual partners experienced any concerns like these, now or in the past? If yes, please tell me a little about how it was for you and for you partner at the time.**

Probe: How long did it last? What effect did it have on you as a person? On your relationship? On other aspects of your life? What did you do about it? Was it resolved? If yes, how?

Cards: 1. [man/partner] having difficulty getting and/or maintaining an erection on a regular basis (75% of the time); 2. [woman/partner] difficulty becoming lubricated; 3. [woman/partner] involuntary vaginal spasm so that intercourse is impossible or difficult; 4. Deliberately avoiding sex; 5. Having too many sexual thoughts or fantasies (excessive sexual drive); 6. Not feeling much desire for sex/ not having any sexual thoughts or fantasies; 7. Not feeling interested in sex but enjoying it once it gets going; 8. Feeling anxious just before having sex about your ability to perform sexually; 9. Feeling distracted or unable to concentrate during sex; 10. Experiencing physical pain during intercourse; 11. Coming to climax (having an orgasm) too quickly [at (or before) two minutes of intercourse on a regular basis]; 12. Coming to a climax (Having an orgasm) less than 25% of the time; 13. Not feeling sexually satisfied; 14. A couple who have sex less than once a month; 15. One partner in a couple wants to have sex much less often than the other; 16. Partner rarely initiates sex

Preferred terms and language [10 minutes]

- What do you understand by the terms sexual desire (wish for sex/sexual drive/libido) and sexual arousal (readiness for sex)? Is arousal different from desire? In what way?
- What do you understand by the term orgasm? How would you describe an orgasm? What other words would you use? What are the signs of an orgasm in a man? And in a woman?
- Were there any words that we used during this interview that you would not use when talking to a) a sexual partner and b) your doctor?

Probe for these terms: desire: arousal: ejaculation; erection; lubrication; orgasm; distress; satisfaction.. What words would you use instead? What words would you prefer to see in a questionnaire about sexual difficulties?

- People use the term measles to define set of symptoms that includes spots, rash and temperature. What term would you use to describe the group of sexual difficulties we've been discussing?

[THANK YOU]

- Any queries or questions about anything we have talked about today?
- Ensure consent form signed and handed back

	Psychosexual clinic		GP depression /diabetes		GP general				
sex	6 men	7 women	6 men	7 women	7 men	6 women			
Age	3 < 30	5 aged 30-49	5 aged 50 plus	3 < 30	5 aged 30-49	5 aged 50 plus	3 < 30	4 aged 30-49	5 age 50 plus
Sexual Orientation	10 Heterosexual	3 gay/lesbian	10 Heterosexual	3 gay/lesbian	10 heterosexual	3 gay/lesbian			
Ethnicity	10 white British	3 non-white British	10 white British	3 Non-white British	10 white British	3 Non-white British			
Partner	10 current partner	3 no current partner	10 current partner	3 no current partner	10 current partner	3 no current partner			

[Clinic letterhead]

[Date]

Dear Sir/Madam,

RE: 'Understanding sexual problems' study

We are currently collaborating with researchers from the London School of Hygiene and Tropical Medicine and University College London on a study looking at difficulties which affect sexual enjoyment and satisfaction. We are asking patients registered at this surgery if they would be interested in taking part.

Taking part involves being interviewed by a woman researcher for about an hour. This interview would take place at a time and venue agreed between you and the researcher. An information sheet is enclosed which provides details about the study and information about the kinds of questions that might be asked in the interview. Please read this carefully before deciding whether to take part.

If you have any questions or concerns about the study, you may ring Kirstin Mitchell on free phone 0800 587 4305 for further information. If you would like to speak to someone at this surgery about the study, you can contact Angela Chesser (Research Co-ordinator) on 0207 794 5174.

Do take time to think about whether to take part. If you do decide to take part, please fill in and sign the enclosed consent form and bring it with you to the interview.

We are writing to many patients at this surgery about this study so please do not feel that you have to participate. Your future care here will not be affected in any way by your decision..

Yours sincerely,

Dr. Irwin Nazareth



Camden **NHS**
Primary Care Trust

'Understanding sexual difficulties' Study

PARTICIPANT INFORMATION SHEET

Introduction to study

The media (television and newspapers) tend to give us the impression that we should enjoy the perfect sex life all of the time. However, the reality is that people vary greatly in their experience of sex. Whilst for some, sex is a constant source of enjoyment, for others there may be physical, emotional, and relationship problems that prevent them from enjoying sexual activities. These problems are referred to by professionals as 'sexual function problems'. From the point of view of providing counseling and treatment services to people, it is important to know how common these problems are and what impact they have on the lives of those who experience them.

Before we can assess how common these problems are we need to know how people think about 'sexual problems', what counts as 'normal', and what a 'perfect' sex life might consist of, to ensure that our definitions stem from everyday life and not medical textbooks. We are interested in what everyone has to say, regardless of whether they have experienced difficulties.

The study will last three years, and by the end we aim to have developed a measure (a brief questionnaire) which will accurately assess sexual function problems in the population. This measure will then be used to provide information about the extent of sexual function problems nationally. It will also be used to assess the impact that diseases such as depression and diabetes have on whether people are able to enjoy sex.

We are at an early stage of the study and we are asking people registered at this surgery if they would like to take part. We would like to interview about 40 people in total. We hope you might be able to help us by taking part.

What does taking part involve?

Taking part would involve being interviewed by a woman researcher for one to one and a half hours. The interview would be tape recorded so that the interviewer can focus on what you say rather than having to write everything down. The tape will be labeled by

code only, stored in a locked cupboard and wiped once the study is complete. The interview would be held at a time and venue agreed between you and the researcher. The interview will be relaxed and informal and will cover various topics around sexual satisfaction and sexual difficulties. Everything said during the interview will be **strictly confidential**. No one will be able to trace anything you say back to you as an individual. Data and results from this study will not bear any names or identifying information. It is hoped that the results of this study will be circulated in scientific journals and through meetings with interested groups. A summary of the results can be made available to respondents on request.

This study has been approved by the Camden and Islington Community Local Research Ethics Committee and the London School of Hygiene and Tropical Medicine Ethics Committee.

Although the topic is sensitive and may be a little embarrassing, many people welcome the opportunity to discuss these issues with a sympathetic stranger. Please note, that this is a research study and that the interviewer is trained in research, not counseling. However, if after expressing your thoughts, you feel that you would like to receive counseling, we will be able to provide you with information about relevant local services.

What do I do if I am interested in taking part?

It is up to you to decide whether or not to take part. If you would like to find out more about the study before deciding whether or not to take part, please ring Kirstin Mitchell on Free phone 0800 587 4305 or email her at kirstin.mitchell@lshtm.ac.uk . She will be happy to answer any questions you may have.

If you would like to take part, please ring Kirstin Mitchell on free phone 0800 587 4305 to arrange an interview. Please fill in the attached consent form and bring it with you to the interview. Please note, that you can change your mind about being interviewed at any time without giving a reason, even if you have already signed the consent form. Your decision not to take part will in no way affect the care you receive at this clinic.

Thank you for taking the time to read about our study.

Please note that if you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

[LHSTM and appropriate NHS headers here]

‘Understanding sexual difficulties’ Study

PARTICIPANT CONSENT FORM

Section one: Agreement to participation

I would like to take part in the ‘understanding sexual difficulties study’

Section two: Participation details

Would you like us to tell your GP that you are taking part in this study?

No Yes. If yes, please give below:

GP name: _____

Would you like us to send you a summary of the results of the study?

No Yes. If yes, please ensure that you fill in your contact details

Section Three: Personal and contact details [optional]

Name: _____ Age: _____ Sex: M / F

Address: _____

Email: _____ Tel: _____

Section Four: Signed consent

Please read the following statements and then sign your name at the end:

- 1) I have read the attached information sheet. I am aware that the interview will be about my views and experiences concerning sexual satisfaction and sexual difficulties. I know where to find out further information if I need it.
- 2) I understand that the interview will be conducted at a time and place that is convenient to me
- 3) I understand that the interview will be tape recorded so that the interviewer can focus fully on the conversation.
- 4) I understand that all the information I give during the interview will be **STRICTLY CONFIDENTIAL**
- 5) I understand that the results of this study will be anonymised. This means that no one will be able to trace anything I say during the interview back to me.
- 6) I understand that I may change my mind about being interviewed at any point. This will in no way affect my medical care or legal rights.

Signature: _____ Date: _____

**London School of Hygiene & Tropical
Medicine
(University of London)**



Keppel Street, London, WC1E 7HT
Switchboard: 020-7636 8636 Telex 8953474

**Centre for Sexual and Reproductive Health Research
Public and Environmental Health Research Unit
Department of Public Health & Policy
Telephone: +44 (0)1273 739209
Fax: +44 (0) 20 7580 6507
Kirstin.mitchell@lshtm.ac.uk**

Dear Respondent,

RE: Sexual Difficulties Study. Summary of findings

I hope this letter finds you well. I am very pleased to enclose a brief summary of the findings from the above study in which you participated last year.

The ideas and opinions emerging from the interviews were rich and varied and it has been difficult to do them justice in only a few pages. However, I hope this highly condensed summary will provide a taster of the results.

Please note that direct quotes are in italics. These are labeled M (male) or F (female) but all other identifiers have been omitted to maintain the anonymity of respondents.

May I take this opportunity to thank you again for contributing your time, ideas and experiences to this study. As researchers, we are indebted to you for providing the raw data on which we can further our understanding of sexual problems and hopefully contribute towards better recognition and treatment.

Kind regards,

Kirstin Mitchell (and colleagues)

Sexual Difficulties Study: Summary of results for respondents

How is sex defined?

Respondents used a variety of definitions:

- 1) Penetrative intercourse (the most common definition).
- 2) Involving a range of activities (e.g. intercourse, oral sex, masturbation) and defined by some other criteria such as both partners being naked, involving genitalia or experiencing orgasm.
- 3) Broadly including all intimate aspects of the relationship

What makes sex good (or good enough)?

- The answers to this question focused on contextual relationship factors more than physical function.
- Good sex need not imply a long-term loving partnership. Fulfilling (though not perfect) sex possible with a casual partner if there is sufficient sexual attraction, or if the partner knows how to touch you.
- Within a long-term relationship, it is often difficult to separate out the quality of the sex from the quality of the relationship.

The table below highlights some of the factors that respondents associated with 'good' or 'satisfactory' sex.

TABLE 1: 'what does it mean to have 'good' or 'OK' sex?' Responses....

Readiness <i>what you bring with you</i>	<i>Understanding your body; Good body image Happy with sexual orientation Wanting to please; Readiness to give of oneself sexually Getting & maintaining an erection (m); Turned on, aroused Comfort with range of sexual activity; able to say 'no'</i>
Ease/Enjoyment <i>what you do</i>	<i>Freedom of expression; Enthusiasm, perspiration Physical movement and abandonment; Using all your senses; Passionate Variety of activities; Straightforward, gentle Happy with contraception</i>
Satisfaction <i>what you get out of it</i>	<i>Physical satisfaction; Mutual satisfaction; Sexually and emotionally satisfied; Orgasm; regular</i>
Partnership <i>who you do it with</i>	<i>Open, honest straightforward communication; Able to talk through problems; Trust Fulfilling relationship; Feel connected; physical and emotional link; wanting the same things; compatibility; warmth balance in who initiates sex; Same level of desire for sex; Sexual and physical attraction Mutual comfort; protective; Respecting each other's vulnerability; Comfort with each other's nakedness Partner is gentle; experienced; knows how to please; concerned about your enjoyment; sensitive to your needs; understands your needs; allows you to have an orgasm without rushing; Reciprocation</i>

Is frequency important to an acceptable sex life?

- Regular sex generally regarded as important in maintaining closeness, connection and keeping alive a degree of 'passion'.
- Wide variation in views, but around 2/3 times a week commonly seen as the ideal for a long term relationship.
- 'Legitimate' reasons for having less sex include young children, pregnancy, poor health and age.
- Sudden decreases in frequency with no obvious and legitimate explanation generally seen as problematic and threatening to the relationship.
- Anything less often than once a month generally felt to be problematic.
- Actual frequency less important than the extent to which expectations regarding frequency were similar across both partners.

Are orgasms integral to sexual satisfaction?

There was wide variation in the ways that respondents experienced orgasm, and in the importance attached to orgasm in determining satisfaction.

- Female respondents generally felt that the female orgasm took '*practice*' and depended on knowing and controlling their body. Several women described how they had 'discovered' orgasms quite late on in their sex lives.
- Both male and female respondents noted that the female orgasm was more '*elusive*'. Perhaps because of this, there was a feeling that women were more able than men to enjoy sex without climax.
- Although the male orgasm was often equated with ejaculation (*'the release of body fluids'*), several respondents distinguished between the release of sperm (ejaculation), and the '*sensation before ejaculation [...] a lovely feeling; your whole body shakes.*' (M)
- Both male and female respondents said they would expect a man to have an orgasm as a matter of course. As a result, when men failed to achieve orgasm, or took a long time to achieve orgasm, their partners tended to interpret it either as failure on their part to provide sufficient stimulation, or as indication that their male partner was not sexually attracted to them.
- There was general agreement that orgasms could span '*a whole gradient of different sexual experiences*' (F), suggesting that the subjective experience of orgasm should be seen as a continuum with '*lower order*' at one end, and '*cataclysmic*' at the other.
- A few respondents equated orgasm with satisfaction or described it as an essential component of sex. The majority of respondents felt that orgasms were important, but not absolutely essential to satisfaction; and a smaller number felt that an orgasm was not necessary to experience satisfaction.

Does sex need to be penetrative in order for it to be satisfying?

- Basically yes. Penetration described as '*all embracing, harmonious and natural*' (F); '*the whole point...the proper thing*' (M)..
- Consequently, a sexual life in which penetration was not possible was described as '*absolutely unsatisfactory*' (M). Interestingly, women were as likely as men to view penetration as vital to satisfaction (and old as likely as young).

- A smaller number of respondents said they would be willing to consider alternatives, such as oral sex, if penetration was not possible. However, there was general agreement that these activities did not enable one to feel '*sufficiently stimulated to pursue over a long period of time*' (M) and could not adequately replace intercourse. The exceptions to this view were gay respondents for whom penetration was not as important.

Are desire and arousal preconditions for satisfactory sex?

- Wanting sex is part of a '*healthy, balanced relationship*'
- Important that your partner feels you are attracted to them and you need sexual drive for that. Attraction needs to be maintained in order to keep the relationship going
- Desiring sex as much (or as little) as your partner is as (more) important than the actual level of desire
- Sexual attraction to partner is very important, especially in casual encounters
- An erection is important in indicating to a female/ gay male that she/he has been able to 'turn on' her/his partner and that he is attracted to him/her; an erection demonstrates to a male that is able to complete the act and satisfy his partner.
- Men with erectile difficulties say they find it difficult to feel properly aroused.

How important is sex? How do people rate sex compared with other things in their life?

- Sex regarded as very important: the '*bed rock*' of a relationship.
- Those who were single and seeking a partner, primarily sought the emotional and social benefits of a sexual relationship; sex was important primarily because it was an integral part of such a relationship.
- Sex generally rated highly compared with other priorities in life. But ratings are not static. Sex can slide down the hierarchy during periods of poor health, periods of being single, periods of focusing on other priorities such as career. Relegation may also be a way of coping with sexual difficulties.

Why are some experiences problematic and others unproblematic?

Respondents described their experiences of a range of sexual difficulties including: infrequent sex, lack of desire, mismatch in desire, no orgasm, early orgasm, erectile difficulties, lack of physical satisfaction and pain.

Not all these experiences were necessarily described as problematic. For instance vaginal dryness was rarely seen as a problem because it was perceived as very simple to fix. Other problems such as '*having too many sexual thoughts or fantasies*' and '*not feeling interested in sex but enjoying it once it gets going*' were also not commonly seen as problematic.

Some events were generally felt to always be problematic regardless of the context. These were pain, erectile difficulties and avoiding sex. The latter was rated as problematic by all respondents. Individuals avoid sex for a number of reasons, for instance, fear of passing on HIV; pregnancy; loss of desire for partner; anxiety about sex due to erectile difficulties. The impact of avoidance was generally hurt and distress both for the individual and their partner. Ultimately avoidance was said to lead to a loss of closeness and intimacy, an end to sex and sometimes an end to a relationship.

The same event, for instance loss of sexual desire was viewed as problematic by some but not by others. Whether or not an experience was perceived to be problematic depended on a range of factors:

The nature of the problem(s)

Duration and severity of symptoms

Degree to which it is perceived as fixable by self, by couple or with external assistance

Extent to which problem has 'knock-on' effects in terms of other sexual difficulties

The perceived cause of the problem(s)

Physical problems seen as less problematic than emotional/relational

Extent to which problem can be easily explained by non-relationship factors

Inter-relationship between different problems (if several present)

Degree to which problem is perceived as signifying other, more serious problem

The relationship context

Single versus casual relationship, versus long term, versus marriage

Degree of openness, communication and trust, ability to deal with issues

Extent to which problem represents a sudden change to 'normality'

Level of 'noise' in the relationship - stress, lack of time or privacy

The reaction of the partner to the problem

Knowledge/Beliefs about sex - individual and couple

Belief that there are adequate alternatives to penetrative sex

Importance of sex vis a vis other priorities

Expectations related to age and life stage

Awareness and understanding of own body and of own sexuality

Response to the problem

Degree to which confidence and self-esteem are affected

Degree to which individual/couple adapt to the situation - by focusing on other things; altering expectations; normalising the problem

How can we define a functional sex life?

To say that an experience is unproblematic is not the same as saying it is 'functional'. We would not say that a person with no legs was fully functional even if they had adapted so well to life without legs that they no longer viewed their situation as problematic. It is probably not that difficult to find everyday functions that people generally agree are important or necessary (e.g. climbing stairs), however, when it comes to sex, the challenge is to establish the basic functions that people generally agree are important. In medical terms, 'dysfunctional' relates to the inability to function normally as a result of disease and impairment. Thus, the challenge is to define what it means to function normally.

Based on our data, we have summarised a functioning sex life as follows:

Functional sexual self:

- Positive sexual identity and orientation
- Positive body image
- Sexual confidence and self-esteem
- Interest in having sex
- Free from anxiety about sex life

Functional sexual activity:

- Responsiveness to sexual cues (able to get aroused, have an erection)
- Free from pain and discomfort
- Free from distractions (inhibitions, interruptions, worry)
- Enjoyment (variation, excitement, orgasm)
- Satisfaction (self and partner rating)
- Frequency (actual relative to desired)

Functional relationship:

- Compatibility with partner (in what you want out of sex etc.)
- Emotional safety (trust, good communication, closeness, mutual attraction etc.)

Self-assessment of Function:

- Perception of sex life as problem free (self and partner)

Notes on Coding Frame

*What does it mean to say that person has sexual dysfunction?
What factors or dimensions need to be present?*

NOTES

- There are two super-codes: SEX which includes all responses related to any aspect of sexual activity and CO-FACTORS which includes all responses related to any factors which impact on, or result from, sexual experiences.
- The sex super-code has 11 codes and the CO-FACTORS super-code has 3 codes. Each code is further subdivided into 5 sub-codes with definitions as follows:

- A** *Perceptions: Beliefs about importance of an issue, norms, acceptability; preferences; opinions about what is good or problematic and why.*
- B** *Definitions: Understanding of terms, activities, issues; what is included in a term; signs (e.g. of arousal); other terms used by interviewee*
- C** *Experience: Positive and problematic experiences - first-hand and describing others*
- D** *Determinants: Perceived factors underlying C above; may be causal or influencing factors*
- E** *Effects: Assessment of severity of issues; impact on self, sex, relationship and other areas of life; ways of addressing issues*

- All respondent-defined problems and sexual experiences are coded under SEX codes (A, B, C, D or E); co-factors mentioned in talking about problems are coded under SEX-D (determinants)
- Where dialogue is about co-factors, *not* in relation to talking about a specific problem, responses are coded under CO-FACTORS and sub-headings; for instance, talking about a relationship or upbringing.
- Cross-referencing is employed where appropriate, to ease retrieval

[Additional columns (codes) include **SUMMARY** which documents the key points; **TERMS** which notes any misc. terms used by respondents; and an **IVW/IVWEE** code documenting respondent-interviewer interactions or respondent comments about the study]

CODING FRAME

SEX

Sex/Types of sex

Perceptions [A] includes perceptions of what it means to have a good sex life; importance accorded sex in comparison with other concerns in life
Includes: Oral sex, anal sex, gay sex, general comments about sexual difficulties

Wanting (or not wanting) sex/interest in sex/Fantasies/Desire

Includes comments about cards:
Excessive drive [5]
Avoidance [4]
Lack of desire/fantasies [6]
Lack of interest but enjoyable when going [7]
Partner disparities in desire [15]
Partner rarely initiates [16]

Build up to sex/foreplay/arousal

Includes comments about cards:
Lubrication [2]

Masturbation

Penetration

Includes comments about cards:
Erectile difficulties [1]

Orgasm

Includes comments about cards:
Premature orgasm [11]
Lack of orgasms [12]

Satisfaction

Perceptions [A] includes perceptions of what it means to be sexually satisfied
Includes comments about cards:
Lack of satisfaction [13]
Performance anxiety [8]
Distraction [9]

Frequency

Includes comments about card: frequency [14]

Pain and discomfort

Includes comments about:

Vaginismus [3]

Physical pain [10]

Gender differences**Help seeking****CO-FACTORS****Relationship****INCLUDES:**

Love/Comfort/trust/companionship/stuff in common (or the opposite)

Communication/negotiation/compromise

Context – intimate versus casual, long versus short relationship, physical context, sexual history

Sexual compatibility/chemistry/attraction (or the opposite)

Non-sexual relationships

Physiological/physical/Organic**INCLUDES:**

Medical: depression, HIV, diabetes, hormonal etc.

Female: pregnancy, menopause, menstruation

Contraception/prophylaxis/ STI transmission

Pharmacological – medication and drug taking

Social/Lifestyle/Psychosocial**INCLUDES:**

Perceived norms

Personal moral codes / beliefs about what is acceptable/expectations

Influences on beliefs e.g. peer and media

Drink and recreational drugs

Stage in life – expectations, experience

Chronic stress, stressful life events, and fatigue

Confidence/feelings about self/body image

Sexual roles and identity/orientation

Upbringing

Sexual history/Defining experiences/internalised norms

CODE	SEX	WANTING
<p>1KWR M56 A</p>	<p>p1 good sex=living with partner, sex twice a week c/f satisfaction. Loving rel is important but can still have satis sex with stranger but that is not the ideal. P2 sex is low priority. P3 job has been prime focus. Has to be low cos has not had any for a long time. c/f want p8 new partner -worry about making right impression, not causing offence, pleasing your partner, but with reg partner you know the rules of the game.</p>	<p>p6 If the physical chemistry no longer exists - cos you don't find them attractive, it can be a problem p7 You become less sexually interested as you get older. P7 c/f freq - with younger partner, he would worry about whether he was coming up to expectations in terms of his level of desire</p>
<p>1KWR M56 B</p>	<p>p1-sex=broad, encompassing. Penetration to one extent. Caressing and kissing as the beginnings of sex. Includes masturbation. p17 dysfunction is off-putting cos not a term that people would use; not instantly appropriate</p>	<p>p6 physical chemistry - very attracted to someone for reasons you can't explain p15desire= the physical and psychological requirement/need to experience sexual satisfaction</p>
<p>1KWR M56 C</p>	<p>p2 Has been celibate for 5 years - but not by choice. Only one or two rels over a long period of time c/f rel p4 Concerned and loving in rels - no 'punishment role' despite upbringing c/f psy but maybe its about power - to give partner pleasure c/f orgasm p5 No confidence - feels that women are totally in charge and he has no control p6 c/f satis p12 Has experienced [8,13,9,10,15,6,11,16,14,12,2]</p>	<p>p3 If he had a higher sex drive would have figured out way to handle his lack of sex. Considers his drive to be low - otherwise he would have had more partners. But not sure what is cause and what is effect. Importance of sex has had to change - much more important in 20s, 30s. p11 [6] is probably common</p>
<p>1KWR M56 D</p>	<p>p3 blames focus on degree/career on why he has not married or lived with people p4 Also lacks confidence in terms of his sexual prowess c/f psy</p>	<p>p3 Had important rel (ended 16 years ago) - seriously affectd him, especially at beginning. Has learned to repress a certain drive/sexuality - didn't seem any point in going out with anyone else. C/f rel</p>
<p>1KWR M56 E</p>	<p>p5 - does not regard his dissatisfactory rel as normal - sees it as penance - something he has to deal with. Would like it to change but doesn't believe he can influence it that much. It's peculiar p10 Major probs that would be upsetting - cause stress and worry for rest of life and affect his rel - [12, 1, 14, 4] - the rest he could deal with. p13 [Q] - its all a pay off between what you want and what you've got - you're prepared to put up with unsatis sex if you appreciate other elements of your partner p13 [16,9,15,7] are all connected - all to do with self-worth - p14</p>	<p>p3 Is very selective about partners. Feels that if he had higher drive, he would be less selective. Low drive has led to him categorising sex as low priority. P10 [6 and 16] would have impact cos it's linked in with confidence p13 [15 and 4] are very hurtful p14 particularly 4 cos it means the end of the rel - when its happened with him either he's ended the rel or his partner has. [4 and 15] both say that the rel is finished - you can't solve that prob, but if reasons are to do with tiredness etc. then you can understand it and deal with it better - but danger cos one partner may go outside the rel - the road to ruin.</p>

Framework Excerpt No.2

CODE	ORGASM	SATISFACTION
9KWR F31 A	p1 - If no climax then its just fooling around. Good rel= willingness to work at sex life from both sides, to participate, reciprocity p9 woman has to be selfish for a minute in order to climax p13 people tend to be really focused on climaxing - young people obsessed with 'end result' - many women don't climax at all.	p2 women have to say what they want 'go left, right, up, down'. P3- for satisfaction, need to have self-confidence c/f psy p10 if both partners happy with no sex, then that's ok, but they both need to feel the same way. P13 many people don't get satisfaction cos of what they think sex is supposed to be like - think it's going to go on all night
9KWR F31 B	p1 - climax=some sort of orgasm	p11-satis is not necessarily just climax - it's the whole thing
9KWR F31 C	p6 - she doesn't climax often; he has problems with climaxing too early - can't control it. Climaxing is not an enjoyable experience for him - does not feel mentally or physically good - it just happens	p6- c/f orgasm. Sex can be great but often she worries that it's not enjoyable for him. c/f orgasm p8- She doesn't relax cos worried about him, then he goes ahead and its over but not enjoyable for him
9KWR F31 D	p6 - he has never explored himself (absolute taboo) and from invasive surgery p7 his unenjoyed orgasm could be cos of her (!), could be surgery, could be lack of knowing own body, his 'late' start (18).	p8 partner does not have good body image c/f psy
9KWR F31 E	p6 - he has to work very hard to not have an orgasm when they are close. Worry about it happening causes him stress and maybe factor in his unwillingness to initiate. She feels its sad that he worries and that it's not a good experience for him sometimes. p7 talk about it after - she probes, then it impacts on them. He's concerned that it's not satisfying for her. but has relaxed a bit cos realises that she doesn't see pen as be and end all. He does see it as a prob, cos she sees it as a prob, otherwise would probably see it as 'just the way life is'. She finds it difficult to relax and climax cos she's aware of how intense things are. Two wounded birds [Q]. p8 doesnt mind that she climaxes less often than him as long as it happens sometimes and as long as he is willing to help her and if he feels good, then its ok. If she doesn't climax and he doesn't enjoy, then 'total waste of time'. p8 - he feels much better if he's helped her to climax	p8- worries that he'll be less inclined to do it if its not enjoyable for him c/f orgasm p11 no satis is major problem

Framework Excerpt No.3

CODE	RELATIONSHIPS	SOCIAL/LIFESTYLE
17KDD M52 A	<p>p2 some gay friends see being in love as problematic, afflicted with disease, pain. Word over-used but important - need to give and receive support. He sees love as positive force for good though it can be destructive, jealous, claustrophobic. Power implied in 'lover and loved' p7 healthy rels are those in which you take turns at sexual roles P8 Best rels are those where there hasn't been a clear division of roles p11 rels are about compromise</p>	<p>p2 different social needs at different stages in life. Expectations of ageing are visible in gay community p3- Diff bars cater for diff 'stages'. People don't expect 50 year olds to be clubbing. p3 - belongs to a generation who has compromised sexual behaviour because of HIV. P3 - lots of people he knows have unsafe atts to sex - he is shocked by this. sexual honesty has been forced on people p4 People's lack of knowledge is staggering p6- just cos in his fifties, doesn't mean that sex life is limited to masturbation p6 after childbearing years, women can focus on better rels, with sexual intimacy. Gay men are image conscious p14 More gay couples are now having children p16 People's needs, wants and drives are very similar but may be enacted very differently c/f satis p18 knowledge c/f orgasm</p>
17KDD M52 B	<p>p1 compatibility means coming from the same planet, same interests and atts to socialising, the way you compromise.</p>	
17KDD M52 C	<p>p2 - His sexual rels have all been quite short whereas friends are long term. P7 When younger, was in rel where he was the loved and his partner was the lover. Now it would be the other way round. P10 love and lust have differentiated his good rels from the bad ones which are characterised by lack of compatibility p11 likes to communicate during sex</p>	<p>p2 - most of his friends go in and out of relationships a lot. He is no longer in late night drink and club scene. P3 because of HIV, he would not have pen sex without condom ever and is wary of blow jobs</p>
17KDD M52 D	<p>p1 takes self-awareness and intelligence to communicate and talk</p>	<p>p4 - has lost friend to HIV - has seen horrors that friends have gone through p12 once women have kids and are settled in rel, they go off sex - sexual rel with partner is dreadful p14 vignette re friend who changed sexual orientation cos he felt he was going nowhere in life</p>
17KDD M52 E	<p>p6 - now that he is on the up, is looking forward to some new relationships in life p12 people find it engaging that he talks about sex, intimacy and kissing</p>	<p>p4- atts to safe sex has not really affected his enjoyment: has never had prob using condoms for pen sex - no detraction from quality. Cautious with oral sex. But HIV is constantly on his mind. It's a focus. Might have meant that he has had less sex, but if it's not a prob for other person, then OK for him p5 is having less sex for reasons other than HIV p14 friend (above) got married and had two kids but were his sexual needs addressed? lots of men arrested for cottaging are married 'heterosexuals'</p>

Themes to explore:

Experiencing sex

- When we talk about sex, do we all understand the same thing by the word? What is involved (what is the model of sex on which we are to understand the problems)?
- What role do penetration and orgasm play in defining a satisfactory sex life?
- What are the key factors characterising a satisfactory sex life?
- To what extent do interviewees construe sex as achievement/accomplishment? Perform term search on words such as *goal-orientated* and *complete*. Are men more task orientated than women? Women like affection for it's own sake whereas men feel it ought to lead somewhere.
- To what extent do interviewees construe sex in terms of comfort?
- To what extent do lived experiences fit with the sexual response cycle?
- How do people understand and experience desire and arousal and how does this fit with existing research?
- Any significant differences across age, gender and generations? For instance, differences in the way that people view a satisfactory sex life. Mapping
- Medication and it's impact on sexual experience – anger and resentment following change
- Is it ever justified to explore sexual difficulties in isolation from their relationship context?
- How important do people rate sex – within a relationship; in life generally?
- The need/desire to prioritise the satisfaction of a partner above one's own satisfaction – what is the impact on ones' own satisfaction?

Experiencing and defining dysfunction

- What are respondent experiences of sexual dysfunction? What do they see as difficult/problematic (and why?)
- Which problems do people think would cause them most distress and why?
- How do respondent experiences of difficulties fit with current classifications?
- What does it mean to say that person is suffering sexual dysfunction? Or, what factors or dimensions need to be there to be able say they are suffering dysfunction? Or..What are the key factors in determining whether an experience is seen as problematic or not?
- How do people explain their own problems (determinants)? To what extent do these beliefs about determinants impact on their experience of the problem and its effects?
- In what ways do people who do and do not self-identify as having sexual problems differ (in terms of problems, severity and impact and coping strategies)?

- How do the various sexual difficulties interrelate with each other? Use vignette to illustrate 'messiness' and knock-on effects. How do respondents believe they inter-relate? (see comments during card ex for instance)
- Do those who have sought help for their problems, describe and understand them differently to those who have not sought help? (think about language, HRC frame of ref)

Impact of problems:

- What are the main impacts that sexual difficulties have on individuals, their partners, and other aspects of their lives? Look at different impacts that different problems have
- In what ways do interviewees adapt to their problems? What are the coping strategies? For instance, in (re)appraising an issue so that it seems less of a big deal or changing the definition of sex so as not to include penetration
- What factors affect the impact of problems? Or what makes an experience problematic? (for instance, in a relationship, lack of desire is more serious than when single)
- Map impacts by determinants. Any patterns emerging? Do people find physical, psychological or relationship related difficulties hardest to deal with?
- What is the impact of sexual difficulties on the partner of individuals with difficulties?
- Why do some people seek help and others not? What factors prompt people to seek help?
- Is loss of desire problematic in itself, or is it only problematic in the way it can affect the making and maintaining of relationships? Do those who have never experienced a loss of desire, understand that it might happen regardless of the relationship context?

Card exercise

- How do people react: some can 'imagine' themselves in a scenario and others cannot. Does this relate to sensing and perceiving as per Myers-Briggs?
- Is there a difference between those who have and have not experienced a problem (on card) in the way that they categorise that card in the exercise? If individuals have experienced a problem, are they likely to rate it as more serious or less serious than those who have not experienced the problem?
- What comments are made regarding the card exercise – how do people find the task of categorising problems?
- Interviews were difficult for those who had not experienced problems because it's difficult to imagine how you would find a problem – like asking hearing people to imagine what it is like to be deaf. However, it was important to interview such people because need 'normal' view on what it means to have sexual health
- Gender and age differences in the way that individuals approached the card exercise?

The 2nd European Female Sexual Dysfunction Conference

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Five Minute Paper Session - Abstract Submission



Medicalising female sexual experience: The case of female orgasmic disorder

Kirstin Mitchell, Anne Johnson, Irwin Nazareth, Michael King, Stefan Cano, Cath Mercer, Kaye Wellings.

Background: Historically, much of what is conjectured about female sexuality has been based on research and understanding of male sexual behaviour. Specifically, the enduring use of the sexual response cycle as the basis for classifying sexual dysfunction has resulted in a system that is conceptually similar for men and women. Recently, it has been acknowledged that women's accounts fail to fit neatly with the DSM and ICD-10 classification. The risk of this 'failure to fit' is that we pathologise what is essentially normal variation in female sexual experience. In the case of 'female orgasmic disorder' we have yet to meaningfully integrate our knowledge of the physiological process of orgasm with a clear understanding of the subjective experience.

Methods: We conducted 32 semi-structured interviews with men and women (aged 23 to 78) recruited from a GP practice waiting room, GP practice diabetes and depression patient lists, and a Psycho-sexual Clinic. The interviews sought to understand the meaning of sexual function from a patient perspective. We briefly report on some of the key insights into subjective views and experiences of the female orgasm. We present both male and female views in recognition of the fact that for many women, the importance accorded orgasm can be heavily influenced by the emotional and relational context.

Results: The subjective experience of orgasm for women appeared highly dependent on the relational context. Respondents perceived the female orgasm as a learned skill which took practice and depended on knowing and controlling one's body. Both men and women felt that the female orgasm was more elusive than the male orgasm and the experience could span a wide spectrum in quality from '*lower order*' to '*cataclysmic*'. For many female respondents, their sexual satisfaction depended as much on their partner's experience of orgasm as their own. For some female respondents, not having an orgasm was problematic, not because it impinged on their own enjoyment, but because it detracted from the enjoyment of their partner.

Conclusion: The complexity of motivations for wanting an orgasm, coupled with greater difficulty in achieving it, suggests we should be wary of labeling female orgasmic disorder without careful attention to the relational context.

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'TAKING IT PERSONALLY': UNDERSTANDING THE VARIATION IN RESPONSES TO SEXUAL DIFFICULTIES

Kirstin Mitchell, Kaye Wellings, Michael King, Irwin Nazareth, Cath Mercer, Stefan Cano, Anne Johnson

Introduction and objectives: It has been argued that existing conceptualisations of sexual (dys)function take insufficient account of the context of people's lives and thus risk pathologising normal variation in sexual experience. The criterion of 'marked distress or interpersonal difficulty' attempts to avoid this pitfall by differentiating between those with transitory/adaptive problems and those with clinical dysfunction. 'Distress' has tended to elude objective measurement. There is no clear association between symptom severity and degree of self-perceived distress and the variation in individual reactions to difficulties is not well understood. We examined this variation through qualitative exploration of personal experiences.

Methods: 32 semi-structured interviews with men and women (aged 23 to 78), purposively sampled to represent a spectrum of sexual function experience. Respondents were recruited from: a UK General Practice (GP) practice waiting room (n=11); GP diabetes and depression patient lists (n=13); and a UK Psycho-sexual Clinic (n=8).

Results: We found that while some difficulties (e.g. erectile dysfunction) always concerned, and often distressed, respondents, others (e.g. low sexual desire) sometimes caused no concern and sometimes caused significant distress. We identified the following factors as important in determining the level of distress: nature of the difficulty (symptom duration, perceived severity, perceived 'fixability', perceived link to more serious problems); perceived cause (physical causes perceived as less distressing than emotional/relational causes); relationship context (level of trust, ability to resolve issues positively, degree of change to 'normality', partner reaction, degree of 'noise' e.g. lack of privacy); beliefs and expectations (for instance, regarding the centrality of penetrative sex); and individual/couple responses to problem (degree to which self-esteem is affected, ability to adjust positively).

Conclusion: Our findings contribute towards more contextually-sensitive understanding of distress, which is essential if we are to avoid misdiagnosing sexual dysfunction.

KEYWORDS: sexual dysfunction, distress, subjective experience

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What Is Sexual Function? Three Versions of 'Function' Derived from Lay Perspectives

Running head: What is sexual function?

Abstract

Medical classifications of sexual function assume universal agreement in what it means to have a functioning sex life. In reality, there is great variation in the way that individuals frame their priorities. This paper presents a bottom-up approach to understanding the concept of sexual function. It is based on the views and experiences of 32 clinical and non-clinical respondents representing a range of sexual function experience. We identified three distinct versions of 'function': the interpersonal, the erotic and the mechanistic. The interpersonal is focused on relational aspects (creating a bond between partners); the erotic is focused on recreational aspects (pleasurable sensations) and the mechanistic on physiological aspects (genital function, physical release and procreation). We show how, as a result of these differing foci, the criteria determining ideal sex and threats to ideal sex, differ across versions. The accounts of individuals may primarily fit a single version or a combination of all three; the accounts of some individuals appear to conform more consistently to a particular version while those of others change throughout their life course and according to specific relational contexts. Understanding how these versions represent the experiences of individuals can help to shed light on the sources of sexual difficulties and assist in identifying avenues for addressing them.

KEY WORDS: sexual function; lay perspectives; relational; recreational; genital function

Introduction

Disease definitions and classification systems are important. They impose meaning and structure upon complex phenomena, facilitate communication among professionals, influence treatment choices and guide sampling decisions in research (Mitchell and Graham, in press; Segraves, Balon & Clayton 2007).

For almost thirty years, the Human Sexual Response Cycle, (HSRC) (Masters & Johnson, 1966; Kaplan, 1974 and Lief, 1977) – comprising a temporal cycle of desire and arousal and orgasm - has provided the theoretical basis upon which sexual function difficulties are categorised. From a biomedical perspective, the HSRC and ensuing diagnostic systems [the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV (American Psychiatric Association, 2000) and International Classification of Diseases (ICD)-10 (World Health Organisation, 1992)] provide standardised criteria for classifying sexual dysfunction. However, the DSM system has been criticised for its weak diagnostic utility (Davis 2001; Bancroft, Graham & McCord, 2001) and has proved even less helpful in understanding broader sexual quality of life, beyond the absence of dysfunction (Tiefer, 1996). Recent recommendations for revising the system have moved towards increasingly precise and measurable physiological criteria (see Segraves, Balon & Clayton, 2007; and Waldinger & Schweitzer, 2006) and away from relational and subjective aspects of the sexual experience. This has been concomitant with an increasing trend towards the medicalisation of sexuality (Tiefer, 1986; Hart & Wellings, 2002; Bancroft 2002; Rowland, 2007) and rise of popular belief in 'miracle pill' stories (Goldacre, 2007). There has been no significant attempt to integrate patient experiences and lived realities into the system using a bottom-up approach. Recommendations to 'improve' the system have been made by panels of experts, primarily composed of clinicians (for instance, NIH Consensus Development Panel 1993; Basson et al., 2000a; Lue, 2004)

The Human Sexual Response Cycle is predicated upon a positivist perspective, constructing sex as a universal and invariable act and physiological process (Tiefer, 1996; Sugrue & Whipple, 2001); it has been criticised for its focus on function rather than people and for positioning genital function as the 'centrepiece of sexuality' (Tiefer, 1996; Tiefer, 2000). It implicitly establishes an 'ideal type' characterised in terms of a well functioning libido and adequate physiological response. But do individuals think of ideal sex in these terms? The essential variability of sexual expression has been documented in successive behavioural surveys such as the Kinsey report (Kinsey, Pomeroy & Martin, 1948; Kinsey, Pomeroy, Martin & Gebhard, 1953) and more recently, the British National Survey of Sexual Attitudes and Lifestyles (Johnson et al., 2001). It seems plausible that if such variation exists in behaviour, it must also exist in preferences, priorities and conceptualisations of 'ideal' or good sex. The presumption of a uniform 'model' of sexual response underlying the current DSM categorical system is a likely source of many of its weaknesses and lack of clinical utility (Mitchell & Graham, in press). The 'one model fits all' idea was recently demonstrated to be a fallacy by Sand & Fisher (2007) who showed that a community sample of women, when asked which best represented their own sexual experience, were equally likely to endorse each of three different current models of sexual response – those of Masters and Johnson (1966), Kaplan (1974) and Basson (2000b).

We remain poorly informed about what sexual function means from a lay perspective. In this paper we attempt to address this gap in knowledge by exploring the concept of sexual function inductively from lay experience. The data come from a study whose aim was to produce a conceptual model of sexual function which would reflect both biomedical and psychosocial aspects, and which would take account of individual

meaning and significance. Here we focus on the ways in which individuals construct their personal ideas about what constitutes a functional or 'ideal' sex life.

Methods

The sample

Thirty two semi-structured interviews were conducted with a purposive sample of men and women. There were three respondents groups: those who self-identified as having sexual difficulties (recruited from an NHS Sexual Problems clinic in London); those with conditions associated with sexual difficulties (recruited by post from a GP surgery in London and from an HIV charity in a regional town); and those with no apparent difficulties (recruited from the same GP waiting room). Table one summarises the recruitment strategy.

[Insert table one about here]

The sampling frame was designed to capture a diverse range of sexual function experience, a wide age range, equal numbers of men and women, and representation from non-heterosexuals and ethnic minorities. Non-English speakers were excluded on practical grounds (lack of resources for adequate translation) and those under 18 were excluded on pragmatic grounds (difficulty of obtaining parental consent). The final sample (n=32) had representation from the major demographic and behavioural groups of interest. In terms of gender and education it was also broadly representative of the London Borough of Camden from which it was drawn (Camden Council 2007). It was of course older (6% under 30 compared with 44% in Camden as a whole) as a result of our purposive sampling for those experiencing sexual difficulties. The final sample is shown in table two.

[Insert table two about here]

Interview format

Audio-taped interviews lasted between 45 minutes and two hours and were undertaken by KM (30) and KW (2). The discussion was semi-structured; guided by an interview schedule that was regularly reviewed and modified to address pertinent issues arising from previous interviews. Open-ended questions probed the various ways in which respondents envisaged a satisfactory sex life and what they saw as problematic and non-problematic for themselves. Questions included, 'What does sex mean for you?', 'How would you describe an ideal sex life?' and 'What kinds of problems or difficulties can affect someone's relationship?' For those who described sexual concerns or problems further discussion sought to understand the impact of that problem on their lives.

Analysis

The interviews were transcribed verbatim by an audio-typist. The first author (KM) listened to all the tapes and checked the transcripts as part of the familiarisation process. Our analysis was informed by the principles of Grounded Theory and in particular, the use of constant comparison of indicators (Strauss 1987; Mays & Pope, 2000; Charmaz, 2006). Initially we engaged open coding to generate initial ideas about the data. This process produced many indicators representing respondent-identified aspects of (dys)functional sex. We explored the dimensions of these indicators (for instance, did they relate to the purpose of sex, or represent a threat to good sex) and looked to see how they were related to each other. Although we began with verbatim codes (for example, *being close*), the final labels used in the typology represent our own summary of respondent accounts (for example, emotional security). Analysis suggested groups of inter-related indicators representing three different orientations towards the notion of functional sex. Once these key conceptual categories had emerged, further development and refinement was informed by the literature on sexual function and sex therapy (what Strauss terms 'experiential data'; Strauss, 1987). A focus of the analysis was on several 'deviant' cases (whether whole accounts or extracts) that did not appear to fit with the emerging typology. Close analysis of these negative cases assisted in further refining the conceptual categories. We were aware that the interview setting, our professional role and interest as perceived by the respondents and our individual disciplinary perspectives might bias both data collection and analysis towards the biomedical framework. Despite this, we found that the emphasis of respondent accounts was actually towards interpersonal aspects. During analysis, we were careful not to let clinical considerations influence the coding structure. Once the typology was established, the first author sought to identify the dominant version of functional sex in each interview. The second author read a sample of transcripts and independently identified the same dominant version for each. In addition to this validity check, we sought the opinion of clinical colleagues on the coherence and plausibility of the typology.

Ethical approval for the study was obtained from Camden and Islington Local Research Ethics Committee and the London School of Hygiene and Tropical Medicine Ethics Committee. The study met the stringent criteria set out by these committees in terms of confidentiality and informed consent. Governance approval was obtained by Camden & Islington Primary Care Trust and Camden & Islington Mental Health and Social Care Trust.

Results

It was possible to categorise the ways in which respondents described and evaluated their sexual experiences, and described their priorities, in terms of three distinct orientations towards sex (see table three). We describe dimensions of each version such as the main purpose and key threats to ideal sex. In particular we explore discrepancies between versions adhered to by a respondent and their partner; and discrepancies between an individual's version of functional sex and their lived experience.

The versions we have identified are abstractions derived from lived experience. Respondent descriptions of their experiences and views of functional sex approximated to these versions, but were seldom completely congruous with one type. In four accounts, the direction taken by the conversation did not furnish sufficient detail to discern a particular orientation. In four of the remaining 28 accounts, two versions appeared to be equally prominent; in the others, one version dominated. The versions were less easy to discern in respondents with less sexual experience. On the other hand, they were more easily discernable in respondents who had experienced difficulties and subsequently spent time and energy thinking about their priorities and using them to guide and evaluate their sexual activities.

It is important to note that we did not use the term 'sexual function' during interviews because of its biomedical connotations. Furthermore this term is not well understood outside of the medical context. Instead we asked respondents to describe their ideal sex life, asking them to think in realistic terms rather perfection. We used this notion of 'realistic ideal' as a lay proxy for the medical concept of function. We use the term 'version' to describe a coherent set of priorities and beliefs about what it means to have a functioning or 'good enough' sex life. Our preferred term for what we have explored is 'orientation towards sex' but we avoided this term because of potential confusion with the term 'sexual orientation' which already has a specific and widely understood meaning.

[Insert Table three about here]

The interpersonal version of ideal Sex

The focus of the interpersonal version was on the relational context of sexual encounters. In other words, sex was given meaning and significance by the relationship in which it took place. In this sense, sex had less to do with a physical act and more to do with the relationship between two individuals. As one respondent put it: *so much of sex has nothing to do with sex (F54)²⁴*. Rather, sex was symbolised as the gift of yourself to another person. *You're giving someone the most special gift you can ever give (F31)*. In this version, the main purpose of sex was construed as creating a bond between partners (*a glue to the relationship (M61)*). Sex was seen as an intimate act requiring both actors to make themselves vulnerable, and premium was placed on the protection of self and partner's self-esteem. Thus, sexual satisfaction was closely tied to the feeling of being wanted:

M48: the uncertainty of...the other person really wanting you and showing that they want you...is probably the primary cause of sexual dissatisfaction

The focus on the interpersonal implied that sex was inextricable from its relational context. Those whose accounts centred on this version were often reluctant to separate

²⁴ Codes following quotes: M-male; F-female; numerical value refers to age of respondent. All italicised text indicate verbatim quotes

the quality of a sex life from the quality of the sexual relationship. For instance, one female respondent described her current sexual relationship as good because:

F35: *there's a real bond between us and we really love each other [...] but that's really more a relationship and the sex is part of that, a very fundamental part [...]. It's hard to separate it.*

On a purely physical level, the sex had *'not been the best ever'* but because it occurred within the context of a loving relationship, she described her sex life as good overall. In other words, because sex for her was inextricably linked to its relational context, she evaluated it as 'good', whilst recognising that on a purely physical level it was not ideal.

In this version, ideal sex was construed primarily as balanced, secure and emotionally connected. Similarity in levels of desire (for each other and for sex) was important: *I couldn't bear to have sex with somebody who I felt didn't really want to* (F35). This appeared to be primarily because of the impact on self-esteem: *[if my partner rarely initiated] I would find it hard to feel the confidence that they were sexually interested in me* (F34). Similarly, reciprocity was important because *your partner doesn't believe in the depth of your feeling if you're not able to communicate it sexually* (M61). Again, because of the recognition of the high level of vulnerability associated with the act, emotional security was emphasised within this version. According to respondents, emotional security was about feeling wanted, confident, comfortable and free from pressure. A range of factors were cited as contributing to this security including trust, communication and simple familiarity:

M61: *[pause]. It's...I don't want it to sound too chauvinistic – it's like a nice comfortable pair of shoes really that you can slip into them and feel at home in – a body you can feel comfortable with.*

The idea of emotional connection was clearly viewed as a component of ideal sex. It was described variously and somewhat nebulously as *a real sort of bond or love for that person* (F35), *that sort of good feeling* (F38), *rapport* (F23) and *an invisible chord that stays on there* (M48). In the absence of this connection, sex would become impersonal. A female respondent described a casual encounter devoid of connection thus: *It was almost like... if we were having sex he could have been with anyone. It wasn't like he cared about me.* (F31)

Underlying the interpersonal outlook was the idea that *you'll always sacrifice good sex for someone you love* (M61). In other words, physical functioning and pleasure were accorded less importance than having a good relationship. An older female respondent, for instance (F70) felt that as long her partner was faithful, appreciated her and gave her plenty of *cuddles and kisses*, the physical functioning problems that she and her partner currently experienced, did not much matter.

For one male respondent whose account emphasised this version, the benefit of Viagra was construed mainly as allowing the experience to feel mutual and reciprocal:

M61... *it's in a sense, more beneficial for your partner than it is for yourself, and you use it I think because you want to give satisfaction to your partner as much as to achieve successful sex yourself.*

Because masturbation was devoid of interpersonal meaning, it was generally construed as lacking *warmth* and *closeness* and was thus only really useful where an imbalance in desire meant that one partner needed to seek sexual relief in addition to the relationship: [...] *It's a very cold thing a vibrator – there is no warmth. You're purely using it for the relief – to have an orgasm* (F64).

Some respondents whose descriptions mainly fitted this version saw masturbation primarily in terms of exploration and viewed it as *not a bad thing* because it enabled an individual to perhaps become better prepared for 'the real thing'.

Emotional and relationship difficulties appeared to represent a more significant threat to ideal sex than physical functioning issues. The problem may begin as a relationship issue, and lead to a loss of intimacy and affection. Sex may become a metaphor for the relationship and as the relationship disintegrates, so the sex itself becomes 'dysfunctional':

M62:– *some of the touchy-feely stuff [...] that has nothing to do with the sexual act itself, goes. You're not any longer doing that with one another. [...] You're not as eager then to get physical and you just dissipate.*

The interpersonal was the most common version of functional sex in our data; the accounts of fifteen respondents were categorised as predominantly corresponding to it. Although this group comprised only five men compared with ten women, further quantitative work would be needed in order to establish a gender difference with any certainty. One might hypothesise that the interpersonal version would become more prevalent as perspectives on sex change with age, particularly where individuals adapt to declining physical function by focusing more on the relationship. Our numbers were too small to show a clear association but again, it would be worth exploring this quantitatively.

The mechanistic version of ideal Sex

The mechanistic version construed sex primarily as a biological or evolutionary act whose primary functions were procreation and the fulfillment of a biological need for sexual release. In this sense, it was primarily focused on the genital organs: *You're not only a human being; you're an animal as well. [Sex is] an important thing* (M65).

Accounts which emphasised this version tended to include reference to sex as a need that had to be fulfilled; for instance one respondent talked about needing to be *charged* in order for your working life to go well (F38). Where such needs were not met, this was a source of concern: *...it worries me that she is not getting any [sex]. It's supposed to be a need* (M65).

The central tenet of the mechanistic version was a belief in vaginal penetration as the *crux* (F34) of the (hetero) sexual encounter. Penetration appeared to be important because of its link to procreation, despite the fact that the desire to conceive was relevant only briefly in the sexual lives of most of the respondents:

IVWR: So penetration is one of the attractions of heterosexuality, or..?

F34: Yes. It's also the way you make babies. It's quite fundamental to procreation. [...] It's the act of creation. It's up there with birth and death.

It should be noted that the importance attached to penetration was pervasive and not limited to the mechanistic version. Many of those subscribing primarily to other versions - such as that of the female respondent above - also valued penetrative intercourse as part of their sexual repertoire. However, within the mechanistic version, penetration tended to be seen as the only activity that mattered. Other sexual activities were seen merely as preludes to penetration and construed as meaningless unless the end point could be achieved: *but then you see if you're good at the romantic side and you both know it's going to lead nowhere it all becomes a bit pointless* (M70).

Given the focus on the biological, physiological function was a central component of ideal sex. Specifically, ideal sex was defined in terms of adequate arousal and maintenance of an erection until orgasm was achieved by both partners (after a not-too-long and not-too-short a time). Successful sex was summed up by one respondent (M33) thus: *we both climaxed while penetrating*. Accordingly, the role of Viagra was primarily construed in terms of enabling successful sex by helping the male partner to achieve an erection. Viagra had not worked for one or two of the male respondents, and this failure was regarded as a signal that a functioning sex life was no longer possible: *I tried [Viagra] again; it didn't work so I didn't touch it again, so now I haven't got any sex life at all* (M65).

In this version, masturbation was seen primarily as an outlet for physical release where sex was not possible; it was seen in terms of meeting an important need for *cleansing [the] body of hormonal surges* (M55). A female respondent saw her partner's porn magazines as unproblematic, fulfilling an understandable need:

F38: [...] sometimes when he was working in G- and when he comes home he has these magazines with him. To me it doesn't bother me because he explained to me he needs them, so that's what he needs.

In mechanistic terms, the inability to have penetrative intercourse posed the most significant threat to ideal sex:

M56: [If I could not have penetrative sex] I'd regard myself as completely useless - or even more useless. I would be letting her down and that would be ...it's unspeakable and why would she stay with me? She would leave at any moment - it just wouldn't work. [She would think] I was no good

The respondent above assumed that his *horrendous fear* of not being able to *accomplish* an erection (M56) would be shared by all men. This goal orientated view of sex could give rise to significant pressure, exacerbating erectile difficulties, and in some instances 'causing' them:

M33: [...] [Sex] was never something that I was enjoying; it was more something that we focused on achieving. So ... it never really got to the stage where I could lie back and enjoy what was happening.

Five respondents were categorised as adhering primarily to the mechanistic version; one woman and four men. The numbers are too small to say with certainty, but it appears that this may be a version typifying men more than women. All the respondents were heterosexual, perhaps not surprisingly since taking on a non-heterosexual identity implies leaving behind beliefs in the centrality of vaginal intercourse. However, it may still be possible for a gay man to utilise elements of this version, for instance, in believing that sex is not possible in the absence of an erection.

The erotic version of Ideal Sex

In this version, sex was construed as a recreational act and the main focus was on giving and receiving pleasure. Since pleasure and not penetration was central, there appeared greater flexibility in what had to happen physically in order for the sex to be defined as 'successful'. For instance, for the gay respondent below, an early ejaculation need not necessarily be construed as an end to sex:

M52: *A lot of men have a problem with premature ejaculation and it's always surprised me that for a lot of them that's it – "thank you very much, I'm off home now" sort of thing, whereas you think "hang on a minute, give it another 15 or 20 minutes and we'll see what can happen".*

Characteristic of this version was the enjoyment of sex as a physical act that was uncomplicated by the interpersonal. That is not to say that personal relationships are unimportant here; only that they tend to be separated from the physical act of sex. For instance, a female respondent who subscribed primarily to this version described how she was excited by the element of surprise afforded by the unknown – the tall dark stranger – in an *unattached* encounter.

Given the greater variability in sexual activities, and the desire to separate sex from interpersonal 'baggage', premium was placed on compatibility between partners in terms of preferred activities. For instance, a male respondent described previous encounters in which a partner had been unwilling to engage in verbal fantasies with him. It meant he had to *shut up* and the *compromise* felt like *vanilla sex* (bland sex) to him (M55). In this version, ideal sex was construed as exciting, varied and novel and Viagra was valued mostly for its role in enhancing this excitement. Masturbation was often seen as a satisfying alternative to sex.

Individuals who favoured this version of ideal sex might seek novel encounters in order to maintain stimulation. As we discuss later, good sex (in erotic terms) could become difficult, if not impossible with someone loved and familiar. A male respondent subscribing to the erotic version was concerned that in his long term partnership, *it's hard to keep things exciting after all these years* (M36). For this respondent, the pressure to demonstrate his excitement to his partner had become a source of distress.

In accounts approximating to this version, the most significant threat to ideal sex stemmed from a loss of physical (or *chemical*) attraction to one's partner such that sex became dull and boring: The 'inevitable' dampening of sexual excitement within long term relationships was viewed as problematic: *that's always the thing with relationships at the beginning – they're very, very exciting and then over time it's less...* (M36). If the excitement went, it was felt that sexual activity would inevitably wane: *There's only so many times you can make love to someone without it being stimulated by the eroticism of their body. This generally implied an end to the relationship: as the sex life diminishes or they've not wanted the sex life so much, the relationship's on its wane and on its way out* (M55).

One gay male respondent felt that opportunities for novel and exciting encounters were less constrained for gay men where there was no expectation to 'settle down' and have children. As he put it:

M52: *You really go into a relationship thinking "I would like this to last but it may not", and it'll last while it's good, but when it's not it will end.*

Eight respondents (6 men) appeared to adhere primarily to the erotic version. Four emphasised the erotic, while the other three gave accounts which blended the erotic with the interpersonal (two) and the mechanistic (one).

Where ideal and lived reality do not match

Two accounts in particular illustrated the difficulties that can arise for individuals when a transition between ideal types may be occasioned by changing circumstances. In both accounts, the individuals appeared torn between a conceptualisation of ideal sex in erotic terms and a desire for a steady and secure interpersonal context where this type of sex was difficult if not impossible. Their expectations of sex as varied, wild, exciting and novel were difficult to meet within the confines of their chosen interpersonal contexts which were characterised by familiarity and intimacy. For instance, a young man with erectile difficulties (M36) said that he was aroused by the idea of *forbidden fruit*, but because his wife was no longer 'forbidden', he did not feel aroused by her: *it's her naked body...I've seen it many, many times, so it doesn't turn me on as much as someone in the street that I'm seeing for the first time.* He also described himself as reserved, not particularly in touch with his own body and thus *unable to take pleasure and let my body just kind of flow.* Having set up an ideal of sex in erotic terms he found he could not access this ideal within his long term relationship and the constraints of his reserved personality.

As one respondent suggested, for those construing sex as an interpersonal act, a hidden desire for erotic encounters devoid of the interpersonal might well be common - the quote below suggests a belief that we all have orgiastic fantasies – but because of the way that sex is constructed in this version, the encounter inevitably comes with interpersonal ‘*baggage*’. The extent to which such fantasies give rise to inner conflict might be influenced by the extent to which present and past interpersonal-orientated sexual encounters are experienced as sexually fulfilling and by the extent to which an individual is wedded to this conceptualisation of sex.

F54 ‘[.....] *I think really, because somewhere in my fantasies, I’d love to be in an orgy – the whole orgiastic thing which we all have. It would be great if we could actually... heaven must be a place where you could do that without any of the baggage*’.

Discontinuities between partners

Since sex occurs in a relational context, the priorities of the sexual partner also come into play. Conflict can arise when the notions of ideal sex subscribed to by partners are divergent. Three accounts in particular illustrated this tension, two of which we describe here. A young man with erectile difficulties (M33) described engaging in plenty of intimate activities such as oral sex with his wife and experienced ‘*times when that is preferable to actually having intercourse*’. However, he sensed that non-penetrative activities were ‘*not enough for her*’ and thus felt ‘*uncomfortable just sticking with the oral sex but feeling that the mood was for going...further and actually going to intercourse*’. In other words, he felt pressure to conform to what he perceived as her more mechanistic expectations of sex.

A second illustration came from the account of an older woman (F70) which largely corresponded to the interpersonal version. She had difficulty reaching orgasm but was satisfied with her sex life until her new partner became ‘*hot and bothered*’ because he wanted her to reach orgasm. Prior to his ‘*interference*’ her concept of enjoyable sex had centred on just feeling *nice*: ‘*I didn’t know I had to do anything like [have an orgasm]*’. The influence of his more mechanistic approach to sex was to make her feel that she was missing something although she was not sure what exactly: ‘*I’m missing something but what is it?*’. She appeared slightly embarrassed and confused by his insistence but nonetheless sought professional help.

Discussion

We have highlighted three versions of functional sex to which individuals adhere in talking about their ideal and non-ideal sexual experiences. Each provides a distinct set of priorities and expectations for a fulfilling sex life, and criteria by which the quality of these experiences might be judged. To an extent, these versions can be viewed as operating rather like sexual scripts; serving as ‘*storage devices for organising memories of past sexual experiences into coherent narratives*’ (Gagnon, Rosen & Leiblum 1982; p46).

Methodological caveats

We deliberately sought to include a high proportion of individuals with sexual difficulties. The implication of this strategy is that our sample is weighted towards older people and those who have spent time reflecting on their sexual experiences. This should be borne in mind when examining the relevance to our typology to other population groups. At this point, we make only tentative suggestions about how common each version might be within a general population.

Theoretical caveats

The three versions of ideal sex presented here are abstractions drawn from individual accounts of how sexual function is perceived and experienced. That is, they are not found in any pure form in the world, but instead can be used as a conceptual framework for understanding sexual priorities and expectations. In abstracting a set of characteristics from the accounts of individuals at one point in time we must avoid falling into the trap of imposing upon them immutable categories. Not only do the versions rarely exist in pure form but, as we have shown, they are prone to vary over time with changing circumstances, and within and between partnerships. The interview therefore captures a 'snapshot' of a dynamic process at one point in time. The lack of perfect fit between a respondent account and a particular ideal type does not undermine the attempt to rigorously categorise them in this way; categorising accounts helps to impose structure on their complexity and to understand how individuals and/or couples frame their sexual priorities. However, it does mean that there are three caveats. Firstly, we should be wary of treating the versions as if they exist materially in the minds of individuals (in other words, of reifying them). Secondly, we should avoid 'squeezing' behaviours, or patterns of sexual activity, into a specific version in cases where there is not actually a precise fit. Finally, we should regard the typology as a means rather than an end. Our aim is to shape an understanding of the meanings that actions have for men and women, and to understand life as it is lived.

Clinical and research applications of the results

- **Shedding light on the source of sexual difficulties and identifying ways of tackling them**

Our typology potentially provides a novel avenue for understanding and tackling sexual difficulties. We present some preliminary ideas that would benefit from further testing within a clinical setting.

Medical histories typically focus on the presenting problem and its social and medical context (see Tomlinson, 1999). However, understanding what sexual function means to the patient and their partner may provide useful insights into possible psychological aetiologies and management. Whilst taking sexual histories, the versions may provide a useful framework for organising respondent beliefs and attitudes towards sex. Can a particular version of functional sex be clearly identified from this client's account? How

important is this version in structuring the individual's priorities for an ideal sex life? Does their adherence to a particular version shed light on the ways in which they have responded to their difficulty?

Relationship factors – the sexual partner as well as the interaction between partners – are often fundamental to the experience of sexual difficulties (Byers, 2001; Candib, 2001; Clement, 2002; Fisher, Rosen, Eardley, Sand & Goldstein, 2005; Zilbergeld, 1980). Where the source of sexual difficulty lies in conflict between partners about their needs and priorities for a fulfilling sex life, a therapist/clinician may help the couple to understand their different perspectives in terms of discontinuities between versions of functional sex. Respecting alternative version may be a useful starting point to the therapeutic process. The therapist may then assist the couple in exploring options for individual adjustments such that these discontinuities are minimised. Alternatively, the therapist might assist the couple in coming to regard these discontinuities as a positive source of variety in their sexual relationship.

Similarly, where an individual patient complains of lack of sexual fulfilment, the therapist may be able to help them explore alternatives to their version that might engender greater fulfilment and that they might not have yet considered. The goal would be to create a perspective for the patient in which they felt most comfortable.

It may be that the lack of fulfilment stems from an inability to shift to a version that is more feasible within a specific life stage. For example, the mechanistic version would seem to fit less well for older couples where vaginal dryness or erection difficulties make penile/vaginal intercourse difficult or impossible. And, as we have shown, the erotic version may be more difficult to maintain once one has 'settled down' in a long term relationship, particularly during life stages where there are competing demands such as work and children. Our results here tie in with previous research suggesting that more flexible personal 'definitions' of sexual function enable individuals to cope better with a sexual difficulty (Barsky, Friedman & Rosen, 2006). This is what is known as 'accommodative coping' where personal preferences are adjusted to fit situational constraints (Brandstadter & Renner, 1990). The therapist can play a role here in helping an individual to adopt a more flexible set of priorities, although this process may be easier for women than men (Baumeister, 2004).

Use of these versions requires clinicians to move away from assuming that the mechanistic version - the version most closely allied with biomedical conceptualisations of sex – is universally 'bought into' by their patients. Indeed, it is imperative that the clinician or therapist does not convey an implicit hierarchy of perspectives such that one version is seen as preferable to another. Patients themselves may bring with them a set of implicit hierarchies; part of the professional's role would be to sensitively challenge them. This may be a difficult task since the experience of being medically examined or counselled may cause a patient to move towards a mechanistic perspective, implicitly transmitted via biomedical procedures. Explicit recognition of this tendency within clinical settings would help to avoid reinforcing messages of failure on those individuals whose sexual difficulties make it hard for them to have fulfilling sex as judged by purely mechanistic standards.

- **Understanding gender and age differences**

There is a common assumption that older people lose interest in sex. This has persisted despite a growing body of evidence to the contrary (Gott & Hinchliff, 2003; Nicolosi et al., 2004). Certainly, many of the older respondents in this study were keen to have an enjoyable sex life. We suggest that as people age, the assumed loss of interest in sex may be more accurately framed in terms of a change in version of functional sex. Successful sexual adjustment with age may depend on willingness to move away from the mechanistic version to a focus on the interpersonal and/or erotic.

We also suggest that women may have less fixed versions than men. This would fit with the greater variation in sexual expression among women (Bancroft et al., 2001; Baumeister, 2000). Furthermore, the interpersonal version may be more common among women, the mechanistic more common among heterosexual men, and the erotic more common among gay men. Current research supports our premise that women are more concerned with the psychological context of sexual encounters, prioritising relationship satisfaction, warmth and emotional security (Carroll, 1985; Byers 2001). And Masters & Johnson themselves noted that compared with heterosexual men, gay men tended to emphasise pleasure without being orientated towards the 'goal' of orgasm (Masters & Johnson, 1979).

- **Measuring sexual function**

Our findings have implications for the measurement of sexual function. Self-report measures of sexual function have increasingly focused on biomedical aspects of function and on providing concise end points in clinical trials (Taylor, Rosen & Leiblum, 1994). Thus, the mechanistic version of functional sex is given primacy. Those whose versions of sex prioritise relational aspects and erotic experiences find themselves 'judged' against standards they do not value themselves. It is also rare to find measures of sexual function developed from patient perspectives, and applicable to both genders and all sexual preferences (Daker-White, 2002; Arrington, Cofrancesco & Wu, 2004). In taking into account the variation in lay constructs of function, a measure derived from the versions outlined in this paper would have wide applicability and good content validity.

Conclusion

This study is a novel attempt to re-conceptualise sexual function based on the reported experiences of our respondents. We suggest that the concept of sexual function is broad, and that individuals adopt one or more versions in prioritising certain aspects. Understanding of the ways in which these versions – the interpersonal, the erotic and the mechanistic – are employed by patients may help to shed light on the sources of sexual difficulties and provide novel avenues for tackling them.

References

- American Psychiatric Association. (2000) Diagnostic and statistical manual of mental disorders, (4th ed., text rev.). Washington, D.C.: American Psychiatric Association.
- Arrington, R., Cofrancesco, J., Wu, A.W. (2004) Questionnaires to measure sexual quality of life. *Quality of Life Research*, 13, 1643-1658
- Bancroft, J., Graham, C. A., & McCord, C. (2001). Conceptualizing sexual problems in women. *Journal of Sex and Marital Therapy*, 27, 95-103.
- Bancroft, J. (2002) The medicalisation of female sexual dysfunction: The need for caution. *Archives of Sexual Behaviour*, 31 (5), 451-455
- Barsky, J., Friedman, M. & Rosen, R.C. (2006). Sexual dysfunction and chronic illness: The role of flexibility in coping. *Journal of Sex & Marital Therapy*, 32, 235-253.
- Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., Laan, E., Leiblum, S., Padma-Nathan, H., Rosen, R., Segraves, K., Segraves, R.T., Shabsigh, R., Sipski, M., Wagner, G., Whipple, B. (2000a) Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and classifications. *Journal of Urology*, 163, 888-93.
- Basson, R. (2000b) The female sexual response: A different model. *Journal of Sex & Marital Therapy*, 26, 51-64.
- Baumeister, R. (2000). Gender difference in erotic plasticity: The female sex drive as socially flexible and responsive. *Psychological Bulletin*, 126(3), 347-374.
- Baumeister, R. (2004). Gender and erotic plasticity: sociocultural influences on the sex drive. *Sexual and Relationship Therapy*, 19(2), 133-139.
- Brandtstadter, J. & Renner, G. (1990) Tenacious goal pursuit and flexible goal adjustment: Explication and age-related analysis of assimilative and accommodative coping. *Psychology and Aging*, 5, 58-67
- Byers, S.E. (2001) Evidence for the importance of relationship satisfaction for women's sexual functioning. In E. Kaschak & L. Tiefer (Eds.) *A New View of women's sexual problems* (pp 23-26). New York: The Haworth Press
- Camden Council (2007). Camden Demographic Profile 2007, http://www.camden.gov.uk/ccm/cms-service/stream/asset/?asset_id=576779. Last updated on 06/07/2007.

- Candib, L.M. (2001) A New View of Women's sexual problems: A family physician's response. In E. Kaschak & L. Tiefer (Eds.) A New View of women's sexual problems (pp 9-15). New York: The Haworth Press
- Carroll, J.L., Volk, K.D., Hyde, J.S. (1985). Difference between males and females in motives for engaging in sexual intercourse. *Archives of Sexual Behaviour*, 14,131-139
- Charmaz, C. (2006) Constructing grounded theory: A practical guide through qualitative analysis. London: Sage
- Clement, U. (2002) Sex in long-term relationships: A systemic approach to sexual desire problems. *Archives of Sexual Behaviour*, 31, 241-6.
- Daker-White, G. (2002) Reliable and valid self-report outcome measures in sexual (Dys)function: a systematic review. *Archives of Sexual Behaviour*, 31 (2), 197-209
- Davis, S. R. (2001). An external perspective on the report of the International Consensus Development Conference on Female Sexual Dysfunction: More work to be done. *Journal of Sex and Marital Therapy*, 27(2), 131-133.
- Fisher, W.A., Rosen, R.C., Eardley, I, Sand, M., Goldstein, I. (2005) Sexual experience of female partners of men with erectile dysfunction: The female experience of men's attitudes to life events and sexuality (FEMALES) study. *Journal of Sexual Medicine*, 2, 675-84.
- Gagnon, J.H., Rosen, R.C., Leiblum, S. (1982) Cognitive and social aspects of sexual dysfunction: Sexual scripts in sex therapy. *Journal of Sex & Marital Therapy*, 8(1), 44-56
- Goldacre, B. (2007) Given the choice, I'd rather have the miracle pill story. *British Medical Journal*. Doi:10.1136/bmj.39203.455856.59
- Gott, M. and Hinchliff, S. (2003). How important is sex in later life? The views of older people. *Social science & medicine*, 56,1617-1628.
- Hart, G. & Wellings K. (2002) Sexual behaviour and its medicalisation: in sickness and in health. *British Medical Journal*, 324, 896-900
- Johnson, A., Mercer, C. H., Erens, B., Copas, A. J., McManus, S., Wellings, K., Fenton, K., Korovessis, C., Macdowall, W., Nanchahal, K., Purdon, S. and Field, J. (2001). Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. *Lancet*, 358(9296), 1835-1842
- Kaplan H. S. (1974). *The New Sex Therapy*. New York: Brunner/Mazel.
- Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual Behaviour in the human male*. Philadelphia: W.B. Saunders.

- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H.. (1953). *Sexual behaviour in the human female*. Philadelphia and London: W.B. Saunders.
- Lief, H. I. (1977). Inhibited sexual desire. *Medical Aspects of Human Sexuality*, 7, 94-95.
- Lue, T., Basson, R., Rosen, R., Giuliano, F., Khoury, S., Montorsi, F., eds. (2004) *Sexual medicine: Sexual dysfunctions in men and women*. Paris: Health Publications
- Mays, N. & Pope, C. (2000) Assessing quality in qualitative research. *British Medical Journal*, 320, 50-52
- Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Boston: Little, Brown.
- Masters, W. H., & Johnson, V. E. (1979). *Homosexuality in perspective*. Boston: Little, Brown.
- Mitchell, K.R. & Graham C.A. (in press) Two challenges for the classification of sexual dysfunction. *Journal of Sexual Medicine*
- Nicolosi, A., Laumann, E.O., Glasser, D., Moreira Jr, E., Paik, A., Gingell, C. (2004). Sexual behaviour and sexual dysfunctions after age 40: the global study of sexual attitudes and behaviours. *Urology*, 64, 991-997.
- NIH Consensus Development Panel on Impotence. (1993) Impotence. *JAMA*, 270, 83-90.
- Rowland, D.L. (2007) Will medical solutions to sexual problems make sexological care and science obsolete? *Journal of Sex & Marital Therapy*, 33, 385-397
- Sand, M., Fisher, W.A. (2007) Women's endorsement of models of female sexual response: The nurses' sexuality study. *Journal of Sexual Medicine*, 4, 708-719.
- Segraves, R., Balon, R., & Clayton, A. (2007). Proposal for changes in diagnostic criteria for sexual dysfunctions. *The Journal of Sexual Medicine*, 4, 567-580.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. New York. Cambridge University Press
- Sugrue, D. & Whipple, B. (2001). The consensus-based classification of female sexual dysfunction: barriers to universal acceptance. *Sex Marital Therapy*, 27(2), 221-6.
- Tiefer, L. (1986) In pursuit of the perfect penis: The medicalisation of male sexuality. *American Behavioural Scientist*, 29(5), 579-599
- Tiefer, L. (1996). The medicalisation of sexuality: conceptual, normative, and professional issues. *Annual Review of Sex Research*, 7, 252-282.

Tiefer, L. (2000) Sexology and the Pharmaceutical Industry: The threat of co-optation. *The Journal of Sex Research*, 37 (3), 273-283

Tomlinson, J. (1999) Taking a sexual history. In J. Tomlinson (Ed.) *ABC of Sexual Health* (pp.12-18). London: BMJ Books

Waldinger, M. D., & Schweitzer, D. H. (2006). Changing paradigms from a historical DSM-III and DSM-IV view toward an evidence-based definition of premature ejaculation. Part II. Proposals for DSM-V and ICD-11. *The Journal of Sexual Medicine*, 3, 693-705.

World Health Organisation. (1992) *ICD-10: International Statistical Classification of Diseases and Related Health Problems*, 10th ed. Geneva: WHO

Zilbergeld, B., Ellison, C.R. (1980) Desire discrepancies and arousal problems in sex therapy. In: Leiblum SR, Pervin LA, (Eds.) *Principles and practice of sex therapy*. (pp. 66-104). New York: Guilford Press

Draft

Tables

	Respondent Group	Method of recruitment
1	Self-identified as having sexual function problems (clinical)	<ul style="list-style-type: none"> Over three sessions at a London Psycho-sexual clinic, the study was explained to repeat patients by Dr. at the end of their appointment. Those interested [n=6] were introduced to KM in waiting room and interviews were subsequently held with all 6.
2	Those with conditions associated with sexual function problems (associated clinical)	<ul style="list-style-type: none"> 220 letters sent to patients drawn randomly from diabetes and depression lists of a London GP practice. Interested individuals were requested to ring researcher (free-phone) to arrange an interview. 13 individuals responded and were interviewed²⁵ HIV positive volunteers recruited via a staff member at an HIV charity [n=3]
3	Sexually active but not fitting into either of the above (non-clinical)	<ul style="list-style-type: none"> Over the course of 6 sessions (1 to 4 hrs duration), 61 patients were approached by KM in GP waiting room whilst waiting for their appointment. 38 individuals took a recruitment pack, 15 agreed to be interviewed and 10 interviews were held.

Table one: Methods of recruitment

Draft

²⁵ Average response rate for postal questionnaire surveys from this clinic is 20%. Our response rate is lower for several reasons: firstly participant involvement was more onerous than completing a questionnaire; secondly the nature of the topic was sensitive; thirdly the target population were in less good mental and/or physical health than the general population and perhaps less inclined to participate in research; finally, due to resource constraints, we opted to throw a wide net once rather than a smaller net with follow up letters.

Characteristics of final sample (n=32)			
GENDER			PARTNERSHIP STATUS
Male	15		Single
Female	17		Co-habiting/married
			Partner, not cohabiting
			12
			16
			4
AGE			LEVEL OF EDUCATION
Under 30	2		Pre-O level/O level
30-49	13		A level
50 plus	17		Degree
			7
			9
			16
SEXUAL ORIENTATION			RESPONDENT GROUP
Gay male	3		Self-identified as having dysfunction
Lesbian	1		Has condition associated with SD
Bi-sexual	1		Neither of the above applies
Heterosexual	27		8
			14
			10
ETHNICITY			
British Asian	2		
Black (non-British)	2		
Asian	1		
White British	19		
Other white	8		

Table two: Sample characteristics

Draft

Version of functional sex:	Interpersonal	Mechanistic	Erotic
Defining term	Relational	Physiological	Recreational
Focus	Emotion Intimacy Reciprocity	Genital	Sensation
Purpose	Bond between partners	Release Procreation	Pleasure Recreation
Motivation	Intimacy Shore up self-esteem	Physiological need Biological drive	Physical attraction 'Chemistry'
Criteria determining ideal sex	Balance between partners Emotional Security Emotional connection	Erection Penetration Achievement of orgasm	Variety Excitement Orgasm
Threats to ideal sex	Relationship/emotional difficulties	Physiological difficulties	Lack of novelty, boredom, over-familiarity Discordant sexual preferences
Sexual repertoires	Negotiable Usually penetrative sex Masturbation as consolation Non-penetrative sexual activities often as prelude to penetration Viagra permits reciprocity	Vaginal intercourse Penetrative sex crux of encounter Masturbation for physical release; as substitution Non-penetrative activities preludes to penetration Viagra assists erection	Broad-ranging Penetrative sex not essential Masturbation intrinsically enjoyable Non-penetrative sexual activities ends in themselves Viagra enhances physical pleasure

Table three: Summary of the versions

Draft

Related measures of Sexual Dysfunction focused on specific aspects of sexual function or designed for specific populations (Para-measures)

Type of measure	Source	Use and main features
Measures of distress, impact of SD on sexual life and overall quality of life		
Sexual Satisfaction Scale for Women (SSS-W)	Meston & Trapnell 2005	Devised from lit search plus iwvs with women with SD. 30 item measure of sexual satisfaction and sexual distress. 5 domains: contentment, communication, compatibility, relational concern, personal concern. Discriminates between clinical and non-clinical samples. $\alpha=0.94$, $r=0.87$
Sexual Symptoms Distress Index (SSDI)	Croog et al. 1986	4 item scale which assesses distress associated with erectile and ejaculation difficulties
Female Sexual Distress Scale (FSDS)	Derogatis et al. 2002	12 item unidimensional scale measuring personal distress associated with female sexual dysfunction. Highly sensitive to treatment induced change. Internal consistency $\alpha =0.88$ for patients and 0.86 for controls. Test-re-test $r=0.91$ for both groups. Also demonstrated ability to discriminate between clinical and non clinical populations.
The Index of Sexual Life (ISL)	Chevret et al. 2004a/b	Designed by experts. 11 items; 3 domains – sexual life satisfaction, sexual drive and general life satisfaction. Designed to measure impact of SD on female partners' sexuality. Demonstrated construct validity, criterion validity and reproducibility. Internal consistency $\alpha = 0.88$, 0.61 and 0.7 for the 3 domains.
Sexual Quality of Life – female questionnaire (SQOL-F)	Symonds, Boolell & Quirk 2005	Developed by Pfizer based on semi-structured interviews. Assesses impact of SD on quality of life in women. Intended as an adjunct to other measures in clinical trials. 18 items; unidimensional. Demonstrated reliability and validity.
Self-esteem and Relationship Questionnaire (SEAR)	Cappelleri et al., 2004	Measures quality of life in ED patients. 14 items, 3 domains. $\alpha=0.93$, $r=0.79$

Psychological Impact of Erectile Dysfunction (PIED)	Latini, Penson & Colwell et al., 2002	16 items, 2 scales – psychological impact of ED on sexual experience, and on emotional life. Measures QoL according to treatment efficacy. $\alpha=0.91$ and 0.72 , $r=0.76$ and 0.66 for each respective sub-scale
Erectile Dysfunction Effect on Quality of Life Questionnaire (ED-EQoL)	MacDonagh, Ewings & Porter, 2002	Designed to quantitatively measure impact of ED on quality of life. Designed for clinical research. 15 items, one domain. $\alpha=0.95$, $r=0.87$ plus sensitivity to change. Cut-off points available
The Index of Sexual Satisfaction (ISS)	Hudson, 1998	Evaluates extent of sexual dissatisfaction among couples. Internal consistency $\alpha = 0.92$, no data for test-retest reliability.
Quality of Sexual Life Questionnaire (QVS)	Costa et al., 2003	Measures quality of life in subjects with ED. 27 items; 3 domains: sexual life, skills, psychosocial well-being. $\alpha=0.78-0.91$, $r=0.41-0.79$ for subscales. Lack of evidence currently regarding usefulness.
Quality of Life in Male Erectile Dysfunction Questionnaire (QoL-MED)	Wagner et al., 1996	Derived from interviews with men with ED. Measures QoL specifically among ED patients. 27 items; 3 domains. $\alpha=0.94$, $r=0.78$. Validity not well established
Sexual Quality of Life in Men with PE or ED (SQOL-M)	Abraham et al, 2008	Developed by Pfizer to measure sexual quality of life in men with PE or ED. 11 items (one overall domain). $\alpha=0.82$ and $ICC=0.77$ for men with PE and 0.79 for men with ED. Able to discriminate between men with and without dysfunction.
Measures of self-efficacy related to sexual function and sexual self esteem		
Sexual Self-Efficacy Scale – Female Functioning (SSES-F)	Bailes et al. 1998	Derived from self-efficacy theory and designed to measure cognitive aspects of sexual function. 8 sub-scales (37 items). Internal consistency $\alpha =0.93$ for overall test. Test re-test $r = 0.83$ for total. Demonstrated to correlate with the SHF and to discriminate between clinical and non-clinical samples
Sexual Self-Efficacy Scale – Erectile Functioning (SSES-E)	Libman et al., 1985	Derived from self-efficacy theory and designed to measure cognitive aspects of erectile response. Partner can also complete. 25 items. Excellent psychometric properties.
The Sexuality Scale	Snell et al, 1992	Measures sexual esteem, sexual depression and sexual preoccupation. 30 items and three sub-scales. Internal consistency $\alpha =0.90$ and test re-test $r=0.69$ to 0.74 . Evidence for discriminant validity

Measures of sexual relationship		
The Sexual Experience Scales (SES)	Frenken & Vennix 1981	Measures cognitive and emotional aspects of marital relationships. 83 items
Locke-Wallace Adjustment Test	Locke & Wallace, 1959	11 items. Widely used but now old!
Golombok Rust Inventory of Marital Status (GRIMS)	Rust et al., 1986	28 items. Companion scale to GRISS. Assesses relationship quality for men and women in a couple. Some evidence for reliability and validity. Split-half reliabilities of 0.92 for men and 0.9 for women
Dyadic Adjustment Scale	Spanier, 1976	Distinguishes between distressed and non-distressed couples. 34 items. Widely used. Revised version is shorter (14 items) and has improved reliability and validity (Busby et al., 1995)
Index of Dyadic Heterosexual Preferences (IDHP)	Pumine, Carey & Jorgensen, 1994	Measures sexual preferences in a couple. 27 items; 6 domains.
Sexual Relationship Scale (SRS)	Snell, 1990	Measures communal versus exchange orientations to sexual relationships. 24 items. Internal consistency $\alpha = 0.78$ (communion subscale) and 0.67 (exchange subscale). Some evidence for construct and concurrent validity.
Hurlbert Index of Sexual Compatibility (HISC)	Hurlbert et al., 1993	25 items, unidimensional. Measures degree of compatibility between sexual partners
Measures of sexual desire and arousal		
Sexual Desire Inventory (SDI)	Spector, Carey & Steinberg, 1996	11 items examining solitary and dyadic desire. Based on theory and expert experience. Internal consistency $\alpha = 0.86$ and 0.96 for dyadic and solitary scales. Test re-test = 0.76 overall. Evidence for concurrent, divergent and discriminant validity. Within couple, the difference in scores between each partner gives a discrepancy score.

Sexual Inhibition Sexual Excitation Scales (SIS/SES)	Janssen et al. 2002	36 items, three higher level factors: Sexual excitation; sexual inhibition due to performance failure; inhibition due to threat of consequences. All three scales showed close to normal distributions, respectable levels of internal consistency, test-retest reliability, and discriminant and convergent validity. Based on Dual Control theory (see chapter 2)
The Sexual Excitation/Sexual Inhibition Inventory for Women (SESI-W)	Graham, Sanders & Milhausen 2006	Designed to assess the propensity for sexual excitation and inhibition in women. Based on focus groups and Dual Control Theory. 36 items; 2 higher order factors –excitation and inhibition; 8 lower-order domains – arousal, rel importance, sexual power dynamics, concerns re function, arousal contingency; partner chars, setting, smell. Test re-test reliability for sexual excitation $r=0.81$, and sexual inhibition $r=0.82$. Mean $\alpha =0.72$.
Sexual Arousal Inventory (SAI)	Hoon & Chambless, 1998	Measures perceived arousability and anxiety in response to variety of sexual experiences. Short (14 item) version available. Internal consistency $\alpha = 0.91$, test-retest data only partial. Evidence for construct validity and discriminant validity for women only
Measures focused on erectile function and PE		
The Male Function Profile/Impotence Questionnaire (MFP/IQ)	Fineman & Rettinger 1991	Designed to differentiate organic from psychogenic causes of erectile difficulties
Psychological and Interpersonal Relationships Scales (PAIRS)	Swindle et al. 2004	Designed by lit review, focus groups/interviews and consultation with experts. Domains: sexual self-confidence, spontaneity, time concerns. Funding by Lilly ICOS LLC (manufacturers of Cialis) and focus on time issues may not be coincidental (!). Good internal consistency and re-test reliability. 23 items; 15-item short form available
Sexual Health Inventory (SHIM)	Cappelleri et al., 2001	An abridged version of the IIEF. 5 items; 2 domains: erectile function and intercourse satisfaction. Normative cut off scores available. Sensitivity 98% and specificity 88%
Florida Sexual History Questionnaire (FSHQ)	Geisser, Murray & Cohen et al., 1993	Designed to distinguish between organic and psychogenic ED. Scoring system complex. 20 items, 4 domains; $\alpha=0.9$, $r=0.86$

Erection Quality Scale (EQS)	Wincze et al., 2004	Designed to assess quality of penile erections (complements IIEF). 15 items, one domain. $\alpha=0.94$; $r=0.85$ Can be used on men of all sexual orientations, with or without a current partner. Able to differentiate between treated ED patients, untreated ED patients and healthy controls
Chinese Index of Premature Ejaculation (CIPE-10)	Yuan et al., 2004	10 items of which 5 (CIPE-5) are significantly associated with diagnosis of PE. Sensitivity=97.6%, specificity=94.7% for CIPE-5. Designed for evaluating PE patients and as end points in clinical trials
Measures assessing interventions/satisfaction with treatment		
Female Intervention Efficacy Index (FIEI)	Berman et al., 2001	Designed to measure efficacy of treatments such as the Eros Clitoral Device or sildenafil in arousal disorders. Still requires validation for general use. 3 of 7 domains treatment focused
Erectile Dysfunction Inventory of Treatment Satisfaction (EDITS)	Althof et al., 1999	11 items for patient; 5 for partner. Designed to assess satisfaction with clinical treatment for ED. Patient $\alpha=0.90$, partner $\alpha=0.76$; patient $r=0.98$, partner $r=0.83$ Focus on satisfaction with quality of erection
Patient and Partner Treatment Satisfaction Scale (TSS)	Kubin et al., 2004	Designed for clinical trials. Measures patient and partner satisfaction with drug treatment for ED. 61 items, 6 domains and 4 modules according to treatment status.
Measures designed for specific populations		
Menopausal Sexual Interest Questionnaire (MSIQ)	Rosen et al., 2004a	Designed by expert panel for use in clinical trials as a measure of sexual interest and desire among menopausal women. Three domains (10 items) – desire, responsiveness and satisfaction. $\alpha =0.87$ and higher; $r=0.79$ for total scale
Sabbatsberg Sexual Rating Scale	Garratt et al., 1995	Measures SD among women with gynecological problems. Unobtrusive and brief. Good reliability and validity

Inventory of Potential Questions for each Domain

Reciprocity – a perception that the giving and receiving of pleasure is balanced across partners

[GRISS – Rust & Golombok, 1985] Do you dislike stroking and caressing your partner's penis? Options: never; hardly ever, occasionally, usually, always.

[SIDI-F – Clayton, 2006] Over the past month, did your partner approach you for sex? IF YES, how often did you accept? And when you accepted, what was your level of enthusiasm? Options: obligation, some interest but little sexual enthusiasm, receptive and interested sexually, sexually enthusiastic and encouraging

[SSS-W – Meston, 2005] I often feel my partner isn't sensitive or aware enough about my sexual likes and desires. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[Hurlbert Index of Sexual Excitability – Hurlbert, 1998a] Pleasing my partner is sexually exciting for me (options: all of the time, most of the time, some of the time, rarely, never)

[Sexual Dysfunction Scale-McCabe, 1998] If you initially accept and respond to your partner's sexual caresses, do you feel obliged to continue on to intercourse? During sexual activity, does awareness of your partner's eagerness for intercourse make you feel pressured? Options: never, almost never, occasionally, almost always, always.

Compatibility in preference for sexual activities across partners

[GRISS – Rust & Golombok, 1985] Do you feel dissatisfied with the amount of time your partner spends on intercourse itself? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you ask your partner what he likes or dislikes about your sexual relationship? Options: never; hardly ever, occasionally, usually, always.

[SEI-Bancroft, Loftus & Long, 2003] How often does your partner understand how you feel and what you enjoy while you are having sex? Options: All of the time; most of the time; some of the time; A little of the time; none of the time

[SSS-W – Meston, 2005] I often feel that my partner and I are not sexually compatible enough. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[SSS-W – Meston, 2005] I sometimes think my partner and I are mismatched in needs and desires concerning sexual intimacy. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[SSS-W – Meston, 2005] I sometimes think my partner and I are mismatched in our sexual styles and preferences. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[ISS - Hudson, 1998] I enjoy the sex techniques that my partner likes or uses

[Hurlbert Index of Sexual Compatibility – Hurlbert, 1993] My partner and I share the same sexual likes and dislikes; My partner is unwilling to do certain sexual things for me that I would like to experience; I feel uncomfortable engaging in some of the sexual activities that my partner desires; My partner and I enjoy the same sexual activities; My partner enjoys doing certain sexual things that I dislike.. Options: all of the time, most of the time, some of the time, rarely, never

Connection and closeness between partners

[SSES-E – Libman, 1985] Feel sexually desirable to the partner.. Options: quite certain through moderately certain to quite uncertain (select number from 10 to 100)

[EMAS-SFQ- O'Connor, 2008] How satisfied have you been with your general (nonsexual) relationship with your partner? Options: very dissatisfied; moderately dissatisfied; about equally satisfied and dissatisfied; moderately satisfied; very satisfied

[SFQ – Quirk, 2002] Over the last 4 weeks, how often did you feel emotionally close to your partner when you took part in sexual activity? Options: not at all; sometimes; often; very often; everytime

[GRISS – Rust & Golombok, 1985] Do you feel there is a lack of love and affection in your sexual relationship with your partner? Options: never; hardly ever, occasionally, usually, always.

[IIEF – Rosen, 1997] In the past four weeks: How satisfied have you been with your sexual relationship with your partner? Options: Very dissatisfied; Moderately dissatisfied; About equally satisfied and dissatisfied; Moderately satisfied; Very satisfied

[SQOL-F – Symonds, 2005] When I think about my sexual life, I feel close to my partner. Options: Completely agree to completely disagree (6 point likert scale)

[SSS-W – Meston, 2005] I often feel I don't have enough emotional closeness in my sex life. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[SSS-W – Meston, 2005] I sometimes feel that my partner and I might not be physically attracted to each other enough. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past 4 weeks - How many times did you feel emotionally close and comfortable with (your partner)? Also: How often does your partner understand how you feel and what you enjoy while you are having sex? Options: All of the time; most of the time; some of the time; A little of the time; none of the time

[SFQoSL – Daker-White, 2003] During the past month, how close or intimate would you say you and your partner were?

[FSFI – Rosen, 2000] Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner? Options: Very satisfied; moderately satisfied; about equally satisfied and dissatisfied; moderately dissatisfied; very dissatisfied.

[Hurlbert Index of Sexual Desire – Hurlbert, 1998b] I think my partner understands me sexually. Options: all of the time, most of the time, some of the time, rarely, never

[Hurlbert Index of Sexual Compatibility – Hurlbert, 1993] I think my partner understands me sexually; I am sexually attracted to my partner; I think my partner is sexually attracted to me. Options: all of the time, most of the time, some of the time, rarely, never

Subjective enjoyment and satisfaction /novelty and variety

[EMAS-SFQ O'Connor, 2008] How satisfied have you been with your overall sex life? Options: very dissatisfied; moderately

dissatisfied; about equally satisfied and dissatisfied; moderately satisfied; very satisfied

[BSFI – O’Leary, 1995] Overall during the past 30 days, how satisfied have you been with you’re your sex life? Options: very dissatisfied; mostly dissatisfied; neutral or mixed (about equally satisfied and dissatisfied); mostly satisfied; very satisfied

[GRISS – Rust & Golombok, 1985] Do you enjoy mutual masturbation with your partner? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Are you dissatisfied with the amount of variety in your sex life with your partner? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you dislike being caressed and cuddled by your partner? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you enjoy having sexual intercourse with your partner? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you enjoy cuddling and caressing your partner’s body? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you find your sexual relationship with your partner satisfactory? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Are you satisfied with the amount of time you and your partner spend on foreplay? Options: never; hardly ever, occasionally, usually, always.

[IIEF – Rosen, 1997] In the past four weeks: How much have you enjoyed sexual intercourse? Options: No intercourse; No enjoyment; Not very enjoyable; Fairly enjoyable; Highly enjoyable; Very highly enjoyable

[IIEF – Rosen, 1997] In the past four weeks: How satisfied have you been with your overall sex life? Options: Very dissatisfied; Moderately dissatisfied; About equally satisfied and dissatisfied; Moderately satisfied; Very satisfied

[SQOL-F – Symonds, 2005] I have lost pleasure in sexual activity. Options: Completely agree to completely disagree (6 point likert scale)

[SQOL-F – Symonds, 2005] When I think about my sexual life, it is an enjoyable part of my life overall. Options: Completely agree to completely disagree (6 point likert scale)

[SIDI-F – Clayton, 2006] How satisfied are you with the sexual aspect of your relationship with your partner? Options: dissatisfied, somewhat dissatisfied, neutral, somewhat satisfied, satisfied.

[SSS-W – Meston, 2005] Overall, how satisfactory or unsatisfactory is your present sex life? Options: completely satisfactory, very satisfactory, reasonably satisfactory, not very satisfactory, not at all satisfactory.

[SSS-W – Meston, 2005] I feel content with the way my present sex life is. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past 4 weeks - How many times was the experience mainly pleasurable and enjoyable? Also: How many times did you enjoy being touched around your genitals (such as by your partner’s hand, mouth, or other part of his body)?

[PFSF-McHorney, 2004] I felt really excited sexually; I got a lot of pleasure from sex; sex felt good; sex was exciting; sex was fulfilling; sex was satisfying; sex was wonderful; sex gave me great feelings all over my body. Options: always, very often, often, sometimes, seldom and never

[CMASH-SFQ – Glick, 1997] How satisfied have you felt after a typical sexual interaction in the past 3 months?

[SPEQ – Dennerstein, 2002] How enjoyable are sexual activities currently for you? Are you satisfied with your partner as a lover?

[ISL – Chevret, 2004] How much have you enjoyed sexual intercourse (defined as vaginal penetration)? Options: No intercourse; Very enjoyable; Enjoyable; Fairly enjoyable; Not very enjoyable; No enjoyment.

[HAT-QoL Holmes, 1998] Over the past 4 weeks I’ve been satisfied with my sexual life.. Options: all of the time; a lot of the time; some of the time; a little of the time; none of the time

[FSFI – Rosen, 2000] Over the past 4 weeks, how satisfied have you been with your overall sexual life? Options: Very satisfied; moderately satisfied; about equally satisfied and dissatisfied; moderately dissatisfied; very dissatisfied.

[Sexuality Scale – Snell, 1992] I am disappointed about the quality of my sex life. I derive pleasure and enjoyment from sex. I feel pleased with my sex life. Options: agree, slightly agree, neither agree or disagree, slightly disagree, disagree.

[Hurlbert Index of Sexual Excitability – Hurlbert, 1998a] In general, sex is satisfying for me (options: all of the time, most of the time, some of the time, rarely, never)

[Osborn, 1988] Over the past three months, on what proportion of occasions that you made love did you find it a pleasant experience?

[Osborn, 1988] Over the past three months, on what proportion of occasions that you made love did you find it an unpleasant experience?

[ISS - Hudson, 1998] Our sex life is very exciting; sex is fun for my partner and me; our sex life is monotonous; I feel that my sex life is boring

[NATSAL - Mercer 2005] Which one of these [statements] best applies to you? When I have sex these days....Options: I always enjoy it; I enjoy it most of the time; I don’t often enjoy it; I never enjoy it; I don’t have sex these days

[FSQ – McCoy, 1998] How enjoyable has sexual activity been for you? (not at all to extremely)

[BISF-W – Taylor, 1994] Overall, how satisfied have you been with your sexual relationship with your partner? Options: I have not had a partner; very satisfied; somewhat satisfied; neither satisfied nor dissatisfied; somewhat dissatisfied; very dissatisfied

[LiSat-11 checklist – Fugl-Meyer, 2002] How satisfying is your sex life? Options: very satisfied, satisfied, rather satisfied, rather dissatisfied, dissatisfied, very dissatisfied

Anxiety

[SSES-E – Libman, 1985] Anticipate (think about) having intercourse without fear or anxiety. Options: quite certain through moderately certain to quite uncertain (select number from 10 to 100)

[SQOL-M – Abraham, 2008] When I think about my sexual life I feel anxious 6 Options from completely agree to completely disagree.

[SQOL-M – Abraham, 2008] I worry about the future of my sex life 6 Options from completely agree to completely disagree.

[GRISS – Rust & Golombok, 1985] Do you become tense and anxious when your partner wants to have sex? Options: never; hardly ever, occasionally, usually, always.

[SQOL-F – Symonds, 2005] When I think about my sexual life, I feel anxious. Options: Completely agree to completely disagree (6 point likert scale)

[SSS-W – Meston, 2005] I’m worried that my partner is sexually unfulfilled. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past 4 weeks - How many times did you experience unpleasant feelings such as tension and anxiety?
[NATSAL – Mercer 2005] In the last year, have you experienced any of the following for one month or longer/at least 6 months in the last year? 2) Felt anxious just before having sex about your ability to perform sexually (options: yes/no)
[BISF-W – Taylor, 1994] Overall, during the past month, how frequently have you become anxious or inhibited during sexual activity with a partner? (Options: I have not had a partner, not at all anxious or inhibited; seldom (less than 25% of the time); sometimes (about 50% of the time); usually, about 75% of the time; always became anxious or inhibited.

Able to have an orgasm/ejaculate when desired

[ASEX- McGahuey, 2000] How easily can you reach an orgasm? Options: extremely easily; very easily; somewhat easily; somewhat difficult; very difficult; never reach orgasm
[EMAS-SFQ – O'Connor, 2008] When you had sexual stimulation, how often did you have the feeling of orgasm or climax? Options: no sexual intercourse/masturbation, almost never/never; a few times (much less than half the time); sometimes (about half the time); most of the time (much more than half the time); almost always/always
[BSFI – O'Leary, 1995] In the past 30 days, how much difficulty have you had ejaculating when you have been sexually stimulated? Options: have had no sexual stimulation in past month; a lot of difficulty; some difficulty; little difficulty; no difficulty
[BSFI – O'Leary, 1995] In the past 30 days, how much did you consider the amount of semen you ejaculate to be a problem for you? Options: did not climax; big problem; medium problem; small problem; no problem
[GRISS – Rust & Golombok, 1985] Do you ejaculate by accident just before your penis is about to enter your partner's vagina? Options: never; hardly ever, occasionally, usually, always.
[GRISS – Rust & Golombok, 1985] Do you ejaculate without wanting to almost as soon as your penis enters your partner's vagina? Options: never; hardly ever, occasionally, usually, always.
[GRISS – Rust & Golombok, 1985] Can you avoid ejaculating too quickly during intercourse? Options: never; hardly ever, occasionally, usually, always.
[GRISS – Rust & Golombok, 1985] Are you able to delay ejaculation during intercourse if you think you may be coming too quickly? Options: never; hardly ever, occasionally, usually, always.
[GRISS – Rust & Golombok, 1985] Do you fail to reach orgasm during intercourse? Options: never; hardly ever, occasionally, usually, always.
[GRISS – Rust & Golombok, 1985] Can you reach orgasm when your partner stimulates your clitoris during foreplay? Options: never; hardly ever, occasionally, usually, always.
[GRISS – Rust & Golombok, 1985] Do you find it impossible to have an orgasm? Options: never; hardly ever, occasionally, usually, always.
[GRISS – Rust & Golombok, 1985] Are you able to experience an orgasm with your partner? Options: never; hardly ever, occasionally, usually, always.
[IEEF – Rosen, 1997] In the past four weeks: When you had sexual stimulation or intercourse, how often did you ejaculate? Options: no sexual stimulation/intercourse; almost never/never; a few times (much less than half the time); sometimes (about half the time); most times (much more than half the time); almost always/always
[IEEF – Rosen, 1997] In the past four weeks: When you had sexual stimulation or intercourse, how often did you have the feeling of orgasm or climax? Options: no sexual stimulation/intercourse; almost never/never; a few times (much less than half the time); sometimes (about half the time); most times (much more than half the time); almost always/always
[ASFQ – Quirk, 2002] Over the last 4 weeks, how often did you have an orgasm when you took part in sexual activity? (may be with or without a partner) Options: 1 Not at all to 5. Every time
[SFQ – Quirk, 2002] Over the last 4 weeks, in general, how pleasurable were the orgasms that you had? Options: 1 Not pleasurable to 5. Extremely pleasurable. (Also: I did not have any orgasms)
[SFQ – Quirk, 2002] Over the last 4 weeks, in general, how easy was it for you to reach orgasm? Options: 1 Very difficult to 5. Very easy (also: I did not have any orgasms)
[ASEX – McGahuey, 2000] Are your orgasms satisfying? Options: 1 Extremely satisfying to 6, Can't reach orgasm
[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past 4 weeks - How many times did [you] ejaculate too quickly (that is more quickly than either you or your partner would prefer)?
[PFSF-McHorney, 2004] I reached orgasm easily; it took a lot of work for me to reach orgasm; having orgasms was difficult. Options: always, very often, often, sometimes, seldom and never
[MSIQ-Rosen, 2004] [...] how much effort is it now to have an orgasm? [...] how much time does it take now to reach an orgasm?
[SAQ-O'Farrell, 1997] How often does the man ejaculate (come to climax) too quickly in intercourse? How often does the woman have a climax (orgasm) during sexual intercourse? Options: 95+%; 75%, 50%, 25%, 5%, Never
[CMASH-SFQ - Glick 1997] How often did you ejaculate (come) more quickly than you would like during intercourse in the past 3 months? How often did it take you longer than you'd like to reach orgasm during intercourse in the past 3 months?
[SFQoS - Daker-White, 2003] During the past month, did you have any problems reaching climax or orgasm?
[CSFQ – Clayton, 1997] Are you able to have an orgasm when you want to? Options: Never; Rarely (much less than half the time); sometimes (about half the time); often (much more than half the time).
[ASEX- McGahuey, 2000] How easily can you reach an orgasm? Options: extremely easily; very easily; somewhat easily; somewhat difficult; very difficult; never reach orgasm
[FSFI – Rosen, 2000] Over the past 4 weeks, when you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)? Options: No sexual activity; extremely difficult or impossible; very difficult; difficult; slightly difficult; not difficult.
[Osborn, 1988] How often during the past three months have you experienced a climax during sex?
[NATSAL – Mercer, 2005] In the last year, have you experienced any of the following for one month or longer/at least 6 months in the last year? 3) Were unable to come to a climax (experience an orgasm); 4) Came to a climax (experience an orgasm) too quickly (options: yes/no)

Balance in levels of desire for sex across sexual partners

[GRISS – Rust & Golombok, 1985] If you want sex with your partner do you take the initiative? Options: never; hardly ever, occasionally, usually, always.

[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past

4 weeks - How many times was the sexual activity initiated mutually by both of you?

[Hurlbert Index of Sexual Compatibility – Hurlbert, 1993] My partner and I disagree over the frequency in which we should have sex; I think my partner desires too much sex; My partner and I share the same level of interest in sex; My partner and I share about the same level of sexual desire. Options: all of the time, most of the time, some of the time, rarely, never

[ISS – Hudson, 1998] My partner does not want sex when I do

Desire for sexual intimacy or activity

[NATSAL – Mercer 2005] In the last year, have you experienced any of the following for one month or longer/at least 6 months in the last year? 1) Lacked interest in having sex (options: yes/no)

[EMAS-SFQ – O'Connor 2008] In the last month, how often did you think about sex? This includes times of just being interested in sex, daydreaming or fantasising about sex, as well as times when you wanted to have sex. Options: Not at all, once in the last month, 2-3 times in the last month, once a week, 2-3 times a week, 4-6 times a week, once a day, more than once a day.

[BSFI – O'Leary 1995] During the past 30 days, on how many days have you felt sexual drive? Options: no days; only a few days; some days; most days; almost every day

[BSFI – O'Leary 1995] During the past 30 days, how would you rate your level of sexual desire? Options: none at all; low; medium; medium high; high. (sexual drive defined as a feeling that may include wanting to have a sexual experience (masturbation, intercourse), thinking about having sex, or feeling frustrated due to lack of sex.

[GRISS – Rust & Golombok, 1985] Do you feel uninterested in sex? Options: never; hardly ever, occasionally, usually, always.

[IIEF – Rosen, 1997] In the past four weeks: How often have you felt sexual desire? Options: almost never/never; a few times (much less than half the time): sometimes (about half the time): most times (much more than half the time): almost always/always

[IIEF – Rosen, 1997] In the past four weeks: How would you rate your level of sexual desire? Options: Very low/none at all; Low; Moderate; High; Very high

[SFQ – Quirk, 2002] Thinking about your sexual life over the last 4 weeks, how often did you look forward to sexual activity? Options: 1 Not at all to 5. Very often

[SFQ – Quirk, 2002] Over the last 4 weeks, how often have you had pleasurable thoughts or feelings about sexual activity? Options: 1 Not at all to 5. Very often

[SFQ – Quirk, 2002] Over the last 4 weeks, how often have you wanted to be sensually touched and caressed by your partner? Options: 1 Not at all to 5. Very often

[SFQ – Quirk, 2002] Over the last 4 weeks, how often have you wanted to take part in sexual activity? Options: 1 Not at all to 5. Very often

[SFQ – Quirk, 2002] Over the last 4 weeks, how often have you initiated sexual activity with your partner? Options: 1 Not at all to 5. Very often

[ASEX – McGahuey, 2000] How strong is your sex drive? Options: 1 Extremely strong to 6, No sex drive.

[SIDI-F – Clayton, 2006] Over the past month, how satisfied were you with your overall level of sexual desire/interest? Options: dissatisfied, somewhat dissatisfied, neutral, somewhat satisfied, satisfied.

[SIDI-F – Clayton, 2006] Over the past month, when you thought about sex or were approached for sex, how distressed (worried, concerned, guilty) were you about your level of desire? Options: never distressed, mildly distressed, moderately distressed, markedly distressed, extremely distressed

[PFSF-McHorney, 2004] I felt like having sex; my sexual desire was high; I really wanted sex; I felt sexual desire; I had strong sexual feelings; I was uninterested in sex. Options: always, very often, often, sometimes, seldom and never

[MSIQ-Rosen, 2004] What has been your general level of sexual interest/desire during the past week? Options: absent, moderate level, very high level. How satisfied are you now with your level of interest in sex? Options: not at all, somewhat satisfied, extremely satisfied.

[HAT-QoL Holmes, 1998] Over the past 4 weeks I've been interested in sex.. Options: all of the time; a lot of the time; some of the time; a little of the time; none of the time

[FSFI – Rosen, 2000] Over the past 4 weeks, how would you rate your level (degree) of sexual desire or interest? (Very high; high; moderate; low; very low or none at all)

[Sexuality Scale – Snell, 1992] I don't think about sex very often. Options: agree, slightly agree, neither agree or disagree, slightly disagree, disagree.

[Sexual Desire Inventory – Spector, 1996] When you have sexual thoughts, how strong is your desire to engage in sexual behaviour with a partner? (no desire to strong desire; scale from 0 to 8); How strong is your desire to engage in sexual activity with a partner (no desire to strong desire; 0 to 8)

[Hurlbert Index of Sexual Desire – Hurlbert, 1998b] Just thinking about having sex with my partner excites me; It is difficult for me to get in a sexual mood; my motivation to engage in sex with my partner is low; I have a strong sex drive; I look forward to having sex with my partner. Options: all of the time, most of the time, some of the time, rarely, never

[Osborn, 1988] Has your interest in having sex been low during the past year?

[BISF-W – Taylor, 1994] Indicate how frequently you have felt a desire to engage in sexually intimate activity [KM insertion] during the past month (options: not at all, once, 2 or 3 times, once a week, 2 or 3 times per week, once a day, more than once a day)

(Not) avoiding sex/ no sex

[GRISS – Rust & Golombok, 1985] Do you refuse to have sex with your partner? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you try to avoid having sex with your partner? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Are there weeks in which you do not have sex at all? Options: never; hardly ever, occasionally, usually, always.

[SQOL-F – Symonds, 2005] I try to avoid sexual activity. Options: Completely agree to completely disagree (6 point likert scale)

[PFSF-McHorney, 2004] I made up excuses to avoid having sex; I avoided doing anything that would get my partner sexually excited; I avoided having sex. Options: always, very often, often, sometimes, seldom and never

[Hurlbert Index of Sexual Desire – Hurlbert, 1998b] I try to avoid situations that will encourage my partner to want sex; I try to avoid having sex with my partner. Options: all of the time, most of the time, some of the time, rarely, never

[PFSF – McHorney, 2004] In the past 3 months have you: Avoided doing anything that would get my partner sexually excited? OR, Made up excuses to avoid having sex?

[ISS – Hudson, 1998] I try to avoid sexual contact with my partner

[NATSAL - Mercer, 2005] During the last year, have you ever avoided having sex because of [problem]? Options: Yes/No

Subjective feelings of arousal/excitement

[GRISS – Rust & Golombok, 1985] Do you become easily sexually aroused? Options: never; hardly ever, occasionally, usually, always.

[SFQ – Quirk, 2002] Over the last 4 weeks, how often did you have feelings of emotional sexual arousal when you took part in sexual activity?(e.g. feeling excited, feeling 'turned on', wanting sexual activity to continue) Options: 1 Not at all to 5. Every time

[SFQ – Quirk, 2002] Over the last 4 weeks, how much emotional sexual arousal did you notice when you took part in sexual activity? (e.g. feeling excited, feeling 'turned on', wanting sexual activity to continue) Options: 1 None to 5. Extremely aroused

[SFQ – Quirk, 2002] Over the last 4 weeks, how often did you have a feeling of 'warmth' in your vagina/genital area when you took part in sexual activity? Options: 1 Not at all to 5. Very often

[SFQ – Quirk, 2002] Over the last 4 weeks, in general how much 'warmth' did you feel in your vagina/genital area when you took part in sexual activity? Options: 1 None to 5. Extremely warm

[SFQ – Quirk, 2002] Over the last 4 weeks, how often did you have a feeling of 'pulsating' ('tingling') in your vagina/genital area when you took part in sexual activity? Options: 1 Not at all to 5. Every time

[SFQ – Quirk, 2002] Over the last 4 weeks, how much 'pulsating' ('tingling') in your vagina/genital area did you notice when you took part in sexual activity? Options: 1 No sensation to 5. A very strong sensation

[SIDI-F – Clayton, 2006] Over the past month, when you had sex, how easily did you become aroused (sexually excited, wet, lubricated etc) in response to sexual stimulation? Options: No sexual activity, not at all aroused, aroused with difficulty, aroused somewhat easily, easily aroused.

[SIDI-F – Clayton, 2006] Over the past month, once you started to become sexually aroused, did you want to receive more stimulation? Options: No sexual activity, no desire/not aroused, little desire, moderate desire, strong desire.

[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past 4 weeks - How many times did you become aroused (for example, just feeling excited or noticing physical changes in your body such as breathing more quickly, heart beating faster, sweating)? Also: how many times did you feel a pleasant tingling in your genitals?

[PFSF-McHorney 2004] I felt tingly all over during sex; I felt really excited sexually; it was very difficult for me to become aroused; I really had to focus to get sexually aroused; getting aroused took forever. Options: always, very often, often, sometimes, seldom and never

[SPEQ – Dennerstein, 2002] How often during sex activities do you feel aroused or excited?

[CSFQ – Clayton, 1997] Are you easily aroused? Options: Never; Rarely (much less than half the time); sometimes (about half the time); often (much more than half the time).

[ASEX- McGahuey, 2000] How easily are you sexually aroused (turned on)? Options: extremely easily; very easily; somewhat easily; somewhat difficult; very difficult; never aroused

[HAT-QoL Holmes, 1998] Over the past 4 weeks it's been difficult to get sexually aroused. Options: all of the time; a lot of the time; some of the time; a little of the time; none of the time

[FSFI – Rosen, 2000] Over the past 4 weeks, how would you rate your level of sexual arousal ('turn on') during sexual activity or intercourse? Options: Very high; high; moderate; low; very low or none at all

[Hurlbert Index of Sexual Excitability – Hurlbert, 1998a] Potential statements: I quickly become sexually excited during foreplay; It is difficult for me to become sexually aroused; I feel I take too long to get sexually aroused; During sex, I seem to lose interest after initial level of sexual excitement; It is hard for me to become sexually excited; Even when I desire sex, it seems hard for me to become excited; I find sexual intercourse to be exciting; When it comes to sex, I think my level of sexual excitement is low (options: all of the time, most of the time, some of the time, rarely, never)

[ISS – Hudson, 1998] It is easy for me to get sexually excited by my partner

[FSQ - McCoy, 1998] How excited or aroused have you been during sexual activity (for instance, increased heartbeat/flushing/heavy breathing etc.)? (not at all excited to extremely excited)

[SHF-Nowinski & LoPiccolo 1979] When you have sex with your mate do you feel sexually aroused (e.g. feeling 'turned on', pleasure, excitement)? (nearly always to never)

[BISF-W – Taylor, 1994] Indicate how frequently you have become aroused by sexual activity [KM insertion] during the past month? Options: have not engaged in this activity; not at all; seldom, less than 25% of the time; sometimes, about 50% of the time, Usually, about 75% of the time, always became aroused

[BISF-W – Taylor, 2004] During the past month, have you felt pleasure from any forms of sexual experience? Options: I have not had a partner; have had no sexual experience during the past month; have not felt any pleasure; seldom, less than 25% of the time; sometimes, about 50% of the time; usually, about 75% of the time; always felt pleasure.

Getting and maintaining an erection (M)

[SSES-E – Libman, 1985] Get an erection sufficient to begin intercourse. Options: quite certain through moderately certain to quite uncertain (select number from 10 to 100)

[SSES-E – Libman, 1985] Keep an erection during intercourse until orgasm is reached. Options: quite certain through moderately certain to quite uncertain (select number from 10 to 100)

[EMAS-SFQ – O'Connor, 2008] In the last month – You are: Always able to keep an erection which would be good enough for sexual intercourse; usually able to keep an erection which would be good enough for sexual intercourse; sometimes able to keep an erection which would be good enough for sexual intercourse; never able to keep an erection which would be good enough for sexual intercourse

[BSFI – O'Leary, 1995] Over the past 30 days, when you had erections, how often were they firm enough to have sexual intercourse? Options: not at all; a few times; fairly often, usually, always

[BSFI – O'Leary, 1995] How much difficulty did you have getting an erection during the past 30 days? Options: did not get erections at all; a lot of difficulty; some difficulty; some difficulty; little difficulty; no difficulty

[GRISS – Rust & Golombok, 1985] Do you lose your erection during intercourse? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you get an erection during foreplay with your partner? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you fail to get an erection? Options: never; hardly ever, occasionally, usually, always.

[IIEF – Rosen, 1997] In the past four weeks: How often were you able to get an erection during sexual activity? Options: no sexual activity; almost never/never; a few times (much less than half the time); sometimes (about half the time); most times

(much more than half the time): almost always/always

[IIEF – Rosen, 1997] In the past four weeks: When you had erections with sexual stimulation, how often were your erections hard enough for penetration? Options: no sexual activity: almost never/never: a few times (much less than half the time): sometimes (about half the time): most times (much more than half the time): almost always/always

[IIEF – Rosen, 1997] In the past four weeks: When you attempted sexual intercourse, how often were you able to penetrate (enter) your partner? Options: did not attempt intercourse: almost never/never: a few times (much less than half the time): sometimes (about half the time): most times (much more than half the time): almost always/always

[IIEF – Rosen, 1997] In the past four weeks: During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse? Options: Did not attempt intercourse; Extremely difficult; Very difficult; Difficult; Slightly difficult; Not difficult

[IIEF – Rosen, 1997] In the past four weeks: During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner? Options: did not attempt intercourse: almost never/never: a few times (much less than half the time): sometimes (about half the time): most times (much more than half the time): almost always/always

[IIEF – Rosen, 1997] How do you rate your confidence that you could get and keep an erection? Options: Very low; Low; Moderate; High; Very high

[ASEX-M – McGahuey, 2000] Can you easily get and keep an erection? Options: 1 Extremely easily to 6, Never.

[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past 4 weeks - How many times did [you] have difficulty getting or keeping an erection?

[SAQ-O'Farrell, 1997] How often does the man have difficulty maintaining an erection when attempting intercourse? Options: 95+%; 75%, 50%, 25%, 5%, Never

[SFQoSL – Daker-White, 2003] During the past month, did you have problems getting erections? Did you have problems keeping or maintaining your erections?

[CSFQ – Clayton, 1997] Do you get an erection easily? And, Are you able to maintain an erection? Options: Never; Rarely (much less than half the time); sometimes (about half the time); often (much more than half the time).

[NATSAL – Mercer, 2005] In the last year, have you experienced any of the following for one month or longer/at least 6 months in the last year? 6) Had trouble achieving or maintaining an erection? (options: yes/no)

Adequate lubrication (W)

[ASEX- McGahuey, 2000] How easily does your vagina become moist or wet during sex? Options: extremely easily; very easily; somewhat easily; somewhat difficult; very difficult; never

[GRISS – Rust & Golombok, 1985] Does your vagina become moist during love making? Options: never; hardly ever, occasionally, usually, always.

[SFQ – Quirk, 2002] Over the last 4 weeks, how often did you notice vaginal wetness/lubrication when you took part in sexual activity? Options: 1 Not at all to 5. Every time

[SFQ – Quirk, 2002] Over the last 4 weeks, in general, how much wetness/lubrication did you notice when you took part in sexual activity? Options: 1 No wetness/lubrication to 5. Extremely wet/lubricated

[SEI-Bancroft, Loftus & Long, 2003] In the past 4 weeks, during sexual activity with your partner did you ever find that your vagina was uncomfortably dry? Options: Yes; No

[SFQoSL – Daker-White, 2003] During the past month, did vaginal dryness cause you problems during sex?

[CSFQ – Clayton, 1997] Do you have adequate vaginal lubrication during sexual activity? Options: Never; Rarely (much less than half the time); sometimes (about half the time); often (much more than half the time).

[FSFI – Rosen, 2000] Over the past 4 weeks, how difficult was it to become lubricated ('wet') during sexual activity or intercourse? Options: No sexual activity; extremely difficult or impossible; very difficult; difficult; slightly difficult; not difficult.

[Osborn, 1988] Do you experience vaginal dryness?

[NATSAL – Mercer, 2005] In the last year, have you experienced any of the following for one month or longer/at least 6 months in the last year? Had trouble lubricating? (options: yes/no)

Pain and discomfort

[GRISS – Rust & Golombok, 1985] Do you find your vagina is rather tight so that your partner's penis can't penetrate very far? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Is it possible for your partner's penis to enter your vagina without discomfort? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Is it possible to insert your finger into your vagina without discomfort? Options: never; hardly ever, occasionally, usually, always.

[GRISS – Rust & Golombok, 1985] Do you find that your vagina is so tight that your partner's penis cannot enter it? Options: never; hardly ever, occasionally, usually, always.

[SFQ – Quirk, 2002] Over the last 4 weeks, how often did you experience pain in your vagina/genital area during or after sexual activity? (e.g. penetration, intercourse) Options: 1 Not at all to 5. Every time

[SFQ – Quirk, 2002] Over the last 4 weeks, in general, how much pain did you experience in your vagina/genital area during or after sexual activity? (e.g. penetration, intercourse) Options: 1 No pain to 5. Extremely painful

[SFQ – Quirk, 2002] Over the last 4 weeks, how often have you been anxious or worried about pain during sexual activity? Options: 1 Not at all to 5. Every time (Includes the options: I did not take part in sexual activity because of being worried or anxious about pain, and I did not take part in sexual activity)

[SIDI-F – Clayton, 2006] Over the past month, did you experience genital pain during sex? Options: Yes and it made me stop, yes, but continued through the pain, yes but pain was transient, no pain, no sexual activity.

[SEI-Bancroft, Loftus & Long, 2003] On the (reported number) of occasions you had sexual activity with your partner in the past 4 weeks - How many times did you experience pain or discomfort as a result of the sexual activity?

[Sexual Dysfunction Scale-McCabe, 1998] Do you ever experience discomfort or pain during intercourse? Options: Never, rarely, sometimes, frequently, always

[SAQ- O'Farrell, 1997] How often does the woman experience pain with intercourse? How often is the man unable to enter the vagina when attempting intercourse because of pain or tight vaginal opening? Options: 95+%; 75%, 50%, 25%, 5%, Never

[SPEQ – Dennerstein 2002] Do you currently experience pain during intercourse?

[SFQoSL – Daker-White, 2003] Do you agree with the statement, 'I could not think about sex at the moment because of pain'

[CSFQ – Clayton, 1997] How often do you have painful intercourse? Options: Never; Rarely (much less than half the time); sometimes (about half the time); often (much more than half the time).

[FSFI – Rosen, 2000] Over the past 4 weeks, how would you rate your level (degree) of discomfort or pain during or following

vaginal penetration? Options: did not attempt intercourse; very high, high, moderate, low, very low or none at all.
 [Osborn, 1988] How often during the past three months have you had any difficulties in sexual intercourse because of discomfort (for example, pain)?
 [NATSAL – Mercer, 2005] In the last year, have you experienced any of the following for one month or longer/at least 6 months in the last year? 5) Experienced physical pain during intercourse (options: yes/no)
 [SHF-Nowinski & LoPiccolo, 1979] Do you feel pain in your genitals (sexual parts) during intercourse (never to nearly always)
 [BISF-W – Taylor, 1994] During the past month, how frequently have you experienced the following? Painful penetration or intercourse, vaginal tightness, lack of vaginal lubrication [others may be added]. Options: not at all; seldom, less than 25% of the time, sometimes, about 50% of the time, usually, about 75% of the time, always.

Partner experience of problems

[SFQ – Quirk, 2002] Thinking about the last 4 weeks, how much did you worry about your partner's negative feelings about your sexual life? (e.g. partner feeling angry, hurt, rejected) Options: Not at all; slightly; moderately; very; extremely
 [SFQoSL – Daker-White, 2003] During the past month, did your partner have a health or other problem that affected either their ability to make love or the level of sexual urges that they had? During the past month, was your partner able to satisfy you sexually?
 [SPEQ – Dennerstein, 2002] Does your partner experience difficulty in sexual performance?
 [Osborn 1988] Has your partner experienced any difficulties with sex? (probe – impotence, PE, low sex drive)? If yes, does it present a problem in sexual intercourse?
 [SHF-Nowinski & LoPiccolo, 1979] Do you feel that your partner plays a part in causing a problem in your sex life? (yes/no)

Perceived duration and severity of symptoms

[NATSAL – Mercer, 2005] In the last year, have you experienced any of the following for one month or longer OR at least 6 months in the last year?
 [Sexual Dysfunction Scale-McCabe, 1998] What percentage of the time is [symptom] a problem? Options: Less than 10% of the time; 25% of the time; 50% of the time; 75% of the time; All the time

Perception of a problem

[SQOL-M – Abraham, 2008] When I think about my sexual life I feel like I have lost something 6 Options from completely agree to completely disagree.
 [BSFI – O'Leary, 1995] In the past 30 days, to what extent have you considered a lack of sex drive to be a problem? Options: big problem; medium problem; small problem; very small problem; no problem
 [BSFI – O'Leary, 1995] In the past 30 days, to what extent have you considered your ability to get and keep erections to be a problem? Options: big problem; medium problem; small problem; very small problem; no problem
 [BSFI – O'Leary, 1995] In the past 30 days, to what extent have you considered your ejaculation to be a problem? Options: big problem; medium problem; small problem; very small problem; no problem
 [SFQ – Quirk, 2002] Thinking about the last 4 weeks, how much did you worry that your partner may look for another sexual relationship because of problems with your sex life? Options: 1 Not at all; slightly; moderately; Very; Extremely
 [SSS-W – Meston, 2005] I often feel something is missing from my present sex life. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree
 [SSS-W – Meston, 2005] I don't have any important problems about sex (arousal, orgasm, frequency, compatibility, communication etc.). Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree
 [SFQoSL – Daker-White, 2003] On a scale of 1-100 would you say that you had a problem with your sex life at the moment?
 [King, Holt & Nazareth, 2007] In general, do you think you have any kind of sexual problem, even of a mild nature? Options: Yes or No
 [BISF-W – Taylor, 1994] Indicate the frequency with which the following factors have influenced your level of sexual activity during the past month. My own health problems, My partner's health problems, conflict in the relationship, lack of privacy, Other. (see BISF-W response categories above)

Degree of distress

[SQOL-M – Abraham, 2008] I have lost confidence in myself as a sexual partner: 6 Options from completely agree to completely disagree.
 [SQOL-M – Abraham, 2008] When I think about my sexual life I feel frustrated 6 Options from completely agree to completely disagree.
 [SQOL-M – Abraham, 2008] When I think about my sexual life I feel depressed 6 Options from completely agree to completely disagree.
 [SQOL-M – Abraham, 2008] Question as above but with the following endings: I feel like less of a man; I feel angry; I am embarrassed; I feel guilty; I worry that my partner feels hurt or rejected
 [EMAS-SFQ – O'Connor, 2008] Are you worried or distressed by your current level of sexual drive/desire? OR by the overall frequency of your sexual activities (including intercourse, kissing and masturbation) OR by your current ability to have an erection? OR by your current orgasmic experience? OR by the frequency of your morning erections? Options: Not at all worried or distressed; a little bit worried or distressed; moderately worried or distressed; very worried or distressed; extremely worried or distressed.
 [SQOL-F – Symonds, 2005] When I think about my sexual life, I feel frustrated AND/OR I feel depressed AND/OR I feel like less of a woman AND/OR I feel good about myself AND/OR I feel angry. Options: Completely agree to completely disagree (6 point likert scale)
 [SSS-W – Meston, 2005] I'm worried that my sexual difficulties will adversely affect my relationship. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree
 [SSS-W – Meston, 2005] I'm worried that my partner will become frustrated with my sexual difficulties. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree
 [SSS-W – Meston, 2005] I'm so distressed about my sexual difficulties that it affects the way I feel about myself. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree
 [SSS-W – Meston, 2005] I'm so distressed about my sexual difficulties that it affects my own well-being. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree
 [SSS-W – Meston, 2005] My sexual difficulties annoy and anger me. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree
 [SSS-W – Meston, 2005] My sexual difficulties make me feel sexually unfulfilled. Options: strongly disagree, disagree a little, neither agree or disagree, agree a little, strongly agree

[SEI-Bancroft, Loftus & Long, 2003] During the past 4 weeks, how much distress or worry has your sexual relationship caused you? Options: A great deal; Moderate; Slight; None
[PFSF-McHorney, 2004] I felt distressed about sex. Options: always, very often, often, sometimes, seldom and never
[King, Holt & Nazareth, 2007] How distressing is this problem? Options: Very much, somewhat, a little, or not at all

Help seeking

[Natsal-Mercer, 2005] During the last year, have you contacted any of the following for help with [reported problem]? Options: GP, VD/STD/Sexual health clinic, Psychiatrist or psychologist, Marriage counsellor, other type of clinic or doctor and Contacted a helpline.

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REFERENCES

- Abraham, L., Symonds, T. & Morris, M.F. (2008). Psychometric Validation of a Sexual Quality of Life Questionnaire for Use in Men with Premature Ejaculation or Erectile Dysfunction. *Journal of Sexual Medicine*, 5(3), 595-601
- Acton (1857). *The Functions and Disorders of the Reproductive Organs in Youth, Adult Age and Advanced Life*. Cited in Hart, G., & Wellings, K. (2002). Sexual Behaviour and Its Medicalisation: In Sickness and in Health. *British Medical Journal*, 324(7342), 896-900.
- Althof, S.E., Corty, E.W., Levine, S.B., Levine, F., Burnett, A.L., Mcvary, K., Stecher, V. & Seftel, A.A.D. (1999). EDITS: Development of Questionnaires for Evaluating Satisfaction with Treatments for Erectile Dysfunction. *Urology*, 53(4), 793-799
- Althof, S.E. (2001). My Personal Distress over the Inclusion of Personal Distress. *Journal of Sex and Marital Therapy*, 27(2), 123-125.
- Althof, S.E., Leiblum, S., Chevret-Measson, M., Hartmann, U., Levine, S., McCabe, M., Plaut, M., Rodrigues, O., & Wylie, K. (2005a). Psychological and Interpersonal Dimensions of Sexual Function and Dysfunction. *Journal of Sexual Medicine*, 2(793-800).
- Althof, S.E., Rosen, R., Derogatis, L., Corty, E., Quirk, F., & Symonds, T. (2005b). Outcome Measurement in Female Sexual Dysfunction Clinical Trials: Review and Recommendations. *Journal of Sex & Marital Therapy*, 31, 153-166.
- Althof, S.E., Dean, J., Derogatis, L.R., Rosen, R.C. & Sisson, M. (2005c) Current Perspectives on the Clinical Assessment and Diagnosis of Female Sexual Dysfunction and Clinical Studies of Potential Therapies: A Statement of Concern. *Journal of Sexual Medicine*, 2(Suppl3), 146-153.
- American Psychiatric Association. (1980) *Diagnostic and Statistical Manual of Mental Disorders (3rd Edition) (DSM-III)*. Washington, DC: American Psychiatric Association.
- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders (4th Edition) (DSM-IV)*. Washington, DC: American Psychiatric Association.

- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, (Revised 4th Edition) (DSM-IV-TR)*. Washington, DC: American Psychiatric Association.
- Apfelbaum, B. (1988) An Ego-Analytic Perspective on Desire Disorders in R.C. Rosen & S.R. Leiblum (Eds) *Sexual Desire Disorders*. (Pp. 75-104). New York, NY, US: Guilford Press.
- Arrington, R., Cofrancesco, J., & Wu, A.W. (2004). Questionnaires to Measure Sexual Quality of Life. *Quality of Life Research*, 13, 1643-1658.
- Bailes, S., Creti, L., Fichten, C.S., Libman, E., Brender, W. & Amsel, R. (1998) Sexual Self-Efficacy Scale for Female Functioning. In S.M.Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L.Davis. & G. Schreer, G. (Eds) *Handbook of Sexuality-Related Measures*. (Pp. 531-533) Thousand Oaks, CA: Sage
- Baldwin, J.D., & Baldwin, J.I. (1997). Gender Difference in Sexual Interest. *Archives of Sexual Behavior*, 26(2), 181-209.
- Baldwin, D.S. (2001). Depression and Sexual Dysfunction. *British Medical Bulletin*, 57, 81-99.
- Balon, R., Segraves, R.T., & Clayton, A.H. (2007). Issues for DSM-V: Sexual Dysfunction, Disorder, or Variation along a Normal Distribution: Toward Rethinking DSM Criteria of Sexual Dysfunctions. *American Journal of Psychiatry*, 164(2), 198-199.
- Balon, R. (2007) Is Medicalisation and Dichotomization of Sexology the Answer? A Commentary. *Journal of Sex & Marital Therapy*, 33, 405-409
- Balon, R. (2008) The DSM Criteria of Sexual Dysfunction: Need for a Change. *Journal of Sex & Marital Therapy* 34, 186-197
- Bancroft, J. (1999). Central Inhibition of Sexual Response in the Male: A Theoretical Perspective. *Neuroscience and Biobehavioural Reviews*, 23, 763-84.
- Bancroft, J. & Janssen, E. (2000) The Dual Control Model of Male Sexual Response: A Theoretical Approach to Centrally Mediated Erectile Dysfunction. *Neuroscience and Biobehavioural Reviews*, 24, 571-579
- Bancroft, J., Graham, C., & McCord, C. (2001). Conceptualising Women's Sexual Problems. *Journal of Sex & Marital Therapy*, 27, 95-103.
- Bancroft, J. (2002). The Medicalisation of Female Sexual Dysfunction: The Need for Caution. *Archives of Sexual Behaviour*, 31, 451-455.

- Bancroft, J., Loftus, J., & Long, J.S. (2003a). Distress about Sex: A National Survey of Women in Heterosexual Relationships. *Archives of Sexual Behavior*, 32(3), 193-208.
- Bancroft, J. Janssen, E., Strong, D. & Vukadinovic, Z. (2003b) The Relation between Mood and Sexuality in Gay Men. *Archives of Sexual Behaviour*, 32(3), 231-242
- Bancroft, J., Janssen, E., Strong, D., Carnes, L., Vukadinovic, Z. & Long, J.S. (2003c) The Relation between Mood and Sexuality in Heterosexual Men. *Archives of Sexual Behaviour*, 32 (3), 217-230.
- Bancroft J. & Vukadinovic Z. (2004) Sexual Addiction, Sexual Compulsivity, Sexual Impulsivity, or What? Toward a Theoretical Model. *Journal of Sex Research*, 41(3), 225-34
- Bancroft, J., Carnes, L., Janssen, E., Goodrich, D., & Long, J.S. (2005a). Erectile and Ejaculatory Problems in Gay and Heterosexual Men. *Archives of Sexual Behavior*, 34(3), 285-297.
- Bancroft, J. (2005) A History of Sexual Medicine in the United Kingdom. *Journal of Sexual Medicine*, 2(4), 569-574
- Bancroft, J., Herbenick, D., Barnes, T., Hallam-Jones, R., Wylie, K. & Janssen, E. (2005b) The Relevance of the Dual Control Model to Male Sexual Dysfunction: The Kinsey Institute/BASRT Collaborative Project. *Sexual and Relationship Therapy*, 20(1), 13-30.
- Bancroft, J. (In Press) *Human Sexuality and Its Problems*. Oxford, UK: Elsevier.
- Barlow, D.H. (1986) Causes of Sexual Dysfunction: The Role of Anxiety and Cognitive Interference. *Journal of Consulting and Clinical Psychology*, 54(2), 140-148
- Barnes, T., & Eardley, I. (2007). Premature Ejaculation: The Scope of the Problem. *Journal of Sex & Marital Therapy*, 33, 151-170.
- Barsky, J., Friedman, M., & Rosen, R. (2006). Sexual Dysfunction and Chronic Illness: The Role of Flexibility in Coping. *Journal of Sex & Marital Therapy*, 32, 235-253.
- Bass, B.A. (1995). In Further Support of the Perfect Penis: The Medicalisation of Male Sexual Dysfunction. *Journal of Sex & Marital Therapy*, 20, 318-320.

- Basson, R., & Riley, A.J. (1994) Vulvar Vestibulitis Syndrome: A Common Condition Which May Present as Vaginismus. *Journal of Sex and Marital Therapy*, 9, 221-224
- Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., Laan, E., Leiblum, S., Padma-Nathan, H., Rosen, R., Segraves, K., Segraves, R.T., Shabsigh, R., Sipski, M., Wagner, G. & Whipple, B. (2000) Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications. *Journal of Urology*, 163, 888-93.
- Basson, R. (2000) The Female Sexual Response: A Different Model. *Journal of Sex & Marital Therapy*, 26, 1-64.
- Basson, R. (2001a). Female Sexual Response: The Role of Drugs in the Management of Sexual Dysfunction. *Obstetrics & Gynaecology*, 98(2), 350-353.
- Basson, R., Berman, J., Burnett, A., L, D., Ferguson, D., Fourcroy, J., Goldstein, I., Graziottin, A., Heiman, J., Laan, E., Leiblum, S., Padma-Nathan, H., R., R., Segraves, K., Segraves, R.T., Shabsigh, R., Sipski, M., Wagner, G., & Whipple, B. (2001). Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications. *Journal of Sex & Marital Therapy*, 27, 83-94.
- Basson, R. (2001b). Are the Complexities of Women's Sexual Function Reflected in the New Consensus Definitions of Dysfunction? *Journal of Sex and Marital Therapy*, 27(2), 105-112.
- Basson, R. (2002). A Model of Women's Sexual Arousal. *Journal of Sex & Marital Therapy*, 28(1), 1-10.
- Basson, R., & Leiblum, S. (2003). Without Industry Funding Little New Research Will be Possible. *British Medical Journal*, 326, 658.
- Basson, R., Leiblum, S., Brotto, L., Derogatis, L., Fourcroy, J., Fugl-Meyer, K., Graziottin, A., Heiman, J.R., Laan, E., Meston, C., Schover, L., Van Lankveld, J., & Schultz, W.W. (2003). Definitions of Women's Sexual Dysfunction Reconsidered: Advocating Expansion and Revision. *J Psychosom Obstet Gynaecol*, 24(4), 221-229.
- Basson, R., Althof, S.E., Davis, S., Fugl-Meyer, K., Goldstein, I., Leiblum, S., Meston, C., Rosen, R., & Wagner, G. (2004a). Summary of the

- Recommendations of Sexual Dysfunctions in Women. *Journal of Sexual Medicine*, 1(1), 24-34
- Basson, R., Leiblum, S., Brotto, L., Derogatis, L., Fourcroy, J., Fugl Meyer, K., Graziottin, A., Heiman, J., Laan, E., Meston, C., Schover, L., Van Lankveld, J., & Schultz, W.W. (2004b). Revised Definitions of Women's Sexual Dysfunction. *Journal of Sexual Medicine*, 1(1), 40-48.
- Basson, R., Brotto, L., Laan, E., Redmond, G., & Wulf, U. (2005). Assessment and Management of Women's Sexual Dysfunctions: Problematic Desire and Arousal. *Journal of Sexual Medicine*, 2, 291-300.
- Basson, R. (2006) Sexual Desire and Arousal Disorders in Women. *New England Journal of Medicine*, 354, 1497-506.
- Basson, R., & Schultz, W.W. (2007). Sexual Sequelae of General Medical Disorders. *The Lancet*, 369, 409-424.
- Baumeister, R. (2000). Gender Difference in Erotic Plasticity: The Female Sex Drive as Socially Flexible and Responsive. *Psychological Bulletin*, 126(3), 347-374.
- Baumeister, R., Catanese, K., & Vohs, K. (2001). Is There a Gender Difference in Strength of Sex Drive? Theoretical Views, Conceptual Distinctions, and a Review of Relevant Evidence. *Personality and Social Psychology Review*, 5(3), 242-273.
- Baumeister, R. (2004). Gender and Erotic Plasticity: Socio-cultural Influences on the Sex Drive. *Sexual and Relationship Therapy*, 19(2), 133-139.
- Beach, S., Wamboldt, M., Kaslow, N., Heyman, R., & Reiss, D. (2006). Describing Relationship Problems in DSM-V: Toward Better Guidance for Research and Clinical Practice. *Journal of Family Psychology*, 20(3), 359-368.
- Bean, J.L. (2002). Expressions of Female Sexuality. *Journal of Sex & Marital Therapy*, 28(Suppl 1), 29-38.
- Beattie, J (2003) Psychosexual Problems in General Practice. *British Medical Journal*, 237 [Rapid Response – [Http://British Medical Journal.British Medical Journaljournals.Com/Cgi/Eletters/327/7412/423](http://BritishMedicalJournal.BritishMedicalJournaljournals.Com/Cgi/Eletters/327/7412/423)]
- Beck, A.T. & Steer, R.A. (1987) *The Beck Depression Inventory*. San Antonio, TX: The Psychological Corporation/Harcourt Brace Jovanovitch
- Beck, J. (1995). Hypoactive Sexual Desire Disorder: An Overview. *Journal of Consulting and Clinical Psychology*, 63(6), 919-927.

- Bell, A.P. & Weinberg, M.S. (1978) *Homosexualities: A Study of Diversity among Men and Women*. New York: Simon and Schuster
- Benedict, A. (1995) Attributions of Causes for Chronic Illness among Aged Persons. *Activities, Adaptation and Aging*, 19(4), 49-59.
- Berger, P.L. & Luckmann, T. (1966) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. New York: Doubleday
- Berman, L., Berman, J., Werbin, T., Chabra, S. & Goldstein, I. (2001) The Use of the Female Intervention Efficacy Index (FIEI) as An Immediate Outcome Measure of Medical Intervention to Treat Female Sexual Dysfunction. *Journal of Sex & Marital Therapy*, 27:427-433
- Beutel M.E., Weidner W., Daig I., Brahler E. (2007). Epidemiology of Sexual Dysfunction in Males. *Journal Fur Reproduktionsmedizin Und Endokrinologie*, 4(5), 244-249
- Bhaskar, R.A. (1989) *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy*. London: Verso
- Bhugra, D., & De Silva, P. (1993). Sexual Dysfunction across Cultures. *International Review of Psychiatry*, 5(2-3), 243-252.
- Bhugra, D. & Wright, B. (1995) Sexual Dysfunction in Gay Men: Diagnosis and Management. *International Review of Psychiatry*, 7(2), 247-252.
- Binik, Y.M., Pukall, C.F., Reissing, E.D., & Khalife, S. (2001). The Sexual Pain Disorders: A Desexualized Approach. *Journal of Sex and Marital Therapy*, 27(2), 113-116.
- Binik, Y.M. (2005). Should Dyspareunia be retained as a Sexual Dysfunction in DSM-V? A Painful Classification Decision. *Archives of Sexual Behaviour*, 34(1), 11-21.
- Bland, J.M. & Altman, D.G. (1997) Statistic Notes: Cronbach's Alpha. *British Medical Journal*, 314, 572
- Both, S., & Everaerd, W. (2002). Comment on 'The Female Sexual Response: A Different Model'. *Journal of Sex & Marital Therapy*, 28(1), 11-15.
- Bova, C., & Durante, A. (2003). Sexual Functioning among HIV-Infected Women. *AIDS Patient Care and STDs*, 17, 75-83.
- Boyle, M. (1993). Sexual Dysfunction or Heterosexual Dysfunction? *Feminism and Psychology*, 3(1), 73-88.

- Bradford, A., Meston, C.M. (2007). Senior Sexual Health: The Effects of Aging on Sexuality. In: L. Vandecreek, F. L. Peterson, & J. W. Bley (Eds.), *Innovations in Clinical Practice: Focus on Sexual Health* (Pp. 35-45). Sarasota, Florida: Professional Resources Press.
- Brandtstadter, J., & Renner, G. (1990). Tenacious Goal Pursuit and Flexible Goal Adjustment: Explication and Age-Related Analysis of Assimilative and Accommodative Strategies of Coping. *Psychology and Aging*, 5(1), 58-67.
- Bridges, S., & Home, S.G. (2007). Sexual Satisfaction and Desire Discrepancy in Same Sex Women's Relationships. *Journal of Sex & Marital Therapy*, 33, 41-53.
- Broderick, G. (2006). Premature Ejaculation: On Defining and Quantifying a Common Male Sexual Dysfunction. *Journal of Sexual Medicine*, 3 (Suppl 4), 295-302.
- Brotto, L.A. (2007) More Non-industry Funding is needed for Sexological Sciences to Endure. *Journal of Sex & Marital Therapy*, 33, 411-413
- Burnett, A.L. (2001). Physiologic Applications of the New Female Sexual Response Classification System. *Journal of Sex and Marital Therapy*, 27(2), 121-122.
- Busby, D.M., Crane, D.R., Larson, J.H. & Christensen, C. (1995). A Revision of the Dyadic Adjustment Scale for Use with Distressed and Non-Distressed Couples: Construct Hierarchy and Multidimensional Scales. *Journal of Marital and Family Therapy*, 21 (3), 289-308
- Busko, M. (2007) Why Dimensional as Well as Categorical Diagnoses are Needed in DSM-V. Medscape Medical News, Available At [Http://Www.Medscape.Com/Viewarticle/558395](http://www.Medscape.Com/Viewarticle/558395); Accessed on 27 June, 2007.
- Bury, M. (1988) Meanings at Risk: The Experience of Arthritis. In R. Anderson and M. Bury (Eds). *Living with Chronic Illness: The Experience of Patients and their Families*. London: Unwin Hyman
- Bury, M. (1991) The Sociology of Chronic Illness: A Review of Research and Prospects. *Sociology of Health and Illness*, 13(4), 451-68
- Butcher, J. (1999). Female Sexual Problems 1: Loss of Desire. In J. Tomlinson (Ed.), *ABC of Sexual Health* (Pp. 19-21). London: BMJ Books.
- Byers, S.E. (2001) Evidence for the Importance of Relationship Satisfaction for Women's Sexual Functioning. In E. Kaschak & L. Tiefer (Eds.) *A New View of Women's Sexual Problems* (Pp 23-26). New York: The Haworth Press

- Byers, E.S., & Grenier, G. (2003). Premature or Rapid Ejaculation: Heterosexual Couples' Perceptions of Men's Ejaculatory Behaviour. *Archives of Sexual Behavior*, 32(3), 261-270.
- Byers, E.S., & MacNeil, S. (2006). Further Validation of the Interpersonal Exchange Model of Sexual Satisfaction. *Journal of Sex & Marital Therapy*, 32, 53-69.
- Camden Council (2007). Camden Demographic Profile 2007:
[Http://Www.Camden.Gov.Uk/Ccm/Cms-Service/Stream/ Asset/?Asset Id =576779](http://www.camden.gov.uk/ccm/cms-service/stream/asset/?asset_id=576779). Accessed on 06/07/2007.
- Candib, L. (2001) 'A New View of Women's Sexual Problems' – A Family Physician's Response. (Pp 9-15) In E. Kaschak & L. Tiefer (Eds.) *A New View of Women's Sexual Problems*. New York: Haworth Press, Inc.
- Cano, S., J. Browne, Lamping, D.L., Roberts, A.H., Mcgrouter, D.A. & Black, N.A. (2004). The Patient Outcomes of Surgery-Hand/Arm (POS-Hand/Arm): A New Patient-Based Outcome Measure. *Journal of Hand Surgery (British and European Volume)* 29B(5): 477-485.
- Cappelleri, J.C., Siegel, R.L., Glasser, D.B., Osterloh, I.H & Rosen, R.C. (2001) Relationship between Patient Self-Assessment of Erectile Dysfunction and the Sexual Health Inventory for Men (SHIM). *Clinical Therapeutics*, 23(10), 1707-19
- Cappelleri, J., Althof, S., Siegel, R., Shipilsky, A., Bell, S. & Dutttagupta S. (2004) Development and Validation of the Self-Esteem and Relationship (SEAR) Questionnaire in Erectile Dysfunction. *International Journal of Impotence Research*, 16, 30-38
- Carpenter, K.M. & Andersen, B.L. (2005) Reclassification Will Not Make the Pain Go Away. *Archives of Sexual Behaviour*, 34(1), 26-28
- Carroll, J.L., Volk, K.D., Hyde, J.S. (1985). Difference between Males and Females in Motives for Engaging in Sexual Intercourse. *Archives of Sexual Behaviour*, 14,131-139
- Carroll, R.A. (2007) Premature Obituary? Commentary on Rowland's Article *Journal of Sex & Marital Therapy*, 33, 415-420
- Carson, R. (1991). Dilemmas in the Pathway of the DSM-IV. *Journal of Abnormal Psychology*, 100, 302-307.
- Catania, J., Gibson, D., Chitwood, D. & Coates, T. (1990) Methodological Problems in AIDS Behavioural Research: Influences on Measurement Error and

- Participation Bias in Studies of Sexual Behaviour. *Psychological Bulletin*, 108, 339-362
- Cayan, S., Bozlu, M., Canpolat, B., & Akbay, E. (2004). The Assessment of Sexual Functions in Women with Male Partners Complaining of Erectile Dysfunction: Does Treatment of Male Sexual Dysfunction Improve Female Partner's Sexual Functions? *Journal of Sex & Marital Therapy*, 30, 333-341.
- Chalder, T., Power, M.J., Wessely, S. (1996) Chronic Fatigue in the Community: 'A Question of Attribution.' *Psychological Medicine*, 26(4), 791-800.
- Charmaz, K. (2000) Experiencing Chronic Illness, In G.L. Albrecht, R. Fitzpatrick & S.C. Scrimshaw (Eds) *The Handbook of Social Studies in Health and Medicine*, London: Sage.
- Charmaz, C. (2006) *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage
- Charon, J. (2007). *Symbolic Interactionism: An Introduction, an Interpretation, an Integration*. New Jersey: Pearson Education, Inc.
- Chen, J. & Ho, S.C. (1999). Contraceptive Status and Sexual Function of Climacteric Chinese Women. *Contraception*, 59(2), 85-90.
- Chevret, M., Jaudinot, E., Sullivan, K., Marrel, A., & De Gendre, A.S. (2004). Quality of Sexual Life and Satisfaction in Female Partners of Men with ED: Psychometric Validation of the Index of Sexual Life (ISL) Questionnaire. *Journal of Sex and Marital Therapy*, 30(3), 141-155a
- Chevret, M., Jaudinot, E., Sullivan, K., Marrel, A., & Solesse De Gendre, A. (2004). Impact of Erectile Dysfunction on Sexual Life of Female Partners: Assessment with the Index of Sexual Life (ISL) Questionnaire. *Journal of Sex & Marital Therapy*, 30, 157-172b.
- Christopher, E. (1987). *Sexuality and Birth Control in Community Work* London: Tavistock Publications
- Clayton, A.H., McGarvey, E.L., & Clavet, G.J. (1997a). The Changes in Sexual Functioning Questionnaire (CSFQ): Development, Reliability, and Validity. *Psychopharmacology Bulletin*, 33(4), 731-745.
- Clayton, A.H., Mcgarvey, E.L., Clavet, G.J., & Piazza, L. (1997b). Comparison of Sexual Functioning in Clinical and Non-clinical Populations using the Changes in Sexual Functioning Questionnaire (CSFQ). *Psychopharmacology Bulletin*, 33(4), 747-753.

- Clayton, A.H., Segraves, R.T., Leiblum, S., Basson, R., Pyke, R., Cotton, D., Lewis-D'agostino, D., Evans, K., Sills, T., & Wunderlich, G. (2006). Reliability and Validity of the Sexual Interest and Desire Inventory-Female (SIDI-F), A Scale Designed to Measure Severity of Female Hypoactive Sexual Desire Disorder. *Journal of Sex & Marital Therapy*, 32, 115-135.
- Cleary, P.D. (1997). Subjective and Objective Measures of Health: Which Is Better When? *Journal of Health Services Research and Policy*, 2(1), 3-4.
- Clement, U. (2002). Sex in Long-Term Relationships: A Systemic Approach to Sexual Desire Problems. *Archives of Sexual Behavior*, 31(3), 241-246.
- Coleman, E. & Reece, R. (1986) Treating Low Sexual Desire among Gay Men. In S.R. Leiblum & R.C. Rosen (Eds) *Sexual Desire Disorders* (Pp 413-445) New York: Guilford Press.
- Conaglen, H.M. (2001). Report of the International Consensus Development Conference on Female Sexual Dysfunction: A View from Down Under. *Journal of Sex and Marital Therapy*, 27(2), 127-130.
- Conaglen, H. M. & Conaglen, J.V. (2008) The Impact of Erectile Dysfunction on Female Partners: A Qualitative Investigation. *Sexual and Relationship Therapy*, 23(2), 147-156
- Constant, A., Castera, L., Quintard, B., Bernard, P.H., De-Ledinghen, V., Couzigou, P. & Bruchon-Schweitzer, M. (2005) Psychosocial Factors Associated with Perceived Disease Severity in Patients with Chronic Hepatitis C: Relationship with Information Sources and Attentional Coping Styles. *Psychosomatics: Journal of Consultation Liaison Psychiatry*, 46(1), 25-33.
- Conte, H.R. (1983). Development and Use of Self-Report Techniques for Assessing Sexual Functioning: A Review and Critique. *Archives of Sexual Behaviour*, 12, 555-576.
- Corona, G., Jannini, E., & Maggi, M. (2006). Inventories for Male and Female Sexual Dysfunctions. *International Journal of Impotence Research*, 18, 236-250.
- Corty, E.W., Althof, S.E., & Kurit, D.M. (1996). The Reliability and Validity of a Sexual Functioning Questionnaire. *Journal of Sex and Marital Therapy*, 22(1), 27-34.
- Costa, P., Arnould, B., Cour, F., Boyer, P., Marrel, A., Jaudinot, E.O. & Sollesse De Gendre A. (2003) Quality of Sexual Life Questionnaire (QVS): A Reliable, Sensitive and Reproducible Instrument to Assess Quality of Life in Subjects

- with Erectile Dysfunction. *International Journal of Impotence Research*, 15(3), 173-184
- Cranston-Cuebas, M.A. & Barlow, D.H. (1990) Cognitive and Affective Contributions to Sexual Functioning *Annual Review of Sex Research*, 1, 119-161
- Creti, L., Fichten, C.S., Amsel, R., Brender, W., Schover, L.R., Kalogeropoulos, D. & Libman, E. (1998) Global Sexual Functioning: A Single Summary Score for Nowinski and Lopiccolo's Sexual History Form (SHF). In S.M.Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L.Davis. & G. Schreer, G. (Eds) *Handbook of Sexuality-Related Measures*. (Pp.261-267) Thousand Oaks, CA: Sage
- Croog, S.H., Levine, S., Testa, M.A., Brown, B., Bulpitt, C.J., Jenkins, C.D. et al. (1986) The Effects of Antihypertensive Therapy on the Quality of Life. *New England Journal of Medicine*, 314, 1657-1664. Cited in Daker-White, G. (2002). Reliable and Valid Self-Report Outcome Measures in Sexual (Dys)function: A Systematic Review. *Archives of Sexual Behaviour*, 31(2), 197-209.
- Crowe, M. (1995). Couple Therapy and Sexual Dysfunction. *International Review of Psychiatry*, 7(2), 195-204.
- Criteria Committee, New York Heart Association.(1964) *Diseases of the Heart and Blood Vessels. Nomenclature and Criteria for Diagnosis, 6th Ed.* (Pp. 114) Boston: Little, Brown and Co.
- Cyranowski, J.M., Aarestad, S., & Andersen, B. (1999). The Role of Sexual Self-Schema in a Diathesis-Stress Model of Sexual Dysfunction. *Applied and Preventive Psychology*, 8, 217-228.
- Daker-White, G. (2002). Reliable and Valid Self-Report Outcome Measures in Sexual (Dys)Function: A Systematic Review. *Archives of Sexual Behaviour*, 31(2), 197-209.
- Daker-White, G., & Crowley, T. (2003). Sexual Function and Quality of Life in Genitourinary Medicine (GUM) Outpatients and Preliminary Validation of a Self-Report Questionnaire Measure. *Quality of Life Research*, 12(3), 315-325.
- Davies, S., Katz, J., & Jackson, J. (1999). Sexual Desire Discrepancies: Effects on Sexual and Relationship Satisfaction in Heterosexual Dating Couples. *Archives of Sexual Behavior*, 28(6), 553-567.

- Davis, S.R. (2001). An External Perspective on the Report of the International Consensus Development Conference on Female Sexual Dysfunction: More Work to be Done. *Journal of Sex and Marital Therapy*, 27(2), 131-133.
- Davis, S.M., Yarber, W.L., Bauserman, R., Schreer, G.E., Davis, S.L. & Schreer, G. (1998) *Handbook of Sexuality-Related Measures*. Thousand Oaks, CA: Sage
- Delamater, J., & Shibley Hyde, J. (1998). Essentialism Vs. Constructionism in the Study of Human Sexuality. *The Journal of Sex Research*, 35(1), 10-18.
- Denis, A. & Hong, S. (2003). Sexual Functioning of Women with HIV: A Comparison with Non-HIV Women. *The Canadian Journal of Human Sexuality* 12: 97-107.
- Dennerstein, L., Lehert, P., Burger, H. & Dudley, E. (1999) Factors Affecting Sexual Functioning of Women in the Midlife Years. *Climacteric*, 2, 254-62.
- Dennerstein, L. (2001). Clinical and Research Perspective. *Journal of Sex and Marital Therapy*, 27(2), 135-136.
- Dennerstein, L., Lehert, P., & Dudley, E. (2001). Short Scale to Measure Female Sexuality: Adapted from McCoy Female Sexuality Questionnaire. *Journal of Sex & Marital Therapy*, 27(4), 339-351.
- Dennerstein, L., Dudley, E. & Burger (2001) Are Changes in Sexual Functioning During Midlife Due to Aging or Menopause? *Fertility and Sterility*, 76(3), 456-460)
- Dennerstein, L., Anderson-Hunt, M., & Dudley, E. (2002). Evaluation of a Short Scale to Assess Female Sexual Functioning. *Journal of Sex & Marital Therapy*, 28(5), 389-397.
- Denton, W.H. (2007) Issues for DSM-V: Relational Diagnosis: An Essential Component of Biopsychosocial Assessment. *American Journal of Psychiatry*, 164,1146-1147.
- Department of Health (2001). *The National Strategy for Sexual Health and HIV*. London: Department of Health.
- Derogatis, L. & Meyer, J.K. (1979) A Psychological Profile of the Sexual Dysfunctions. *Archives of Sexual Behavior*, 8, 201-224.
- Derogatis, L.R. (1997). The Derogatis Interview for Sexual Functioning (DISF/DISF-SR): An Introductory Report. *Journal of Sex & Marital Therapy*, 23(4), 291-304.

- Derogatis, L.R. (1998) The Derogatis Sexual Functioning Inventory. In S.M.Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L.Davis. & G. Schreer, G. (Eds) *Handbook of Sexuality-Related Measures*. (Pp 269-271) Thousand Oaks, CA: Sage
- Derogatis, L.R., Rosen, R., Leiblum, S., Burnett, A., & Heiman, J. (2002). The Female Sexual Distress Scale (FSDS): Initial Validation of a Standardized Scale for Assessment of Sexually Related Personal Distress in Women. *Journal of Sex & Marital Therapy*, 28(4), 317-330.
- Derogatis, L.R. & Burnett, A. L. (2008) The Epidemiology of Sexual Dysfunctions. *Journal of Sexual Medicine*, 5, 289-300
- Dillman, D. (1978) *Mail and Telephone Surveys: The Total Design Method*. New York: Wiley
- Dunn, K.M., Croft, P.R. & Hackett, G.I. (1998) Sexual Problems: A Study of Prevalence and the Need for Health Care in the General Practice. *Family Practice*, 15, 519-524
- Dunn, K.M., Croft, P.R., & Hackett, G. (2000). Satisfaction in the Sex Life of a General Population Sample. *Journal of Sex & Marital Therapy*, 26, 141-151.
- Dunn, K.M., Jordan, K., Croft, P.R., & Assendelft, W.J. (2002). Systematic Review of Sexual Problems: Epidemiology and Methodology. *Journal of Sex and Marital Therapy*, 28(5), 399-422.
- Eisner, E. (1981) On the Difference between Scientific and Artistic Approaches to Qualitative Research. *Educational Researcher*, 10, 5-9 Cited in Kelle, U. (2004) See Below.
- Ellison, C.R. (2000) *Women's Sexualities*. Oakland, CA: New Harbinger.
- Ellison, C.R. (2001) A Research Inquiry into Some American Women's Sexual Concerns and Problems (Pp 147-159) In E. Kaschak & L. Tiefer (Eds.) *A New View of Women's Sexual Problems*. New York: Haworth Press, Inc.
- Everaerd, W., & Both, S. (2001). Ideal Female Sexual Function. *Journal of Sex and Marital Therapy*, 27(2), 137-139.
- Feldman, H.A., Goldstein, I. Hatzichristou, D.G., Krane, R.J. & Mckinlay, J.B. (1994) Impotence and Its Medical and Psychosocial Correlates: Results of the Massachusetts Male Ageing Study. *Journal of Urology*, 151, 54-61
- Fichten, C. S., Spector, I. & Libman, E. (1988) Client Attributions for Sexual Dysfunction. *Journal of Sex and Marital Therapy*, 14(3), 208-224.

- Fineman, K.R. & Rettinger, H.I. (1991) Development of the Male Function Profile/Impotence Questionnaire. *Psychological Reports*, 68, 1151-1175.
Cited in Daker-White, G. (2002). Reliable and Valid Self-Report Outcome Measures in Sexual (Dys)Function: A Systematic Review. *Archives of Sexual Behaviour*, 31(2), 197-209.
- First, M.B., Bell, C.C., Cuthbert, B., Krystal, J.H., Malison, R., Offord, D.R., Reiss, D., Shea, M.T., Widiger, T. & Wisner, K.L. (2002) Personality and Relational Disorders: A Research Agenda for Addressing Crucial Gaps in DSM. In: D.J. Kupfer, M.B. First, D.A. Regier (Eds.) *A Research Agenda for DSM-V*. (Pp 123-199) Washington DC: American Psychiatric Association.
- First, M.B. (2005) Mutually Exclusive Versus Co-Occurring Diagnostic Categories: The Challenge of Diagnostic Co-morbidity. *Psychopathology*, 38(4), 206-210
- First, M.B. (2006). Relational Processes in the DSM-V Revision Process: Comment on the Special Edition. *Journal of Family Psychology*, 20(3), 356-358.
- Fisher, W.A., Rosen, R., Eardley, I., Sand, M., & Goldstein, I. (2005). Sexual Experience of Female Partners of Men with Erectile Dysfunction: The Female Experience of Men's Attitudes to Life Events and Sexuality (FEMALES) Study. *Journal of Sexual Medicine*, 2, 675-684.
- Food & Drugs Authority Guidance Document, Guidance for Industry: Female Sexual Dysfunction: Clinical Development of Drug Products for Treatment (2000)
[Www.Fda.Gov/Cder/Guidance/3312dft.Htm](http://www.fda.gov/cder/guidance/3312dft.htm)
- Foucault, M. (1979). *The Will to Knowledge: The History of Sexuality Volume 1*
London: Penguin Books
- Frenken, J. & Vennix, P. (1981) *Sexuality Experience Scales: Manual*. Netherlands Institute for Social Sexological Research. Zeit, Netherlands: Swets & Zeitlinger. Cited in Daker-White, G. (2002). Reliable and Valid Self-Report Outcome Measures in Sexual (Dys)function: A Systematic Review. *Archives of Sexual Behaviour*, 31(2), 197-209.
- Freud, S. (1953) *The Standard Edition of the Complete Works of Sigmund Freud*, VII (Pg 26) London: Hogarth Press. Cited in Hoenig, J. (1976) Sigmund Freud's Views on the Sexual Disorders in Historical Perspective. *British Journal of Psychiatry*, 129, 193-200

- Fugl-Meyer, A.R. & Fugl-Meyer, K.S. (1999) Sexual Disabilities, Problems and Satisfaction in 18-74 Year Old Swedes. *Scandinavian Journal of Sexology*, 2, 79-105
- Gabe, J., Bury, M., & Elston, M. (2004). *Key Concepts in Medical Sociology* London: Sage
- Gagnon, J.H. & Simon, W. (1973) *Sexual Conduct: The Social Sources of Human Sexuality*. Hutchinson; London
- Gagnon, J., Rosen, R., & Leiblum, S. (1982). Cognitive and Social Aspects of Sexual Dysfunction: Sexual Scripts in Sex Therapy. *Journal of Sex & Marital Therapy*, 8(1), 44-56.
- Garratt, A., Torgerson, D., Wyness, J. Hall, M.H. & Reid, D.M. (1995) Measuring Sexual-Functioning in Premenopausal Women. *British Journal of Obstetrics & Gynaecology*, 102:311-316
- Geisser, M., Murray, F., Cohen, M., Shea, P. & Addeo, R. (1993) Use of the Florida Sexual History Questionnaire to Differentiate Primary Organic from Primary Psychogenic Impotence. *Journal of Andrology*, 14, 298-303
- Giddens, A. (1992). *The Transformation of Intimacy* Cambridge: Polity Press
- Giraldi, A. & Kristensen, E. (2007) Medical Solutions Have Improved the Treatment of Sexological Problems and Created More Demand for Sexological Care. *Journal of Sex & Marital Therapy*, 33, 433-437
- Glaser, B.G. & Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine
- Glick, H.A., Mccarron, T.J., Althof, S.E., Corty, E.W., & Willke, R.J. (1997). Construction of Scales for the Center for Marital and Sexual Health (CMASH) Sexual Functioning Questionnaire. *Journal of Sex & Marital Therapy*, 23(2), 103-117.
- Godson, S. (2002) *The Sex Book*. London: Cassell Illustrated
- Goldacre, B. (2007). Given the Choice, I'd Rather Have the Miracle Pill Story. *British Medical Journal*, 334, 932.
- Goldmeier, D., Judd, A., & Schroeder, K. (2000). Prevalence of Sexual Dysfunction in New Heterosexual Attendees at a Central London Genitourinary Medicine Clinic in 1998. *Sexually Transmitted Infections*, 76(3), 208-209.
- Goldmeier, D. (2001). 'Responsive' Sexual Desire in Women - Managing the Normal? *Sexual and Relationship Therapy*, 16(4), 381-387.

- Gott, M., & Hinchliff, S. (2003a). Barriers to Seeking Treatment for Sexual Problems in Primary Care: A Qualitative Study with Older People. *Family Practitioner*, 20(6), 690-695
- Gott, M., & Hinchliff, S. (2003b). How Important Is Sex in Later Life? The Views of Older People. *Social Science & Medicine*, 56, 1617-1628.
- Gott, M., Hinchliff, S., & Galena, E. (2004). General Practitioner Attitudes to Discussing Sexual Health Issues with Older People. *Social Science & Medicine*, 58(11), 2093-2103.
- Graham, C.A., Sanders, S.A., Milhausen, R. & McBride, K. (2004) Turning on and Turning Off: A Focus Group Study of the Factors That Affect Women's Sexual Arousal. *Archives of Sexual Behaviour*, 33, 527-38.
- Graham, C., & Bancroft, J. (2005). Assessing the Prevalence of Female Sexual Dysfunction with Surveys; What Is Feasible? In I. Goldstein, C. Meston, S. Davis, & A. Traish (Eds.), *Women's Sexual Function and Dysfunction: Study, Diagnosis and Treatment*. UK: Taylor and Francis.
- Graham, C., Sanders, S., & Milhausen, R. (2006). The Sexual Excitation/Sexual Inhibition Inventory for Women: Psychometric Properties. *Archives of Sexual Behavior*, 35, 397-409.
- Graham, C.A. & Bancroft, J. (2008) The Sexual Dysfunctions. In: Gelder M, Lopez-Ibor, J, Andreasen N, and Geddes J, Eds. *New Oxford Textbook of Psychiatry. 2nd Edition*. (Pp 472-483) Oxford: Oxford University Press.
- Granvold, D.K. (2001) Promoting Long Term Sexual Passion. *Constructivism in the Human Sciences*, 6(1-2), 73-83.
- Granzig, W.A. (2006) The Legacy of Alfred C. Kinsey. *Sexuality and Culture: An Interdisciplinary Quarterly*, 10(1), 99-102.
- Graziottin, A. (2007). Prevalence and Evaluation of Sexual Health Problems - HSDD in Europe. *Journal of Sexual Medicine*, 4 (Suppl 3), 211-219.
- Green, J. (1998) Commentary: Grounded Theory and the Constant Comparative Method. *British Medical Journal*, 316, 1064-1065
- Green, J. & Thorogood, N. (2004) *Qualitative Methods for Health Research*. London: Sage Publications
- Gregoire, A. (1999). Assessing and Managing Male Sexual Problems. In Tomlinson J. (Ed.), *ABC of Sexual Health*. London: BMJ Books.
- Grigg, E. (1999) Sexuality and Older People. *Elderly Care*, 11(7), 12-15.

- Grindle, M.S. (2007) Good Enough Governance Revisited. *Development Policy Review*, 25(5), 553-574
- Hall, M. (2001). Small Print and Conspicuous Omissions: Commentary on the "FSD" Classification Report. *Journal of Sex and Marital Therapy*, 27(2), 149-150.
- Hammersley, M. (1992) *What's wrong with Ethnography: Methodological Explorations*. London: Routledge
- Hart, G., & Wellings, K. (2002). Sexual Behaviour and its Medicalisation: In Sickness and in Health. *British Medical Journal*, 324(7342), 896-900.
- Hawton, K., Gath, D., & Day, A. (1994). Sexual Function in a Community Sample of Middle-Aged Women with Partners: Effects of Age, Marital, Socio-Economic, Psychiatric, Gynaecological and Menopausal Factors. *Archives of Sexual Behaviour*, 23, 375-395.
- Hayes, R.D., & Dennerstein, L. (2005). The Impact of Aging on Sexual Function and Sexual Dysfunction in Women: A Review of Population-Based Studies. *Journal of Sexual Medicine*, 2, 317-330.
- Hayes, R.D., Bennett, C., Fairley, C., & Dennerstein, L. (2006). What Can Prevalence Studies Tell Us about Female Sexual Difficulty and Dysfunction? *Journal of Sexual Medicine*, 3, 589-595.
- Hayes, R.D., Dennerstein, L., Bennett, C. & Fairley, C.K. (2008) What Is the 'True' Prevalence of Female Sexual Dysfunctions and Does the Way We Assess These Conditions Have An Impact? *Journal of Sexual Medicine*, 5, 777-787
- Heiman, J., Talley, D., Bailen, J., Oskin, T., Rosenberg, S., Pace, C., Creanga, D. & Bavendam T. (2007) Sexual Function and Satisfaction in Heterosexual Couples When Men are Administered Sildenafil Citrate (Viagra®) for Erectile Dysfunction: A Multi-centre, Randomised, Double-Blind, Placebo-Controlled Trial. *BJOG: International Journal of Obstetrics and Gynaecology*, 114, 437-47.
- Hemmings, J. (2007) *Infertility and Women's Life Courses in Northern Malawi*. Unpublished PhD Thesis. London: London School of Hygiene & Tropical Medicine
- Hoening, J. (1976) Sigmund Freud's Views on the Sexual Disorders in Historical Perspective. *British Journal of Psychiatry*, 129, 193-200

- Holmes, W.C., & Shea, J.A. (1998). A New HIV/AIDS-Targeted Quality of Life (HAT-Qol) Instrument: Development, Reliability and Validity. *Medical Care*, 36(2), 138-154.
- Hoon, E.F. & Chambless, D. (1998). Sexual Arousability Inventory and Sexual Arousability Inventory-Expanded. In S.M.Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L.Davis. & G. Schreer, G. (Eds) *Handbook of Sexuality-Related Measures*. (Pp.71-74) Thousand Oaks, CA: Sage
- Hudson, W.W. (1998). Index of Sexual Satisfaction. In Davis, S.M., Yarber, W.L., Bauserman, R., Schreer, G.E., Davis, S.L. & Schreer, G. (1998) *Handbook of Sexuality-Related Measures*. (Pp.512-513) Thousand Oaks, CA: Sage
- Hughes, C.C. (1996). The Culture Bound Syndromes and Psychiatric Diagnosis. In J. Mezzich, A. Kleinman, H. Fabrega et al. *Culture and Psychiatric Diagnosis: A DSM-IV Perspective* (Pp. 298-308). Washington, DC: American Psychiatric Association. Cited in Sumathipala, A., Siribaddana, S.H., & Bhugra, D. (2004). Culture-Bound Syndromes: The Story of Dhat Syndrome. *British Journal of Psychiatry*, 184, 200-209.
- Humphrey, S. & Nazareth, I. (2001). GP's Views on their Management of Sexual Dysfunction *Family Practice*, 18(5), 516-518
- Hurlbert, D.F., White, L.C., Powell, R.D. & Apt, C. (1993). Orgasm Consistency Training in the Treatment of Women Reporting Hypoactive Sexual Desire: An Outcome Comparison of Women-Only Groups and Couples-Only Groups. *Journal of Behaviour Therapy & Experimental Psychiatry*, 24, 3-13
- Hurlbert, D.F. (1998a). Hurlbert Index of Sexual Excitability. In S.M. Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L. Davis, & G. Schreer *Handbook of Sexuality-Related Measures*. (Pp.223-224) Thousand Oaks, CA: Sage
- Hurlbert, D.F. (1998b). Hurlbert Index of Sexual Desire. In S.M. Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L. Davis, & G. Schreer *Handbook of Sexuality-Related Measures*. (Pp.173) Thousand Oaks, CA: Sage
- Hyman, S. (2003). Forward. In: Phillips K, First M, and Pincus H, Eds. *Advancing DSM: Dilemmas in Psychiatric Diagnosis*. Arlington, VA: American Psychiatric Association; Xi-Xix.
- Iasenza, S. (2001) Sex Therapy with 'A New View' (Pp 43-46) In E. Kaschak & L. Tiefer (Eds.) *A New View of Women's Sexual Problems*. New York: Haworth Press, Inc.

- Idler, E.L. & Kasl, S. (1991) Health Perceptions and Survival: Do Global Evaluations of Health Status Really Predict Mortality? *Journal of Gerontology*, 46, S55-S65. Cited in Cleary, P.D. (1997). Subjective and Objective Measures of Health: Which Is Better When? *Journal of Health Services Research and Policy*, 2(1), 3-4.
- Jackson, G. (2004) Sexual Dysfunction and Diabetes. *International Journal of Clinical Practice*, 58(4), 358-362
- Jackson, S. (2008) Ordinary Sex. *Sexualities*, 11, 33-37
- Janssen, E., Vorst, H., Finn, P. & Bancroft J. (2002) The Sexual Inhibition and Sexual Excitation Scales: I. Measuring Sexual Inhibition and Excitation Proneness in Men SIS/SES *Journal of Sex Research*
[Http://Findarticles.Com/P/Articles/Mi M2372/Is 2 39/Ai 91475119](http://findarticles.com/p/articles/mi_m2372/is_2_39/ai_91475119)
- Janssen, E., McBride, K., Yarber, W., Hill, B., & Butler, S. (2008). Some Men are from Mars, Others from Venus: A Focus Group Study of the Factors That Influence Sexual Arousal in Men. *Archives of Sexual Behaviour*, 37, 252-265.
- Jeffreys, S. (1990) *Anticlimax. A Feminist Perspective on the Sexual Revolution*. London: the Women's Press. Cited in Boyle, M. (1993). Sexual Dysfunction or Heterosexual Dysfunction? *Feminism and Psychology*, 3(1), 73-88.
- Johnson, A.M., Mercer, C.H., Erens, B., Copas, A.J., Mcmanus, S., Wellings, K., Fenton, K.A., Korovessis, C., Macdowall, W., Nanchahal, K., Purdon, S., & Field, J. (2001). Sexual Behaviour in Britain: Partnerships, Practices, and HIV Risk Behaviours. *Lancet*, 358(9296), 1835-1842.
- Jones, S. (1985). *Applied Qualitative Research*. Aldershot: Gower. Reprinted in C. Seale (Ed) *Social Research Methods: A Reader*. (Pg 258-260) London: Routledge
- Kaplan, H.S. (1974) *The New Sex Therapy*. New York: Brunner/Mazel.
- Kaplan, H.S. (1977). Hypoactive Sexual Desire. *Journal of Sex and Marital Therapy*, 3(1), 3-9.
- Kaschak, E. & Tiefer, L. (2001). *A New View of Women's Sexual Problems*. New York, Haworth Press.
- Kaslow, F.W. (1996). History, Rationale, and Philosophic Overview of Issues and Assumptions. In: F.W. Kaslow (Eds.) *Handbook of Relational Diagnosis and Dysfunctional Family Patterns*. (Pp.3-18). New York: John Wiley.

- Kaye, J.A., & Jick, H. (2003). Incidence of Erectile Dysfunction and Characteristics of Patients Before and After the Introduction of Sildenafil in the United Kingdom: Cross Sectional Study with Comparison Patients. *British Medical Journal*, 326, 424-425.
- Kelle, U. (2004) Theory Building in Qualitative Research and Computer Programs for the Management of Textual Data. From Sociological Research Online 2, 2:[Http://Www.Soc.Surrey.Ac.Uk/Socresonline](http://www.soc.surrey.ac.uk/socresonline). Reprinted in C. Seale (Ed) *Social Research Methods: A Reader*. (Pp.19-25) London: Routledge
- Kendell, R. & Jablensky, A. (2003) Distinguishing between the Validity and Utility of Psychiatric Diagnoses. *American Journal of Psychiatry*, 160, 4-12.
- King, M., Smith, G., & Bartlett, A. (2004). Treatments of Homosexuality in Britain since the 1950's - An Oral History: The Experience of Professionals. *British Medical Journal*, 328(429).
- King, M., Holt, V., & Nazareth, I. (2007). Women's Views of their Sexual Difficulties: Agreement and Disagreement with Clinical Diagnosis. *Archives of Sexual Behavior*, 36, 281-288.
- King, R. (2007) A Practical Guide to Overcoming Desire Discrepancy. *18th Congress of the World Association for Sexual Health, Sydney*, Abstract 05-1
- Kinsey, A.C., Pomeroy, W.B., & Martin, C.E. (1948) *Sexual Behaviour in the Human Male*. Philadelphia: W.B. Saunders.
- Kinsey, A.C., Pomeroy, W.B., Martin, C.E., & Gebhard, P.H.. (1953). *Sexual Behaviour in the Human Female*. Philadelphia and London: W.B. Saunders.
- Kline, P. (1986). *A Handbook of Test Construction: Introduction to Psychometric Design*. London, Methuen.
- Kubin, M., Trudeau, E., Gondek, K., Seignobos, E. & Fugl-Meyer, A. (2004). Early Conceptual and Linguistic Development of a Patient and Partner Treatment and Satisfaction Scale (TSS) for Erectile Dysfunction. *European Urology*, 46, 768-774
- Laan, E. & Everaerd, W. (1998) Physiological Measures of Vaginal Vasocongestion. *International Journal of Impotence Research*, 10, S107-S110
- Lamping, D., Schroter, S., Marquis, P., Marrel, A., & Duprat-Lomon, I. (2002). The Community-Acquired Pneumonia Symptom Questionnaire: A New, Patient Based Outcome Measure to Evaluate Symptoms in Patients with Community-Acquired Pneumonia. *Chest* 122, 920-929

- Lamping, D., Schroter, S., Kurz, X., Kahn, S. & Abenhaim, L. (2003) Evaluation of Outcomes in Chronic Venous Disorders of the Leg: Development of a Scientifically Rigorous, Patient-Reported Measure of Symptoms and Quality of Life. *Journal of Vascular Surgery* 37, 410-419.
- Latini, D., Penson, D., Colwell, H., Lubeck, D., Mehta, S., Henning, J. & 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 (5), 2086-2091
- Laumann, E.O., Paik, A., & Rosen, R.C. (1999). Sexual Dysfunction in the United States: Prevalence and Predictors. *Journal of the American Medical Association (JAMA)*, 281(6), 537-544.
- Laumann, E.O., Nicolosi, A., Glasser, D.B., Paik, A., Gingell, C., Moreira, E., & Wang T. (2005) Sexual Problems among Women and Men Aged 40-80 Years: Prevalence and Correlates Identified in the Global Study of Sexual Attitudes and Behaviors. *International Journal of Impotence Research*, 17, 39-57.
- Laumann, E.O., Paik, A., Glasser, D., Kang, J.-H., Wang, T., Levinson, B., Moreira, E.D., Jr., Nicolosi, A., & Gingell, C. (2006). A Cross-National Study of Subjective Sexual Well-Being among Older Women and Men: Findings from the Global Study of Sexual Attitudes and Behaviours. *Archives of Sexual Behavior*, 35, 145-161.
- Lavee, Y. (1991). Western and Non-Western Human Sexuality: Implications for Clinical Practice. *Journal of Sex & Marital Therapy*, 17(3), 203-213.
- Lawrence, K. & Byers, E. (1995) Sexual Satisfaction in Long-Term Heterosexual Relationships: The Interpersonal Exchange Model of Sexual Satisfaction. *Personal Relationships*, 2, 267-285
- Leiblum, S.R. (2001). Critical Overview of the New Consensus-Based Definitions and Classification of Female Sexual Dysfunction. *Journal of Sex and Marital Therapy*, 27(2), 159-168.
- Leiblum, S.R. & Nathan, S.G. (2001) Persistent Sexual Arousal Syndrome in Women: A Newly Discovered Pattern of Female Sexuality. *Journal of Sex & Marital Therapy*, 27, 365-380
- Leiblum, S., Symonds, T., Moore, J., Soni, P., Steinberg, S., & Sisson, M. (2006). A Methodology Study to Develop and Validate a Screener for Hypoactive

- Sexual Desire Disorder in Post Menopausal Women. *Journal of Sexual Medicine*, 3, 455-464.
- Levin, R. (2007). Sexual Activity, Health and Well-Being - the Beneficial Roles of Coitus and Masturbation. *Sexual and Relationship Therapy*, 22(1), 135-148.
- Levine, S. (2002). Re-exploring the Concept of Sexual Desire. *Journal of Sex and Marital Therapy*, 28, 39-51.
- Levine, S. (2003). The Nature of Sexual Desire: A Clinician's Perspective. *Archives of Sexual Behavior*, 32(3), 279-285.
- Levine, S.B. (2007) Commentary on David Rowland's "Will Medical Solutions to Sexual Problems Make Sexological Care and Science Obsolete?" *Journal of Sex & Marital Therapy*, 33: 449-453
- Levinson, B. (1999). Erectile Dysfunction and Culture in South Africa. *Journal of Sex & Marital Therapy*, 25(4), 267-270.
- Lewin, J., & King, M. (1997). Sexual Medicine: Towards an Integrated Discipline. *British Medical Journal*, 314(1432).
- 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
- Lief, H. (1977). Inhibited Sexual Desire. *Medical Aspects of Human Sexuality*, 7, 94-95.
- Lippa, R.A. (2007) The Relation between Sex Drive and Sexual Attraction to Men and Women: A Cross-National Study of Heterosexual, Bisexual, and Homosexual Men and Women. *Archives of Sexual Behaviour*, 36, 209-22.
- Locke, H. & Wallace, K. (1959) Short Marital-Adjustment and Prediction Tests: Their Reliability and Validity. *Marriage and Family Living*, 21, 251-255
- Loewenthal, K.M. (2001) An Introduction to Psychological Tests and Scales. Hove, England: Psychology Press
- Lopiccolo, J. & Steger, J.C. (1974) The Sexual Interaction Inventory: A New Instrument for Assessment of Sexual Dysfunction. *Archives of Sexual Behaviour*, 3, 585-595
- Lue, T., Basson, R., Rosen, R., Giuliano, F., Khoury, S., Montorsi, F., Eds. (2004a) *Sexual Medicine: Sexual Dysfunctions in Men and Women*. Paris: Health Publications

- Lue, T.F., Guiliano, F., Montorsi, F., Rosen, R., Andersson, K., Althof, S.E., Christ, G., Hatzichristou, D.G., Hirsch, M., Kimoto, Y., Lewis, R., Mckenna, K., Macmahon, C., Morales, A., Mulcahy, J., Padma-Nathan, H., Pryor, J., Saenz De Tejada, I., Shabsigh, R., & Wagner, G. (2004b). Summary of the Recommendations on Sexual Dysfunctions in Men. *Journal of Sexual Medicine*, 1(1), 6-23.
- Lykins A.D. Janssen E. & Graham C.A. (2006) The Relationship between Negative Mood and Sexuality in Heterosexual College Woman and Men. *Journal of Sex Research*, 43(2):136-43
- Lynch, P. (2002) Yearning for Love and Cruising for Sex: Returning to Freud to Understand Some Gay Men. *The Annual of Psychoanalysis*, 30, 175-189.
- Macdonagh, R., Ewings, P. & Porter, T. (2002) The Effect of Erectile Dysfunction on Quality of Life: Psychometric Testing of a New Quality of Life Measure for Patients with Erectile Dysfunction. *Journal of Urology*, 167: 212-217
- Mah, K. & Binik, Y.M. (2001) The Nature of the Human Orgasm: A Critical Review of Major Trends. *Clinical Psychology Review*, 21, 823-856
- Maines, R.P. (1999) *The Technology of Orgasm: 'Hysteria', The Vibrator, and Women's Sexual Satisfaction*. Baltimore: The Johns Hopkins University Press
- Malinowski, B. (1927) *Sex and Repression in Savage Society*. London, Routledge & Kegan Paul.
- Manne, S.L. & Zautra, A.J. (1990) Couples Coping with Chronic Illness: Women with Rheumatoid Arthritis and their Healthy Husbands. *Journal of Behavioural Medicine*, 13(4), 327-342.
- Mason, J. (1996). *Qualitative Researching* London: Sage Publications
- Masters, W.H. & Johnson, V.E. (1966) *Human Sexual Response*. Boston: Little, Brown, & Co.
- Masters, W.H. & Johnson, V.E. (1966) *Human Sexual Inadequacy*. Boston: Little, Brown, & Co.
- Masters, W.H. & Johnson, V.E. (1979). *Homosexuality in Perspective*. Boston: Little, Brown.
- Maurice, W.L. (2001). Understanding Female Sexual Dysfunction and the Consensus Conference: This Is Progress? *Journal of Sex and Marital Therapy*, 27(2), 171-174.

- Mays, N. & Pope, C. (2000) Assessing Quality in Qualitative Research. *British Medical Journal*, 320, 50-52
- McCabe, M. (1997). Intimacy and Quality of Life among Sexually Dysfunctional Men and Women. *Journal of Sex & Marital Therapy*, 23(4), 276-290.
- McCabe, M. (1998) Sexual Dysfunction Scale. In S.M.Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L.Davis. & G. Schreer, G. (Eds) *Handbook of Sexuality-Related Measures*. (Pg 191-192) Thousand Oaks, CA: Sage
- McCabe, M.P. (2001). Do We Need a New Classification System for Female Sexual Dysfunction? A Comment on the 1999 Consensus Classification System. *Journal of Sex and Marital Therapy*, 27(2), 175-178.
- McCoy, N.L. & Matyas, J.R. (1998) McCoy Female Sexuality Questionnaire. In S.M.Davis, W.L Yarber, R. Bauserman, G.E. Schreer, S.L.Davis. & G. Schreer, G. (Eds) *Handbook of Sexuality-Related Measures*. (Pp.249-251) Thousand Oaks, CA: Sage
- McGahuey, C.A., Gelenberg, A.J., Laukes, C.A., Moreno, F.A., Delgado, P.L., Mcknight, K.M., & Manber, R. (2000). The Arizona Sexual Experience Scale (ASEX): Reliability and Validity. *Journal of Sex & Marital Therapy*, 26(1), 25-40.
- McGuirl, K., & Wiederman, M. (2000). Characteristics of the Ideal Sex Partner: Gender Differences and Perceptions of the Preferences of the Other Gender. *Journal of Sex & Marital Therapy*, 26, 153-159.
- Mchorney, C.A., Rust, J., Golombok, S., Davis, S., Bouchard, C., Brown, C., Basson, R., Sarti, C.D., Kuznicki, J., Rodenberg, C., & Derogatis, L. (2004). Profile of Female Sexual Function: A Patient-Based, International, Psychometric Instrument for the Assessment of Hypoactive Sexual Desire in Oophorectomized Women. *Menopause*, 11(4), 474-483.
- McLaren, A. (1999). *Twentieth-Century Sexuality. A History* Oxford: Blackwell Publishers Inc.
- Meana, M., Binik, Y.M., Khalife, S., & Cohen, D. (1997). Dyspareunia: Sexual Dysfunction or Pain Syndrome? *Journal of Nervous and Mental Disease*, 185(9), 561-569.
- Mechanic, D. & Volkart, E.H. (1960) Illness Behaviour and Medical Diagnosis. *Journal of Health and Human Behaviour*, 1:86-94. Cited in: Gabe, J., Bury,

- M. & Elston, M.A. (2004) *Key Concepts in Medical Sociology*.(Pg 65).
London: Sage
- Mechanic, D. (1978) *Medical Sociology*. 2nd Ed. New York: Free Press. Cited in:
Gabe, J., Bury, M. & Elston, M.A. (2004) *Key Concepts in Medical Sociology*.(Pg 65). Sage: London.
- Mercer, C.H., Fenton, K.A., Johnson, A.M., Wellings, K., Macdowall, W., McManus, S., Nanchahal, K., & Erens, B. (2003). Sexual Function Problems and Help Seeking Behaviour in Britain: National Probability Sample Survey. *British Medical Journal*, 327(7412), 426-427.
- Mercer, C.H., Fenton, K., Johnson, A.M., Copas, A.J., Macdowall, W., Erens, B., & Wellings, K. (2005). Who Reports Sexual Function Problems? Empirical Evidence from Britain's 2000 National Survey of Sexual Attitudes and Lifestyles. *Sexually Transmitted Infections*, 81, 394-399
- Medical Foundation for AIDS and Sexual Health (Medfash) (2005) *Recommended Standards for Sexual Health Services*. Medfash
- Meston, C. (1997). Aging and Sexuality. *Western Journal of Medicine*, 167(4), 285-290.
- Meston, C.M., Heiman, J.R. & Trapnell, P.D. (1999). The Relation between Early Abuse and Adult Sexuality. *Journal of Sex Research*, 36, 385-395
- Meston, C.M., & Derogatis, L.R. (2002). Validated Instruments for Assessing Female Sexual Function. *Journal of Sex & Marital Therapy*, 28 (Suppl 1), 155-164.
- Meston, C., Hull, E., Levin, R., & Sipski, M. (2004). Disorders of Orgasm in Women. *Journal of Sexual Medicine*, 1, 66-68
- Meston, C., & Trapnell, P. (2005). Development and Validation of a Five-Factor Sexual Satisfaction and Distress Scale for Women: The Sexual Satisfaction Scale for Women (SSS-W). *Journal of Sexual Medicine*, 2, 66-81.
- Meston, C.M. & Buss, D.M. (2007) Why Humans Have Sex. *Archives of Sexual Behaviour*, 36, 477-507
- Metz, M.E. & McCarthy, B.W. (2007) The 'Good-Enough Sex' Model for Couple Sexual Satisfaction. *Sexual and Relationship Therapy*, 22(3), 351-362
- Mitchell, J. C. (1983) Case and Situational Analysis. *Sociological Review*, 3(2), 187-211
- Mitchell, K.R., Wellings, K., Elam, G., Erens, B., Fenton, K. & Johnson, A. (2007) How Can We Facilitate Reliable Reporting in Surveys of Sexual Behaviour?

- Evidence from Qualitative Research *Culture, Health & Sexuality*, 9(5), 519-531
- Mitchell, K.R. & Graham, C. (2008) Two Challenges for the Classification of Sexual Dysfunction. *Journal of Sexual Medicine*. Doi:10.1111/J.1743-6109.2008.0084.X
- Montorsi, F. (2001). The Impact of Female Sexual Dysfunction in the Evaluation and Management of Impotent Patient. *Journal of Sex and Marital Therapy*, 27(2), 183-185.
- Morokoff, P. & Gilliland, R. (1993) Stress, Sexual Functioning and Marital Satisfaction. *Journal of Sex Research*, 30, 43-53
- Moynihan, R., Heath, I., & Henry, D. (2002). Selling Sickness: The Pharmaceutical Industry and Disease Mongering. *British Medical Journal*, 324, 886-891.
- Moynihan, R. (2003). The Making of a Disease: Female Sexual Dysfunction. *British Medical Journal*, 326, 45-47.
- Moynihan, R. (2005). The Marketing of a Disease: Female Sexual Dysfunction. *British Medical Journal*, 330, 192-194.
- Mumford, D.B. (1996) The 'Dhat Syndrome': A Culturally Determined Symptom of Depression? *Acta Psychiatrica Scandinavica* 94(3), 163-167
- Murphy, E., Dingwall, R. & Greatbatch, D. (1998) Qualitative Methods in Health Technology: A Review of the Literature. *Health Technology Assessment*, 2 (16) Download from [Http://www.Soton.Ac.Uk/-Hta](http://www.Soton.Ac.Uk/-Hta)
- Nathan, S.G. (1986). The Epidemiology of the DSM-III Psychosexual Dysfunctions. *Journal of Sex & Marital Therapy*, 12, 267-281.
- National Institutes of Health Consensus Development Panel on Impotence (1993). Impotence. *Journal of the American Medical Association (JAMA)*, 270, 83-90.
- Nazareth, I., Boynton, P., & King, M. (2003). Problems with Sexual Function in People Attending London General Practitioners: Cross Sectional Study. *British Medical Journal*, 327(7412), 423.
- Nettleton, S. (2006). *The Sociology of Health and Illness*. Cambridge: Polity Press
- NIH Consensus Development Panel on Impotence. (1993) Impotence. *Journal of the American Medical Association (JAMA)*, 270, 83-90.
- Nicolosi, A., Laumann, E.O., Glasser, D., Moreira, E.D., Jr., Paik, A., & Gingell, C. (2004). Sexual Behaviour and Sexual Dysfunctions after age 40: The Global Study of Sexual Attitudes and Behaviours. *Urology*, 64, 991-997.

- Nicolson, P., & Burr, J. (2003). What Is 'Normal' about Women's (Hetero)Sexual Desire and Orgasm?: A Report of An in-Depth Interview Study. *Social Science & Medicine*, 57(9), 1735-1745.
- Nowinski, J. & Lopiccolo, J. (1979) Assessing Sexual Behaviours in Couples. *Journal of Sex & Marital Therapy*, 5, 225-243
- Nunnally, J. (1970). *Introduction to Psychological Measurement*. New York, McGraw-Hill
- Nunally, J.C. (1978) *Psychometric Theory*. New York: McGraw-Hill
- Öberg, K Fugl-Meyer, K.S. & Fugl-Meyer, A.R. (2002) On Sexual Well-Being in Sexually Abused Swedish Women: Epidemiological Aspects. *Sexual and Relationship Therapy*, 17, 329-341 Cited in Laumann, E.O., Paik, A., Glasser, D., Kang, J.-H., Wang, T., Levinson, B., Moreira, E.D., Jr., Nicolosi, A., & Gingell, C. (2006). A Cross-National Study of Subjective Sexual Well-Being among Older Women and Men: Findings from the Global Study of Sexual Attitudes and Behaviours. *Archives of Sexual Behavior*, 35, 145-161.
- Öberg, K., Fugl-Meyer, A.R., & Fugl-Meyer, K.S. (2004). On Categorisation and Quantification of Women's Sexual Dysfunctions: An Epidemiological Approach. *International Journal of Impotence Research*, 16, 261-269.
- Öberg, K., Fugl-Meyer, A.R., & Fugl-Meyer, K.S. (2007). On Orgasm, Some Correlates and Sexual Satisfaction. *The 18th Congress of the World Association for Sexual Health, Sydney: April 2007*, Abstract O5-5
- O'Connor, D.B., Corona, G., Forti, G. Tajar, A., Lee, D.M., Finn, J.D., Bartfai, G., Boonen, S., Casanueva, F., Giwercman, A., Huhtaniemi, I., Kula, K., O'Neill, T., Pendleton, N., Punab, M., Silman, A.J., Vandershueren, D., Wu, F. & the European Male Ageing Study Group (2008) Assessment of Sexual Health in Aging Men in Europe: Development and Validation of the European Male Ageing Study Sexual Function Questionnaire. *Journal of Sexual Medicine* DOI: 10.1111/J.1743-6109.2008.00781.X
- O'Donohue, W. (2001). Are We Ready for this Classification System? *Journal of Sex and Marital Therapy*, 27(2), 187-190.
- O'Farrell, T.J., Kleinke, C.L., & Cutter, H.S. (1997). A Sexual Adjustment Questionnaire for Use in Therapy and Research with Alcoholics and their Spouses. *Journal of Substance Abuse Treatment*, 14(3), 259-268.
- Ogden, J. (2003). What Do Symptoms Mean? *British Medical Journal*, 327, 409-410.

- O'Leary, M., Fowler, F., Lenderking, W., Barber, B., Sagnier, P. & Guess, H. (1995) A Brief Male Sexual Function Inventory for Urology. *Urology*, 46 (5), 697-706
- Osborn, M., Hawton, K., & Gath, D. (1988). Sexual Dysfunction among Middle Aged Women in the Community. *British Medical Journal*, 296, 959-962.
- Pakenham, K.I. (2007) Making Sense of Multiple Sclerosis. *Rehabilitation Psychology*, 52(4), 380-389
- Patrick, D.L., Rowland, D., & Rothman, M. (2007). Interrelationships among Measures of Premature Ejaculation: The Central Role of Perceived Control. *Journal of Sexual Medicine*, 4, 780-788.
- Payer, L. (1992) *Disease-Mongers: How Doctors, Drug Companies and Insurers are Making You Feel Sick*. USA: John Wiley & Sons, Inc.
- Perel, E. (2007). *Mating in Captivity: Sex, Lies and Domestic Bliss*. London: Hodder & Stoughton
- Pertot, S. (2006). Sex Therapy and the Cultural Construction of Sexuality. *Contemporary Sexuality*, 40(4), 9-13.
- Pertot, S. (2007). *When Your Sex Drives Don't Match: Discover Your Libido Types to Create a Mutually Satisfying Sex Life* New York: Marlowe and Company
- Petrone, L., Mannucci, E., Corona, G., Bartolini, M., Forti, G., Giommi, R. & Maggi, M. (2003) Structured Interview on Erectile Dysfunction (SIEDY): A New Multidimensional Instrument for Quantification of Pathogenetic Issues on Erectile Dysfunction. *International Journal of Impotence Research*, 15, 210-220
- Pilgrim, D. & Bentall, R. (1999) The Medicalisation of Misery: A Critical Realist Analysis of the Concept of Depression. *Journal of Mental Health*, 8(3), 261-274
- Pincus, H.A., Frances, A., Davis, W.W., First, M.B., & Widiger, T.A. (1992). DSM-IV and New Diagnostic Categories: Holding the Line on Proliferation. *American Journal of Psychiatry*, 149(1), 112-117.
- Plummer, K. (1975) *Sexual Stigma. An Interactionist Account*. Routledge & Kegan Paul: London
- Potts, S., & Bhugra, D. (1995). Classification of Sexual Disorders. *International Review of Psychiatry*, 7(2), 167-174.

- Potts, A., Gavey, N., Grace, V.M., & Vares, T. (2003). The Downside of Viagra: Women's Experiences and Concerns. *Sociology of Health and Illness*, 25(7), 697-719.
- Potts, A., Grace, V., Gavey, N., & Vares, T. (2004). "Viagra Stories": Challenging 'Erectile Dysfunction'. *Social Science and Medicine*, 59, 489-499.
- Pukall, C.F. & Reissing, E.D. (2007) The Demise of Sexological Science is not Imminent in the Face of Sexual Medicine: Commentary on "Will Medical Solutions to Sexual Problems Make Sexological Care and Science Obsolete?" *Journal of Sex & Marital Therapy*, 33:455-459
- Purdon, C. & Holdaway, L. (2006) Non-Erotic Thoughts: Content and Relation to Sexual Functioning and Sexual Satisfaction. *Journal of Sex Research*. 43(2), 154-162.
- Purnine, D., Carey, M. & Jorgensen, R. (1994) Gender Differences Regarding Preferences for Specific Heterosexual Practices. *Journal of Sex and Marital Therapy*, 20 (4), 271-287
- Quirk, F.H., Heiman, J.R., Rosen, R.C., Laan, E., Smith, M.D., & Boolell, M. (2002). Development of a Sexual Function Questionnaire for Clinical Trials of Female Sexual Dysfunction. *Journal of Womens Health and Gender Based Medicine*, 11(3), 277-289.
- Raphael, C., Briscoe, C., Davies, J., Whinnett, Z.I., Manistry, C., Sutton, R., Mayet, J. & Francis, D.P. (2007). Limitations of the New York Heart Association Functional Classification System and Self-Reported Walking Distances in Chronic Heart Failure. *Heart*, 93(4), 476-82. Doi:10.1136/Hrt.2006.089656. PMID 17005715.
- Read, S., King, M., & Watson, J. (1997). Sexual Dysfunction in Primary Medical Care: Prevalence, Characteristics and Detection by the General Practitioner. *Journal of Public Health Medicine*, 19(4), 387-391.
- Regan, P.C. & Berscheid, E. (1996) Beliefs about the State, Goals, and Objects of Sexual Desire. *Journal of Sex & Marital Therapy*, 22(2), 110-120
- Reissing, E.D., Binik, Y.M., Khalife, S., Cohen, D. & Amsel, R. (2004) Vaginal Spasm, Pain, and Behavior: An Empirical Investigation of the Diagnosis of Vaginismus. *Archives of Sexual Behavior*, 33(1), 5-17
- Rellini, A. & Meston, C. (2006). The Sensitivity of Event Logs, Self-Administered Questionnaires and Photoplethysmography to Detect Treatment-Induced

- Changes in Female Sexual Arousal Disorder (FSAD) Diagnosis. *Journal of Sexual Medicine*, 3, 283-291
- Reynolds, C.F., Frank, E., Thase, M.E., Houck, J., Jennings, R., Howell, J.R., Lilienfeld, S.O. & Kupfer, D.J. (1988) Assessment of Sexual Function in Depressed, Impotent and Healthy Men: Factor Analysis of a Brief Sexual Function Questionnaire for Men. *Psychiatry Research*, 24, 231-250
- Riessman, C.K. (1993) *Narrative Analysis*. Newbury Park, CA: Sage
- Riley, A. (2007) Commentary on Rowland's Article. *Journal of Sex & Marital Therapy*, 33, 461-6.
- Ritchie, J. & Lewis, J. (Eds.) (2003). *Qualitative Research Practice*. London: Sage
- Robinson, C. (1993) Managing Life with a Chronic Condition: The Story of Normalization. *Qualitative Health Research*, 3(1), 6-28
- Rorer, L. (1965) The Great Response-Style Myth. *Psychological Bulletin*, 67, 273-293
- Rosen, R., & Leiblum, S.R. (1995). Treatment of Sexual Disorders in the 1990's: An Integrated Approach. *Journal of Consulting and Clinical Psychology*, 63(6), 877-890.
- Rosen, R.C., Riley, A., Wagner, G., Osterloh, I.H., Kirkpatrick, J., & Mishra, A. (1997). The International Index of Erectile Function (IIEF): A Multidimensional Scale for Assessment of Erectile Dysfunction. *Urology*, 49(6), 822-830.
- Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., Ferguson, D., & D'Agostino, R., Jr. (2000). The Female Sexual Function Index (FSFI): A Multidimensional Self-Report Instrument for the Assessment of Female Sexual Function. *Journal of Sex & Marital Therapy*, 26(2), 191-208.
- Rosen, R.C. (2001). Measurement of Male and Female Sexual Dysfunction. *Current Psychiatry Reports*, 3(3), 182-187.
- Rosen, R.C. (2002). Assessment of Female Sexual Dysfunction: Review of Validated Methods. *Fertility and Sterility*, 77(4, Suppl 4), S89-93.
- Rosen, R.C., Lobo, R.A., Block, B.A., Yang, H.M., & Zipfel, L.M. (2004a). Menopausal Sexual Interest Questionnaire (MSIQ): A Uni-dimensional Scale for the Assessment of Sexual Interest in Postmenopausal Women. *Journal of Sex and Marital Therapy*, 30(4), 235-250.

- Rosen, R., Catania, J., Pollack, L., Althof, S., O'Leary, M. & Seftel, A. (2004b) Male Sexual Health Questionnaire (MSHQ): Scale Development and Psychometric Evaluation. *Urology*, 64, 777-782
- Rosen, R. & Barsky, J. (2005) Psychological Assessment and Self-Report Questionnaires. In I. Goldstein, C. Meston, S. Davis, & A. Traish (Eds.) *Women's Sexual Function and Dysfunction: Study, Diagnosis and Treatment*. UK: Taylor and Francis.
- Rosen, R. (2007a). Sexual Dysfunction in the Context of the Couple's Relationship: Current Findings and Theory. *Journal of Sexual Medicine*, 4 (Suppl 1), 38.
- Rosen, R.C. (2007b) Erectile Dysfunction: Integration of Medical and Psychological Approaches. In: S.R. Leiblum (Ed.) *Principles and Practice of Sex Therapy*. (Pp 277-312) Fourth Ed. NY: Guildford Press.
- Rosen, R.C. & Althof, S. (2008) Impact of Premature Ejaculation: The Psychological, Quality of Life, and Sexual Relationship Consequences. *Journal of Sexual Medicine* DOI: 10.1111/J.1743-6109.2008.00825.X
- Rosser, B. R. S., Metz, M. E., Bockting, W.O. & Buroker, T. (1997) Sexual Difficulties, Concerns, and Satisfaction in Homosexual Men: An Empirical Study with Implications for HIV Prevention. *Journal of Sex and Marital Therapy*, 23(1), 61-73
- Rowland, D.L. (2007) Will Medical Solutions to Sexual Problems Make Sexological Care and Science Obsolete? *Journal of Sex & Marital Therapy*, 33, 385-397
- Rust, J., & Golombok, S. (1985). The Golombok-Rust Inventory of Sexual Satisfaction (GRISS). *British Journal of Clinical Psychology*, 24 (1), 63-64.
- Rust, J., & Golombok, S. (1986). The GRISS: A Psychometric Instrument for the Assessment of Sexual Dysfunction. *Archives of Sexual Behaviour*, 15(2), 157-165.
- Rust, J., Bennun, I.S., Crowe, M. & Golombok S. (1986) The Golombok Rust Inventory of Marital Status. *Sexual and Marital Therapy*, 1, 55-60
- Rust, J., Golombok, S., & Collier, J. (1988). Marital Problems and Sexual Dysfunction: How are They Related? *British Journal of Psychiatry*, 152, 629-631.
- Sanchez, D. T. & Kiefer, A. K. (2007) Body Concerns in and out of the Bedroom: Implications for Sexual Pleasure and Problems. *Archives of Sexual Behavior*, 36(6), 808-820

- Sand, M., & Fisher, W.A. (2007). Women's Endorsement of Models of Female Sexual Response: The Nurses' Sexuality Study. *Journal of Sexual Medicine*, 4, 708-719.
- Sanders, C., Donovan, J. & Dieppe, P. (2002) The Significance and Consequences of Having Painful and Disabled Joints in Older Age: Co-Existing Accounts of Normal and Disrupted Biographies. *Sociology of Health and Illness*, 24, 2:227-53
- Sanders, S.A., Graham, C.A., Milhausen, R.R. (2008). Predicting Sexual Problems in Women: The Relevance of Sexual Excitation and Inhibition. *Archives of Sexual Behavior*. 37 (2): 241-251.
- Sandfort, T.G.M. & De Keizer (2001) Sexual Problems in Gay Men: An Overview of Empirical Research *Annual Review of Sex Research*, 12, 93-120
- Schneidewind-Skibbe, A., Hayes, R.D., Koochaki, P.E., Meyer, J. & Dennerstein, L. (2008) The Frequency of Sexual Intercourse Reported By Women: A Review of Community-Based Studies and Factors Limiting their Conclusions. *Journal of Sexual Medicine*, 5, 301-335
- Scientific Advisory Committee of the Medical Outcomes Trust (2002). Assessing Health Status and Quality-of-Life Instruments: Attributes and Review Criteria. *Quality of Life Research*, 11, 193-205.
- Searle, J. (1995) *The Construction of Social Reality*. New York: Free Press
- Seale, C. (1999) *The Quality of Qualitative Research*. London: Sage
- Segraves, R.T., Schoenberg, H.W., Zarins, C.K., Knopf, J. & Carmic, P. (1982) Referral of Impotent Patients to a Sexual Dysfunction Clinic. *Archives of Sexual Behaviour*, 11, 521-528
- Segraves, K., & Segraves, R.T. (1991). Hypoactive Sexual Desire Disorder: Prevalence and Co-morbidity in 906 Subjects. *Journal of Sex & Marital Therapy*, 17(55).
- Segraves, R.T. (2006). Rapid Ejaculation: A Review of Nosology, Prevalence and Treatment. *International Journal of Impotence Research*, 18, S24-S32.
- Segraves, R.T., & Woodward, T. (2006). Female Hypoactive Sexual Desire Disorder: History and Current Status. *Journal of Sexual Medicine*, 3, 408-418.
- Segraves, K., Balon, R., & Clayton, A.H. (2007). Proposal for Changes in Diagnostic Criteria for Sexual Dysfunctions. *Journal of Sexual Medicine*, 4, 567-580.
- Seidman, S.N. (2007) Editorial Reply. *Journal of Sex & Marital Therapy*, 33:469-472

- Sharpe, L., Kuriansky, J.B., & O'Connor, J.F. (1976). A Preliminary Classification of Human Functional Sexual Disorders. *Journal of Sex and Marital Therapy*, 2(2), 106-114.
- Shaw, J. (2001). Another Procrustean Bed for Female Sexual Functioning. *Journal of Sex and Marital Therapy*, 27(2), 211-214.
- Simon, W., & Gagnon, J. (1986). Sexual Scripts: Permanence and Change. *Archives of Sexual Behavior*, 15(2), 97-120.
- Simons, J.S., & Carey, M.P. (2001). Prevalence of Sexual Dysfunctions: Results from a Decade of Research. *Archives of Sexual Behaviour*, 30, 177-219.
- Skinner, E.A., Edge, K., Altman, K. & Sherwood, H. (2003). Searching for the Structure of Coping: A Review and Critique of Category Systems for Classifying Ways of Coping. *Psychological Bulletin*, 129 (2), 216-269
- Smith, G., Bartlett, A., & King, M. (2004). Treatments of Homosexuality in Britain since the 1950s—An Oral History: The Experience of Patients. *British Medical Journal*, 328(427).
- Smout, S., Koudstaal, P.J., Ribbers, G.M., Janssen, W.G.M. & Passchier, J. (2001) Struck By Stroke: A Pilot Study Exploring Quality of Life and Coping Patterns in Younger Patients and Spouses. *International Journal of Rehabilitation Research*. 24(4), 261-268
- Snell, W. (1990) The Sexual Relationship Scale.
[Http://Www4.Semo.Edu/Snell/Scales/SRS.Htm](http://www4.semo.edu/Snell/Scales/SRS.Htm)
- Snell, W.E., Fisher, T.D. & Schuh, T. (1992) Reliability and Validity of the Sexuality Scale: A Measure of Sexual-Esteem, Sexual-Depression and Sexual-Preoccupation. *The Journal of Sex Research*, 29, 261-273
- Spanier, G.B. (1976) Measuring Dyadic Adjustment: New Scales for Assessing the Quality of Marriage and Similar Dyads. *Journal of Marriage and the Family*, 38(1):15-28
- Spector, I.P., & Carey, M.P. (1990). Incidence and Prevalence of the Sexual Dysfunctions: A Critical Review of the Empirical Literature. *Archives of Sexual Behaviour*, 19, 389-408.
- Spector, I.P., Carey, M.P. & Steinberg, L. (1996). The Sexual Desire Inventory: Development, Factor Structure, and Evidence of Reliability. *Journal of Sex & Marital Therapy*, 22(3), 175-190

- Stead, M.L., Fallowfield, L., Brown, J.M., & Selby, P. (2001). Communication about Sexual Problems and Sexual Concerns in Ovarian Cancer: Qualitative Study. *British Medical Journal*, 323(7317), 836-837.
- Stone, A., Shiffman, S., Schwartz, J., Broderick, J. & Hufford, M. (2003) Patient Compliance with Paper and Electronic Diaries. *Controlled Clinical Trials*, 24 (2), 182-199
- Stopes, M. (1918) *Married Love*. London: Fifiels
- Strangeways, I (2006) *Precipitation. Theory, Measurement and Distribution*. Cambridge: Cambridge University Press. DOI: 10.2277/0521851173
- Strauss, A. (1987). *Qualitative Analysis for Social Scientists*. New York. Cambridge University Press
- Strauss, A. & Glaser, B. (1975) *Chronic Illness and Quality of Life*. St. Louis, MO: Mosby.
- Streiner, D.L., & Norman, G.R. (1995). *Health Measurement Scales: A Practical Guide to their Development and Use* Oxford: Oxford University Press
- Sugrue, D.P., & Whipple, B. (2001) The Consensus-Based Classification of Female Sexual Dysfunction: Barriers to Universal Acceptance. *Journal of Sex & Marital Therapy*, 27(2), 221-226.
- Sumathipala, A., Siribaddana, S.H., & Bhugra, D. (2004). Culture-Bound Syndromes: The Story of Dhat Syndrome. *Br J Psychiatry*, 184, 200-209.
- Swain, P.A. & Cameron, N. (2003) 'Good Enough Parenting': Parental Disability and Child Protection. *Disability and Society*, 18(2), 165-177
- Swindle, R.W., Cameron, A.E., Lockhart, D.C. & Roen, R.C. (2004) The Psychological and Interpersonal Relationship Scales: Assessing Psychological and Relationship Outcomes Associated with Erectile Dysfunction and Its Treatment. *Archives of Sexual Behaviour*, 33 (1), 19-30
- Symonds, T., Boolell, M., & Quirk, F. (2005). Development of a Questionnaire on Sexual Quality of Life in Women. *Journal of Sex & Marital Therapy*, 31, 385-397.
- Taylor, J.F., Rosen, R., & Leiblum, S. (1994). Self-Report Assessment of Female Sexual Function: Psychometric Evaluation of the Brief Index of Sexual Function for Women. *Archives of Sexual Behaviour*, 23, 627.
- The Working Group for a New View of Women's Sexual Problems. (2001). A New View of Women's Sexual Problems. (Pp 1-8) In: E. Kaschak & L. Tiefer

- (Eds.) *A New View of Women's Sexual Problems* New York: The Haworth Press.
- Tiefer, L. (1986). In Pursuit of the Perfect Penis. *American Behavioural Scientist*, 29(5), 579-599.
- Tiefer, L. (1991). Historical, Scientific, Clinical and Feminist Criticisms of "The Human Sexual Response Cycle" Model. *Annual Review of Sex Research*, 2, 1-23.
- Tiefer, L. (1994). Three Crises Facing Sexology. *Archives of Sexual Behavior*, 23(4), 361-374.
- Tiefer, L. (1996). The Medicalisation of Sexuality: Conceptual, Normative and Professional Issues. *Annual Review of Sex Research*, 7, 252-282.
- Tiefer, L. (2000). Sexology and the Pharmaceutical Industry: The Threat of Co-optation. *The Journal of Sex Research*, 37(3), 273-283.
- Tiefer, L. (2001a). A New View of Women's Sexual Problems: Why New? Why Now? *Journal of Sex Research*, 38(2), 89-96.
- Tiefer, L. (2001b). The Selling of 'Female Sexual Dysfunction'. *Journal of Sex & Marital Therapy*, 27(5), 625-628.
- Tiefer, L. (2001c). The "Consensus" Conference on Female Sexual Dysfunction: Conflicts of Interest and Hidden Agendas. *Journal of Sex & Marital Therapy*, 27(2), 227-236.
- Tiefer, L. (2001d) Arriving at a 'New View' of Women's Sexual Problems: Background, Theory and Activism (Pp 63-98) In E. Kaschak & L. Tiefer (Eds.) *A New View of Women's Sexual Problems*. New York: Haworth Press, Inc.
- Tiefer, L., Hall, M., & Travis, C. (2002). Beyond Dysfunction: A New View of Women's Sexual Problems. *Journal of Sex & Marital Therapy*, 28, 225-232.
- Tiefer, L. (2006) Female Sexual Dysfunction: A Case Study of Disease Mongering and Activist Resistance. *Public Library of Science Med* 3(4): E178.
[Http://Medicine.Plosjournals.Org/Perlserv/?Request=Gct-Document&Doi=10.1371/Journal.Pmed.0030178](http://Medicine.Plosjournals.Org/Perlserv/?Request=Gct-Document&Doi=10.1371/Journal.Pmed.0030178)
- Tomlinson, J. (1999) Taking a Sexual History. In J. Tomlinson (Ed.) *ABC of Sexual Health* (Pp.12-18). London: British Medical Journal Books

- Tomlinson, J., & Wright, D. (2004). Impact of Erectile Dysfunction and Its Subsequent Treatment with Sildenafil: Qualitative Study. *British Medical Journal*.
- Tunariu, A.D. (2003). *Sexual Boredom and Sexual Desire Discrepancy in Long-Term Romantic Relationships*. Unpublished PhD Thesis. London: South Bank University.
- Vroege, J.A., Gijs, L., & Hengeveld, M.W. (2001). Classification of Sexual Dysfunctions in Women. *Journal of Sex and Marital Therapy*, 27(2), 237-243.
- Wagner, T.H., Patrick, D.L., Mckenna, S.P. & Froese, P.S. (1996) Cross-Cultural Development of a Quality of Life Measure for Men with Erection Difficulties. *Quality of Life Research*, 5(4), 443-449
- Waldinger, M., & Schweitzer, D. (2006a). Changing Paradigms from a Historical DSM-III and DSM-IV View: Toward An Evidence-Based Definition of Premature Ejaculation. Part I - Validity of DSM-IV-TR. *Journal of Sexual Medicine*, 3, 682-692.
- Waldinger, M., & Schweitzer, D. (2006b). Changing Paradigms from a Historical DSM-III and DSM-IV View: Toward An Evidence-Based Definition of Premature Ejaculation. Part II - Proposals for DCM-V and ICD-10. *Journal of Sexual Medicine*, 3, 693-705.
- Waldinger, M. (2008) Not Medical Solutions But Overmedicalisation by Pharmaceutical Company Policies Endanger Both Sexological Care, Science and Sexual Medicine. A Commentary. *Journal of Sex & Marital Therapy*, 34(3), 179-183
- Ware, J., Harris, W., Gandek, B., Rogers, B., & Reese, P. (1997). MAP-R for Windows: Multitrait/Multi-Item Analysis Program-Revised User's Guide. Boston, MA: Health Assessment Lab
- Weeks, J. (1981) *Sex, Politics and Society. The Regulation of Sexuality since 1800*. Longman: London
- Weeks, J. (1986). *Sexuality* London: Ellis Horwood Ltd and Tavistock Publications
- White, M. & Epston, D. (1975) *Narrative Means to Therapeutic Ends*. New York: Norton
- Widiger, T.A. (2005) A Dimensional Model of Psychopathology. *Psychopathology*, 38, 211-14.

- Widiger, T.A. & Samuel, D.B. (2005) Diagnostic Categories or Dimensions? A Question for the Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition. *Journal of Abnormal Psychology*, 114, 494-504.
- Wincze, J. Rosen, R., Carson, C., Korenman, S., Niederberger, C., Sadovsky, R., Mcleod, L., Thibonnier, M. & Merchant, S. (2004) Erection Quality Scale: Initial Scale Development and Validation. *Urology*, 64(2), 351-356
- Wise, T.N. (1999). Psychosocial Side Effects of Sildenafil Therapy for Erectile Dysfunction. *Journal of Sex and Marital Therapy*, 25(2), 145-150.
- World Health Organisation (1993). *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: World Health Organisation.
- World Health Organisation (1994). *ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th Ed*. Geneva: World Health Organisation.
- World Health Organisation (2006). Defining Sexual Health. Report of a Technical Consultation on Sexual Health 28-31 January 2002. Geneva: World Health Organisation
- Wright Mills, C. (1959). *The Sociological Imagination*. Oxford: Oxford University Press. Reprinted in C. Seale (Ed) *Social Research Methods: A Reader*. (Pg 19-25) London: Routledge
- Wylie, K.R., Hallam-Jones, R. & Perrett, A. (1999). Some of the Potential Implications of Integrated Assessment for Male Erectile Disorder. *Sexual and Marital Therapy*, 14, 359-369
- Wylie, K.R. (2001a). Is Normal Sexual Function Desirable When Promoting Sexual Health? *Sexual and Relationship Therapy*, 16(4), 317-319
- Wylie, K.R. (2001b). Can Classification Systems Help the Sexual Therapist? *Sexual and Relationship Therapy*, 16(1), 5-6
- Wylie, K.R.(2004). A Sense of Well Being from Good Sex. *Sexual and Marital Therapy*, 19(1), 3-4
- Wylie, K.R., & Ralph, D. (2005). Premature Ejaculation: The Current Literature. *Current Opinion in Urology*, 15, 393-398.
- Yuan Y.M., Xin Z.C., Jiang, H., Guo, Y.J., Liu, W.J., Tian, L.& Zhu J.C. (2004) Sexual Function of Premature Ejaculation Patients Assayed with Chinese Index of Premature Ejaculation. *Asian Journal of Andrology*, 6(2), 121-126

Zilbergeld, B. & Ellison, C.R. (1980) Desire Discrepancies and Arousal Problems in Sex Therapy. In: S.R. Leiblum & L.A. Pervin (Eds.) *Principles and Practice of Sex Therapy*. (Pp 66-104) New York: Guilford Press; 1980:66-104.