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UNRAVELLING A RELATIONSHIP BETWEEN SEXUAL
BELIEFS, SEXUAL DIFFICULTIES AND FACTORS OF
SEXUAL EXCITATION AND INHIBITION IN A
PORTUGUESE SAMPLE

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Yet, in truth, mine is a fairy tale of a Prince who lived in a faraway kingdom, who one day stumbled across a land of fantasy and amidst the wars and struggles to maintain prosperity and happiness within his own domains, still he never failed to believe in the impossible... to him I dedicate this article.

Abstract

Up to date no studies can be found which evaluate the effect of sexual beliefs on sexual arousal, or their relationship with sexual difficulties. This study aimed to determine the existence of a relationship between sexual beliefs, sexual difficulties and factors of sexual excitation and inhibition in a Portuguese-speaking population. The main sexual difficulties reported by men and women were also identified. Psychometric properties of the Sexual Excitation/Sexual Inhibition Inventory for Women and Men (SESII-W/M), and of the Sexual Dysfunctional Beliefs Questionnaire (SDBQ), were tested. A non-clinical sample of 1,878 men and women, with a mean age of 35.9 years, whose sexual activity had been exclusively with the opposite sex (92.6%), was recruited through the Internet. Instruments included socio-demographic information, a relationship status questionnaire, the SESII-W/M, the SDBQ and self-reported sexual difficulties. Data analyses considered a significance level of $\alpha < 0.05$ and revealed significant differences in all tests applied. The most frequently reported sexual difficulty referred to “premature ejaculation” in men and “difficulty in experiencing orgasm” in women. The SESII-W/M model fit proved to be weak, but acceptable. Reliability of both questionnaires suggested the exclusion of some dimensions. The findings in this study clearly indicate an association between variables, although further investigation is needed in order to determine causation. Validation of the SESII-W/M into Portuguese could benefit future studies regarding factors of sexual excitation and inhibition.

Keywords: sexual beliefs, sexual difficulties, the dual control model, sexual excitation, sexual inhibition

Resumo

Até o momento não encontramos estudos para avaliar o efeito das crenças sexuais na excitação sexual, ou a sua relação com dificuldades sexuais. Este estudo teve como objetivo determinar a existência de uma relação entre as crenças sexuais, dificuldades sexuais e fatores de excitação e inibição sexual numa amostra de respondentes de língua portuguesa. Também foram identificadas as principais dificuldades sexuais relatados por homens e mulheres. As propriedades psicométricas do Inventário de Excitação Sexual/Inibição Sexual para Mulheres e Homens (SESII-W/M), e do Questionário de Crenças Sexuais Disfuncionais (SDBQ), foram testadas. A amostra não-clínica de 1.878 homens e mulheres, com uma média de idade de 35,9 anos, cuja atividade sexual tinha sido exclusivamente com o sexo oposto (92,6%), foi recrutada através da Internet. Os instrumentos incluíram informação sócio-demográfica, um questionário sobre o estado do relacionamento, o SESII-W/M, o SDBQ e dificuldades sexuais auto-relatadas. A análise dos dados considerou um nível de significância $\alpha < 0,05$ e revelou diferenças significativas em todos os testes aplicados. A dificuldade sexual mais frequentemente relatada referiu a "ejaculação precoce" nos homens e a "dificuldade em conseguir o orgasmo" em mulheres. O SESII-W/M revelou-se um instrumento fraco, mas aceitável. A fiabilidade de ambos os questionários sugeriu a exclusão de algumas dimensões. Os resultados deste estudo indicam claramente uma associação entre as variáveis, embora sejam necessários mais estudos para determinar a causa. A validação do SESII-W/M para o português pode beneficiar estudos futuros de fatores de excitação e inibição sexual.

Palavras-Chave: crenças sexuais, dificuldades sexuais, o *dual control model*, excitação sexual, inibição sexual

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Introduction

Sexual beliefs are considered an underlying cause for sexual dysfunctions (Nobre, Gouveia, & Gomes, 2003; Soares & Nobre, 2013). Nobre et al. (2003) define a *belief* as a conceived idea regarding oneself, others and the world, and these representations are what determine one's actions and emotions. This simple concept is, however, much deeper rooted and is based on a cognitive theory of personality disorders proposed by Beck (1996, as cited in Nobre & Gouveia, 2006), who divides beliefs into two separate levels. The first refers to unconditional beliefs (or cognitive schemas), which represent the essence of our ideas, or rather, how we perceive who we are, or our surroundings. The second refers to conditional beliefs, which are the outcome of our life experiences and our learning processes. Conditional beliefs activate unconditional beliefs, causing or conditioning stimuli.

Both culture and upbringing imprint beliefs on individuals that determine their sexual performance, consequently dictating their perspective of a healthy sexual life (Carvalho & Nobre, 2011). In a study carried out by Nguyen et al. (2012) with Asian Americans, African Americans and Caucasian Americans, ethnicity proved to be a moderator between sexual traits and high-risk sexual activity, which suggests that where we live and how we are reared have an impact on what we consider as a valid and healthy sex life or, alternatively, dysfunctional.

Sexual dysfunction is referred to as a difficulty experienced during any stage of normal sexual activity (American Psychiatric Association, 2013). According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) sexual dysfunctions in men refer to delayed and premature ejaculation, erectile dysfunction and hypoactive sexual desire. Women present genito-pelvic pain, sexual interest/arousal disorders and orgasmic disorders. Dysfunction can also occur in a clinical setting due to the inducement of substance or medication. However, before a diagnosis of sexual dysfunction is determined, a person's culture should be considered, as this may influence one's perception and response to sexual pleasure (American Psychiatric Association, 2013). It is also necessary to bear in mind that the interference of factors such as stress, anxiety, sexual satisfaction, mood and traits, negatively impact on excitation and increase the tendency for inhibition, serving as triggers for sexual difficulties (Lykins, Janssen, Newhouse, Heinman, & Rafaeli, 2012). Therefore, sexual problems are quite common and may not necessarily be considered dysfunctional in the clinical term of the word. A clinical diagnosis should be reserved for situations where sexual problems prove to be persistent and recurring (American Psychiatric Association, 2013; Gomes & Nobre, 2014).

According to Nobre (2006), negative thoughts, or beliefs, regarding sex, differentiate men with sexual dysfunction from sexually healthy men. Likewise, these factors are also very strong predictors of sexual dysfunction in women (Carvalho & Nobre, 2010). Once these negative schemes are activated and if confronted with an unsuccessful sexual experience, men and women will have a tendency to face future situations of a sexual nature in a more negative way, thus further cultivating their sexual difficulties (Fonseca, Figueiredo, & Nobre, 2003). Studies within the Portuguese population indicate that men with sexual dysfunction present stronger sexual convictions of masculinity (“macho” beliefs), as well as preconceived ideas on what satisfies a woman, whereas women present stronger sexual beliefs on topics regarding the impact of age and body-image on sexual functioning (Nobre & Gouveia, 2006; Nobre et al., 2003; Soares & Nobre, 2013). Another study performed with 650 sexually healthy Portuguese men, sought to classify sexual difficulties within this population and found that erectile problems presented a prevalence rate of 10%. This figure increased to 21% when the participants indicated having only mild sexual difficulties. However, rapid ejaculation constituted the most frequently reported sexual difficulty (Gomes & Nobre, 2014).

In an attempt to establish the foundations for sexual dysfunctions, recent investigation has been oriented towards determining factors of sexual excitation and inhibition, or to speak in more general terms of arousal, to discover what precisely it is that turns us on and off (Graham, Sanders, Milhausen, & McBride, 2004; Janssen, McBride, Yarber, Hill, & Butler, 2008). The dual control model was first presented by Bancroft in 1999 and postulates that there exist both excitatory and inhibitory mechanisms within the central nervous system that are responsible for sexual responses, enabling an individual to adapt adequately towards a certain sexual stimulus. In order to become sexually aroused, levels of excitation rise, whereas there is a decrease in inhibition. In the face of a threat, the propensity for sexual inhibition is adjusted accordingly, allowing a person to stay out of trouble. Considering the aforesaid, a high level of inhibition could be indicative of sexual dysfunction, whereas low rates could lead to high risk sexual behaviour (Bancroft, 1999; Janssen, Vorst, Finn, & Bancroft, 2002a).

Focus group studies carried out first with women and then men (Graham et al., 2004; Janssen et al., 2008) strongly suggest the existence of similar factors which enhance or inhibit sexual arousal in both genders. Based on the results of these studies, Milhausen, Graham, Sanders, Yarber, and Maitland (2010), identified six factors responsible for sexual functioning in men and women: Inhibitory Cognitions, Relationship Importance, and Dyadic Elements of the Sexual Interaction were considered factors of sexual inhibition, whereas Arousability, Partner Characteristics and Behaviours and Setting (Unusual or Unconcealed) were identified

as factors of sexual excitation. These six dimensions set the framework for the Sexual Excitation/Sexual Inhibition Inventory for Women and Men (SESII-W/M; Milhausen et al., 2010), a questionnaire designed to assess the intensity of sexual arousal when presented with a certain stimulus or when placed in a specific situation. The comparison of results between women and men revealed that women scored higher on the dimensions of Inhibitory Cognitions, Relationship Importance, Partner Characteristics and Behaviours and Dyadic Elements of the Sexual Interaction, whereas men scored higher on the dimensions of Arousability and Setting (Unusual or Unconcealed). These results suggest that although men and women may share similar ground when it comes to factors of sexual arousal, gender differences are still evident.

During the past few years several investigations have been carried out in the attempt to measure the propensity for sexual arousal in men and women, individuals and couples, and they focus primarily on unearthing some association with sexual dysfunction (e.g. Bancroft & Janssen, 2000; Lykins et al., 2012; Sanders, Graham, & Milhausen, 2008; Vendeira, Monteiro, Serrano, & Carvalheira, 2011; Vendeira, Pereira, Tomada, & de Carvalho, 2011). Myths and beliefs regarding sexual practices are still very present in our society and interfere with sexual functioning and although they form a topic which now begins to capture the interest of investigators, there is still much research to be done in this area (Nobre & Gouveia, 2006). Portugal is a country strongly dominated by the doctrines of the Catholic Church, hence inducing conservative beliefs regarding sexual activity. On the other hand, it is a country that has always looked towards France for guidance, following its example in terms of therapeutic practices, therefore focusing mainly on psychiatric and psychoanalytical approaches, *id est*, maintaining a clinical predisposition (Soares & Nobre, 2013). Consequently, although the influence of beliefs on sexual functioning has largely contributed to the development of several theories based on clinical practice, it has not undergone systematic empirical research and, moreover, investigation is conducted primarily towards the understanding of sexual dysfunction (Nobre, 2006). Furthermore, up to date no studies can be found which evaluate the effect of sexual beliefs on sexual arousal in either clinical or non-clinical samples, or which consider the relationship of either of these variables with sexual difficulties. Thus, the present study aims to fill in this gap in existing literature.

Aims

The purpose of this study was to determine the existence of a relationship between sexual beliefs, sexual difficulties and factors of sexual excitation and inhibition in a Portuguese-speaking population.

This study also sought to identify the main sexual difficulties reported by men and women.

As this is the first attempt to apply the Sexual Excitation/Sexual Inhibition Inventory for Women and Men (SESII-W/M; Milhausen et al., 2010) on a Portuguese-speaking population and in the absence of a validated version, so as to confirm the model presented by the authors, the psychometric properties of the questionnaire used in this study were tested.

In order to verify the results obtained by the authors of the SESII-W/M, the following hypotheses were established:

Hypothesis 1. Men and women shall present significant differences in each sub-scale;

Hypothesis 2. Women shall present statistically significant differences and higher scores on the subscales of Inhibitory Cognitions, Relationship Importance, Partner Characteristics and Behaviours and Dyadic Elements of the Sexual Interaction;

Hypothesis 3. Men shall present statistically significant differences and higher scores on the subscales of Arousability and Setting (Unusual or Unconcealed).

Cronbach's alphas were determined for dimensions of Sexual Conservatism and "Macho" Beliefs in the male version, and Sexual Conservatism and Body-Image Beliefs in the female version of the Sexual Dysfunctional Beliefs Questionnaire (SDBQ; Nobre et al., 2003).

The results of these analyses should better help us to understand the effects of beliefs on sexual functioning and allow us to assess underlying implications for sexual difficulties. Considering the theme under study and the lack of research in this area, this investigation hopes to prove both pertinent and valuable to the scientific field.

Method

Participants

This study was carried out within a Portuguese-speaking population. The sample consisted of 1,878 participants, of which 983 were men (52.3%) and 895 were women (47.7%), with a mean age of 35.9 years ($SD = 11.9$; range = 18-79). However, an independent-samples t -test indicated that age was significantly higher for men ($M = 40.4$, $SD = 12.46$) than for women ($M = 32.0$, $SD = 9.94$), $t_{(1,114)} = 13,129$, $p < .001$. Respondents

included residents from all the Portuguese districts, but mainly from Lisbon (31.5%), Oporto (12.1%) and Setúbal (8.3%). A district option of "I do not live in Portugal" was added, providing the possibility for Portuguese-speaking non-residents to participate. This option represented 9.2% of the sample.

In terms of academic qualifications, 64.5% reported having a degree. When inquired about their relationship status, 85.8% indicated that they were in a committed relationship. Sexual activity with exclusively the opposite sex in the past five years was a pre-defined inclusion criterion and represented 92.6% of the respondents. A more detailed description of these data can be found in Table 1.

The mean duration of the relationship was 11.1 years ($SD = 10.72$). Close to half of the participants in this situation informed that they had children (49.8%), with 40.9% reporting that they had one child and 46.1% declaring that they had two children.

Table 1
Socio-Demographic and Sexuality-Related Information

	<i>n</i>	Percent
<i>Academic Qualifications</i>		
GCSE	128	6.8
A Level	539	28.7
Bachelor's degree	876	46.6
Master's degree	284	15.1
Doctoral degree	46	2.4
<i>Relationship Status</i>		
In a compromised relationship without cohabitation	541	28.8
In a compromised relationship with cohabitation (or married)	1,071	57.0
Not in a compromised relationship or with no sexual partners	72	3.8
Not in a compromised relationship but with sexual partners	194	10.3
<i>Sexual Activity During the Last 5 Years was with People</i>		
Exclusively of the opposite sex	1,878	92.1
Mainly of the opposite sex	50	2.5
Equally of the opposite sex and the same sex	8	.4
Mainly of the same sex	15	.7
Exclusively of the same sex	71	3.5
With no sexual partners	7	.3

Procedure

Participants were recruited through the Internet. Online questionnaires present several advantages. For one, they reduce social desirability, allowing participants to respond honestly, especially regarding delicate matters such as sexuality, while maintaining their anonymity (Carvalho, 2007; Cooper, Scherer, & Mathy, 2001; Mustanski, 2001). They are also time-

saving and can reach a larger and more diversified population (Shaughnessy, Zechmeister, & Zechmeister, 2006). However, using this method in an investigation also presents its risks. To give an example of such liabilities, there is the risk of biased answers and a lack of control over the setting in which the questionnaires are answered (Shaughnessy et al., 2006).

Nevertheless, the Internet has become an important tool for accessing data when dealing with a sensitive subject such as sexuality (Carvalho, 2007; Mustanski, 2001; Pealer, Weiler, Pigg, Miller, & Dorman, 2001; Shaughnessy et al., 2006; Turner et al., 2001).

Between March and April 2014 an online questionnaire, using the web survey SurveyMonkey, was posted on a popular Portuguese news website (Visão Online) and on a portal related to the promotion of health and well-being (MSN Saúde). An informed consent statement described the aims of the study, guaranteed anonymity and confidentiality and confirmed that the participants had read the statement and were over 18 years of age. No incentives or payments were offered for the participation in this study.

A total of 3,378 individuals followed the e-mail link to the online survey and completed the questionnaire. However, one individual who indicated being 17 years old was immediately excluded from the study. Besides the restriction on age limit, other exclusion criteria were determined. From the respondents, 227 individuals who had not been sexually active during the last 12 months and also those who did not indicate their gender ($n = 516$), were excluded from the analysis. According to Graham, Sanders, Milhausen and McBride (2003, as cited in Milhausen et al., 2010), different sexual orientation presents different response patterns. Therefore, of the remaining 2,040 respondents (1,078 men and 962 women), only individuals whose sexual activity had been exclusively with the opposite sex (92.6%) were considered for this study. Although the SDBQ does not specifically state this, questions seem to be explicitly directed at heterosexual couples and, therefore, this exclusion criterion seemed an imperative and cautious decision. Our final sample consisted of 1,878 participants (983 men and 895 women).

Measures

Socio-Demographic and Sexuality-Related Information

This questionnaire was designed for the purpose of this study. Socio-demographic information included age, residential area by district and academic qualifications. Considering the nature of the present investigation, it was important to have some knowledge of participants' sexual orientation and status. Therefore, variables included: "Gender preference", referring to behavioural habits, which was accessed by inquiring whether a person's sexual

activity during the last five years had been with a partner, 1. Exclusively of the opposite sex, 2. Mainly of the opposite sex, 3. Equally of the opposite sex and the same sex, 4. Mainly of the same sex, 5. Exclusively of the same sex, or 6. With no sexual partners; “Partnership status”, with response options of 1. In a compromised relationship without cohabitation, 2. In a compromised relationship with cohabitation (or married), 3. Not in a compromised relationship or with no sexual partners, and 4. Not in a compromised relationship but with sexual partners; (see Table 1) and “The duration of the relationship”, in which the number of years was to be indicated (less than one year was referred to as zero). A further question inquired as to whether there were children in the relationship and if so, how many. A final question determined whether a person had been sexually active during the last 12 months.

The Sexual Excitation/Sexual Inhibition Inventory for Women and Men

The Sexual Excitation/Sexual Inhibition Inventory for Women and Men (SESII-W/M) was created by Milhausen et al. (2010) and measures an individual’s propensity for sexual arousal when presented with certain stimuli, or if placed in a specific sexual situation.

This inventory consists of six factors with a total of 30 items: Factor 1: Inhibitory Cognitions (eight items), refers to cognitions or emotions which serve as inhibitors of sexual arousal; Factor 2: Relationship Importance (five items), defines the need to experience security and quality in a relationship, as well as feelings of being used, or emotionally hurt, as inhibitors of sexual arousal; Factor 3: Arousability (five items), indicates facilitators of arousal when presented with certain sexual stimuli; Factor 4: Partner Characteristics and Behaviours (five items), serves to induce arousability, such as a partner’s personality and characteristics (e.g., intelligence or talent) and tasks performed by a partner (e.g., doing chores); Factor 5: Setting (Unusual or Unconcealed) (four items), intensifies arousal based on the sexual setting, for instance, the risk of being caught, or knowing that someone is nearby; and Factor 6: Dyadic Elements of the Sexual Interaction (three items), applies to inhibitors of sexual arousal, such as lack of sensitivity regarding one’s sexual signals on behalf of the partner. Options for response contain a 4-point Likert scale which ranges from 1 (strongly disagree) to 4 (strongly agree). Scores are obtained by calculating the mean for each factor, with higher scores indicating a stronger propensity in each domain. Items 11, 24 and 25 are inversely coded (Milhausen et al., 2010).

In terms of psychometric properties and for each of the factors, internal consistency presents Cronbach's alphas of .78 for Inhibitory Cognitions, .75 for Relationship Importance,

.72 for Arousability, .71 for Partnership Characteristics and Behaviours, .76 for Setting (Unusual or Unconcealed), and .66 for Dyadic Elements of the Sexual Interaction.

For construct validity the authors established low to moderate correlations between the Behavioural Inhibition/Behavioural Activation Scales (BIS/BAS; Carver & White, 1994), the Sexual Opinion Survey (SOS; Fisher, Byrne, White, & Kelley, 1988), the Sexual Sensation Seeking Scale (SSS; Kalichman & Rompa, 1995) and the Social Desirability Scale (SDSR; Hays, Hayashi, & Stewart, 1989) (authors as cited in Milhausen et al., 2010).

Test-retest results were significant ($p < .005$), ranging from $r = .66$ to $r = .82$ with a mean correlation of .76 (Milhausen et al., 2010).

This inventory has not been validated for the Portuguese population. Therefore, for the purpose of this study, I translated it into Portuguese. Linguistic validation was performed by a group specialised in the area of psychology, resulting in the version applied herein.

The Sexual Dysfunctional Beliefs Questionnaire

The Sexual Dysfunctional Beliefs Questionnaire (SDBQ) was designed by Nobre et al. (2003) in order to assess beliefs regarding sexuality, which could be an underlying cause for the development of sexual disorders. The questionnaire can be applied in both clinical settings and educational programs. It contains a male and female version, with six factors in each version. The male version consists of 37 items and the female of 34. These items are rated on a 5-point Likert scale, ranging from 1 (completely disagree) to 5 (completely agree). Scores are summed and the higher the score, the greater the dysfunctional belief. In the male version, item 37 is scored in reverse order, whereas in the female version, reversed codifications apply to items 1, 3, 22, 23 and 24.

The six factors of the male version contain the following classifications: Factor 1: Sexual Conservatism (ten items), refers to conservative beliefs regarding sexual behaviour; Factor 2: Female Sexual Power (eight items), presents the need for the man to control his urges in order not to fall subject to a woman's dominion; Factor 3: "Macho" beliefs (seven items), supports the idea that a man is always ready for sex and should always be able to maintain an erection; Factor 4: Beliefs About Women's Sexual Satisfaction (five items), sustains the notion that penis erection and vaginal coitus are essential to a woman's sexual satisfaction; Factor 5: Restricted Attitude Toward Sexual Activity (four items), regards sexual fantasies and oral and anal sex as unhealthy and perverse; Factor 6: Sex as an Abuse of Men's Power (three items), sustains the idea that by engaging in sexual activity, a man is abusing his power and violating a woman's body.

The six factors of the female version are described as follows: Factor 1: Sexual Conservatism (nine items), establishes coitus as the centrality of sexual activity and renders a woman passive and receptive, highlighting the importance of her virginity before marriage; Factor 2: Sexual Desire and Pleasure as a Sin (six items), declares sex as a man's activity and therefore a woman must control her desire and satisfaction, as these are considered sinful experiences; Factor 3: Age Related Beliefs (five items), supports the idea that as age advances, desire, pleasure and the ability to experience orgasm decrease, especially after menopause; Factor 4: Body-Image Beliefs (four items), defines a woman's body as the main aspect of female sexuality, implying that only a beautiful woman has the ability to satisfy her partner; Factor 5: Affection Primacy (six items), focuses on the importance of affection, love and agreement between partners; Factor 6: Motherhood Primacy (four items), considers motherhood as being a woman's main function in life and, therefore, sexual activity serves the sole purpose of procreation.

Psychometric properties of the SDBQ are satisfactory, presenting values for internal consistency with Cronbach's alpha for the total scale of .93 and .81 for male and female versions, respectively. However, despite these high values, Cronbach's alphas for some factors present unacceptable results. This is demonstrated in Table 2.

Test-retest reliability rendered statistically significant results ($p < 0.05$) of $r = .73$ (male version) and $r = .80$ (female version), demonstrating the instruments' stability across time (Nobre et al., 2003).

Convergent validity was assessed through the relationship with other measures of general and sexual beliefs and functioning, namely the Sexual Beliefs and Information Questionnaire (SBIQ; Adams et al., 1996), the Sexual Self-Schema (SSS; Andersen & Cyranowski, 1994 – female version; Andersen, Cyranowski, & Espindle, 1999 – male version), the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978), the International Index of Erectile Function (IIEF; Rosen et al., 1997) and The Female Sexual Function Index (FSFI; Rosen et al., 2000) (authors as cited in Nobre et al., 2003).

In order to determine the discriminant validity, the authors applied a *t*-test of mean differences, using a clinical versus control group consisting of community volunteers. Results supported the ability to distinguish between sexually functional and dysfunctional individuals.

Based on the evaluation of individual values of Cronbach's alphas, and in an attempt to avoid deviant results, only two factors from each questionnaire were applied in this study. Considering the strong prevalence of conservative sexual beliefs within the Portuguese population (Soares & Nobre, 2013), the dimensions of Sexual Conservatism from male and

female versions were selected. This choice was further reinforced as this dimension bore the highest values of Cronbach's alphas in both versions. A second selection included "Macho" Beliefs from the male version and Body-Image Beliefs from the female version. The choice of the first is justified based on studies which indicate that men with stronger beliefs in the "macho" myth present higher scores for sexual dysfunction (Nobre et al., 2003). Although Age Related Beliefs would have been a safer choice for the second option from the female version, Body-Image Beliefs presented more of a challenge, as there is little research and grounding evidence regarding this factor as a facilitator of sexual dysfunction in women, apart from the various studies performed by Nobre and colleagues mentioned herein. Furthermore, in the validation of the questionnaire, this dimension proved to be one of the main beliefs presented by women (Nobre et al., 2003). The DSM-5 (American Psychiatric Association, 2013) further supported the decision in terms of body image, as it is considered one of the individual vulnerability factors for promoting sexual dysfunction.

Table 2
Cronbach's Alphas for SDBQ

Factor		Scores		N Items	Cronbach's alpha
		Min.	Max.		
<i>Female Version</i>					
F1	Sexual Conservatism	9	45	9	.78
F2	Sexual desire and pleasure as a sin	6	30	6	.75
F3	Age related beliefs	5	25	5	.74
F4	Body-image beliefs	4	20	4	.66
F5	Denying affection Primacy	6	30	6	.59
F6	Motherhood primacy	4	20	4	.50
Total		34	170	34	.81
<i>Male Version</i>					
F1	Sexual Conservatism	10	50	10	.89
F2	Female Sexual Power	8	40	8	.77
F3	"Macho" Belief	7	35	7	.75
F4	Beliefs about women's satisfaction	5	25	5	.75
F5	Restrictive attitude toward sex	4	20	4	.54
F6	Sex as an abuse of men's power	3	15	3	.63
Total		37	185	37	.93

Adapted from "Sexual Dysfunctional Beliefs Questionnaire: An Instrument to Assess Sexual Dysfunctional Beliefs as Vulnerability Factors to Sexual Problems" by P. J. Nobre, J. P. Gouveia, and F. A. Gomes, 2003, *Sexual and Relationship Therapy*, 18(2), p. 188.

Applied Definition of Sexual Difficulties

The DSM-5 (American Psychiatric Association, 2013) defines sexual dysfunction as a group of clinically significant disorders which contribute to a person's inability to respond sexually, or to feel sexual pleasure. In order to assume a valid diagnosis, the symptoms must be experienced during approximately 75% to 100% of the time. Sexual dysfunction may include one or several disorders simultaneously. However, as sexual functioning is comprised of biological, psychological and socio-cultural factors, all of these should be considered during diagnosis.

This study sought to tap self-reported sexual difficulties in a non-clinical sample. Therefore, based on the sexual dysfunctions identified in the DSM-5 (American Psychiatric Association, 2013), questionnaires individually suitable for men and women were designed. These questionnaires consisted of four identified symptoms for men: 1. Delayed ejaculation; 2. Premature ejaculation; 3. Difficulty in achieving or maintaining erection; 4. Lack of sexual interest; and three for women: 1. Lack of sexual interest; 2. Difficulty experiencing orgasm; 3. Pain during sexual intercourse. A final question inquired about unidentified sexual difficulties and was appropriate for both genders: Other sexual difficulties. The options for answers were “Never”, “Occasionally”, “Half of the time” and “Most of the time”. Answers were assumed to represent 0% to 24%, 25% to 49%, 50% to 74% and 75% to 100% of occurrences, respectively, thus adopting the criterion represented in the DSM-5. Individuals who answered “Never” or “Occasionally” were classified as possessing no sexual difficulties, whereas individuals who answered “Most of the time” were considered to acknowledge experiencing sexual difficulties. The answer “Half of the time” was disregarded.

Data Analyses

Statistical analyses included measures for descriptive (absolute and relative frequencies, means and standard deviations) and inferential statistics tests. A value of $\alpha < 0.05$ was considered as a reference for accepting or rejecting the null hypothesis significance level. A Confirmatory Factor Analysis (CFA) was conducted for the SESII-W/M in order to determine whether the factor structure was in accordance with the original model. Student's *t*-tests were applied for independent samples and Pearson's correlation coefficient was administered in order to measure the strength and direction of the linear relationship between variables. The assumptions of Student's *t*-test, namely the normal distribution and homogeneity of variance assumptions, were analysed using the Kolmogorov-Smirnov test and Levene's test, respectively. Given that the sample size was greater than 30 and based on the central limit

theorem, a normal distribution was assumed (Smith & Wells, 2006). In situations where the assumption of homogeneity of variance was not fulfilled, a Student's *t*-test with Welch correction was performed.

Analyses were carried out using the Statistical Package for the Social Sciences (SPSS; version 21.0) and SPSS Amos (version 21.0).

Results

The Relationship between Factors of Sexual Excitation/Sexual Inhibition and Sexual Difficulties among Men

An independent-samples *t*-test was conducted to compare men with and without sexual difficulties and the factors of the SESII-W/M. Men with sexual difficulties obtained significantly higher scores in the dimensions of Inhibitory Cognitions ($M = 2.40, SD = .42$ vs. $M = 2.09, SD = .42$), and Dyadic Elements of the Sexual Interaction ($M = 2.73, SD = .62$ vs. $M = 2.60, SD = .50$) (see Table 3).

Table 3
Comparison between the SESII-W/M and Sexual Difficulties in Men

	No		Yes		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Inhibitory Cognitions	2.09	.42	2.40	.60	-5,450***
Relationship Importance	2.50	.50	2.57	.53	-1,320
Arousability	2.65	.45	2.70	.53	-1,065
Partner Characteristics and Behaviours	2.34	.44	2.34	.45	-.085
Setting (Unusual or Unconcealed)	2.81	.39	2.75	.43	1,463
Dyadic Elements of the Sexual Interaction	2.60	.50	2.73	.62	-2,123*

* $p \leq .05$, *** $p \leq .001$

The Relationship between Factors of Sexual Excitation/Sexual Inhibition and Sexual Difficulties among Women

Women with sexual difficulties obtained significant differences in scores for the dimensions of Inhibitory Cognitions ($M = 2.79, SD = .41$ vs. $M = 2.27, SD = .43$), Relationship Importance ($M = 3.03, SD = .56$ vs. $M = 2.92, SD = .57$), and Dyadic Elements of the Sexual Interaction ($M = 2.99, SD = .46$ vs. $M = 2.80, SD = .52$), whereas women without sexual difficulties obtained significantly higher scores in the dimensions of Arousability ($M = 2.43, SD = .48$ vs. $M = 2.15, SD = .51$), Partner Characteristics and Behaviours ($M = 2.45, SD = .46$ vs. $M = 2.29, SD = .52$), and Setting (Unusual or Unconcealed) ($M = 2.74, SD = .43$ vs. $M = 2.62, SD = .45$) (see Table 4).

Table 4

Comparison between the SESII-W/M and Sexual Difficulties in Women

	No		Yes		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Inhibitory Cognitions	2.27	.43	2.79	.41	-14,148***
Relationship Importance	2.92	.57	3.03	.56	-2,400*
Arousability	2.43	.48	2.15	.51	6,556***
Partner Characteristics and Behaviours	2.45	.46	2.29	.52	3,554***
Setting (Unusual or Unconcealed)	2.74	.43	2.62	.45	3,362***
Dyadic Elements of the Sexual Interaction	2.80	.52	2.99	.46	-4,833***

* $p \leq .01$, *** $p \leq .001$

Dysfunctional Sexual Beliefs as Vulnerability Factors for Sexual Difficulties among Men

Men with sexual difficulties obtained significantly higher values in the dimensions of both Sexual Conservatism ($M = 13.31$, $SD = 4.55$ vs. $M = 11.73$, $SD = 3.56$), and “Macho” Beliefs ($M = 18.24$, $SD = 6.03$ vs. $M = 15.09$, $SD = 5.22$) (see Table 5).

Table 5

Comparison between the SDBQ Male Version x Sexual Difficulties in Men

	No		Yes		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Sexual Conservatism	11.73	3.56	13.31	4.55	-3,561***
“Macho” Beliefs	15.09	5.22	18.24	6.03	-5,295***

*** $p \leq .001$

Dysfunctional Sexual Beliefs as Vulnerability Factors for Sexual Difficulties among Women

Women with sexual difficulties presented significantly higher values in the dimension of Sexual Conservatism ($M = 12.29$, $SD = 4.25$ vs. $M = 11.07$, $SD = 3.51$) (see Table 6).

Table 6

Comparison between the SDBQ Female Version and Sexual Difficulties in Women

	No		Yes		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Sexual Conservatism	11.07	3.51	12.29	4.25	-3,556***
Body-Image Beliefs	4.80	1.56	4.86	1.47	-.489

*** $p \leq .001$

Factors of Sexual Excitation/Sexual Inhibition and Sexual Beliefs

Pearson’s correlation was used to assess the relationship between the SESII-W/M and the SDBQ. Results indicated significant correlations between variables. Relationship

Importance and Sexual Conservatism in women presented the highest association ($r = .241, p < .01$), followed by Arousability and “Macho” Beliefs ($r = .205, p < .01$) (see Table 7).

Table 7
Correlations between the SESII-W/M and the SDBQ

	Sexual Conservatism (Men)	Macho Beliefs (Men)	Sexual Conservatism (Women)	Body-Image Beliefs (Women)
Inhibitory Cognitions	.135**	.065*	.169**	.040
Relationship Importance	.126**	-.039	.241**	.129**
Arousability	.082*	.205**	-.127**	-.052
Partner Characteristics and Behaviours	.121**	.054	-.166**	-.117**
Setting (Unusual or Unconcealed)	.013	.020	-.116**	-.005
Dyadic Elements of the Sexual Interaction	.085**	.010	.125**	.048

* $p \leq .05$, ** $p \leq .01$

Sexual Difficulties

Following the criterion defined by the DSM-5 (American Psychiatric Association, 2013) sexual difficulties were assessed considering responses of “Most of the time”, representing 75% to 100% of occurrences during sexual activity with a partner. The answers of “Never” (representing 0% to 24%) and “Occasionally” (25% to 49%) were assumed to refer to individuals without sexual difficulties. The answer “Half of the time” (50% to 74%) was not considered in this analysis. The results of the answers are represented in Table 8.

Table 8
Self-Reported Sexual Difficulties

	Never	Occasionally	Most of the time
<i>Men</i>			
Delayed ejaculation	37.6%	50.8%	4.7%
Premature ejaculation	30.1%	49.4%	7.7%
Difficulty in achieving or maintaining erection	49.3%	43.6%	1.6%
Lack of sexual interest	55.4%	39.8%	1.4%
Other sexual difficulties	66.7%	30.5%	.7%
<i>Women</i>			
Lack of sexual interest	22.0%	52.6%	12.1%
Difficulty experiencing orgasm	24.3%	49.8%	14.4%
Pain during coitus	45.5%	43.3%	4.9%
Other sexual difficulties	53.5%	39.1%	2.4%

In the comparison of men with and without sexual difficulties, those who indicated having sexual difficulties reported more ejaculation problems, of which 7.7% informed experiencing “Premature ejaculation” and 4.7% “Delayed ejaculation”. “Difficulty in achieving or maintaining erection” represented 1.6% of this sample and “Lack of sexual interest” represented 1.7%. Only .7% reported experiencing other sexual difficulties.

The main sexual difficulty identified by women was “Difficulty in experiencing orgasm” (14.4%), followed by “Lack of sexual interest” (12.1%) and “Pain during coitus” (4.9%). “Other sexual difficulties” obtained a value of 2.4%.

The Sexual Excitation/Sexual Inhibition Inventory for Women and Men

Confirmatory Factor Analysis

In order to confirm the model presented by Milhausen et al. (2010) for the SESII-W/M, a CFA of the six factors, defined by the 30 items from this inventory, was designed (see Fig. 1). To be able to adjust the model, items 9 and 22 from the dimension "Relationship Importance", and items 4 and 25 from the dimension "Arousability", had to be eliminated. The final model resulted in a weak, but acceptable, fit: $\chi^2/df=5,898$ (poor); CFI = .863 (poor); PCFI = .754 (good); GFI = .930 (good); PGFI = .752 (poor); RMSEA = .051 (good). Factor loadings ranged from -.34 to .71, with an average factor loading of .53. All factor loadings were significantly inter-correlated ($p < .001$), except for Partner Characteristics and Behaviours and Dyadic Elements of the Sexual Relationship, Partner Characteristics and Behaviours and Relationship Importance, and Partner Characteristics and Behaviours and Inhibitory Cognitions.

Psychometric Properties

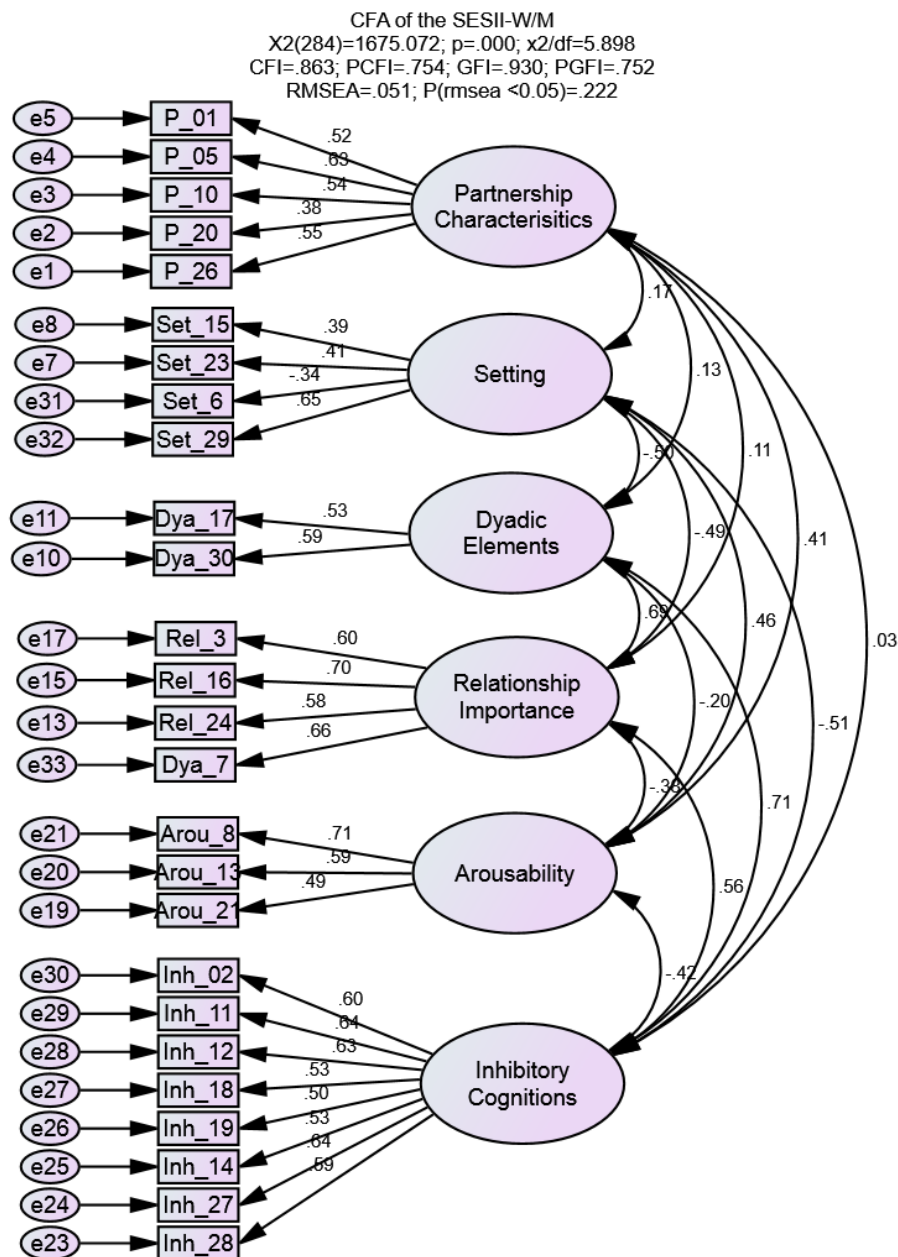
All factors fell within the normal range for skewness and kurtosis. Chronbach's alphas for each of the dimensions were .80 for Inhibitory Cognitions, .71 for Relationship Importance, .65 for Arousability, .65 for Partnership Characteristics and Behaviours, .14 for Setting (Unusual or Unconcealed), and .51 for Dyadic Elements of the Sexual Interaction (see Table 9).

Table 9

Psychometric Properties of the Sexual Excitation/Sexual Inhibition Inventory for Women and Men

	Min.	Max.	M (SD)	Skewness	Kurtosis	Alfa Cronbach
Inhibitory Cognitions	1	4	2.31 (.49)	-.08	.31	.80
Relationship Importance	1	4	2.73 (.58)	.06	-.16	.71
Arousability	1	4	2.51 (.50)	.11	.10	.66
Partner Characteristics and Behaviours	1	4	2.37 (.46)	.10	.23	.65
Setting (Unusual or Unconcealed)	1	4	2.75 (.42)	.02	.71	.14
Dyadic Elements of the Sexual Interaction	1	4	2.75 (.52)	-.21	.32	.51

Figure 1. Results of Confirmatory Factor Analysis of the SESII-W/M



Gender Differences and Scores Regarding the Factors of Sexual Excitation/Sexual Inhibition

All six dimensions of the SESII-W/M presented significant gender differences ($p < .01$). Women obtained significantly higher values in the dimensions of Inhibitory Cognitions ($M = 2.46, SD = .47$ vs. $M = 2.19, SD = .47$), Relationship Importance ($M = 2.97, SD = .56$ vs. $M = 2.51, SD = .50$), Partner Characteristics and Behaviours ($M = 2.40, SD = .48$ vs. $M = 2.34, SD = .45$), and Dyadic Elements of the Sexual Interaction ($M = 2.87, SD = .51$ vs. $M = 2.64, SD = .52$), whereas men obtained significantly higher values in the dimensions of Arousability ($M = 2.66, SD = .46$ vs. $M = 2.34, SD = .49$), and Setting (Unusual or Unconcealed) ($M = 2.79, SD = .40$ vs. $M = 2.71, SD = .43$) (see Table 10).

Table 10
Comparison between the SESII-W/M, Gender and Scores

	Men		Women		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Inhibitory Cognitions	2.19	.47	2.46	.47	-12,298***
Relationship Importance	2.51	.50	2.97	.56	-18,307***
Arousability	2.66	.46	2.34	.49	14,589***
Partner Characteristics Behaviours	2.34	.45	2.40	.48	-2,786**
Setting (Unusual or Unconcealed)	2.79	.40	2.71	.43	4,515***
Dyadic Elements of the Sexual Interaction	2.64	.52	2.87	.51	-9,515***

** $p \leq .01$, *** $p \leq .001$

The Sexual Dysfunctional Beliefs Questionnaire

Psychometric Properties

Table 11 displays descriptive and psychometric results for the SDBQ for the female and male versions.

Sexual Conservatism in the male version attained minimum and maximum scores of 10 and 50, respectively, with a mean of 12.11 ($SD = 4.03$). Cronbach's alpha was .84. For "Macho" Beliefs, the scores ranged from 7 (minimum) to 32 (maximum) with a mean of 15.76 ($SD = 5.53$). Cronbach's alpha supported a good internal consistency at .74. Analysis for a normal distribution for Sexual Conservatism showed that the data were highly positively skewed (4.16) and kurtosis presented a leptokurtic distribution (24.19).

Scores for Sexual Conservatism in the female version achieved a minimum value of 9 and a maximum value of 37, with a mean score of 11.44 ($SD = 3.75$). Internal consistency was good, with Cronbach's alpha of .77. Scores for Body-Image Beliefs were a minimum of 4 and a maximum of 16 ($M = 4.82; SD = 1.58$). Alpha's Chronbach was unacceptable at .45.

Table 11

Psychometric Properties of the Sexual Dysfunctional Beliefs Questionnaire

	Min.	Max.	M (SD)	Skewness	Kurtosis	Cronbach's Alpha
<i>Male Version</i>						
Sexual Conservatism	10	50	12.11 (4.03)	4.16	24.19	.84
Macho Beliefs	7	32	15.76 (5.53)	.47	-.34	.74
<i>Female Version</i>						
Sexual Conservatism	9	37	11.44 (3.75)	2.43	7.58	.77
Body-Image Beliefs	4	16	4.82 (1.58)	2.44	7.24	.45

Discussion

The purpose of this study was to determine the existence of a relationship between sexual beliefs, sexual difficulties and factors of sexual excitation and inhibition.

In the comparison of sexual difficulties with the SESII-W/M it is clear to see that those who reported sexual difficulties presented higher scores on all factors related to sexual inhibition. Men obtained higher scores in the dimensions of Inhibitory Cognitions and Dyadic Elements of the Sexual Interaction, whereas women obtained higher scores in the dimensions of Inhibitory Cognitions, Relationship Importance and Dyadic Elements of the Sexual Interaction. The dual control model infers that individuals with a high propensity for sexual inhibition display a greater vulnerability to sexual dysfunctions (Bancroft, 1999; Bancroft & Janssen, 2000). Although research of the dual control model has been mainly orientated towards the association with sexual dysfunctions in men, the present study reveals that a connection with sexual difficulties is also apparent in men and women. It seems equally important to note that women who did not report sexual difficulties, presented higher scores on all factors of sexual excitation, namely Arousability, Partner Characteristics and Behaviours and Setting (Unusual or Unconcealed). This association, however, is not quite clear, as it could simply indicate a normal and healthy sexual activity, but no empirical evidence to support this supposition can be located. Findings also reveal that the SESII-W/M seems to be a better instrument for differentiating individual with and without sexual difficulties in women, rather than in men.

When comparing sexual difficulties with the SDBQ, men with sexual difficulties obtained significantly higher scores in Sexual Conservatism and "Macho" Beliefs. This complies with the theory presented by Nobre (2006) who proposes that negative thoughts, or beliefs, differentiate sexually dysfunctional men from sexually healthy men. On the other hand, sexual difficulties in women were only strongly correlated with Sexual Conservatism.

Contrary to the results from previous studies (e.g., Nobre et al., 2003), sexual difficulties produced no significant impact on Body-Image Beliefs. Research has shown that although women present greater concerns with body-image throughout their lives than men, these concerns are more evident in adolescents (ages 12 to 18 years) and young adults (ages 19 to 29 years) than in midlife adults (ages 31 to 49 years) and older adults (ages 55 to 66 years) (Esnaola, Rodríguez, & Goñi, 2010). Furthermore, older women present a better control over awareness and expectations, and less dissatisfaction with their bodies, than younger women (Pujols, Meston, & Seal, 2009). The women from our sample presented a mean age of 32 years, falling within the classification of "midlife adults".

The comparison of Sexual Conservatism in men with the SESII-W/M resulted in significant correlations with all factors, except for Setting (Unusual or Unconcealed). "Macho" Beliefs correlated significantly with Arousability ($r = .205, p < .01$), bearing the strongest correlation in the male version, and Inhibitory Cognitions. Nobre et al. (2003) have identified "Macho" Beliefs (a man is always ready for sex, can always achieve and maintain an erection and upholds his performance until the end) as one of the most persistent sexual beliefs among men, suggesting that for men with these beliefs, sexual arousal is easily summoned. Therefore, the relation with Arousability would appear to be evident, assuming an increase in mechanisms of sexual excitation when presented with a sexual stimulation and upholding the theoretical basis of the dual control model (Bancroft, 1999; Bancroft & Janssen, 2000). The model also states that a low propensity of sexual inhibition could promote high-risk sexual behaviour (Bancroft, 1999; Bancroft & Janssen, 2000). However, it is not possible to incur any support to this affirmation from the relationship between these variables in the present study.

Sexual Conservatism in women correlated significantly with all six factors of the SESII-W/M, whereas Body-Image Beliefs only correlated significantly with Relationship Importance and Partnership Characteristics and Behaviours. The reasons a woman chooses to engage in sexual intercourse are diverse and complex, yet they may often include the need to feel close to her partner, or to boost her own self-image. A more positive body-image has been associated with a larger frequency of sexual activity. Initially, a woman may not even feel sexually aroused and relies on sexual stimulation from both herself and her partner, enabling her to enjoy her sexual experience (Basson, 2005; Pujols et al., 2009; Swami, Neto, Tovée, & Furnham, 2007). It seems, therefore, only natural that Relationship Importance and Partner Characteristics and Behaviours are the two dimensions that are significantly correlated

to both Sexual Conservatism in women and Body-Image Beliefs, sustaining the evidence from current literature.

The strong correlations of sexual conservatism in men and women with all factors of the SESII-W/M (except for Setting - Unusual and Unconcealed, among men), demonstrate the prevalence of sexual conservative beliefs within the Portuguese population, and the influence of culture on sexual functioning and perception (Nobre et al., 2013), the strongest significant correlation being between Sexual Conservatism in women and Relationship Importance ($r = .241, p < .01$). The theory presented by Nobre et al. (2003) states that individuals with strong sexual beliefs present a greater propensity for sexual dysfunction. Relationship Importance is defined as a factor of sexual inhibition (Milhausen et al., 2010) and according to the dual control model, high levels of inhibition could lead to sexual dysfunction (Janssen et al., 2002a). The variables of Sexual Conservatism in women, Relationship Importance and Sexual Difficulties in women were not evaluated altogether, but the results might indicate a dangerous tendency for sexual dysfunctions. Further investigation would certainly help to clarify this liaison.

This study also sought to identify the main sexual difficulties reported by men and women. In terms of sexual difficulties for the male population, the highest reported sexual difficult was Premature Ejaculation, representing 7.7% of the sample. This result is consistent with those of other Portuguese studies, with Portuguese men (Gomes & Nobre, 2014; Vendeira, Pereira, et al, 2011). The second most reported difficulty was Delayed Ejaculation, representing 4.7% of the sample. These findings indicate a predisposition for ejaculation problems in men.

The most reported sexual difficulty in women was Difficulty in Experiencing Orgasm (14.4%), closely followed by Lack of Sexual Interest (12.1%). Caution in the interpretation of these results is necessary, as most women need clitoral stimulation in order to reach orgasm (American Psychiatric Association, 2013) and it is important to remember that these are self-reported situations. One of the largest studies on sexual dysfunctions carried out among 1,250 Portuguese women with a clinical situation, produced very close results among various disorders (35% for sexual interest/arousal disorders, 34.1% for genito-pelvic pain and 31.6% for orgasmic disorders) and found that 11% of the women presented more than one dysfunction, clearly indicating an overlap of sexual dysfunctions (Vendeira, Monteiro, et al., 2011). Yet once again, these results are based on the analysis of sexual dysfunctions, proving that research, previous and recent, is still investing mainly on the investigation of sexual dysfunctions in women (e.g., Carvalho, Veríssimo, & Nobre, 2013; Oliveira & Nobre, 2013),

as opposed to sexual difficulties. Therefore, the subject of sexual difficulties within the female population is still a contemporary topic in the scientific field and could merit from further investigation.

The adaptation into Portuguese of the SESII-W/M resulted in a poor, but acceptable model, with the need to exclude some of the items. Reliability for Setting (Unusual and Unconcealed) and Dyadic Elements of the Sexual Interaction attained unacceptable and poor Chronbach's alphas of .14 and .51, respectively, rendering a weakness in the application of the instrument as a whole. The questionnaire applied in this study could benefit from improvement and validation into Portuguese would contribute to its use in further investigations.

The comparison of gender with the SESII-W/M proved to be in line with the findings of the authors of the questionnaire. *Hypothesis 1* was confirmed in revealing gender differences among each subscale, presenting the most noteworthy difference in the Relationship Importance factor, with women scoring significantly higher than men. *Hypotheses 2*, which dictated that women would present statistically significant differences and higher scores on the subscales of Inhibitory Cognitions, Relationship Importance, Partner Characteristics and Behaviours and Dyadic Elements of the Sexual Interaction, was confirmed. *Hypothesis 3*, which predicted that men would present statistically significant differences and higher scores on the subscales of Arousalability and Setting (Unusual or Unconcealed), was also confirmed.

It is also important to note that women scored higher on factors of sexual inhibition (with the exception of Partner Characteristics and Behaviours), whereas men achieved higher scores on factors of sexual excitation. These findings are coherent with the results from the validation of the Sexual Excitation/Sexual Inhibition Scales (SIS/SES) for women, performed by Carpenter, Janssen, Graham, Vorst, and Wicherts (2008). The authors claim that this result is justified by previous research which suggests that women are subject to greater biological risks (such as undesired and long-term pregnancy) when engaging in casual and random sex and so have developed inhibitory mechanisms to help them control their sexual desire, explaining their tendency for higher levels of sexual inhibition. For men, on the other hand, fertilization is a low-cost liability and therefore they present higher levels of sexual excitation. Several questionnaires have been created in order to measure sexual propensity, but specifically apply to either men or women and it was believed that genders reacted differently to different stimuli (e.g., Graham, Sanders, & Milhausen, 2006; Janssen et al., 2002a; Janssen, Vorst, Finn, & Bancroft, 2002b). The SESII-W/M was designed based on focus group studies and is the first questionnaire to be applied to both men and women. Nevertheless, gender

differences are still apparent and perhaps further research into factors associated with arousal in both genders is still necessary.

Finally, internal validity was tested for the dimensions of Sexual Conservatism and "Macho" Beliefs in the male version, and Sexual Conservatism and Body-Image Beliefs in the female version, of the SDBQ. The results in the current study for the first three dimensions were very similar to those of the original instrument, presenting values of Chronbach's alphas of .84 (vs. .89), .74 (vs. .75) and .77 (vs. .78). The only unexpected result was from the dimension of Body-Image Beliefs, with an unacceptable Chronbach's alpha of .45 (vs. .66). It is possible that the answers were biased by this particular sample. The participants of this study were mainly highly educated and, therefore, not representative of the lower-class population. A reapplication of this dimension to a more diverse population could demystify this result.

Limitations of the Study

Although the subject of sexual dysfunction has been widely studied, there is little research on sexual difficulties and it is also important to note that the difficulties from the present study were self-reported and could be misguided. The results from the male sample could simply be representing a man's self-expectation in a sexual situation, or the interference of some other confounding variable. As for women, difficulty in experiencing orgasm could be merely due to a lack of stimulation.

The application of the SESII-W/M to a Portuguese-speaking population raises many questions. This questionnaire has not been validated for the Portuguese population and the version herein applied resulted in a weak, although acceptable model, as can be verified by the CFA. Internal consistency for the dimensions of Setting (Unusual or Unconcealed) and Dyadic Elements of the Sexual Interaction were unacceptable and poor ($\alpha = .14$ and $\alpha = .51$, respectively) and seem to further emphasize the need for validation of the questionnaire. Likewise, the low internal consistency obtained in the dimension of Body-Image Beliefs from the SDBQ could be compromising the results related to this variable.

Participants were recruited online using a web survey. Although the Internet is becoming an increasingly popular means for assessing large samples, it still remains limited to those who have access to the Internet and represents a lack of control over the conditions in which the questionnaires are answered. Furthermore, the websites which agreed to the publication of the instrument resulted in a highly educated sample, with 64.5% reporting

having a degree. Therefore, the sample used in this study can be considered under-representative of the lower-class population.

Conclusions and Future Directions

Previous research has shown us that sexual beliefs serve as vulnerability factors for sexual dysfunctions. The current research goes further and reveals an evident relationship with sexual arousal. Furthermore, sexual difficulties play a decisive role in their relationship with both sexual beliefs and sexual arousal. However, a correlation design was applied and although associations among variables are apparent, causation cannot be implied. Therefore, the factors of these occurrences were not determined and in order to establish a causal relationship, further investigation is required. Nonetheless, this study has proven to be innovating in the combination of these variables and in disclosing a relationship between them.

Another novelty in this study was the application of the SESII-W/M on a Portuguese-speaking population. This inventory is not only relatively recent, but could also prove to be of relevant importance in studies regarding factors of sexual excitation and inhibition in Portugal. The pertinence of its use and the imperfections of the adaptation encountered in this research could serve as a stepping stone for its validation.

Comparisons using socio-demographic information were not applied in this study, yet results could diverge in terms of age, academic qualifications, and even residential area, among others. For future studies and an extensive understanding of this topic, it would be interesting to perform these analyses with this sample, or another.

Sexual beliefs and sexual difficulties are not uncommon and discreetly weave their way into our everyday lives, impacting on sexual arousal. It is important to maintain harmony between levels of sexual excitation and inhibition, or an imbalance could cause problems, leading to high-risk sexual activity if levels of excitation are too high, or to sexual dysfunctions when dealing with excessive levels of inhibition. Individually, the previous variables are a menace and must be adequately regulated, yet it now seems apparent that perhaps they do not only work separately, but also walk hand-in-hand and could be seriously impairing our sexual functioning.

This study has opened a new door for the investigation of sexuality through the association of factors which have not before been studied in unison. There is undoubtedly a long path to follow from here, yet the results presented in this research provide a solid ground for further exploration.

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Appendix 1: Literature Review

Human sexuality is a natural and healthy aspect of life, yet despite the attention given to this matter, it persistently seems to be cause for embarrassment and raises many taboos. This is evident in adolescents, who are discovering their sexuality for the first time, as well as in adults, who struggle throughout their entire lives to achieve satisfying sexual experiences. How one expresses one's sexuality is a very personal matter and can be approached from many different angles. Recent studies are orientated towards determining which factors motivate an individual to engage in, or restrain from, sexual activity, or to speak in more general terms of arousal, to discover what precisely is it that turns us on and off (Goldenberg, Pyszczynski, McCoy, Greenberg, & Solomon, 1999; Kukulcu, Gürsoy, & Sözer, 2009; World Health Organization, 2006).

The Dual Control Model: A New Insight on Sexual Arousal

When speaking of sexual arousal, studies have often identified a lack of sexual arousal as the absence of excitation and even though inhibition of arousal has been undoubtedly accepted, it has not, until recently, been properly studied. The dual control model suggests the existence of adaptive inhibitory and excitatory mechanisms in the brain, and states that the propensity for the inhibition and excitation of sexual response varies in every individual. A predisposition for inhibitory factors is essential to all human beings, inasmuch as it keeps them out of trouble. A person who presents high levels of sexual inhibition will most probably manifest some sort of sexual dysfunction (such as erectile, in men), whereas someone with a low propensity for sexual inhibition is more likely to lunge into high-risk sexual behaviour. Considering this, it seems apparent that a balance between sexual inhibition and excitation is necessary in order to guarantee healthy sexual functioning (Bancroft et al., 2005; Bancroft & Janssen, 2000; Graham, Sanders, Milhausen, & McBride, 2004).

Bancroft (1999) suggests that there are four types of functions that could benefit from inhibition to a sexual response. The first is in the presence of a sexual situation that is perceived as threatening and from which a sexually inhibiting reaction could help to evade danger. The second refers to the perception of a non-sexual threat which requires an avoidance response, in which inhibition, or some other sort of unsuitable behaviour, serves as a distraction. In the third, sexual inhibition intrudes, putting a break on arousability and certifying that the search of sexual pleasure does not become excessive. Finally, in the fourth, sexual performance and reproduction are hindered by chronic stress. In several social species and based on the theory of natural selection, over population is reduced by repressing

reproductive conduct in creatures at the bottom of social ladder, which have a tendency to be more vulnerable to chronic stress.

Based on this theoretical model, Janssen, Vorst, Finn, and Bancroft (2002a, 2002b), developed the Sexual Inhibition (SI) and Sexual Excitation (SE) scales, in order to measure the propensity for sexual arousal in men. These scales produced one higher-order excitatory factor and two higher-order inhibitory factors, the first referring to the threat of performance failure and the second to the threat of performance consequences. Although the foundations for the concepts applied in this study are just as valid for sexual response in women, research at the time presented a delimitation and focus on the neurophysiological and psychophysiological sexual response and dysfunction in men, and therefore the scales were designed specifically for the male gender (Janssen & Bancroft, 2007).

Sexual arousal involves both psychological and physiological characteristics. The first is a manifestation of emotions, appeal and desire, whereas the latter is perceived by changes in the genitalia. Several researchers have used functional brain imaging in order to identify areas in the neural system responsible for sexual arousal. In a study carried out by Rauch et al. (1999), the authors sought to provoke sexual arousal through script imaging in healthy men and compared the results with arousal caused by a desire to compete. In another study, Redouté et al. (2000) presented sexual arousing, humorous and emotionally neutral film clips to healthy males and compared the results of the three. Both studies found increased brain activity in a number of locations within the boundaries of the cerebral cortex, as well as in sub-cortical structures, whereas other parts of the brain presented decreased activity. Although there is still much need for study in this area, this strongly suggests that sexual behaviour and arousal are based on a balance between excitatory and inhibitory mechanisms within the brain. Even so, and despite this evidence, inhibitory mechanisms have still not been physically identified within the human brain and much less is understood regarding these networks (Pfaus, 2009; Simon & Valente, 2006). Therefore, the dual control model relies more on conceptual systems, rather than anatomically tangible structures (Janssen & Bancroft, 2007; Janssen et al., 2002a).

Considering that the theoretical background used for the development of the Sexual Excitation and Sexual Inhibition Scales (SES/SIS) was based mainly on research involving men, it is only natural that the first studies on sexual excitation and inhibition which applied these scales were an attempt to determine sexual dysfunction in the male gender. Findings supported the efficiency of the dual control model in predicting sexual responses (Janssen et al., 2002a, 2002b). In a study which mainly compared erectile dysfunction in clinical versus

non-clinical samples, Bancroft et al. (2005) amazingly discovered that when measuring erectile problems, both samples presented very similar results. In order to justify this, the authors refer that at the time of the study, it was still not clear as to what extent the SIS/SES scales could be measuring "traits" or individual differences which could justify a tendency for sexual dysfunction.

The subject of sexual arousal soon began to turn its attention towards women's interests and a focus group study carried out by Graham et al. (2004), aimed to determine factors associated with sexual excitation and inhibition in women. The most significant aspects perceived by these women as either enhancing or inhibiting sexual arousal were: how a woman felt about her body, concerns regarding one's reputation, the need to "put on the brakes" in certain situations (stopping oneself from becoming aroused), fear of unwanted pregnancy (the importance of contraceptive methods), feeling desired versus feelings of being used, the acceptance of a woman's sexual responses by her partner, how a man approaches a woman (e.g., "pick-up" lines), and the effect of negative moods on stimulation. Other relevant topics of discussion were indicators of sexual arousal, such as cognitive-emotional and behavioural responses. The issue of genital sensations was also addressed as, according to some of these women and contrary to common belief, lubrication was not always a sign of arousal. This study was a stepping stone which led to the creation of the Sexual Excitation/Sexual Inhibition Inventory for Women (SESII-W). This questionnaire revealed two higher-order factors, namely Sexual Excitation, with five sub-scales: arousability, sexual power dynamics, smell, partner characteristics and setting (unusual or unconcealed), and Sexual Inhibition, with three sub-scales: relationship importance, arousal contingency and concerns about sexual function (Graham, Sanders, & Milhausen, 2006).

And so still, up to this date, no scale had been developed which could measure the propensity for sexual arousal in both men and women, allowing for a comparison between the two. In order to assess factors of sexual arousal in men, Janssen, McBride, Yarber, Hill, and Butler (2008) performed a focus group study which revealed some similarities with the results obtained from the focus group study with women, indicating that perhaps the gap between genders was not as large as was initially believed to be. For example, in the latter, how a woman felt about herself greatly influenced a man's sexual arousal. In the study involving men, the same could be said about how a man felt about himself. In other words, a greater self-esteem revealed a higher display of sexual arousal in both men and women. This study with men was absent of comments regarding safe sex and contraception, as well as specific sexual behaviours such as positions, oral or anal sex, the size of a man's penis and women's

orgasms. It was not clear, however, whether the absence of discussion on these topics was due to a lack of interest, discomfort on behalf of the participants, or merely due to the characteristics of this particular sample. Nevertheless, this focus group study was of outstanding importance in understanding the motives for a man's sexual arousal.

Convinced that both men and women shared the same response to sexual stimuli, through the comparison between male and female samples, Carpenter, Janssen, Graham, Vorst, and Wichers (2008) attempted to validate the SIS/SES scales in women. Although psychometric properties were satisfactory and there appeared to be some resemblances in the processes which accounted for stimulation in both genders, the authors were not sure to what extent the items clearly represented factors of arousal in women and therefore advised the use of the SIS/SES in studies involving men, and the SESII-W with regards to women.

Based on previous research and using the same items which served as the foundation for the SESII-W, Milhausen, Graham, Sanders, Yarer, and Maitland (2010) developed the Sexual Excitation/Sexual Inhibition Inventory for Women and Men (SESII-W/M). This inventory consists of six higher-order factors: Inhibitory Cognitions, Relationship Importance, Arousability, Partner Characteristics and Behaviours, Setting (Unusual or Unconcealed), and Dyadic Elements of the Sexual Interaction. This is the first attempt to create a scale which assesses the propensity for sexual arousal in both men and women and although the psychometric properties need to be further tested, this inventory is certainly innovating and challenging. Due to its relevant recency, it does not seem to have yet been explored in studies following its publication.

Sexual Beliefs

Both culture and upbringing imprint beliefs on individuals regarding sexual functioning, consequently determining their perspective of a healthy sexual life (Carvalho & Nobre, 2011). According to Zilbergeld (1999, as cited in Chang, Klein, & Gorzalka, 2013; Soares & Nobre, 2013), it is difficult to demolish our beliefs, built on a life-time of experiences, but clinical evidence has shown us that some beliefs could be the foundation for sexual difficulties and preying on these beliefs grants persistence to these maladies.

Nobre, Gouveia and Gomes (2003), define sexual beliefs as cognitive-emotional factors which promote sexual dysfunction. In turn, sexually dysfunctional men and women more frequently activate negative thoughts when confronted with a sexual failure. Sexually dysfunctional individuals possess a number of sexual beliefs which are allegedly responsible for their failure. These beliefs are a result of social, cultural and personal experiences

(Fonseca, Figueiredo, & Nobre, 2003). As far back as 1995, in a study carried out in Sri Lanka, de Silva and Rodrigo demonstrated that culture and beliefs can indubitably be a source leading to sexual problems.

In order to assess sexual beliefs and how these might influence sexual functioning, Nobre et al. (2003), developed the Sexual Dysfunctional Beliefs Questionnaires (SDBQ), one for women and one for men. In both questionnaires six sub-scales were identified. For women these referred to: 1) Sexual Conservatism; 2) Sexual Desire and Pleasure as a Sin; 3) Age Related Beliefs; 4) Body-Image Beliefs; 5) Affection Primacy; 6) Motherhood Primacy. For men, the six sub-scales were: 1) Sexual Conservatism; 2) Female Sexual Power; 3) "Macho" Belief; 4) Beliefs about Women's Satisfaction; 5) Restrictive Attitude Toward Sex; 6) Sex as an Abuse of Male's Power. Research in data-bases reveals that these questionnaires do not seem to have been applied in countries other than Portugal, which is the birthplace of this instrument.

Nobre et al. (2003) characterizes each of the dimensions from the female version as follows:

Sexual conservatism: This places coitus in the centre of human sexuality and considers all other activities, such as masturbation, oral and anal sex, as sinful and perverse. A woman's role is passive and submissive and an unmarried woman must preserve and value her virginity.

Sexual desire and pleasure as a sin: A woman believes that sex is an activity restricted to men and therefore she must control her urges and desires. To feel pleasure and satisfaction is a sin.

Age related beliefs: Here resides the assumption that sexual desire, pleasure and orgasm decrease with age, especially after menopause.

Body-image beliefs: Body image is the central aspect of female sexuality and therefore only beautiful women are able to experience and give pleasure.

Affection primacy: Love, affection and mutual agreement constitute the basis for a relationship and a healthy sex life. This dimension is scored in reversed order.

Motherhood primacy: the sole purpose of a woman's existence is to experience motherhood. Sexual activity is justified only for procreation.

The male version contains Sexual Conservatism as common dimension to that of the female version, although the contents are different. The six factors from the male version are described as follows (Nobre et al., 2003):

Sexual Conservatism: Men retain very strict and conservative ideas about sexual behaviour: no sex before marriage, get the job done quickly, focus on coitus, foreplay is unnecessary and only the missionary position is acceptable.

Female sexual power: A man needs to maintain control over his urges, or he will fall under the power of a woman. For him, female sexual power represents a serious threat and can be dangerous.

"Macho" beliefs: A man's performance must be impeccable. He is always ready for sex, always satisfies a woman and is able to maintain his penis erect until the end of the sexual intercourse.

Beliefs about women's sexual satisfaction: In order to satisfy a woman, an erect penis and vaginal coitus are essential to sexual activity.

Restricted attitude toward sexual activity: Sexual fantasies, as well as oral and anal sex are inappropriate and unhealthy sexual activities.

Sex as an abuse of men's power: When a man has sex, he is abusing his power and violating a woman's body.

In Portugal, men present strong beliefs on what is expected of them in regards to sexual performance. These beliefs are very persistent and are not restricted to age or education. Portugal is a Catholic-based country, which could be a cause for nourishing such beliefs. Also, high standards of sexual performance are passed down from generation to generation, from father to son, and through the media. On the other hand, sexual education in schools is quite recent and may explain the endurance of these beliefs in our present society (Soares & Nobre, 2013).

As for Portuguese women, beliefs with reference to age and body-image prove to be the most prevalent and differentiate sexually dysfunctional woman from sexually healthy women. Women believe that sexual desire decreases with age, especially after menopause. Likewise, body-image seems to be a determinant factor for sexual success and satisfaction. Finally, conservative beliefs are still very present, regardless of age, and could be due to the strong influence of the Catholic Church (Soares & Nobre, 2013).

Diagnostic Features of Sexual Dysfunctions

The diagnostic features of sexual dysfunctions are herein described. This section is entirely based on the definitions from the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) and aims to

justify the classification of sexual difficulties applied in this study. Presentation follows the order of appearance as in the DSM-5.

The first sexual dysfunction presented for men in the DSM-5 refers to *delayed ejaculation* and diagnosis requires a distinct delay in ejaculation or an inability to reach ejaculation, even when presented with sexual stimulation. Normally, diagnosis is based on self-reports and this ailment usually involves sexual activity with a partner. There is no time limit placed on the term “delay”, however, it is possible that the prolonged thrusting in the attempt to reach orgasm could result in exhaustion, followed by genital discomfort and finally abandonment of efforts.

The second male dysfunction found in the DSM-5 is *erectile disorder*. The main feature of this disorder refers to constant failures to obtain or maintain erection during sexual activity with a partner. In order to reach a diagnosis, it is important to verify if the problem has persisted for more than six months and if complaints occur in least 75% of sexual occasions. Difficulties could arise in the presence of a certain sexual situation, or with a specific partner, or may not be related to either of the two.

Female orgasmic disorder is the first female disorder to be mentioned in the DSM-5 and diagnostic features are rather complex. This disorder refers to difficulty in experiencing orgasm and/or an evident reduction of the intensity in orgasmic sensations. Description of an orgasm is very subjective and has been described differently by different women and even differently by the same women, at different times. For diagnosis, symptoms must occur on 75% to 100% of occasions of sexual activity and must have lasted for a minimum of six months. Clinically significant distress must also accompany the disorder so as to confirm diagnosis. Psychological stressors such as severe distress in a relationship, or intimate partner violence, eliminate diagnosis. It is important to bear in mind that most women need clitoral stimulation to be able to reach orgasm and very few report experiencing orgasm through penile-vaginal penetration, therefore if a woman reaches orgasms through clitoral stimulation, but not through penetration, she does not fit the diagnosis for this disorder.

The DSM-5 states that in order to consider a valid diagnosis of *female sexual interest/arousal disorder*, at least three of the following six indicators must be met (p. 433).

1. Absent/reduced interest in sexual activity.
2. Absent/reduced sexual/erotic thoughts or fantasies.
3. No/reduced initiation of sexual activity, and typically unreceptive to a partner’s attempts to initiate.

4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75%-100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
6. Absent/reduced genital or non-genital sensations during sexual activity in almost all or all (approximately 75%-100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).

The following medical conditions must be presented separately and individually in *genito-pelvic pain/penetration disorder* in women: “1) difficulty having intercourse, 2) genito-pelvic pain, 3) fear of pain or vaginal penetration, and 4) tension of the pelvic floor muscles” (p. 437).

Male hypoactive sexual desire disorder refers to a low level, or even an absence of desire to engage in sexual activities and a deficiency and/or absence of sexual thoughts or fantasies. The latter must be persistent and recurrent, with a minimum duration of at least six months.

Premature (early) ejaculation is defined by ejaculation which occurs before, shortly (approximately one minute) or immediately after vaginal penetration and before the individual wishes for this to happen, causing him significant clinical distress. Once again, the symptoms must exist for at least six months and must represent 75% to 100% of occasions of sexual activity.

Substance/medication-induced sexual dysfunction requires the existence of a clinically significant interruption in sexual functioning in a clinical scenario. These symptoms develop during or immediately after intoxication through substances (or through withdrawal), or after the administration of medication. In order to assume diagnosis, this disturbance must not fit the criteria of any of the above mentioned sexual dysfunctions.

The diagnosis of *other specified sexual dysfunction* is evoked in face of symptoms typical of sexual dysfunction which create great clinical distress in an individual, but do not completely fulfil the criteria for a diagnosis of any other sexual dysfunction. The clinician may also choose to specify a reason for a disorder which does not apply to any other sexual dysfunction, in which case “other specified sexual dysfunction” is recorded, after which the specific reason is given.

The definition of *unspecified sexual dysfunction* is similar to *other specified sexual dysfunction*, with the exception that in this case the clinician chooses not to specify a reason

for which the criteria of other sexual dysfunctions have not been met and justifies this by stating that there is insufficient information to present a more detailed diagnosis.

Sexual Problems: The State of the Art

Several studies have contributed to defining and analysing sexual problems and are worth mentioning. A brief description of the most relevant studies is given here.

A meta-analysis carried out by Lewis et al. (2010) sought to determine prevalence rates of sexual dysfunction world-wide. General results revealed that for women, sexual desire dysfunctions varied from 17% to 55% (with prevalence increasing with age), arousal and lubrication disorders ranged from 8% to 15%, orgasmic disorders presented values of 16% to 25% and dyspareunia (genito-pelvic pain) fluctuated between 14% and 27%. For men, prevalence rates were 12% to 19% for delayed ejaculation, 8% to 30% for premature ejaculation and 8% to 18% for sexual desire disorder. Erectile dysfunction presented the strongest evidence-based prevalence data and varied according to age. For men below 40 years of age, prevalence rates varied from 1% to 10%. From 40 to 49 years of age, prevalence rates ranged from 2% to 15%. The age group of 50 to 59 reported prevalence rates of 12% to 22%. Rates increased 20% to 40% for ages 60 to 69 years. Finally, men in their 70s and 80s presented prevalence rates of 50% to 100%. Scattered studies of genital pain in men during sexual intercourse were found and rates were from 3% to 6%. It is important to note that the results found were inconsistent among studies and varied largely according to each country. Therefore, further investigation is necessary to support these findings.

A very recent study sought to determine the prevalence of sexual difficulties in Portugal, using a sample of 650 sexually active men from ages 18 to 70 years. Four sexual difficulties were determined, based on the disorders presented in the DSM-5. The first referred to erectile difficulties, defined as the inability to achieve or maintain erection during intercourse. The second was rapid ejaculation, a situation in which orgasm was achieved too soon, or before the desired moment. The third, orgasm difficulty, was considered when a man had difficulty, or could not reach orgasm during sexual activity with his partner. The fourth was low sexual desire and referred to a lack of interest in having sex. Results showed that difficulties intensified with age, except for rapid ejaculation, which was frequent among younger men. Rapid ejaculation was represented the most frequently self-reported sexual difficulty, followed by erectile problems, difficulty in reaching or maintaining an erection, and lastly, difficulty in achieving orgasm (Gomes & Nobre, 2014). These findings are an

important contribution to the study of sexuality inasmuch as they focus on problems that are quite frequent and not necessarily dysfunctional, and are triggered by various circumstances.

The National Survey of Sexual Attitudes and Lifestyles: An Important Step to Understanding Sexual Function

The National Survey of Sexual Attitudes and Lifestyles (Natsal) took place in Britain during the years 1990 (Natsal-1), 2000 (Natsal-2) and 2012 (Natsal-3) and these studies are regarded as the largest regarding sexual behaviour. They consisted of samples of 18,876 adults (ages 16 to 59 years), 12,110 adults (ages 16 to 44 years), and 15,162 adults (ages 16 to 74 years), respectively. In these studies, respondents were requested to answer several questions regarding their sexual lifestyles and attitudes (Natsal, 2014a, 2014b). These questions were based on the US National Health and Social Lifestyle Survey (NHSLs), which acknowledges the dimensions of sexual dysfunction identified in the International Classification of Diseases tenth revision (ICD-10; Mercer et al., 2005).

Highlights from Natsal-3 refer to the topics of changes in sexual behaviour, sex and health, sexual function, sexually transmitted infections (STIs), non-volitional sex and unwanted pregnancy (Natsal, 2014c).

Changes in sexual behaviour indicate that more people reported opposite-sex and same-sex partners than in the previous surveys. Moreover, the increase in these reports refers to women, thus narrowing the gender gap (Natsal, 2014c).

Concerning sex and health, more than 60% reported having had sex recently and the same percentage informed that they were satisfied with their sexual activity. However, those who reported poorer health were also less likely to have engaged recently in sexual activity. Nonetheless, this did not necessarily mean that they no longer had an active or satisfying sex life, as over one in every three people with ill health reported having had sex recently and approximately half indicated that they were satisfied with their sex lives (Natsal, 2014c).

In order to determine sexual function, the survey sought to tap sexual difficulties persisting for over three months or more (such as lack of interest, anxiety during sex, dyspareunia, vaginal dryness and difficulties in achieving or maintaining an erection) and results revealed that sexual difficulties were quite common, although reports on distress or worries about one's sex life were not as common (Natsal, 2014c).

Through urine analyses, STIs were tested in a sample of men and women with ages between 16 and 44 years. Human papillomavirus proved to be the most common STI, followed by Chlamydia (Natsal, 2014c).

Non-volitional sex referred to sex against one's will. One out of every 10 women and one out of every 71 men reported having experienced non-volitional sex. Results also revealed that these victims were more likely to be exposed to dangerous health behaviours and presented poorer physical, mental and sexual health (Natsal, 2014c).

Finally, unwanted pregnancy proved to be less common than revealed in previous studies and only one in every six pregnancies were unplanned. Contraceptive methods are distributed freely in Britain, and could be an influence of this result. Also, there seem to be larger gaps between the age of a person's first sexual experience, the age couples start living together, as well as the age of their first-born child (Natsal, 2014c).

Investigations of this dimension are important in understanding sexual functioning and Natsal serves as a precedent and encouragement for similar studies in other countries.

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Appendix 2: Material

Informed Consent

Estudo de um Modelo de Resposta Sexual: Dual Control Model

O presente estudo tem como objetivo compreender melhor a resposta sexual à luz de um modelo teórico: o "Dual Control Model", de Bancroft e Janssen (2000).

Para participar, basta responder às questões que se encontram nas páginas seguintes.

A participação no estudo é voluntária e são garantidos o anonimato e a confidencialidade das respostas. Para além disso, cada participante tem o direito de livremente abandonar, a qualquer momento, a sua colaboração, não podendo daí resultar quaisquer consequências negativas.

Ao clicar no botão “Seguinte”, o participante declara simultaneamente que:

- Aceita participar livremente no estudo;
- É maior de idade;
- Tomou conhecimento dos objetivos do estudo e das condições de participação;
- Autoriza que os dados fornecidos sejam trabalhados pelos investigadores.

Muito obrigado pela sua colaboração, que é para nós da máxima importância.

Se não concordar com o acima exposto, pedimos-lhe que não prossiga para a página seguinte, encerrando a janela do seu browser.

Os investigadores responsáveis,

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ISPA – Instituto Universitário

Lisboa – Portugal

Socio-Demographic and Sexuality-Related Information

Qual a sua idade?

Idade

Qual o seu distrito de residência?

- | | | |
|--------------------------------------|--|--|
| <input type="radio"/> Aveiro | <input type="radio"/> Faro | <input type="radio"/> Região Autónoma dos Açores |
| <input type="radio"/> Beja | <input type="radio"/> Guarda | <input type="radio"/> Santarém |
| <input type="radio"/> Braga | <input type="radio"/> Leiria | <input type="radio"/> Setúbal |
| <input type="radio"/> Bragança | <input type="radio"/> Lisboa | <input type="radio"/> Viana |
| <input type="radio"/> Castelo Branco | <input type="radio"/> Portalegre | <input type="radio"/> Vila Real |
| <input type="radio"/> Coimbra | <input type="radio"/> Porto | <input type="radio"/> Viseu |
| <input type="radio"/> Évora | <input type="radio"/> Região Autónoma da Madeira | <input type="radio"/> Não resido em Portugal |

Habilitações literárias completas:

- Até ao 9º ano de escolaridade
- Até ao 12º ano de escolaridade
- Licenciatura
- Mestrado
- Doutoramento

Nos últimos 5 anos, a sua atividade sexual foi com pessoas:

- Exclusivamente do sexo oposto
- Maioritariamente do sexo oposto
- Iguamente do sexo oposto e do mesmo sexo
- Maioritariamente do mesmo sexo
- Exclusivamente do mesmo sexo
- Não tive parceiros sexuais

Qual a sua situação relacional?

- Com relação de compromisso, sem coabitação
- Com relação de compromisso em coabitação (ou casado)
- Sem relação de compromisso e sem parceiros sexuais
- Sem relação de compromisso mas com parceiros ocasionais

Há quanto tempo dura a relação?

Número aproximado de anos (se tiver menos de 1 ano, indique "0")

Tem filhos?

- Sim
- Não

Qual o número de filhos?

Número de filhos

Foi sexualmente ativo(a) nos últimos 12 meses [qualquer tipo de atividade sexual com parceiro(a)]?

- Sim
- Não

Indique o seu sexo:

- Masculino
- Feminino

The Sexual Excitation/Sexual Inhibition Inventory for Women and Men

O próximo grupo de itens incidirá sobre situações que podem influenciar a sua excitação sexual.

Homens e mulheres descrevem a sua excitação sexual em termos de mudanças genitais (ex.: estar "teso", estar "húmida"), não genitais (ex.: aumento do ritmo cardíaco) ou em termos de sentimentos (ex.: sentir-se "disponível").

Estamos interessados na sua reação mais típica atual. Poderá ler uma frase e sentir que não se aplica a si ou que se refere a uma situação eventualmente ocorrida no passado, mas que é pouco provável que ocorra agora. Nestes casos, indique por favor como pensa que responderia se estivesse nessa situação.

Por favor leia cada questão cuidadosamente, mas não pense demasiado antes de responder. Transmita a sua primeira reação a cada questão.

	Discordo fortemente	Discordo	Concordo	Concordo fortemente
1. Fico excitado(a) quando o(a) parceiro(a) faz algo simpático por mim.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Às vezes tenho tantas preocupações que não consigo ficar excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Se sinto que estou a ser usado(a) sexualmente, perco totalmente a excitação.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Quando penso em alguém que considero sexualmente atraente, fico facilmente excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ver o(a) parceiro(a) a fazer algo que mostra o seu talento, pode excitar-me bastante sexualmente.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Se houver a possibilidade de ser visto(a) ou ouvido(a) durante o sexo, é-me mais difícil ficar excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Se não tiver a certeza dos sentimentos do(a) meu (minha) parceiro(a) por mim, é-me mais difícil ficar excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Basta falar em sexo para ficar logo com vontade.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ser-me-ia difícil ficar sexualmente excitado(a) por alguém que estivesse envolvido(a) com outra pessoa.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ver o(a) parceiro(a) fazer as tarefas domésticas sem eu estar à espera, desperta o meu interesse sexual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Se sinto que esperam de mim uma resposta sexual, tenho dificuldades em ficar excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Às vezes sinto-me tão tímido(a) ou preocupado(a) com o que faço e sinto durante o sexo, que não consigo ficar totalmente excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Basta estar fisicamente próximo do(a) parceiro(a) para ficar excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Durante o sexo, preciso de me focar nas minhas sensações sexuais para me manter excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Excita-me mesmo fazer sexo num ambiente diferente do habitual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Preciso mesmo de confiar no(a) parceiro(a) para ficar totalmente excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Discordo fortemente	Discordo	Concordo	Concordo fortemente
17. A falta de equilíbrio entre dar e receber prazer durante o sexo, afeta a minha excitação.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Se eu pensar se vou ter um orgasmo, é-me muito mais difícil ficar excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. A não ser que as coisas estejam “perfeitas”, é-me difícil ficar sexualmente excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Se vejo o(a) parceiro(a) a interagir bem com outras pessoas, excito-me com mais facilidade.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Penso muito em sexo quando estou aborrecido(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Se me sinto muito atraído(a) sexualmente por alguém, não preciso de estar numa relação com essa pessoa para ficar sexualmente excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Fico mesmo excitado(a) quando penso que posso ser apanhado(a) durante o ato sexual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Se penso que um parceiro(a) me pode magoar emocionalmente, ponho travões a nível sexual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Às vezes sinto-me tão atraído(a) por alguém que não consigo evitar ficar sexualmente excitado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Ver alguém a mostrar a sua inteligência excita-me sexualmente.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Se eu ficar preocupado(a) em demorar demasiado tempo a ficar excitado(a), isso pode perturbar a minha excitação.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Se estiver preocupado(a) em ser um(a) bom (boa) amante, é menos provável ficar excitado(a).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Tenho mais dificuldade em ficar sexualmente excitado(a) se estiverem outras pessoas por perto.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Se o meu (minha) parceiro(a) não for sensível aos meus sinais durante o sexo, a minha excitação diminui consideravelmente.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Milhausen, R. R., Graham, C. A., Sanders, S. A., Yarber, W. L., & Maitland, S. B. (2010). Validation of the Sexual Excitation/Sexual Inhibition Inventory for Women and Men. *Archives of Sexual Behavior*, 39, 1091-1104. doi:10.1007/s10508-009-9554-y

The Sexual Dysfunctional Beliefs Questionnaire

Male Version

Indique em que medida concorda com as seguintes afirmações, considerando que não existem respostas certas nem erradas.

	Discordo completamente	Discordo parcialmente	Não concordo nem discordo	Concordo parcialmente	Concordo completamente
1. Um verdadeiro homem" tem relações sexuais com grande frequência.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. O orgasmo só é possível através do coito (penetração) vaginal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A homossexualidade é uma doença.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A mulher não tem outra hipótese senão subjugar-se sexualmente ao poder do homem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. "Um verdadeiro homem" deve conseguir aguentar o tempo necessário para satisfazer a mulher.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. A rapidez sexual do homem é um sinal da sua potência.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. No sexo o que conta é conseguir chegar ao fim.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Numa relação tudo o que vai para além do coito (penetração) vaginal é inaceitável.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. O coito (penetração) vaginal é a única forma legítima de ter relações sexuais.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Os preliminares sexuais são uma perda de tempo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. O sexo só é legítimo como forma de procriação (para ter filhos).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. No sexo, quanto mais rápido melhor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. "Um verdadeiro homem" está sempre pronto e deve ser capaz de satisfazer qualquer mulher.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Os homens devem ser capazes de manter o pénis ereto e rijo até ao final de uma relação sexual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Só existe uma forma aceitável de ter relações sexuais (homem por cima).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Ter relações sexuais antes do casamento é um pecado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. O sexo pode ser bom mesmo sem orgasmo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nobre, P. (2006). *Disfunções sexuais: Teoria, investigação e tratamento*. Lisboa, Portugal: Climepsi Editores.

Nobre, P. J., Gouveia, J. P., & Gomes, F. A. (2003). Sexual Dysfunctional Beliefs Questionnaire: an instrument to assess sexual dysfunctional beliefs as vulnerability factors to sexual problems. *Sexual and Relationship Therapy, 18* (2), 171-204. doi:10.1080/1468199031000061281

Female Version

Indique em que medida concorda com as seguintes afirmações, considerando que não existem respostas certas nem erradas.

	Discordo completamente	Discordo parcialmente	Não concordo nem discordo	Concordo parcialmente	Concordo completamente
1. A masturbação é um ato errado e pecaminoso.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A melhor prenda que a mulher pode levar para o casamento é a virgindade.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A masturbação não é própria de uma mulher respeitada.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mulheres fisicamente pouco atraentes não conseguem ser sexualmente felizes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Uma boa mãe não pode ser uma mulher sexualmente ativa.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. O clímax/orgasmo é próprio dos homens e não das mulheres.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. O homem é que deve iniciar qualquer atividade sexual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. O orgasmo só é possível através do coito vaginal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Relações sexuais durante o período menstrual podem causar problemas de saúde	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Sexo oral é uma das maiores perversões.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Sexo anal é uma atividade doentia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Uma mulher feia não consegue satisfazer sexualmente o companheiro.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Uma rapariga pura não tem relações sexuais.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nobre, P. (2006). *Disfunções sexuais: Teoria, investigação e tratamento*. Lisboa, Portugal: Climepsi Editores.

Nobre, P. J., Gouveia, J. P., & Gomes, F. A. (2003). Sexual Dysfunctional Beliefs Questionnaire: an instrument to assess sexual dysfunctional beliefs as vulnerability factors to sexual problems. *Sexual and Relationship Therapy, 18* (2), 171-204. doi:10.1080/1468199031000061281

Sexual Difficulties

Male Version

Por vezes, atravessamos períodos de alguma dificuldade ou desinteresse sexual.
Assinale uma dificuldade sexual que tenha tido nos últimos 6 meses.

	Nunca	Ocasionalment e	Metade das vezes	A maior parte das vezes
Demorar demasiado tempo a ejacular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ejaculação demasiado rápida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dificuldade em conseguir ou manter a ereção	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falta de desejo sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outras dificuldades sexuais	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Female Version

Por vezes, atravessamos períodos de alguma dificuldade ou desinteresse sexual.
Assinale uma dificuldade sexual que tenha tido nos últimos 6 meses.

	Nunca	Ocasionalment e	Metade das vezes	A maior parte das vezes
Falta de desejo sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Não conseguir ter orgasmo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dor durante o coito	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outras dificuldades sexuais	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 3: Adaptation of the Sexual Excitation/Sexual Inhibition Inventory for Women and Men into Portuguese

Inhibitory Cognitions / *Cognições Inibitórias*

- 1) Sometimes I have so many worries that I am unable to get aroused
Às vezes tenho tantas preocupações que não consigo ficar excitado/a
- 2) If I feel that I am expected to respond sexually, I have difficulty getting aroused
Se sinto que esperam de mim uma resposta sexual, tenho dificuldades em ficar excitado/a
- 3) Sometimes I feel so “shy” or self-conscious during sex that I cannot become fully aroused
Às vezes sinto-me tão tímido/a ou preocupado/a com o que faço e sinto durante o sexo, que não consigo ficar totalmente excitado/a
- 4) If I think about whether I will have an orgasm, it is much harder for me to become aroused
Se eu pensar se vou ter um orgasmo, é-me muito mais difícil ficar excitado/a
- 5) Unless things are “just right” it is difficult for me to become sexually aroused
A não ser que as coisas estejam “perfeitas” é-me difícil ficar sexualmente excitado/a
- 6) If I am worried about taking too long to become aroused, this can interfere with my arousal
Se eu ficar preocupado/a em demorar demasiado tempo a ficar excitado/a, isso pode perturbar a minha excitação
- 7) When I am having sex, I have to focus on my own sexual feelings in order to stay aroused
Durante o sexo, preciso de me focar nas minhas sensações sexuais para me manter excitado/a
- 8) If I am concerned about being a good lover, I am less likely to become aroused
Se estiver preocupado/a em ser um/a bom/boa amante, é menos provável ficar excitado/a

Relationship Importance / A Importância da Relação

- 9) If I think that I am being used sexually it completely turns me off
Se sinto que estou a ser usado/a sexualmente, perco totalmente a excitação
- 10) It would be hard for me to become sexually aroused with someone who is involved with another person
Ser-me-ia difícil ficar sexualmente excitado/a por alguém que estivesse envolvido/a com outra pessoa
- 11) If I am very sexually attracted to someone, I don't need to be in a relationship with that person to become sexually aroused (reverse coded)
Se me sinto muito atraído/a sexualmente por alguém, não preciso de estar numa relação com essa pessoa para ficar sexualmente excitado/a (codificação invertida)
- 12) I really need to trust a partner to become fully aroused
Preciso mesmo de confiar no/a parceiro/a para ficar totalmente excitado/a
- 13) If I think that a partner might hurt me emotionally, I put the brakes on sexually
Se penso que um parceiro/a me pode magoar emocionalmente, ponho travões a nível sexual

Arousability / Excitabilidade

- 14) When I think about someone I find sexually attractive, I easily become sexually aroused
Quando penso em alguém que considero sexualmente atraente, fico facilmente excitado/a
- 15) I think about sex a lot when I am bored
Penso muito em sexo quando estou aborrecido/a
- 16) Just talking about sex is enough to put me in a sexual mood
Basta falar em sexo para ficar logo com vontade
- 17) Sometimes I am so attracted to someone, I cannot stop myself from becoming sexually aroused
Às vezes sinto-me tão atraído/a por alguém que não consigo evitar ficar sexualmente excitado/a
- 18) Just being physically close with a partner is enough to turn me on
Basta estar fisicamente próximo do/a parceiro/a para ficar excitado/a

Partner Characteristics and Behaviors / Características e Comportamentos do/a Parceiro/a

19) Seeing a partner doing something that shows his/her talent can make me very sexually aroused

Ver o/a parceiro/a a fazer algo que mostra o seu talento, pode excitar-me bastante sexualmente

20) Someone doing something that shows he/she is intelligent turns me on

Ver alguém a mostrar a sua inteligência excita-me sexualmente

21) I find it arousing when a partner does something nice for me

Fico excitado/a quando o/a parceiro/a faz algo simpático por mim

22) If I see a partner interacting well with others, I am more easily sexually aroused

Se vejo o/a parceiro/a a interagir bem com outras pessoas, excito-me com mais facilidade

23) If a partner surprises me by doing chores, it sparks my sexual interest

Ver o/a parceiro/a a fazer as tarefas domésticas sem eu estar à espera, desperta o meu interesse sexual

Setting (Unusual or Unconcealed) / Setting (Invulgar ou Exposto)

24) If it is possible someone might see or hear us having sex, it is more difficult for me to get aroused (reverse coded)

Se houver a possibilidade de ser visto/a ou ouvido/a durante o sexo, é-me mais difícil ficar excitado/a (codificação invertida)

25) I find it harder to get sexually aroused if other people are nearby (reverse coded)

Tenho mais dificuldade em ficar sexualmente excitado/a se estiverem outras pessoas por perto (codificação invertida)

26) I get really turned on if I think I may get caught while having sex

Fico mesmo excitado/a quando penso que posso ser apanhado/a durante o ato sexual

27) Having sex in a different setting than usual is a real turn on for me

Excita-me mesmo fazer sexo num ambiente diferente do habitual

Dyadic Elements of the Sexual Interaction / Elementos Diádicos da Interação Sexual

28) If I am uncertain how my partner feels about me, it is harder for me to get aroused

Se não tiver a certeza dos sentimentos do/a meu/minha parceiro/a por mim, é-me mais difícil ficar excitado/a

29) While having sex, it really decreases my arousal if my partner is not sensitive to the signals I am giving

Se o meu/minha parceiro/a não for sensível aos meus sinais durante o sexo, a minha excitação diminui consideravelmente

30) It interferes with my arousal if there is not a balance of giving and receiving pleasure during sex

A falta de equilíbrio entre dar e receber prazer durante o sexo, afeta a minha excitação

References

- Milhausen, R. R., Graham, C. A., Sanders, S. A., Yarber, W. L., & Maitland, S. B. (2010). Validation of the Sexual Excitation/Sexual Inhibition Inventory for Women and Men. *Archives of Sexual Behavior, 39*, 1091-1104. doi:10.1007/s10508-009-9554-y

Appendix 4: Additional Statistical Analyses

Socio-Demographic Information

Table 12

Geographic Information

Qual o seu distrito de residência?				
	Frequency	Percent	Valid Percent	Cumulative Percent
	Aveiro	88	4.7	4.7
	Beja	17	.9	5.6
	Braga	92	4.9	10.6
	Bragança	15	.8	11.4
	Castelo Branco	20	1.1	12.5
	Coimbra	125	6.7	19.2
	Évora	24	1.3	20.5
	Faro	53	2.8	23.3
	Guarda	11	.6	23.9
	Leiria	59	3.1	27.1
Valid	Lisboa	586	31.2	58.5
	Portalegre	13	.7	59.2
	Porto	225	12.0	71.3
	Região Autónoma da Madeira	28	1.5	72.8
	Região Autónoma dos Açores	34	1.8	74.7
	Santarém	57	3.0	77.7
	Setúbal	154	8.2	86.0
	Viana	23	1.2	87.2
	Vila Real	21	1.1	88.3
	Viseu	46	2.4	90.8
	Não resido em Portugal	171	9.1	100.0
	Total	1862	99.1	100.0
Missing	System	16	.9	
Total		1878	100.0	

Table 13

Academic Qualifications

Habilitações literárias completas:

		Frequency	Percent	Valid Percent	Cumulative Percent
	Até ao 9º ano de escolaridade	128	6.8	6.8	6.8
	Até ao 12º ano de escolaridade	539	28.7	28.8	35.6
Valid	Licenciatura	876	46.6	46.8	82.4
	Mestrado	284	15.1	15.2	97.5
	Doutoramento	46	2.4	2.5	100.0
	Total	1873	99.7	100.0	
Missing	System	5	.3		
Total		1878	100.0		

Exploratory Factor Analysis of the Sexual Excitation/Sexual Inhibition Inventory for Women and Men

The 30 items from the SESII-W/M were factor analysed (Table 14), using a principal components method with varimax rotation. The principal components analysis revealed six factors with eigenvalues over 1.0, which, when combined, accounted for 48.23% of the total variance. Factorial validity was assessed using the Kaiser-Mayer-Olkin (KMO) index (0.882, Good) and Bartlett's sphericity test (significant).

The factor loadings ($> .40$) can be seen in Table 14. The first factor is composed of all eight items related to Inhibitory Cognitions and explains 18.73% of the total variance. The second factor assembles three items from Relationship Importance and three items from Dyadic Elements of the Sexual Interaction and accounts for 9.94% of the total variance explained. The third factor combines all five items from Partner Characteristics and Behaviours and explains 7.15% of the total variance. The fourth factor gathers two items from Relationship Importance and two items from Arousability, representing 4.42% of the total variance explained. The fifth factor contains three items from Arousability and explains 4.32% of the total variance. Finally, factor six contains all four items from Setting (Unusual or Unconcealed) and represents 3.66% of the total variance explained.

Table 14

Factor Loadings for Exploratory Factor Analysis With Varimax Rotation of the SESII-W/M

	Component					
	1	2	3	4	5	6
Inhibitory Cognitions (12)	.674					
Inhibitory Cognitions (27)	.663					
Inhibitory Cognitions (28)	.651					
Inhibitory Cognitions (11)	.623					
Inhibitory Cognitions (18)	.614					
Inhibitory Cognitions (14)	.579					
Inhibitory Cognitions (2)	.537					
Inhibitory Cognitions (19)	.535					
Relationship Importance (24)		.640				
Relationship Importance (16)		.640				
Dyadic Elements of the Sexual Interaction (7)		.620				
Relationship Importance (3)		.537				
Dyadic Elements of the Sexual Interaction (30)	.425	.441				
Dyadic Elements of the Sexual Interaction (17)		.417				
Partner Characteristics and Behaviours (10)			.686			
Partner Characteristics and Behaviours (5)			.673			
Partner Characteristics and Behaviours (26)			.658			
Partner Characteristics and Behaviours (1)			.555			
Partner Characteristics and Behaviours (20)			.549			
Relationship Importance (22)				-.686		
Arousability (25)				.609		
Arousability (4)				.593		
Relationship Importance (9)		.473		-.485		
Arousability (8)					.699	
Arousability (13)					.659	
Arousability (21)					.595	
Setting (Unusual or Unconcealed) (23)						.686
Setting (Unusual or Unconcealed) (15)						.638
Setting (Unusual or Unconcealed) (29)						.561
Setting (Unusual or Unconcealed) (6)						-.511
Total Variance Explained	18.73	9.94	7.15	4.42	4.32	3.66

Measures of Skewness and Kurtosis

The Sexual Excitation/Sexual Inhibition Inventory for Women and Men

None of the items from this scale present absolute values of skewness above 3 or kurtosis above 7 which compromise the sensitivity of the items (Table 15).

Table 15
Median, minimum, maximum and measures of asymmetry (Sk) e Kurtosis (Ku) with respective critical ratios (Sk/SE_{sk}; Ku/SE_{Ku}) for the 30 items belonging to the SESII-W/M

	Median	Skewness	Sk/SE _{sk}	Kurtosis	Kurtosis/SE _{Ku}	Min.	Max.
SESII-W/M_01	3	-.153	-2.818	-.143	-1.321	1	4
SESII-W/M_02	3	-.113	-2.076	-.618	-5.701	1	4
SESII-W/M_03	3	.004	.081	-.857	-7.914	1	4
SESII-W/M_04	3	-.198	-3.658	-.259	-2.395	1	4
SESII-W/M_05	3	.027	.507	-.400	-3.697	1	4
SESII-W/M_06	2	.029	.541	-.687	-6.340	1	4
SESII-W/M_07	3	-.175	-3.236	-.458	-4.231	1	4
SESII-W/M_08	2	.213	3.938	-.291	-2.683	1	4
SESII-W/M_09	2	.349	6.445	-.632	-5.835	1	4
SESII-W/M_10	2	.375	6.911	.055	.509	1	4
SESII-W/M_11	2	.350	6.459	-.010	-.091	1	4
SESII-W/M_12	2	.289	5.341	-.510	-4.705	1	4
SESII-W/M_13	3	.054	.990	-.331	-3.058	1	4
SESII-W/M_14	2	.084	1.542	-.335	-3.092	1	4
SESII-W/M_15	3	-.475	-8.765	.189	1.742	1	4
SESII-W/M_16	3	-.084	-1.543	-.650	-6.001	1	4
SESII-W/M_17	3	-.238	-4.388	-.186	-1.719	1	4
SESII-W/M_18	2	.422	7.783	.094	.870	1	4
SESII-W/M_19	2	.469	8.649	.531	4.899	1	4
SESII-W/M_20	2	.387	7.145	.031	.284	1	4
SESII-W/M_21	2	.340	6.277	-.420	-3.880	1	4
SESII-W/M_22	3	.567	10.458	.064	.590	2	5
SESII-W/M_23	2	.380	7.005	-.286	-2.644	1	4
SESII-W/M_24	3	-.165	-3.045	-.498	-4.601	1	4
SESII-W/M_25	3	-.148	-2.728	-.510	-4.709	1	4
SESII-W/M_26	2	.167	3.088	-.338	-3.118	1	4
SESII-W/M_27	3	-.306	-5.639	-.238	-2.194	1	4
SESII-W/M_28	2	-.048	-.892	-.307	-2.830	1	4
SESII-W/M_29	3	.108	1.989	-.525	-4.848	2	5
SESII-W/M_30	3	-.473	-8.726	.585	5.396	1	4

The Sexual Dysfunctional Beliefs Questionnaire

Many of the items are biased presenting skewness above 3 and kurtosis above 7 (Table 16)

Table 16
Median, minimum, maximum and measures of asymmetry (Sk) e Kurtosis (Ku) with respective critical ratios (Sk/SEsk; Ku/SEKu) for the 17 items from the male version and 13 items from the female version belonging to the SDBQ

	Median	Skewness	Sk/SE _{SW}	Kurtosis	Kurtosis/ SE _{KU}	Min.	Max.
SBDQ_M_01	2	.374	4,985	-,897	-5,975	1	5
SBDQ_M_02	1	2.857	38,052	8,688	57,900	1	5
SBDQ_M_03	1	1.514	20,165	1,220	8,132	1	5
SBDQ_M_04	1	3.346	44,560	11,775	78,472	1	5
SBDQ_M_05	2	.190	2,529	-1,389	-9,256	1	5
SBDQ_M_06	1	1.624	21,624	1,793	11,952	1	5
SBDQ_M_07	1	1.144	15,235	,316	2,104	1	5
SBDQ_M_08	1	3.933	52,372	16,183	107,850	1	5
SBDQ_M_09	1	3.880	51,673	15,848	105,617	1	5
SBDQ_M_10	1	4.465	59,461	22,741	151,557	1	5
SBDQ_M_11	1	6.584	87,683	46,510	309,970	1	5
SBDQ_M_12	1	3.955	52,669	18,514	123,390	1	5
SBDQ_M_13	2	.912	12,147	-,365	-2,433	1	5
SBDQ_M_14	3	.114	1,524	-1,351	-9,001	1	5
SBDQ_M_15	1	6.083	81,004	40,082	267,131	1	5
SBDQ_M_16	1	4.281	57,009	18,487	123,208	1	5
SBDQ_M_17	2	.877	11,681	-,431	-2,874	1	5
SBDQ_W_01	1	3.831	48,311	15,712	99,166	1	5
SBDQ_W_02	1	2.567	32,364	6,290	39,698	1	5
SBDQ_W_03	1	4.521	57,013	21,499	135,688	1	5
SBDQ_W_04	1	2.829	35,674	8,110	51,186	1	5
SBDQ_W_05	1	5.685	71,687	33,722	212,831	1	5
SBDQ_W_06	1	6.574	82,892	48,925	308,784	1	5
SBDQ_W_07	1	2.811	35,440	7,957	50,217	1	4
SBDQ_W_08	1	3.657	46,108	14,640	92,401	1	5
SBDQ_W_09	1	2.202	27,764	4,446	28,059	1	5
SBDQ_W_10	1	3.430	43,249	12,583	79,418	1	5
SBDQ_W_11	1	1.645	20,745	1,843	11,631	1	5
SBDQ_W_12	1	3.626	45,722	13,396	84,546	1	4
SBDQ_W_13	1	3.119	39,325	9,699	61,216	1	5

Sexual Difficulties

This section of the questionnaire was created specifically for the purpose of this study and therefore the questions placed were regarded as investigation questions. However, reliability was tested so as to verify if this instrument could be supported as a questionnaire for future investigation (Table 17). Internal consistency for sexual difficulties in men and women revealed unacceptable Cronbach's alpha of .49 and .59, respectively. Skewness and kurtosis were well within a tolerable range for assuming a normal distribution.

Table 17
Psychometric Properties of Sexual Difficulties

	Min.	Max.	<i>M</i> (<i>SD</i>)	Skewness	Kurtosis
<i>Men</i>					
Delayed ejaculation	1	4	1.78 (.79)	.98	1.10
Premature ejaculation	1	4	1.97 (.84)	.74	.16
Difficulty in achieving or maintaining erection	1	4	1.59 (.67)	1.02	1.14
Lack of sexual interest	1	4	1.51 (.63)	1.17	1.73
Other sexual difficulties	1	4	1.37 (.56)	1.49	2.59
<i>Women</i>					
Lack of sexual interest	1	4	2.14 (.87)	.68	-.03
Difficulty experiencing orgasm	1	4	2.14 (.92)	.68	-.23
Pain during coitus	1	4	1.70 (.78)	1.17	1.31
Other sexual difficulties	1	4	1.56 (.69)	1.17	1.45