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A MIXED METHODS ANALYSIS OF THE CONCEPT OF
FEMALE SEXUAL HEALTH

by

Laura C. Ford

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Interdisciplinary Health Studies
Dr. Amy B. Curtis, Advisor

Western Michigan University
Kalamazoo, Michigan
December 2007

A MIXED METHODS ANALYSIS OF THE CONCEPT OF FEMALE SEXUAL HEALTH

Laura C. Ford, Ph.D.

Western Michigan University, 2007

The theoretical concept of health includes the ability to function physiologically, perceive a state of wellness, participate in social relationships, and be disease-free. Currently, the medical field approaches sexuality from a disease prevention and treatment perspective. Female sexual health must be understood holistically (i.e., emotionally, sociologically, and physiologically) for healthcare providers to help their patients optimize their sexual health; however, little research has been conducted from a holistic perspective. This study's purpose was to begin an exploration of the meaning of female sexual health.

This study utilized focus groups and a survey to explore the concept female sexual health as self-reported by women. The attributes of female sexual health that emerged (156) from the dimensional analysis of the focus groups ($n = 21$) were collapsed into nine dimensions. These dimensions were incorporated into an instrument that was mailed to 1,000 female faculty and staff of a Midwestern university to determine potential correlations with self-reported female sexual health. The respondents were also asked to rank four of the most commonly examined dimensions, part of the author's FORD mnemonic: Frequency, Orgasm, Relationship, and Distress. Survey data ($n = 240$, 24% response rate) were analyzed using nonparametric statistical tests.

Of the nine dimensions discovered during the qualitative phase, survey results indicated that eight were positively correlated with self-reported female sexual health. The eight were authentic self, communication on a deep and intimate level, emotional health, frequency of sexual activity, presence of sexual pleasure, relationship health, absence of discomfort or distress, and sisterhood. Spearman's correlation coefficients, r_s , for the eight dimensions and female sexual health ranged from .501, $p < .0001$ (authentic self) to .154, $p = .019$ (sisterhood). The average rank order for the FORD mnemonic dimensions from most to least important was relationship health, absence of distress, pleasure or orgasm, and libido or frequency of activity.

Information from this study should serve to educate healthcare providers about female sexual health. The dimensions to emerge from these analyses should undergo further testing; a rapid assessment device, such as the FORD mnemonic, should be developed that healthcare providers can use in their daily primary care practice.

UMI Number: 3293175

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ACKNOWLEDGMENTS

My sincere gratitude is extended to the women who informed this study, and who served as mentors to me on the journey toward completion of this dissertation. Thank you to Dr. Amy Curtis, Chair, Dr. Angela (Angie) Moe, and Dr. Barbara Barton for serving on the committee; thank you also to Dr. Marie Gates, Dr. Karen Morin, and Dr. Zoann Snyder for assisting in the production of the proposal. Thank you to the Graduate College of WMU for the Patricia Lee Thompson Award of Merit for my Dissertation. Several experts in the field of sexology served to inform the process—special thanks go to Dr. Leonore Tiefer, Dr. Hani Miletski, and Dr. Laura Berman. Dr. Nan Lackey provided good counsel on the concept development process. My mentor and support through this whole process, Dr. Marianne DiPierro, has been a Godsend. My professional colleagues encouraged me in the journey and are thanked for their words and prayers of encouragement. I am grateful for the clerical support received from my good friend Dawn Mahoney, and the data entry from Esther Reigel, my dear Mom—who was my first and best teacher.

My children should be commended for putting up with their mother's pursuit of this dream. Thank you, Tom and Jessegrace, for letting me study and write instead of playing with you at the drop of a hat. May the development of my mind and heart through this process reward you deeply. Thank you, Jeff, for keeping the house running while I

Acknowledgments—Continued

pursued my dream. A final word of thanks goes to all those who expressed genuine interest in my authentic self.

Laura C. Ford

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CHAPTER I

INTRODUCTION

“Health” as a Framework

Health has been described as a complete state of physical, mental, and social well-being (World Health Organization [WHO], 1947). Brülde (2000) reports that the concept of *health* can be used as a conceptual framework for health care when it is in complete form: the ability to function, to perceive a state of wellness, to function within a social context, and to be free of disease or dysfunction. *Sexual health* is considered to comprise freedom from disease or dysfunction within the medical world, and the absence of sexual cathexis (aberrant behavior such as pedophilia) within the psychology disciplines (Foucault, 1978). Yet when a state of health is defined or described based upon only one dimension of the concept (such as is the case here with the medical definition of lack of disease or the psychological definition as nonaberrant behavior), it may lack a full understanding or description of that concept. Even within the discipline of sexology (i.e., the scientific study of sex, sexual function, and the sexual self), a lack of information exists regarding a multidimensional exploration of the concept of sexual health, notably pertaining specifically to women (Berman & Berman, 2001, 2005; Daker-White, 2002; Durant & Carey, 2002; Maurice, 1999; Nusbaum, Gamble, Skinner, & Heiman, 2000). The purpose of this research is to explore the concept of *female sexual health*, and to

develop an understanding of the properties of that concept in order to better inform health care providers (HCPs).

Sexual health has been declared as a recognized human right. The World Health Organization has stated that women's rights to sexual and reproductive health are a component of freedom from oppression and of equity to men (WHO, 2002). In addition to the World Health Organization, Maslow (1943, 1954, 1968) recognized certain fundamental physiologic needs of human function that include "sex" along with breathing, food, water, sleep, homeostasis, and excretion. A hierarchical view of health was presented in his theory of total health and has been utilized as a framework for understanding the human condition (Nicholson, 2001). The higher level domain of love and belonging includes sexual intimacy along with friendship and family (Maslow, 1968). Maslow's hierarchy has been recognized as a concept expressing how individuals can achieve a higher state of function and well-being as they progress in maturity from fundamental physiologic needs to the need for self-actualization. Under this conceptualization, sexual function is considered a basic physiologic need, while sexual intimacy (the relationship or social aspect of sexual expression) is a mid-level need on the journey to self actualization (Nicholson, 2001).

The human experience is more than base physiology. Overall health and well-being should incorporate aspects of life that express those basic physiologic needs in addition to other components of the human experience, including sex. Being sexually healthy is important for overall well-being and relationship health (Kaschak & Tiefer, 2001). If sexual health is only understood within the context of physiologic function, it minimizes the importance of sexual health and of understanding the broader concept for

the rich component it provides to a person's life. Reducing the concept of sexual health to simply the physiologic absence of disease or sociologic absence of distress (Kaschak et al., 2001) removes the relational context of sexuality and the personal view of how sexuality is expressed in one's life.

If it is an accepted statement that sex and sexual expression are important aspects of life and of health, HCPs need to have knowledge and understanding of sexual health as it pertains to women. However, limited knowledge of female sexual health exists (Berman et al., 2001, 2005; Daker-White, 2002; Durant & Carey, 2002; Maurice, 1999; Nusbaum et al., 2000) that can serve HCPs in conducting holistic assessments and intervention efforts with their patients in health promotion and disease prevention strategies. To best help their patients attain and maintain sexual health, HCPs need to understand health as more than simply the absence of disease or distress. Providers also need to incorporate the ability to function sexually, to perceive a state of wellness and pleasure, and to function within a sexual relationship in their assessment(s), if these are found to be aspects of female sexual health.

Prior research regarding sexual health has been conducted from various disciplines with differing paradigms. The disciplines of medicine, psychology, and sociology have varying paradigms of sexual health that separate the domains of health (Kaschak & Tiefer, 2001) as discussed further in Chapter II. It is my premise that these paradigms can be complementary if unified and based upon the concept of health, not of disease. In the remainder of this chapter, I will introduce the concepts that lead to the need for research into female sexual health from a holistic point of view, based upon a health rather than lack-of-disease paradigm.

Discipline Views of Sexual “Health”

Within the discipline of medicine, *sexual health* is defined as “lack of disease, lack of discomfort, lack of distress” (Maurice, 1999). In primary care medicine, it is understood that male sexual function complaints may be pathognomic for underlying disease states (Min, Williams, Okwuosa, Bell, Panutich, & Ward, 2006) such as diabetes, hypertension, dyslipidemia, depression, or androgen deficiency (Seftel, 2004). Correction of this may rectify the sexual dysfunction complaint, and the male patient then is restored to a state of sexual function (Seftel, 2004). However, after reviewing the literature in the health-related disciplines of medicine, sociology, and psychology, I could not identify research regarding what women mean when they say they are sexually healthy (using the more holistic definition of health) (Basson, Leiblum, Brotto, Derogatis, Fourcroy, Fugl-Meyer et al., 2004; Berman & Bassuk, 2002; Everaerd & Both, 2001; Kaschak & Tiefer, 2001; Maurice, 1999; McKenna, 2002; Meston, 2000; Quirk, Heiman, Rosen, Laan, Smith, & Boolell, 2002; Seftel, 2004; Symonds, Boolell, & Quirk, 2005; Tiefer, 1991; Westheimer & Lopater, 2005; WHO, 2002). An understanding of what constitutes normalcy assists in recognizing symptoms of disorder or distress in a clinical practice. If healthy function is recognizable and understood, dysfunction may be recognized as not representing a norm. For instance, the *DSM-IV* manual (*Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, 2006) includes several diagnostic criteria for the billable codes “female sexual dysfunction.” These codes all stem from physical complaints (e.g., discomfort, desire or arousability problems) but require this to be a stated problem or concern for the patient; the patient must note a state

of distress along with the sexual function complaint. If the diagnosis of dysfunction is reliant upon the patient claiming personal distress along with a pathophysiologic state, it may serve the clinician to understand what is meant by a functional or nondistressed state.

Psychology as a discipline cares for individuals based upon the sexual cathexis and not upon the sexual health state. Prior studies from the psychology disciplines have demonstrated that women will often not broach the subject of altered desire, comfort, or decreased frequency in their sexual expressions (Berman et al., 2001, 2005; Daker-White, 2002; Durant et al., 2002; Maurice, 1999; Nusbaum et al., 2000). Sociologic studies have indicated that this may be due to concern on the part of the woman that she will be perceived as morally questionable, nonfeminine, or seeking sexual attention from their health care provider (Durant et al., 2002; Laumann, Paik, & Rosen, 1999; Maurice, 1999; Nusbaum et al., 2000).

Psychology and Sociology have determined that women's receptivity and sexual seeking behaviors may not have a physical basis. Instead, there may be a mental component to desire and receptivity that is not a diagnosable component to their state of sexual activity (Bancroft, 1998; Hartmann, Heiser, Ruffer-Hesse, & Kloth, 2002; Hicks, 2005; Levine, 2003; Meston, 2000; Simons & Carey, 2001; Taylor, Rosen, & Leiblum, 1994). Many women will offer that they receive mixed messages, and that they are unclear what is expected of them: actively seeking sexual expression is not socially acceptable or desirable, yet media focuses on the sexual and sensual female (Hicks, 2005; Seftel, 2004; Tepper, 2003; Wallace, 2005; Westheimer & Lopater, 2005).

Within the disciplines of medicine, psychology, and sociology, there has been an emphasis on separate domains or dimensions of sexuality from a disease focus. Medicine

has focused upon sexual health as being free from distress/disease (Seftel, 2004). Psychology has focused upon sexual health as being absent of cathexis (Westheimer et al., 2005). Sociology has investigated the role that sexual health has within society and specifically the role of sexual dysfunction within social relationships (Kaschak & Tiefer, 2001). What does not exist is a unified understanding of all the domains of the concept of sexual health with women and the properties of that concept. The woman as a sexual being has been investigated in prior research (reviewed in Chapter II), yet this has also focused upon a singular domain of health or mono-factorial exploration of the concept (Maurice, 1999; Kaschak & Tiefer, 2001).

Limitations of Prior Sexologic Research

In order to understand why sexual health has come to the point of mono-factorial definitions, it is important to review prior research in female sexology. Research on what females experience in sexual activity began with the phenomenological and psycho-sociological work of Freud (Bancroft, 1998). Kinsey in the 1950s further explored the phenomena of what women experience in their sexual lives (Kinsey, Pomeroy, Martin, & Gebhard, 1953). Masters and Johnson (1966) utilized couple observation and therapy to determine the feminine aspect of human sexuality. Yet all of the research conducted by these scientists and physicians focused upon subjects that did not represent the general “healthy” populace (Bancroft, 1998; Berman & Berman, 2001; Hicks, 2005). Freud discussed sex with male psychiatric clients and assumed sexual function in females (Bancroft, 1998). Kinsey et al. (1953) evaluated female sexual and sensual needs from interviews, second hand reports, and men. Sexual activity was designated to have

occurred when it culminated in orgasm. Masters and Johnson (1966) evaluated couples who were experiencing dysfunction by pairing the men with “sex workers” and surrogates, not the lifelong mate of the male subject (Hicks, 2005). Female subjects who provided data regarding the “normal” female sexual response were prostitutes (Masters & Johnson, 1966). Shere Hite (1976) published a report on female sexual normal behavior in the 1970s and later was discovered to have fabricated her research (Kaschak & Tiefer, 2001) in the survey process. Hicks has reported that drug companies in the 21st century, such as Pfizer, Lilly, and Merck, are investigating female response to erectile dysfunction medications and are ending the research early in frustration as the physiologic reaction to pleasure in sexual activity (the clitoral response) does not seem to represent what “good” or “satisfying” sex really means to women (Hicks, 2005).

Assessment of the Well Patient

Despite the focus on sexual dysfunction, rather than health, several researchers (Berman & Bassuk, 2002; Nusbaum et al., 2000) have noted that women are not screened for sexual dysfunction complaints and that HCPs do not include questions and interventions regarding sexuality in routine women’s health care. Current instruments address the assessment of dysfunction when a complaint is registered; there is lack of a screening survey for primary care providers to utilize in health care settings to screen for sexual function issues (Heiman & Meston, 1997; Jones, 2002; Meston & Derogatis, 2002; Quirk et al., 2002). In order to label a sexual dysfunction, there must exist an awareness of what “normal” function can mean to the individual (Rosen, 2002a, 2002b). Thus,

health care providers may miss an essential health care intervention in women patients. Screening for sexual function issues in women may assist in their overall health.

As previously stated, from a physiologic point of view male sexual dysfunction can direct the clinician to evaluate for hypertension, depression, dyslipidemia, prostate disease, vascular disease, or hypogonadism (Min et al., 2006). From a sociologic point of view, sexual dysfunction contributes to altered mental status and may cause relationships to fail (Anastadias, Davis, Ghafar, Burchardt, & Shabsigh, 2002). Because a patient complaint of personal distress is necessary for a diagnosis of sexual dysfunction, a lack of sexual health may not be apparent to the health care provider. "None of the measures to date provide a comprehensive, reliable assessment of key dimensions of sexual function in women, including sexual desire, orgasm and satisfaction" (Taylor et al., 1994, p. 629). Prior survey instruments and assessment tools adapted male concepts of sexual function to women subjects; little research exists regarding the concept of female sexual health (Anastadias et al., 2002; Berman & Bassuk, 2002; Kaschak & Tiefer, 2001; Maurice, 2001). As sexuality is a component of physiologic, mental, and sociologic functioning, an assessment survey may assist HCPs in addressing the holistic health of their patient(s).

The Assessment of Sensitive Matter in the Health Care Setting

From a sociological perspective, sexuality and the sexual response are considered sensitive matters to discover or discuss, and talking openly about sex is not easy for many HCPs (Frith, 2000). When assessing sensitive matter in a clinical setting, HCPs may note increased comfort by adopting a nonjudgmental, nonevaluative manner with the client or patient (Frith, 2000). Patient self-disclosure regarding sensitive subjects is enhanced

when the HCP is perceived to be objective and receptive (Farber, 2003). Use of a standardized set of questions may assist in this endeavor (Daker-White, 2002; Durant & Carey, 2002; Gerbert, Bronstone, Pantilat, McPhee, Allerton, & Moe, 1999). If HCPs are informed and able to include the multifactorial dimensions of sexual health, a holistic evaluation and intervention strategy may ensue (Maurice, 1999).

One of the more common instruments used in sexologic research is the Brief Index of Sexual Function in Women (BISF-W). This instrument has two limitations for its use in the assessment and evaluation or treatment of female sexual function: (1) it is usually available for use in research settings (Taylor et al., 1994) and is not routinely available for use in a clinic setting, and (2) it addresses only specific domains of health as a concept (sexual desire, sexual activity, and sexual satisfaction). Clients cared for in a primary care setting present with a variety of needs and problems as well as for routine health maintenance exams (Maurice, 1999). Several instruments exist to evaluate sexual dysfunction complaints and are reviewed in Chapter II. These instruments have the limitations of only addressing a portion of domains recognized within a health concept (such as Brölde's [2000] more holistic concept of health representing function, social function, perceived state of wellness, and lack of complaint). The instruments are also not routinely available outside of a research protocol or research setting, or have limited applicability to female patients (Meston et al., 2000).

Research Significance, Purpose, and Questions

The significance of this research is to investigate the concept of what women mean when they report a state of sexual health. The essence of the state of health is the

ability to function physically and within a social context, to perceive a state of wellness, and to be free of disease or dysfunction (Brölde, 2000). Sociology has investigated sexual health from the viewpoint of the (dis)ability to function, psychology from the viewpoint of perceived state of (un)wellness, and medicine from the viewpoint of disease or dysfunction. It is understood that distress and dysfunction carry psychological burden; it is also understood that pathophysiology may present with disorders of bodily function including the sexual response (Anastadias et al., 2002; Berman & Bassuk, 2002; Kaschak & Tiefer, 2001; Maurice, 2001). What is not understood is what a holistic meaning of the “healthy” state of sexual function is for women (Anastadias et al., 2002; Berman & Bassuk, 2002; Kaschak & Tiefer, 2001; Maurice, 2001).

Informing the practice of HCPs about the multifactorial properties of the concept of female sexual health should allow them to holistically evaluate their well clients and support their efforts in optimum health. Because of the sensitivity of the general subject of sex, women who experience no distress in their sexual lives may not disclose to their provider/practitioner any information about their sexual health (Farber, 2003). In addition, it is not clear from prior studies on primary care and addressing sensitive health issues that women desire their HCPs to question or assess aspects of their sex lives (Maurice, 1999). Further information is needed about what women expect from their HCPs in regards to the assessment and evaluation of sexual health, and how the holistic addressing of total wellness (including sexual issues) is appropriate for the health care setting.

The purpose of this research is to explore the concept of female sexual health and what this means to women who report they are not in any distress over their sexual

function. The research seeks to determine if common domains exist and are true components to the concept of female sexual health. Common domains of the concept then may be utilized to frame an assessment questioning structure or mnemonic for use in the health care setting. This research will also examine women's beliefs about whether HCPs should address aspects of their female patients' sexual health.

Research questions for this study include the following: *What does the concept female sexual health mean to women? Do common dimensions of the concept female sexual health exist? Can these dimensions be evaluated further through a convergence of findings in mixed method design? Do women want these components addressed by their HCP?*

In order to achieve an understanding of the concepts discussed under the term of female sexual health, several terms (listed below) require explanation and clarification.

Definition of Terms

Sexual excitement/Arousability: The ability to achieve a state of sexual responsivity, perception of the ability to participate in sexual acts for pleasure. The “subjective feeling of arousal or sexual pleasure and accompanying physiologic changes, includes [in the female] vaginal lubrication and genital swelling” (Anastadias et al., 2002, p. 74).

Libido/Sexual desire: The “motivational or appetitive aspects of sexual response” which includes sexual urges, wishes, and fantasies (Anastadias et al., 2002, p. 74).

Distress: Self-reported and perceived state of physical or emotional discomfort.

Health: A state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity (WHO, 1946); “Health is not only to be well, but to be able to use well every power we have to use” (Florence Nightingale, 1859).

Orgasm: The culmination of pleasurable stimulation (Bancroft, 1998) The neuro-humoral-biological control of which is not limited to external genitalia, but involves the neurologic system, hormonal pathways, and psychological response involved in the vasocongestion and myotonic spasms of genital tissue that is perceived to be pleasurable (McKenna, 2002).

Receptivity: Emotional/intellectual/physical readiness and willingness to become sexually aroused, sexually stimulated, or sexually approached (Anastadias et al., 2002; McKenna, 2002).

Sexology: The scientific study of sex, sexuality, and the sexual response (American Association of Sex Educators and Clinical Therapists, 2007).

Sexual dysfunction: The various ways in which an individual is unable to participate in a sexual relationship as he or she would wish (WHO, 1992).

Sexuality: “A dimension and an expression of personality” (Masters & Johnson, 1966, p. 301) of the body engaged in sexual activity.

Sexual health: “There are no established norms for male and female sexuality in our society” (Masters & Johnson, 1966, p. 302).

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2002, p. 5)

CHAPTER II

REVIEW OF THE LITERATURE

This chapter will discuss the literature reviewed regarding health as a general concept, and female sexual health from the disciplines of sexology, medicine, marital therapy, and humanistic science. Noted gaps in the research and literature will be identified. Because existing evaluation measures primarily address dysfunction, the chapter also includes a critique of existent instrumentation for the evaluation of sexual function. The chapter will then summarize the problem of note: that female sexual health is poorly researched, and that existent instruments do not address the state of health. A discussion regarding qualitative research methods for discovery, grounded theory development through dimensional analysis, and construction of a rapid health assessment instrument concludes this chapter.

Health as a General Concept

Concepts are used to frame theory and research paradigms; the concept of health is used as a framework or goal for HCPs and as a rubric to evaluate individual and population health states (Pender, Murdaugh, & Parson, 2006). As a conceptual framework for healthcare, the essence of health includes the ability to function physiologically, to have the individual perceive a state of wellness, to function within social relationship(s), and to be free of disease or dysfunction (Brülde, 2000). The World Health Organization

has declared since 1947 that the definition of health must include aspects of physical, mental, and social well-being. Dimensions of health are multifactorial and include indicators of emotional well-being, social relationship(s), and participation in endeavors to gain pleasure in life (Stewart-Brown, 1998). Health may be defined differently in various disciplines, but the basic attributes of the health state are recognized to be on a continuum, to incorporate objective evidence of limited disease process, and to represent both the subjective experience of wellness along with the ability to function (Brülde, 2000). When a discipline such as medicine defines health, it uses one dimension of the health state, evidence of disease process, as a defining factor. This limits the emphasis of the discipline in regards to the total health state of the individual or community served (Brülde, 2000). The target of health care, the patient, also misses the valuable insight from health care providers that their emotional, social, psychological, and physical well-being is of importance for intervention (Pender et al., 2006). Holistic provision of health care is by nature more comprehensive, therefore increases in health care quality and patient satisfaction occurs (Sutton & McLean, 2006).

Sexual Health as a Concept

Sex has been described by Maslow (1943, 1968) as a basic physiologic need along with the need for breathing, food, water, sleep, homeostasis, and excretion. The Maslow hierarchy (1968) (see Figure 1) of human needs has at its base the physiologic needs that are developed in childhood. These include the safety needs: security of body, employment, resources, morality, family, health, and property. The next need fulfillment

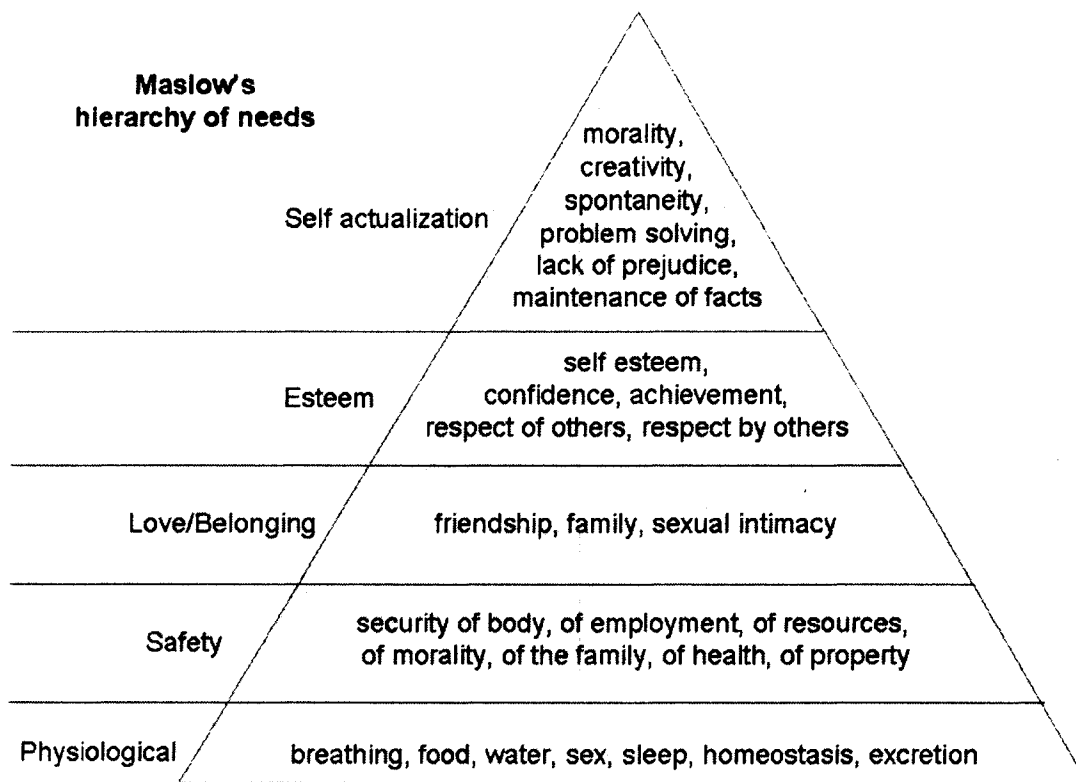


Figure 1. Maslow's hierarchy of needs (1943, 1968).

is for love/belonging, which incorporates the need of friendship, family, and sexual intimacy.

Esteem is the next level, incorporating self-esteem, confidence, achievement, and respect of and by others. The pinnacle of Maslow's hierarchy is self-actualization, which is the need for morality, creativity, spontaneity, lack of prejudice, and the ability to problem solve and to accept facts. This theory-driven concept map has been utilized by the disciplines of medicine, sociology, psychology, and nursing to explain and predict the human response to life and disease, to societal factors and stress, and the process of growth and development (Nicholson, 2001; Pender et al., 2006). Fundamental to the

concept is an acceptance that sex is a fundamental physiologic need, as is sexual intimacy with others. He intimated that libido or sexual urges are an animalistic drive, but the desire for sexual intimacy or relationship with a sexual partner occurs when a person is able to feel and give love and when there is a sense of belonging. Sexual function as a basic drive includes the ability to copulate and procreate; sexuality as a higher need incorporates the role of sex in relationship to other.

In addition to inclusion in Maslow's hierarchy of needs, sexual and reproductive healths are recognized by the World Health Organization (2002) as fundamental to human and feminist rights. At a special *programmē* of research and development (WHO, 2002), the WHO recognized that sexuality and sexual health must be addressed holistically, and integration of the physical, emotional, mental, and social aspects of sexuality and sexual expression must be addressed as fundamental to the health and well-being of all individuals. A working definition of sexual health was presented as follows:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled. (WHO, 2002, p. 5)

Medicine as a discipline defines health as the absence of disease or infirmity (Maurice, 1999). When a multidimensional concept (such as *health*) is defined by a lack of one single dimension, then the other dimensions are ignored, limiting the use of that definition in an evaluation device. The state of health has been recognized as multidimensional and belonging to a continuum; as such, *health* is a state that cannot be defined dichotomously as either presence or absence of disease (Brölde, 2000). However,

sexual health within medicine is defined and diagnosed when dysfunction exists and patient distress is expressed (APA, 2006). Referring back to Brülde's (2000) definition of *health* (to function physiologically and within social relationships, to perceive a state of wellness, and to be free of disease), a definition within the discipline of medicine that focuses upon only the dimension of disease or dysfunction does not address the attributes of patient perception of wellness and social relationship. It also ignores the concept that health is a continuum, not a singular event or specific state.

Psychology as a discipline focuses upon mental health and sociologic function, a seeming blend of the fields of medicine and of sociology. Within the realm of sexology, however, psychology focuses upon sexual cathexis, such as pedophilia, bestiality, and voyeurism, and their treatment (Westheimer & Lopater, 2005). This focus does not incorporate the perceived state of wellness or paradigm of health that is espoused by the WHO or other researchers who are calling for a more inclusive health paradigm (Sandfort & Ehrhardt, 2004). Within the field of sociology, *sexual health* is a term used to describe the person in social relationship to other, the ethnographic construct of the role sex plays within a society, and impact upon family and societal groups (Edwards & Coleman, 2004). Although sociology views sexual health in relationship to other, and the need for sexual intimacy on the Maslow hierarchy, it still does not fully utilize the multiple dimensions of the concept of "health." If the concept of health is accepted to incorporate the dimensions of physiologic and societal role function, and a perceived state of wellness in addition to absence of disease or distress, then the sociologist view of relationship to other misses the components of physiologic function, perceived wellness state, and disease absence. Using the same logic, the field of psychology by focusing upon absence

of cathexis misses the impact of perceived state of wellness and physiologic function, along with absence of disease. Medicine, by focus upon lack of disease and physiologic function, misses the additional information that societal relationship and perceived state of wellness add to the understanding of health assessment and intervention strategies.

The concept of sexual health has shown increasing utilization as an evaluative measure in the last two decades from the health discipline fields (Sandfort & Ehrhardt, 2004). As stated above, use of the term *sexual health* within the disciplines of medicine and psychology or sociology has different meanings and approaches from different paradigms: medicine from the physical functionality, psychology from the social impact of cathexis, and sociology from the role of sexual discord in individuals and their relationships. Sexual health is a broader issue than function or structure. Recognized dimensions of health can apply to a holistic view of sexual health (Brölde, 2000). In the following section, I will review the state of sexual health research and what is understood about the concept of female sexual health.

The State of Women's Sexual Health Research

Women's sexual health as a holistic concept has been reported to be little understood and inadequately researched (Anastadias et al., 2002; Berman & Bassuk, 2002; Kaschak & Tiefer, 2001; Maurice, 2001). Medical scientists, psychologists, sociologists, and sexologists have decried that there is little research into the broader issues of sexual health such as knowledge, self-acceptance, and partner attributes (Edwards & Coleman, 2004), nor is there a critical and interdisciplinary reflection on the concept of sexual health and its attributes for women (Sandfort & Ehrhardt, 2004).

Psychologists and sociologists have determined that women's receptivity and sexual seeking behaviors may not have a physical basis. There may instead be a mental component to desire and receptivity that is not a diagnosable component to women's state of sexual activity (Bancroft, 1998; Hartmann et al., 2002; Hicks, 2005; Levine, 2003; Meston, 2000; Simons & Carey, 2001; Taylor et al., 1994). Many women will offer that they are unclear regarding what is expected of their sexual expression (Hicks, 2005; Tepper, 2003; Wallace, 2005; Westheimer & Lopater, 2005). In many cases, men may express their affections with sexual groping and women may just desire physical connection when they know they have been heard (Seftel, 2004; Westheimer & Lopater, 2005). Sexual expression, sexual activity, and the act of sexual intercourse are considered to mean sexual acts of function. Sexual health is intended by my writing to mean a more holistic concept. In regards to a definition of sexual health, sexology research has reported that there are no established norms for understanding human sexuality (Masters & Johnson, 1966), and a need exists for understanding female versus male sexual health (Basson, Berman, Burnett, Derogatis, Ferguson, & Fourcroy, 2001). "There is a paucity of data concerning the anatomy, physiology, and pathophysiology of sexual function in women" (Munnariz, Kim, Traish, & Goldstein, 2004, p. 275). In this section, I will review the gender differences in sexology and sexual pathology.

Male and Female Views of Sexual Health

Sexologists have published research and repeatedly note that a paucity of data is present (as compared to male sexual health research) to begin to explore the multifactorial events of female sexual function (Bancroft, Graham, & McCord, 2001;

Tiefer, 2006a, 2006b). These authors (Bancroft, Graham, & McCord, 2001; Tiefer, 2002) use the term *function* to represent both physiologic function and perceived role of sexual activity within a relationship. The few studies that have focused on gender differences have examined etiological factors associated with sexual dysfunction (Bancroft, 1998; Hartmann et al., 2002; Hicks, 2005; Levine, 2003; Meston, 2000; Simons & Carey, 2001; Taylor et al., 1994). These studies suggest that men and women differ in important ways (Bancroft et al., 2001). Studies regarding gender difference have focused upon physiologic function, or upon arousal or receptivity issues (Bancroft, 2002). Limits to prior examinations include studies that examines sexual health beyond physiologic function (Bancroft, 1998; Meston, 2000; Simons & Carey, 2001). It is important to note here that male sexual health is described as absence of dysfunction with the ability to achieve and maintain a satisfactory erection and ejaculation (Maurice, 1999; Seftel, 2004). Male sexual function is the vasocongestion and myotonia of their sexual organs (Kaschak & Tiefer, 2001; Tiefer, 1996, 2006a, 2006b) within the medical model.

Although alluding that sexual health has emotive constructs through their title *Human Sexuality: A Psychosocial Perspective* (2005), Westheimer and Lopater refer to sexual health as belonging to a domain of freedom from disease and ability to function sexually. The relational aspects of sexual health, the perceived state of wellness, and the ideology of sexual health serving a broader concept of overall health and well-being are missing from their examination in this text. Sexual health is perceived to be achieved if orgasm or pleasure is attained, libido is aroused, and no distress ensues (Westheimer & Lopater, 2005). Nowhere in their text, which has an intended audience of those taking a secondary education course in human sexuality (p. vii), is the term *sexual health* or *health*

defined or described, albeit sexual dysfunction, sexual cathexis, and erotica are explored in depth. The text presents 762 pages of discussion regarding sexuality from the mental and social perspective, including 10 of the 19 chapters regarding the medical or physiologic aspects of sexuality, sexual dysfunction, paraphilias, and disease.

Abundant research into dysfunction from a medical and psychological point of view exists. Seftel (2004) in the text *Male and Female Sexual Dysfunction* focuses upon the sexually dysfunctional state, for the intended audience of health care providers and practitioners. Again, no definition or description of the concept of sexual health is presented to enlighten the reader on what dysfunction can mean, other than “the absence of function.” The text devotes 18 chapters and 241 pages to male gender sexual dysfunction and disorders, 3 chapters and 29 pages to the female; no mention of normalcy exists in this text. This medical text focuses upon male sexual dysfunction and presents a medicalized model of sexual health that is disease or dysfunction oriented.

Furthermore, Hicks reports that drug companies in the 21st century, such as Pfizer, Merck, and Lilly, that have been evaluating studies of female response to erectile dysfunction medications, have been ending the research early in frustration because application of the male sexual function model (erection and orgasm) to female sexual function does not address the total issue of sexual health for women (Hicks, 2005).

“It is not the absence of a penis but rather the relative absence of androgen that marks us as female” (Kaplan, 1974b, p. 95). If gender differences are not limited to reproductive organs, then gender differences in sexual health should not be limited to the structure or function of those organs. The female model of sexual response has been noted to occur differently than in the male (Maurice, 1999); what factor(s) indicate female

sexual health, what comprises sexual satisfaction in the female, and what women consider to be noted as normal with their sexuality is missing in sexologic research (Anastadias et al., 2002; Berman & Bassuk, 2002; Hartmann et al., 2002). As discussed previously, identification and exploration of the difference between male and female sexuality needs further attention; a need for theoretical analysis of the dimensions of female sexual health to guide research is also needed (Bancroft et al., 2001). The gynecology and urology specialties address physiologic function and dysfunction, viewing sexual expression in women as functional when libido exists, when sexual activity can occur without distress, and orgasm is possible. These dimensions (frequency and orgasm abilities) mimic the male sexual activity concerns (Maurice, 1999). Recall the health paradigm that incorporates the aspects of the ability to function, perceive a state of wellness, be part of a social relationship, and be free of disease (Brölde, 2000). The medical model misses the perception of wellness and relationship domains, therefore missing the holistic dimensions of the concept. With a focus upon male sexual function (although recognition exists that female sexual function differs from male), emphasis is not placed upon the unique differences between the genders in sexual health, sexual expression, or the role of sex in the individual's life.

Groundwork and Sentinel Studies

Scientific inquiry into the human sexual experience is a relatively recent undertaking of the last six decades (Alexander, 2004; Bancroft, 1998; Basson, 2000; Everaerd & Both, 2001; Hicks, 2005; Kaschak & Tiefer, 2001; Maurice, 1999; Tepper, 2003). Much of sexual research has focused upon a relatively homogenous group of

women: the sexually active college age woman (Taylor et al., 1994). From the paradigms of biology, medicine, psychology, and sociology several notable works will be reviewed and critiqued in this section. Four general views that exist in the study of human sexuality will be reviewed: the sentinel work of early sexological research, the medical fields of psychiatry and reproductive physiology sciences, the sex therapist as coach and fellow traveler in the enjoyment of sexual expression, and the humanistic view espoused by psycho-sociology.

Kinsey

Alfred Kinsey and his colleagues Wardell Pomeroy, Clyde Martin, and Paul Gebhard began an investigation into the sexual behavior of humans in the late 1930s. Their research is reported in the volumes *Sexual Behavior in the Human Male* (published 1948) and *Sexual Behavior in the Human Female* (published 1953). Details of their methodology and demographic characteristics are presented in these volumes, along with discussions on sexual activity in the genders. Kinsey et al. also include a segment comparing female and male responses in the *Female Volume* (1953). Although their sexologic research has been reported to be the largest investigation into the sexual behaviors of humans (Bancroft, 1998), it has also received criticism for methodological flaws from members of the scientific disciplines, including sexology, medicine, and psychology (Baker & Ussher, 1983; Bancroft, 1998; Basson, 2000; Durant & Carey, 2002; Heiman, 1976, 2006; Hicks, 2005; Kaplan, 1974b; Kaschak & Tiefer, 2001; Masters & Johnson, 1966; Masters, Johnson, & Kolodny, 1988; Seftel, 2004; Sutherland & Althof, 2004; Tiefer, 1991, 1996, 2006a, 2006b; Westheimer & Lopater, 2005). The

study scope reported case histories on 5,940 white female participants. The researchers interviewed each participant, coding the interview at the time of the data collection, and they did not maintain any transcripts or recordings of the interviews. The codebook and original record books of the coded data have been destroyed (Bancroft, 1998). In the *Female Volume*, Kinsey et al. (1953, p. 68) report that validation of the coding process through “retakes” of the interviews occurred in 124 females and the range of correct replies were 77 to 97%. Sources of data for the analysis on female sexual behavior were the interviews, calendars, diaries, personal recollection, and naturalistic observations along with a review of 31 American and 16 international studies on sexual behavior in the male. Inclusion criteria for use of data from an interview were that Kinsey and colleagues perceived the participant to be reliable and willing to respond to the questions posed. Statistical significance testing was not calculated by these researchers; they reported that it was an undesirable test due to nonnormal frequency distributions (Kinsey et al., 1953, p. 51). Data regarding the physiologic response were collected from second-hand reports of gynecologists ($n = 879$) along with the reports of the female participants who were interviewed. Fifteen female participants were directly observed by the researchers for physiologic response to sexual stimulation. This information was compared to prior data obtained in other sexologic inquiries numbering 31, 11 of which were published in peer reviewed journals 1918–1951 (Kinsey et al., 1953). Kinsey’s study (1953) was an exploratory study with a clear research purpose of developing a database on the human’s sexual behavior. Prior published studies were considered when the data were analyzed, albeit these studies had been conducted on men (Kinsey et al., 1953). The demographic data and frequencies are reported for the women included in the statistical analysis.

Kinsey and colleagues did not report all participant histories, e.g., the prison inmates were not included in the final analysis (Kinsey et al., 1953). The demographic data and frequency responses to the interview questions will allow portions of the study to be replicated; however, the original codebook and any notes from the interview process are not available for the study to be replicated in totality. Contrary findings or alternative interpretations are not alluded to in the volume, e.g., the physiologic response of mammals (dogs, rabbits, etc) to sexual activity are reported along with the male sexual response and there are no statements beyond that female sexual activity is not limited to copulation or the orgasm (Kinsey et al., 1953). Conclusions and discussions based upon the findings are not presented in a summative format; the limitations of the study are not identified specifically in the presentation of findings, either. For the purpose of this discussion, limitations of Kinsey and colleagues' research include not reporting the perception of sexual health, limited attention to nonorgasmic sexual activity, and the sampling techniques. Statistical significance was not calculated for the data and nonparametric testing was not performed; it is difficult to reach a summative conclusion of their findings based upon this analysis of the data.

Masters and Johnson

Following Kinsey's work, Masters and Johnson (1966) presented a linear model of the human sexual response including the successive phases of excitement, plateau, orgasm (the acme of the curve) and resolution. This model (Figure 2) has been utilized as a base to ground subsequent research in sexology (Tiefer, 1991). Yet recently this approach has been criticized for its goal-oriented view of "vasocongestion and myotonia"

(Tiefer, 2006a, 2006b) and the absence of variability that incorporates a humanistic view (Althof, 2001; Bancroft et al., 2001; Basson, 2001a, 2001b). The model focus is upon copulation or orgasm as a function of sexual health and does not incorporate perception of wellness or social relationship.

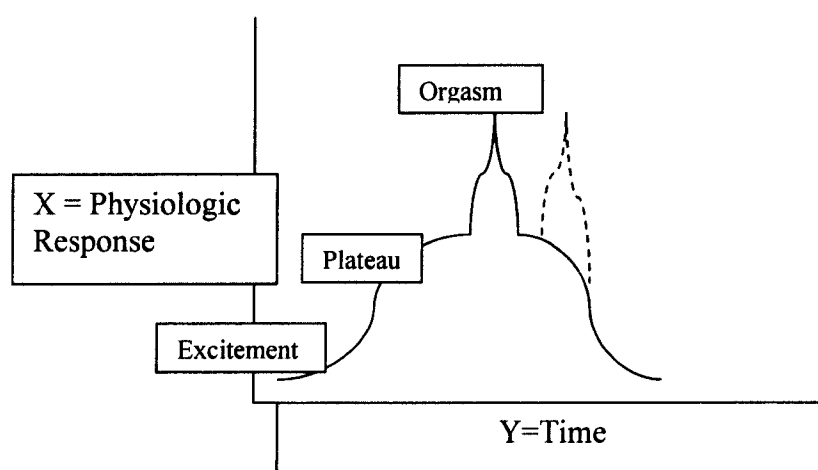


Figure 2. The sexual response cycle (Masters & Johnson, 1966).

A review of Masters and Johnson's original work (1966) notes that the original subjects consisted of 118 female and 27 male prostitutes who contributed socio-sexual, occupational, and medical histories. Of this original study, eight women and three men were selected to be evaluated in a clinical laboratory and to contribute to the anatomy and physiology study. It is upon these 11 sex workers that the model of the "Human Sexual Response" was first formulated. Findings from this pilot group were further tested upon 382 women who presented to George Washington University's School of Medicine with a pathology or complaint. Population characteristics indicate that these participants were residents of an academic community and of upper socioeconomic and intellectual strata

who were self-presenting due to clinical problems of either sexual dysfunction or infertility (Masters & Johnson, 1966, p. 11). The limitations of this study include study participant self-selection, small sample size number of subjects, and subjects weighted toward a specific intelligence, age demographic, and socioeconomic level. For instance, a majority (83.5%) of the participants ($n = 382$) were ages 21 to 40.

The purpose of Masters and Johnson's (1966) work was to obtain observational and physiological recordings of the human male and female response to effective sexual stimulation. Women were evaluated under "artificial coition" with a dildo or penile shaped vibrator, and both Masters and Johnson report the participants may have provided an inaccurate portrayal of reaction to stimulus, affecting a legitimate assessment (p. 21). The study also reported that no attempt was made to maintain an accurate count of sexual response cycles and that the sample size was limited to eight female prostitutes, and they were unable to fully investigate the study purpose (Masters & Johnson, 1966). They also recognized that the human females' response to sexual stimulation is not limited to the reproductive tissue (Masters & Johnson, 1966) and that there was more to the experience of enjoyable sexual function than the end goal of vaginal and clitoral response to stimuli. Masters and Johnson did contribute information regarding the variability in women's sexual experience and how it differs from men: from variance in frequency of orgasm to length of time required for arousal, to stating that female and male sexual responses differ in physiologic function as a focus of satisfaction. There is recognition in this study, although heavily critiqued for its lack of scientific validity (Daker-White, 2002; Hicks, 2005; Laumann et al., 1999), that women experience their state of sexual satisfaction in different ways than men. Masters and Johnson (1966) report that "orgasm is a psycho-

physiologic experience occurring within, and made meaningful by, a context of psychosocial influence” (p. 127). This statement is echoed further in the work of Helen Singer Kaplan (1974a, 1974b) and Rosemarie Basson (2000): women experience their sexual lives in different ways and would be limited by an analysis simply of genitalia response. As stated previously, gender differences in sexual health exist. Masters and Johnson also conclude that differences between the genders are present; however, their description of sexual function and dysfunction is limited to the reproductive organs (male model) and does not address sexuality within the emotive or mental domains (medical model).

Helen Singer Kaplan

Kaplan (1974a) further evaluated Master’s and Johnson’s work through the application of the “Human Sexual Response” to discovery of discrepancies in appetite for sexual expression between genders. She proposed a male model that was less linear and incorporated the aspect of arousal (Sutherland & Althof, 2004). Again, the goal of desire was the culmination of the sexual experience in sexual release through orgasm (Kaplan, 1974a). Desire was noted in men to include physiologic representations of vasocongestion and orgasm in myotonia, and this model was applied to the female participants in the Kaplan (1974a) study. This led clinicians to think of the female sexual response as one of distinct and successive stages that must be completed for true response to sexual stimulation (spontaneous or aroused) to be considered within a normal range (Sutherland & Althof, 2004; Tiefer, 1991, 2006a, 2006b). In fact, many sexologists to this point (e.g., Kinsey, Masters and Johnson, and Kaplan), all termed “successful sexual

activity” to be that which culminated in orgasm, and did not consider sexual activity without orgasm to be indicative of sexual health (Kaschak & Tiefer, 2001).

In the 1990s, several sexologists stepped forward with a more humanistic model of the sexual response (Sutherland & Althof, 2004). Rosemarie Basson (2000) presented a model (Figure 3) of a nonlinear sexual response that is context-centered. Her work has focused primarily upon the female response to sexual stimuli and the concepts of female sexual satisfaction (Basson, 2000, 2001a; Brotto, 2006; Sutherland & Althof, 2004). Application of her proposed model, which was formulated from Basson's experience as a clinical sex therapist, has been utilized in several studies on problematic low sexual desire in women, albeit with limited numbers of participants with no noted distress

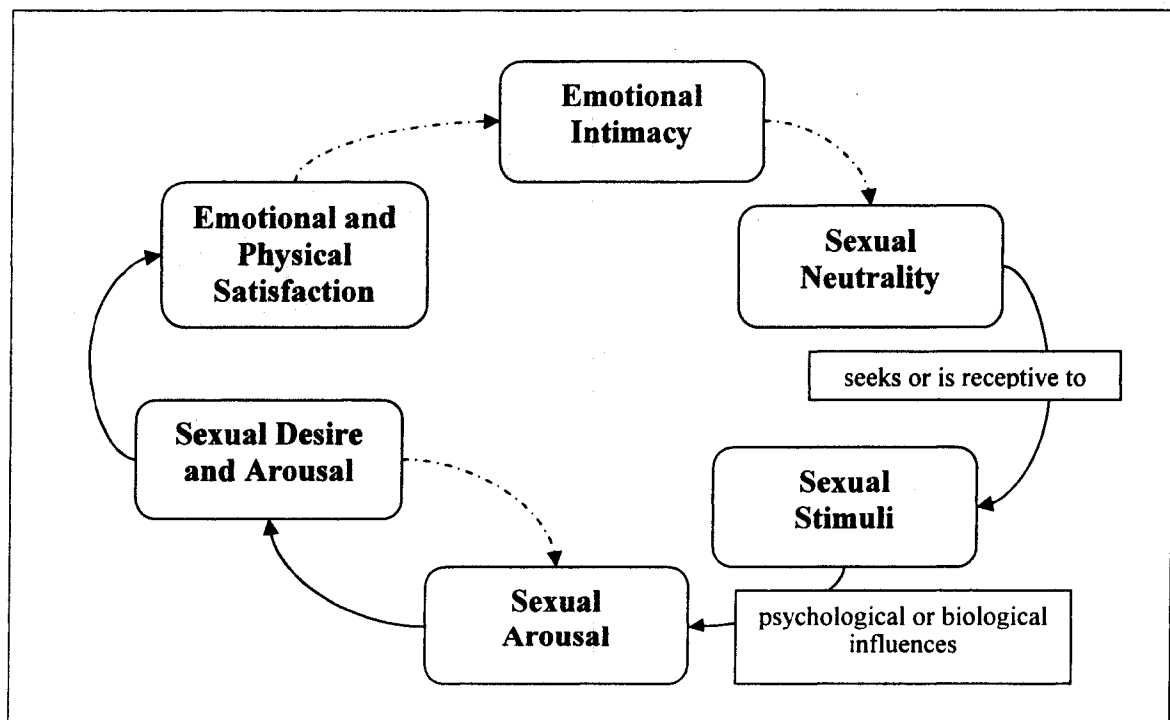


Figure 3. Sexual response continuum (Basson, 2001b).

(Basson, 2001b; Tiefer, 2006a, 2006b). Basson herself reports that there is a need to further discover the emotional aspects of female sexual desire and response (2000, 2001a). This model views the sexual response as a continuum and incorporates the health domains of perception of wellness, but does not specifically incorporate the domain of function or of social relationship other than consideration for intimacy. It does allude to the psychological or biological influence upon sexual health, but indicates that this affects arousal, not the other points on the cycle.

Medicine

In contrast to sexology research, a medicalized view of sexual function is one in which the expression of human experience, involving physical and genital intimacy, is able to occur with vasocongestion (blood flow maintained to the penis or vulvar and vaginal tissue), myotonia (contractile activity of the genital tissue), and without pain or distress. In primary care medicine, it is understood that male sexual function complaints may be pathognomic for underlying disease states (Min et al., 2006). A standard screening question to pose to the male patient is, “Any difficulties with achieving or maintaining an erection?” and, “Has there been a change in the libido?” (Daker-White & Crowley, 2002). When a male patient or client complains of difficulty achieving and maintaining an erection, or that their desire for sexual play or receptivity to a partner is diminished, the health care provider recognizes that this may be a sign of underlying pathology. Tests for diabetes, hypertension, dyslipidemia, depression, or androgen deficiency may reveal an underlying disease process (Seftel, 2004). Correction of this

may rectify the sexual dysfunction complaint, and the male patient then is restored to a state of sexual function (Seftel, 2004).

When patient or clients present to their HCP with a concern regarding sexual function, the practitioner can address their concerns through evaluation and intervention. Providers utilize diagnostic codes for billing of their services and to register the client for appropriate tests. No diagnostic code exists for evaluating the state of sexual health. The Diagnostic Code Manual (WHO, 1992) contains a classification system for sexual dysfunction based upon the linear and discrete models of Masters and Johnson and Kaplan. The system includes disorders of desire, arousal, orgasm, and sexual pain.

The *DSM-IV* definition of Hypoactive Sexual Desire Disorder is

Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual function, such as age and context of the person's life.

The disturbance causes distress or interpersonal difficulty.

The sexual dysfunction is not better accounted for by another Axis I disorder. (American Psychiatric Association, 1994, p. 498)

In contrast to the WHO or Brölde's definition of health, the diagnostic codes for health care in sexual medicine are missing the aspects of relationship and utilize a disease viewpoint. Addressing sexual and reproductive health is recommended to be a component of physical examinations (United States Preventive Services Task Force [USPTF], 2007); *The Guide to Clinical Preventive Services* document that serves as a rubric to evaluate the comprehensive nature of health promotion and risk reduction activities does not address sexual health beyond sexually transmitted disease screening or intimate partner violence (USPTF, 2007). This again represents a medical (disease or dysfunction focused) model.

Sociology, Sex, and Marital Therapy

In the sixth and seventh decades of the 20th century, early sex therapists utilized surrogate partners in a controversial form of body work with clients who experienced sexual dysfunction (Tiefer, 2006a, 2006b). The surrogates worked with counselors, or with clients of the sex therapist counselor, and instructed clients in the mechanics of sexual function and physical relationship function by providing scripts and demonstrating behaviors to mimic when sexual difficulties were the presenting complaint (Baker & Ussher, 1993; Brewer, 1978; Cole, 1982; Dauw, 1988; Tiefer, 2006a). Sexual surrogacy was a behavioral technique based on the premise that sexual behavior is partly the product of learning and conditioning and was used to treat sexual dysfunction, sexual anxiety, and sexual ambivalence (Brewer, 1978). This approach introduced the domain of relationship into sexual function; the sex surrogate served as an actor with whom the client could practice being in a sexual relationship.

Psychotherapists and marital counselors began to note the importance of relationship coaching in addressing sexual function complaints in the mid 20th century (Tiefer, 2006a). When clients entered into a marital or relationship counseling session, addressing the couple's sexual and physical intimacy level occurred by evaluation and intervention (Westheimer & Lopater, 2005). Dysfunctional complaints, then, are the basis for intervention. The complaint may surface from the partner at discord and represents the presence of a poor match between individuals in sexual need fulfillment. However, beyond the social function of sexual intimacy in a relationship, sexual health is not addressed. The psycho-social fields of marital therapy and counseling address sexual

health by focusing upon its function within a social relationship and not in the realm of perceived wellness state or physiologic function.

What is noted in the literature is that sexual dysfunction has parameters for diagnosis (“lack of function” “presence of distress”); however, there is little to no discussion on what function actually is and what this concept means to women (Althof, 2001; Bancroft et al., 2001; Basson, 2001a, 2001b; Davis, 2001; Everaerd & Both, 2001; Leiblum, 2001; Maurice, 2001; Meston, 2001; Tiefer, 2001a, 2001b).

Humanistic/New View Approach

Tiefer (2006a, 2006b) reports that there exists a humanistic view of sexuality specifically for women outside of the medicalized view of sex as simply the success or failure of vasocongestion and myotonia (frequency, orgasm, distress). Basson (2000) reports that women are not motivated by physical needs for release and satisfaction of sexual tension as men experience. Rather, women’s pursuit of sexual expression is goal oriented for satisfaction of relationship and emotional needs along with physical enjoyment (introducing the domains of relationship and self-perception of wellness). This enjoyment does not always lead from arousal to orgasm for women, and yet for many women this does not add to a state of distress, a view of dysfunction, or complaints of dissatisfaction (Basson, 2000). Basson (2000) states in her model that women are aware of nonsexual needs to be sexual, and that “sexual desire is a responsive rather than a spontaneous event” (p. 53). Women experience more emotion, and are not as aware of vasocongestion; women experience many forms of sexual expression and release that are not orgasm-focused (Basson, 2000). Although this model incorporates the emotive and

psychological domains of sexual health, it implies relationship and does not address function specifically outside of the achievement of pleasure or arousal. Again, this theory emphasizes only a portion of a holistic health paradigm.

A New View of Female Sexual Health incorporates the contribution of a woman's sexual history, the presence or absence of sociologic threat, and access to health care (Hicks, 2005; Kaschak & Tiefer, 2001) (Figure 4). It recognizes that female sexuality is more than structure and function (frequency and orgasm) and that distress or discomfort can exist in the mind or emotions, not just the physical realm (lack of distress). The New View emphasizes social constructs and how they relate to female sexual function (Hicks, 2005). As a psychology discipline, it incorporates many of the domains noted to consist in health: physical function, social function, perceived wellness, and physical capacity. It is, however, couched in terms that are considered to be disease-focused. See Appendix C for a full description of the New View categories.

The above noted disciplines view sexual health from their separate paradigms. A holistic health focused paradigm would incorporate emotional, intellectual, physical, and social aspects of sexuality. Using the WHO definition of sexual health, the different dimensions of the concept are physical, emotional, mental, and social well-being. To incorporate the attributes of "health," then a concept of sexual health would include the domains of physical function—desire or libido along with sexual ability, perception of wellness (self-rated level of health) and the presence of pleasure, the role of relationship as a social construct, and the absence of distress or discomfort.

- | | |
|------|--|
| I. | Sexual Problems due to socio-cultural, political, or economic factors |
| a. | Ignorance and anxiety due to inadequate sex education, lack of access to health services, or other social constraints. |
| b. | Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality. |
| c. | Inhibitions due to conflict between the sexual norms of one's subculture or culture of origin and those of the dominant culture. |
| d. | Lack of interest, fatigue, or lack of time due to family and work obligations. |
| II. | Sexual problems relating to partner and relationship. |
| a. | Inhibition, avoidance, or distress |
| b. | Discrepancies in desire |
| c. | Ignorance or inhibition |
| d. | Loss of sexual interest and reciprocity |
| e. | Inhibitions in arousal or spontaneity due to partner health |
| III. | Sexual problems due to psychological factors |
| a. | Sexual aversion, mistrust, or inhibition of pleasure |
| b. | Sexual inhibition due to fear |
| IV. | Sexual problems due to medical factors |
| a. | Physiologic condition |
| b. | Pregnancy |
| c. | Side effects of drugs or medical treatments |
| d. | Iatrogenic conditions |

Figure 4. New View of women's sexual problems (Kaschak & Tiefer, 2001).

Sexual Health Assessment

Women are not screened for sexual dysfunction complaints and health care providers do not routinely include questions and interventions regarding sexuality in women's health care (Berman & Bassuk, 2002; Nusbaum et al., 2000).

We are told of the need for research into the anatomy and neurophysiology of female sexual response, in the development of measurement devices to measure such physiological parameters, and the role of hormones; however, apart from a passing mention of a common discrepancy between women's satisfaction with their sexual life and their capacity for physiological aspects of sexual arousal, no attention is given to the fundamental need to research how culturally determined

influences and constraints interact with psychological factors to shape women's sexual experiences. (Bancroft et al., 2001, p. 102)

Existing instruments assess dysfunction; in order to label a sexual dysfunction there must exist an awareness of what "normal" function can mean to the individual (Rosen, 2002a). A recent issue of the *World Journal of Urology* (Steiner, 2002) focused upon female sexual dysfunction. Several of the articles note that there exists little knowledge regarding the theory of female sexual function and emphasis is placed upon dysfunction with very little regard to understand the concepts of health and receptivity (Anastadias et al., 2002; Berman & Bassuk, 2002; Hartmann et al., 2002).

Sexual Dysfunction

Sexuality is defined by Masters and Johnson (1966) as "a dimension and an expression of personality" (p. 301) and by Westheimer and Lopater (2005) as "sensual pleasure that comes from the stimulation of the body, often with the anticipation of an enjoyable, erotic feeling (p. 24). Sexual dysfunction has been defined (Anastadias et al., 2002; Berman & Bassuk, 2002) as the presence of personal distress co-morbid to pathology (the existence of inability to achieve arousal, to be receptive, pain with sexual activity, or aversion to sexual expression). Westheimer and Lopater (2005) define sexual dysfunctions as "problems people experience in desiring sexual interaction, as well as physiological problems in the human sexual response cycle" (p. 506). These definitions and many other descriptions of sexual dysfunction have two common factors: personal distress and inability to achieve or enjoy sexual expression. The focus of this literature

review has been upon sexual function and what factors are involved in female sexual satisfaction.

The *International Classification of Diseases* (ICD-10) system (WHO, 1992) provides a billable code to apply to patient complaints. A consensus opinion has been published by the Sexual Function Health Council of the American Foundation for Urologic Disease, and has further defined and clarified female sexual dysfunction to the following:

Sexual Desire Disorders: Hypoactive sexual desire disorder is the persistent or recurrent deficiency (or absence) of sexual fantasies/thoughts, and/or desire for or receptivity to sexual activity, which causes personal distress.

Sexual Aversion Disorder is the persistent or recurrent phobic aversion to and avoidance of sexual contact with a sexual partner, which causes personal distress.

Sexual Arousal Disorder is the persistent or recurrent inability to attain or maintain sufficient sexual excitement, causing personal distress, which may be expressed as a lack of subjective excitement, or genital (lubrication/swelling) or other somatic responses.

Orgasmic Disorder is the persistent or recurrent difficulty, delay in or absence of attaining orgasm following sufficient sexual stimulation and arousal, which causes personal distress.

Sexual pain disorders: Dyspareunia is the recurrent or persistent genital pain associated with sexual intercourse. Vaginismus is the recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with vaginal penetration, which causes personal distress. Noncoital sexual pain disorder is recurrent or persistent genital pain induced by noncoital sexual stimulation. (Basson et al., 2001, p. 87)

The above classification system notes that there must be pathology present with a state of distress. These diagnostic labels are utilized by HCPs in order to achieve a reimbursable code for services. Many sexologists disagree with its focus upon disease (allopathy) and distress (Althof, 2001; Bancroft et al., 2001; Basson, 2001a, 2001b; Davis, 2001;

Everaerd & Both, 2001; Leiblum, 2001; Maurice, 2001; Meston, 2001; Tiefer, 2001a, 2001b).

Instrumentation for Evaluation and Management of Sexual Function

Consistent with diagnoses focused on dysfunction, current instruments also address the assessment of dysfunction (discomfort, lack of libido, lack of desire) when a complaint is registered; however, primary care providers lack an instrument that can be utilized in health care settings to screen for sexual function issues (Meston & Derogatis, 2002). Thus, health care providers may miss an essential health care intervention in women patients. Screening for sexual function issues in women should assist in their overall health (Symonds et al., 2005).

Assessments of sexual health in psychology have also focused on lack of health rather than health. Prior studies on the psychosocial impact of sexual desire disorders in women have indicated that these disorders are a component of mental distress and relationship conflict (Anastadias et al., 2002). The focus of the instruments is upon the medical issues of discomfort, lack of libido, lack of response, and inability to function. The following section describes the common instruments and surveys with this medical and male model focus.

The Assessment of Sexual Function

Several instruments and surveys exist that address the assessment of female sexual dysfunction (Table 1). These instruments are based on Masters and Johnson or Kaplan's linear model of successive stages of response (male model). Other instruments

Table 1

Existent Assessment Instruments in Sexology

Instrument	Male/ Female	Usage	Domains Tested	Validity
BISF-W	Female	Clinical trials 22 item instrument	<ul style="list-style-type: none"> ▪ Sexual interest or desire ▪ Sexual activity ▪ Sexual satisfaction 	Correlation to DSFI .54; “moderate” test-retest reliability and internal consistency (0.70 for desire, other domains low)
BSFQ	Male		<ul style="list-style-type: none"> ▪ Sexual activity or performance ▪ Sexual interest ▪ Sexual satisfaction ▪ Physiologic competence 	No testing on women.
CSFQ	Male and Female	35 item, measures illness and medication related changes in sexual function	<ul style="list-style-type: none"> ▪ Sexual desire or interest ▪ Sexual frequency ▪ Sexual pleasure ▪ Sexual arousal ▪ orgasm 	“modest” consistency and reliability, no published norms for FSD. Correlations .42–.76
DSFI	Male and Female	Considered gold standard 261 item self report	<ul style="list-style-type: none"> ▪ Sexual information ▪ Sexual attitudes ▪ Sexual experience ▪ Sexual drive ▪ Sexual fantasy ▪ Sexual and other body image ▪ Sexual satisfaction 	Test–retest reliability .42–.96; internal consistency .56–.97; demonstrates predictive ability for sexual dysfunction analysis.

Table 1—Continued

Instrument	Male/ Female	Usage	Domains Tested	Validity
DISF/DISF-SR		25 item semistructured interview. No norms established for evaluation of FSD	<ul style="list-style-type: none"> Sexual cognition or fantasy Sexual arousal Sexual behavior or experience Orgasm Sexual drive or relationship 	No norms for FSD
FSFI	Female	19 item self report	<ul style="list-style-type: none"> Desire Arousal Lubrication Orgasm Satisfaction and pain 	Correlation “generally modest” (.53 control, .22 FSD). Internal reliability good to excellent, discriminate validity present.
GRISS	Male and Female	56 item (28 female) designed for use in heterosexual couples. Limited to dysfunction.	<ul style="list-style-type: none"> Anorgasmia Vaginismus Avoidance Nonsensuality Dissatisfaction Frequency of sexual contact noncommunication 	Internal consistency (.70) Test-retest reliability (.47–.82). Discriminate between FSD and FSH in all but non-communication.
SSDI	Male	4 item measure	<ul style="list-style-type: none"> Sexual frequency (libido) Sexual desire Arousal Self satisfaction (Orgasm) 	No testing on women.
SQOL-F		18 item self report on the impact of FSD on QOL. Tested on women in stable relationships, in women with both FSD and FSH	<ul style="list-style-type: none"> Physical QOL Social QOL Emotional QOL Psychological QOL 	Statistically significant ($p < .05$) between sexual function and SQOL.

Source: Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994

focus upon a specific unilateral dimension of health and do not incorporate aspects of the multifactorial dimensions of the concept health. In this section, I will review and summarize what instruments are available and the domains addressed by these instruments.

The *SSDI: Sexual Symptoms Distress Index* was developed by Croog and colleagues. It is a four-item measure of the male sexual desire, arousal, and orgasm response and includes the domains of sexual frequency, sexual desire, sexual arousal, and self-satisfaction. This instrument has been tested on men (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

The *BSFQ: Brief Sexual Function Questionnaire* was developed by Reynolds and colleagues. It is a 21-item self-report inventory of sexual interest, activity, satisfaction, and preference. The domains of sexual activity or performance, sexual interest, sexual satisfaction, and physiologic competence are assessed. This instrument has been tested on men, of whom only 60% were in stable relationships (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

The *DSFI: Derogatis Sexual Function Inventory* was developed by Derogatis and colleagues. It is a 261-item self-report inventory that addresses the domains of sexual information, sexual attitudes, sexual experience, sexual drive, sexual fantasy, sexual and other body image, sex role, and sexual satisfaction. It was tested on male and female subjects and is considered to be a “gold standard” instrument for use in the assessment of sexual dysfunction (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

The *DISF/DISF-SR: Derogatis Interview for Sexual Functioning / Derogatis Interview for Sexual Functioning Self Report* was developed by Dr. Derogatis in 1979 and further evaluated against the DSFI. It is a brief 25-item semistructured interview. The five domains of sexual cognition or fantasy, sexual arousal, sexual behavior or experience, orgasm, and sexual drive or relationship are addressed. There are no norms established for evaluation of Female Sexual Dysfunction (Meston & Derogatis, 2002).

Hoon and colleagues developed the *Sexual Arousability Index*. The domain of arousability is assessed and has been determined to represent a limited scope and failed discrimination (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

Taylor, Rosen, and Leiblum (1994) developed the *BISF-W: Brief Index of Sexual Functioning for Women*. This instrument was developed for use in clinical trials, contains 22 questions, and is designed for use on healthy women or for those whose sexual function is affected by medications or psychiatric issues. It may be suitable for hetero- or homosexual women and requires 15 to 20 minutes to complete. The domains of sexual interest or desire, sexual activity, and sexual satisfaction are addressed. The seven sexuality dimensions of thoughts/desire, arousal, frequency of sexual activity, receptivity/initiation, pleasure/orgasm, relationship satisfaction, and problems affecting sexual function are the components of the instrument. The authors report a “modest” internal consistency and reliability; comparison to the DSFI indicates correlation at 0.54. Expert post hoc analysis questions the ability of this instrument to differentiate the physiological responsivity in self-reports (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

The *CSFQ: Changes in Sexual Functioning Questionnaire* (Clayton, McGarvey, & Clavet, 1997) is a 35-item structured interview. It measures illness and medication related changes in sexual function. There are different instruments for men or women, and the interview instrument requires 20 minutes for the provider to administer. The five domains of sexual desire or interest, sexual frequency, sexual pleasure, sexual arousal, and orgasm are assessed. No published norms exist for FSD, and correlation data of .42 to .76 have posed “modest” consistency and reliability measures (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

The *FSFI: Female Sexual Function Index* (Rosen, Brown, Heiman, Leiblum, Meston, Shabsigh, et al., 2000) is a 19-item self-report instrument that requires 15 minutes to administer is the only instrument available free of charge on the World Wide Web. The five domains of desire, arousal, lubrication, orgasm, satisfaction and pain are assessed. Correlational studies on this instrument are “generally modest” (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

The *Golombuk Rust Inventory of Sexual Satisfaction (GRISS)* is a 56-item survey, with 28 questions each for men or women. It is designed for use in heterosexual couples and takes 15 minutes to administer. The 12 domains (5 for women, 5 for men, and 2 common gender domains) assessed present an internal consistency of .70 or greater with the exception of sexual communication (.61); test-retest reliability is .47 to .82. The 5 domains for female client use are anorgasmia, vaginismus, avoidance, nonsensuality, and dissatisfaction. The 2 common gender domains are frequency of sexual contact and noncommunication (Meston & Derogatis, 2002; Rust & Golombuk, 1986; Symonds et al., 2005; Taylor et al., 1994).

The *SQOL-F: Sexual Quality of Life – Female* (Symonds et al., 2005) assesses the impact of FSD on QOL. It is an 18-item self-report instrument that looks at the four dimensions of physical, social, emotional and psychological quality of life. It was tested on a subset of women in stable relationships, on women with both FSD and FSH and women with spinal cord injuries. Tests include correlation coefficients, and test-retest reliability (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994).

What is missing from the above noted instruments is (a) a screening instrument for the health care provider to utilize to screen for sexual function issues among female clients, and (b) a holistic approach to the concept of female health that incorporates all the components noted in WHO definition of health (i.e., physical, mental, and social state of well-being). The ICD10-DSM (APA, 2006) codebook states that in order to utilize the diagnostic codes of female sexual dysfunction it is necessary for the woman to have a degree of personal distress. Assessment surveys and research protocols include questions regarding frequency, discomfort, and receptivity, but have been tested on men or are designed for assessment of male sexual dysfunction (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994). Instruments and surveys that have been published and investigated using women focus on dysfunction and partner complaint, or demonstrate limited validity (Bancroft, 2002; Frank-Stromberg & Olsen, 1992, 1997; Jones, 2002).

Summary of What Has Been Identified by Sex Research

Research into the female sexual self has occurred within the disciplines of medicine, psychology, and sociology. The contribution of this to an understanding of the

concept of female sexual health has been flawed for several reasons, including a focus on the diseased or dysfunctional state in medicine and psych-sociologic disciplines, a lack of generalizability in sexology research and a lack of an interdisciplinary focus. General consensus exists that for women their sexual health is more than physiologic function, and that emotional and relationship factors must figure into sexual well-being. There is limited understanding of the woman's viewpoint of what attributes of sexual health exist, and how important these attributes are to overall sexual health.

Noted Gaps in the Research and Approach of Sexology

Much of the research has focused upon dysfunction and distress to the sexual response. Basson (2000) reports that studies on women's sexuality, health, and dysfunction rarely include the components of women's sexual satisfaction. Prior assessment surveys focus upon the sexual act and ability to achieve copulation or orgasm. Testing the male instruments on women may not lead to valid results regarding what is meant by "healthy sexuality" for women (Bancroft, 1998). This gap in the literature and research has been observed by a group of sexologists who have created a "New View" of female sex research and knowledge (Kaschak & Tiefer, 2001).

As stated earlier, Kinsey (1953) investigated sexual health and termed success with function the achievement of orgasm, but limiting sexual health to a description of physiologic function such as achieved orgasm does not address what women may view as normal for their health state (Taylor et al., 1994). In addition, his analysis of the female sexual response utilized questionable sampling techniques and was not representative of the U.S. population overall (Bancroft, 1998).

Masters and Johnson (1966) also looked at the sexual response cycle as inclusive of the orgasm, indicating that women view the attainment of orgasm as a component of achieved sexual health. In describing the limitations of their research, Masters and Johnson report that no norms exist for understanding the concepts of male or female sexuality in our society:

The division of the human male's or female's cycle of sexual response into four specific phases admittedly is inadequate for evaluation of finite psychogenic aspects of elevated sexual tensions. However, the establishment of this purely arbitrary design provides anatomic structuring and assures inclusion and correct placement of specific physiologic response within the sequential continuum of human response to effective sexual stimulation. (Masters & Johnson, 1966, p. 7)

Masters' and Johnson's research (1966) also utilized a population that was not representative of the U.S. population. As discussed previously, further validation of Kinsey's work and Masters' and Johnson's study with a dysfunctional population does not forward the discovery of normal female function. Hicks (2005) reports upon a "New View" of female sexual health that begins by acknowledging that women may not view satisfaction or dissatisfaction with their sexuality based upon the achievement of orgasm.

Tiefer (2006a) communicates that it is important for the scientific community to appreciate the diversity inherent in how women experience their sexual health. A qualitative view could help discover what is occurring among women and raise the visibility that there exists normalcy in variability of sexual function. Heiman (2006) also supports the view that sex is a subjective experience of behavior, emotions, and neurophysiology. Prior research has focused upon mechanism and that there exists little information regarding women's subjective experience of their sexuality. Prior research, as

discussed above, has also focused upon the male model, medical problems, or physiologic complaints.

Because a diagnosis of sexual dysfunction calls for a patient complaint of personal distress, lack of sexual health may not be apparent to the health care provider. "None of the measures to date provide a comprehensive, reliable assessment of key dimensions of sexual function in women, including sexual desire, orgasm and satisfaction" (Taylor et al., 1994, p. 629) Prior survey instruments and assessment instruments adapted male concepts of sexual function (frequency and orgasm) to women subjects: little research exists upon what the concept of female sexual health means outside of the linear and goal directed medical model (dysfunction or distress, and function of organs). The domains or dimensions of sexual dysfunction as reviewed in the discussion regarding sexual assessment instruments are noted to include libido (frequency of desire and activity), pleasure (orgasm and sensual enjoyment), relationship issues, and distress or discomfort's presence or absence, along with quality of life issues. This prior knowledge of sexual domains assists in the construction of new theoretical constructs (Flick, 2002). The commonly reported dimensions fit into a mnemonic of FORD: F (frequency), O (orgasm), R (relationship), and D (discomfort or distress presence or absence).

Identified gaps in women's health research include the concept of what constitutes female sexual satisfaction/perceived holism. In order to differentiate between the states of sexual function (no distress, a sense of sexual expression that meets individual needs) from sexual dysfunction, I will refer to the state of sexual function, holism, and satisfaction with that state as female sexual health. This term encapsulates the full view of

what women mean by “no complaints” and assists to avoid any medicalized view of sexual expression.

Mixed Methods Analysis

What is currently missing from the sexual health research is an analysis of what women understand to mean about their sexual lives being healthy, from an interdisciplinary perspective that incorporates a holistic definition of health. Methodology of domain discovery of a concept for further quantitative hypothesis testing lends itself to mixed methods research designs. An initial approach to understanding a concept is to utilize qualitative methods of data collection and to allow a theory to emerge from the analysis (Glaser & Strauss, 1967). Qualitative methods, such as focus group or individual interviews, can help inform researchers’ understanding of a complex concept (Flick, 2002) and serve as a part of knowledge production. Grounded theory as a specific qualitative research methodology combines concepts and hypotheses that have emerged from the qualitative data (Glaser & Strauss, 1967). Prior dimensions are not abandoned in further exploration of an overarching concept, but are kept in mind when analyzing the data that emerges from the study. In mixed methods analysis, the theory that emerges from qualitative analysis is tested using quantitative methods (Hays, Anderson, & Revicki, 1993; Patton, 2002). Use of a mixed methods analysis from an interdisciplinary focus will allow for rich description of a concept. “[Mixed method] research designs are relevant, meaningful, understandable, and able to produce useful results that are valid, reliable, and believable . . . and a variety of data types can contribute to methodological rigor” (Patton, 2002, p. 68).

In order to discover what the concept of female sexual health means to women, I planned to utilize grounded theory through dimensional analysis and test the correlation of these dimensions with self-reported female sexual health through use of a survey instrument. Alvermann, O'Brien, and Dillon (1996) suggest that in qualitative research, theory directs the questions, data collection, and analysis and that before doing qualitative research, the investigator must demonstrate that relevant contributing work is understood and a problem is formulated based upon the research in a discipline. Theory must play a role in the shaping of ideas, design, and methods. The theoretical basis for the query into the concept is detailed further in this discussion regarding the New View, and in the Methods section (Chapter III) of the dissertation.

Qualitative Research Methodology: Focus Group

Focus group methodology has been used in research to provide a rich description of a concept of interest, to provide a credible and comprehensive description of a topic, and to generate hypotheses for testing (Alvermann et al., 1996; Belgrave, Zablotsky, & Guadagno, 2002; Bender & Ewbank, 1994; Flick, 2002; Glaser & Strauss, 1967; Morse, Hutchinson, & Penrod, 1998). Focus group studies have provided illuminating data on sexology, and have key advantages for sexuality researchers: they are useful for exploratory research; they can enable the researcher to learn the language used by respondents and provide conditions in which people feel comfortable in discussing sexual experiences (Frith, 2000). Focus group data analysis is a traditional and tested method of qualitative research. Focus groups contribute to development of a quantitative investigation (Flick, 2002) by informing the actual content of survey questionnaires, and

provide an understanding of what research topics or concepts mean to members of the study population (O'Brien, 1993).

Grounded Theory and Dimensional Analysis

Grounded theory is a method of critical thinking about a social area, where data are conceptualized to formulate a theory that is grounded in empirical substance (Bonoliel, 1996, p. 407). It is oriented toward the generation of theory (Glaser & Strauss, 1967; Kools, McCarthy, Durham, & Robrecht, 1967) through a naturalistic inquiry and provides theoretical development in hermeneutics and phenomenology (Malterud, 2001). Grounded theory differs from a "fine description" and is instead the science behind the development of "thick descriptions" which generate theory, hypotheses, and beginning knowledge bases in sociology (Glaser & Strauss, 1967; Kools et al., 1996; Malterud, 2001; Miller & Fredericks, 1999). "A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (Glaser & Strauss, 1967, p. 23).

Dimensional analysis goes beyond grounded theory, having its own epistemology and set of operations.

The key process in dimensional analysis is the construction or novel reconstruction of the multiple components of a complex social phenomenon. . . . As originally conceived, the objective of grounded theory method was to answer the conceptual questions, "What is the *basic social process* that underlies the phenomenon of interest? Instead, when dimensionalizing a phenomenon of interest, one attempts to address the question, What *all* is involved here?" (Kools et al., 1996, pp. 316-317)

Dimensional analysis is a method of analysis of qualitative data: the transcript of discovery. Grounded theory provides a theoretical basis for the evaluation of the subject of interest (Strauss & Corbin, 1990). It is a self-conscious and deliberate search for logical explanations of a phenomenon of interest, and is the process of category formation, refinement, and analysis. Dimensional analysis is the specific method of categorizing data and allowing certain dimensions of the concept to emerge from the data analysis (Kools et al., 1996; Strauss & Corbin, 1990).

Development of Assessment Guides and Instrument Development

In order to develop an assessment guide, a well developed theory is necessary as prerequisite (Morse et al., 1998). The researcher's pathway is to conduct a qualitative study, develop a qualitatively derived theory, develop an assessment guide, and then perform an outcome analysis (see Figure 5). Qualitative approaches contribute to the development of clinical assessment tools by including identified concepts, definitions, and generating items (Gilgun, 2004). Rapid assessment devices (surveys or instruments, or verbal exchanges of information) can assist the health care team in evaluation and interaction with clients, streamlining the assessment and providing a comprehensive exchange of information (Springer, Abell, & Nugent, 2002); mnemonic tools to help the provider recall parameters have demonstrated usefulness in a clinical setting (Springer et al., 2002). The rapid assessment device is constructed based upon theoretical domains of a concept and evidence based practice (Dillman, 2007; O'Brien, 1993; Springer et al., 2002).

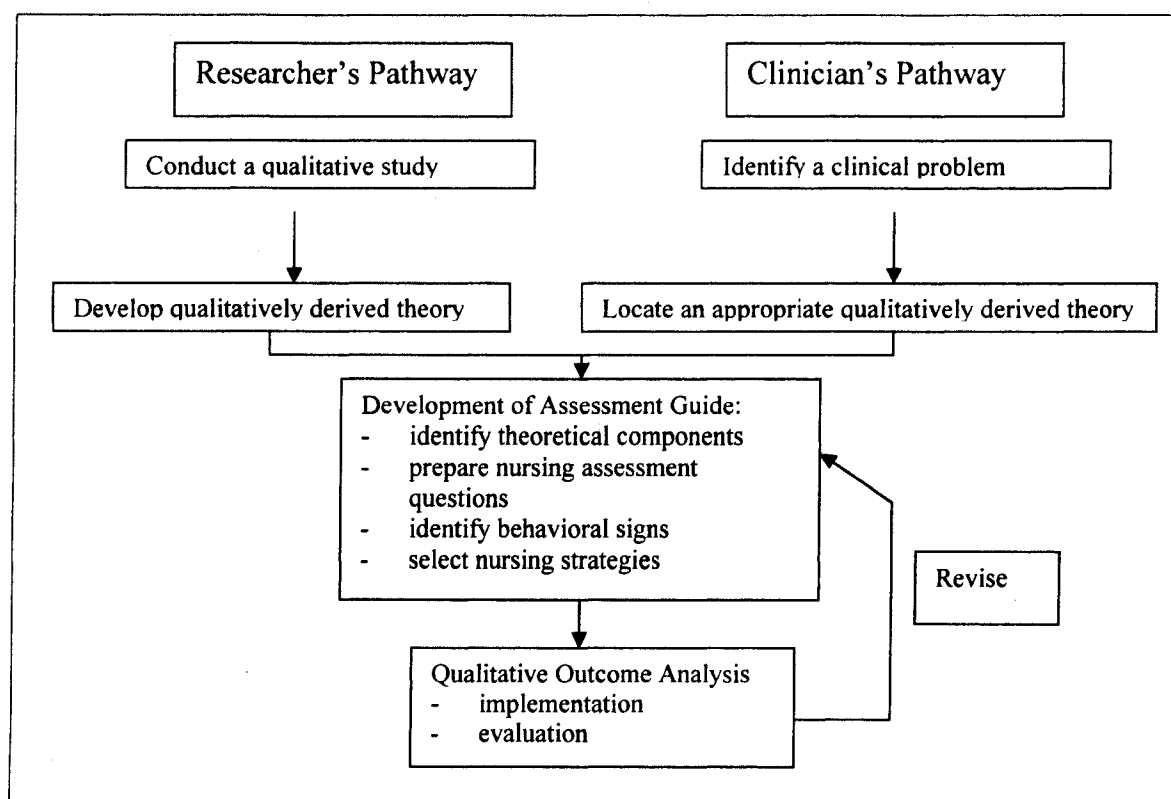


Figure 5. Overview of the process of developing and applying qualitative research to a clinical problem (Morse et al., 1998). The development of assessment guides from qualitatively derived theory.

Grounded theory, once developed and evaluated, often undergoes validation through the use of statistical testing with quantitative studies. This can occur with instrument development, face and construct validity testing, comparison to known psychometric properties of existent instruments, or further analysis in phenomenology studies (Kools et al., 1996; Strauss & Corbin, 1990). Theory is then used to direct the format and content of questions and the framework of investigational instruments to validate the theory or findings from the qualitative piece of the research study (Rea & Parker, 2005). The grounded theory contributes a deeper understanding of the subject matter to the development of an analysis of the concept. After the qualitative research has

informed the concepts to frame the study, then quantitative research assists to validate the formed theory and dimensions to emerge. Quantitative research techniques provide further validity testing and can be used to correlate the items of the newly described concept to known measures.

As theory directs the questions, data collection, and analysis, following is a statement of the purpose and questions that guided this research study. The following segment reviews how theory played a role in shaping research ideas, design and methods and how the purpose statement and questions served to focus the research providing a springboard for the study design, methodology, analysis, and interpretation (Alvermann et al., 1996).

The Orienting Paradigm

As theory directs the questions, data collection, and analysis (Alvermann et al., 1996)—a framework for the conduction of focus group questions in existent sociology and sexology was sought. The *New View Paradigm* (discussed in the Literature Review, Chapter II) was selected to be representative of a more holistic framework within which to frame the focus group questions, as it incorporated the majority of domains of the concept “health.” This framing paradigm (Hicks, 2005; Kaschak & Tiefer, 2001) was chosen after preparation for the doctoral study through a rigorous process of obtaining a certificate in Clinical Sex Therapy from Maimonides University, reading classic research in sexology including the works of Kinsey (1953), Masters and Johnson (1966), Masters et al. (1988), Basson (2000, 2001a, 2001b), Basson, Berman, et al. (2001), Basson, Leiblum, et al. (2003, 2004), and Kaplan (1974a, 1974b, 1976), in addition to the

currently published work of Berman, Berman, Werbin, and Goldstein (1999), Berman and Berman (2001, 2005), Berman and Bassuk (2002), Berman and Goldstein, (2002), Berman, Berman, Miles, Pollets, and Powell (2003, 2005), Hicks (2005), Meston (2000, 2001, 2003), Tiefer (1991, 1996, 2001a, 2001b, 2006a, 2006b), and others in no less than 167 published peer reviewed resources. The framework was also based upon the researcher's experience in providing women's health as an Advanced Practice Nurse for over 15 years. Appendix D contains the script used in the focus group.

In grounded theory development, a framework for understanding the concept emerges from the analysis of the qualitative data (Glaser & Strauss, 1967; Kools et al., 1996). Hence, the theories of the New View and the aforementioned sexologists and medical providers (used to initiate the focus group question process) were not utilized as a framework for the survey instrument development process; rather the dimensions that emerged from the qualitative analysis were used. The very essence of grounded theory development is that what the researcher develops is unique (Glaser & Strauss, 1967) and should not be strictly aligned with other theories. The grounded theory's unique properties are further studied and tested for psychometric properties based upon the dimensions that emerge (Kools et al., 1996; Miller & Fredericks, 1999; Peshkin, 1993; Strauss & Corbin, 1990).

Purpose Statement and Objectives

The purpose of this research was to explore the concept of female sexual health and to understand that concept from an interdisciplinary focus. What is the meaning of the term *female sexual health* to women? Are there common dimensions of the concept

female sexual health? Do these common dimensions incorporate ones commonly understood to contribute to sexual dysfunction complaints (lack of libido, lack of orgasm, distress, relationship problems)? For clarification: an individual item is termed a dimension, when the dimensions then interconnect and are related to each other and the global concept, they are termed a domain. The research purpose was to explore the concept of female sexual health and what this means to women who report they are not in any distress over their sexual function.

The significance of the research was to begin a scholarly investigation into the concept of what women mean when they report a state of sexual health (no dysfunction). Prior research in the field of Sexology and Women has focused upon dysfunction and distress. Little is understood about function and lack of distress (health). While it is known that distress and dysfunction carry psychological burden and pathophysiology may present with disorders of bodily function including the sexual response (Seftel, 2004), what is not understood is what the “healthy” state of sexual function is for women. This study lends itself to mixed method discovery for analysis of the concept, and survey testing of the dimensions to study possible domains of female sexual health.

The research also addressed the lack of an assessment device to utilize in the health care setting to address sexual function in female clients. If common dimensions are understood to incorporate the concept of female sexual health, it may assist HCPs to address an important aspect of well-being. Research questions were also posed to the participants to address the concern that sensitive topics such as sexuality may not be perceived by women as appropriate for routine health maintenance care in their HCPs offices.

Research Questions

The research questions addressed by this mixed methods study and described by Chapter III (Methods) and Chapter IV (Results) are as follows:

Qualitative

1. *What is the meaning of the concept female sexual health to a group of women?*
 - a. *Can attributes of sexual health be identified through dimensional analysis?*
 - b. *Are there differences in the attributes by age, race/ethnicity, education level, menopausal status, relationship status?*

Quantitative

1. *What is the self-reported level of female sexual health in a population of women?*
 - a. *Are there differences in the self-reported level of sexual health by age, race/ethnicity, education level, menopausal status, relationship status?*
2. *Are the identified dimensions of female sexual health correlated with overall self-reported level of sexual health?*
 - a. *Are there differences in correlations by age, race/ethnicity, education level, menopausal status, relationship status?*
3. *Are the dimensions of female sexual health correlated to each other?*

4. *How do women rank four commonly perceived attributes of sexual health?*
 - a. *Are there differences in the ranking by age, race/ethnicity, education level, menopausal status, relationship status?*

CHAPTER III

METHODS

Chapter I has introduced the concept of interest, female sexual health, and has discussed the implications of this concept for health care practice. A discussion on related concepts and constructs revealed that instruments exist to determine a woman's level of dysfunction or distress, yet no instrument measures or identifies the domains of the concept female sexual health. In order to conceptualize and operationalize the construct, Chapter II presented an integrated review of the literature. Alvermann et al. (1996) and Glaser and Strauss (1967) recommend that prior to the performance of qualitative research, the investigator demonstrates that relevant work is understood and the problem is formulated based upon a corpus of research in a discipline. In order to establish the scientific basis for utilization of qualitative methods (grounded theory through dimensional analysis) with assessment instrument development, Chapter II also presented a brief review of the literature to describe this research methodology, and the theoretical basis for the survey design. In this chapter, both the design of the study and the organization of analysis performed will be described. In relating the results of qualitative research, the method section contains the following: a description of the orienting paradigm for the study, a description of the specific research design, the research-as-instrument statement, a description of participant selection and demographics, sources of data analyzed, and how data were analyzed.

Design

This mixed method study occurred in two phases. In Phase One, the “Discovery Phase,” the researcher utilized qualitative research methodology through focus groups. This phase was undertaken to understand the items to utilize in determining the dimensions of “female sexual health” as a concept. In order to identify the empirical indicators of the construct female sexual health, and to identify the experiences that identify the components of that construct, focus groups were convened to collect information and study those experiences of women who claim sexual health. Grounded theory development specifically through dimensional analysis of the data (Kools et al., 1996) provided an understanding of the concept through the dimensions to emerge.

In Phase Two of the study, the dimensions that emerged during the discovery phase were tested for their psychometric properties using a survey instrument. The instrument (draft and pilot) was developed using the items and dimensions discovered in Phase One (Dillman, 2007; Kools et al., 1996; O’Brien, 1993). The pilot survey instrument was reviewed by experts in the fields of sexology, sociological research, and instrument design and piloted in women who participated in the focus groups. Following feedback from the pilot and expert review, the survey instrument was revised and sent to sample population. This phase culminated in an analysis of the dimensions in “female sexual health” (Kools et al., 1996), and of a rapid assessment instrument (mnemonic) for further development and testing (Springer et al., 2002).

Phase One: Discovery Through Qualitative Research Methodology

Prior to the commencement of the study, approval for the focus groups was obtained from the Institutional Review Board at Western Michigan University.

Focus Groups

The focus group moderator was selected for her expertise in qualitative research methods. When collecting data for grounded theory, the researcher may either serve as moderator or as observer to the focus group process (Bender & Ewbank, 1994; Glaser & Strauss, 1967; Henderson, 1995; Malterud, 2001; O'Brien, 1993); in order to not lead the responses from the group, I served as an observer and not a moderator. Focus groups were held in sociologically neutral and aesthetically pleasant surroundings (McLafferty, 2004; Patton, 2002), with participants grouped based upon age (Belgrave et al., 2002).

Grounded theory through dimensional analysis was the research method chosen for interpretation of focus group data (Bonoliel, 1996; Henderson, 1995; Hsieh & Shannon, 2005; Kools et al., 1996; Miller & Fredericks, 1999; Robrecht, 1995; Walker & Myrick, 2006; Yeh & Inman, 2007). Dimensional analysis (Kools et al., 1996) was utilized to enhance the development and evaluation of the assessment tool developed in the study (Gilgun, 2004). The survey instrument developed was constructed based upon the dimensions that emerged from the qualitative study's dimensional analysis. Practical strategies were utilized (Morgan, 1998b) to combine the qualitative and quantitative methods (Denzin, 1970; Flick, 2002; Greene, Caracelli, & Graham, 1989; Peshkin, 1993) investigating the concept of female sexual health, the dimensions to emerge from the

analysis (Kools et al., 1996), and the validation of those dimensions through further testing using an assessment survey (Belgrave et al., 2002; Morse et al., 1998).

Statement of the Research-as-Instrument

Although there was a specific framework for the questions used in the focus groups (Hicks, 2005; Kaschak & Tiefer, 2001), the questions were framed in a neutral or positive fashion, and structured to flow from least intrusive to most likely to be interpreted as personal information (Robinson, 1999). I did not wish to introduce any statements that would discourage participation in the discussion. Confidentiality was assured to the participants, and they were aware of the general purpose of the study prior to the commencement of the focus group sessions. As the data collection in the initial phase would be utilized as the foundation for the instrument development for phase two, the focus group moderator was made cognizant of the importance of adhering to a specific structure for the questions. The qualitative research methodology employed thus served as key to instrument development in this process.

Participants

Focus Group Recruitment

Three separate focus groups of seven subjects during the winter of 2006–2007 occurred. The subject pool was fairly homogenous based upon age categories of college age, middle age women (30 to 55), and retirement age (over age 60) to encourage the group to share ideas and opinions (Pett, Lackey, & Sullivan, 2003). Additional inclusion

criteria for attendance within the focus groups were that the participants were female, and that they had “no issues or complaints with their sexual health.” A flyer was developed in order to solicit potential participants (Appendix B). I approached a variety of women’s groups: a business club, a continuing education class, two different Bible studies, and a social club. At these group meetings, I introduced myself, the purpose of the doctoral research, and provided the flyers to all participants with contact information. These women were asked to only identify their age group (“college age,” “middle aged,” “retirement age”) and first name when they called to register for the focus groups. I also utilized student mailboxes within a specific building on the campus of a Midwestern university to distribute the flier recruiting potential participants.

Focus Group 1: Professional Women (“Middle Age”)

I convened the first group of women from the potential pool of participants in the business club, continuing education class, Bible study, and the social club. Seven women met for a tea at a meeting room within a Victorian home restored for use in small group meetings on the campus of a Midwestern U.S. university. The focus group was held in a living room setting, two data recorders were present on the central coffee table, and the women sat in a circle surrounding the table. Refreshments were served. The participants were provided with a name tag to designate their name to be used for the evening, e.g., “Lana” instead of the real identity presumably. After an ice breaker, the moderator (seated at the edge of the circle) began the session. I sat outside the circle and made notations regarding nonverbal behavior. At the conclusion of the focus group, the women were thanked for their participation and provided with a token gift (a \$20 bookstore gift card)

to thank them for their time and travel expenses. The participants were also asked if they wished to provide feedback to me regarding the instrument that was to be developed. If they wished to participate in this portion of the study, they provided me with a mailing label designating their name and address. This label's information was not stored in any fashion. See the Method section "Instrument Development" for further description of this use of the participant pool.

Focus Group Two: Retirement Age Women

I convened the second group of women from the potential pool of participants invited from the business club, continuing education class, Bible study, and the social club. Seven women met for a tea at a meeting room within a Victorian home restored for use as a bed and breakfast and meeting facility in a Midwestern U.S. city. The focus group was held in a dining room setting, two data recorders were present on the central table, and the women sat in a circle surrounding the table. A Victorian type tea was served. The same method of participant observation was employed as the first focus group details.

Focus Group Three: College Age Women

I convened the third group of women from the potential pool of participants in the continuing education class, and from the mailbox drop of flyers on the campus of a Midwestern U.S. university. Seven women met for a provided luncheon using a conference room within the university. The focus group was held at a conference table setting, two data recorders were present on the central table, and the women sat in a circle

surrounding the table. A box lunch was served. The same method of participant observation was employed as the first and second group details.

Sources of Data

All three transcripts were typed verbatim from the digital data recordings of the focus groups. A transcriptionist trained in the maintenance of confidentiality with expertise in medical terminology was utilized. The transcript (considered raw data for analysis) was checked for accuracy by a comparison to notes and audio recording and was shown to be accurate. Additional information regarding the nonverbal behaviors of the focus group participants was added to the file on each separate session. The data audio and written recordings were stored on my personal computer until the culmination of the doctoral research, and then were stored in the (locked) designated area of the Ph.D. program office on the university campus. The transcriptionist and the focus group moderator did not maintain in any storage system the data obtained from the discovery segment of this doctoral research.

Data Analysis

The transcripts and notations from the three focus groups are the raw data for the discovery phase of this research study. The data consist of the audio recording(s), the written transcript recording, and the notes I wrote to document nonverbal behaviors, the setting of the group meetings, and photos taken of the meeting rooms. See the latter part of this chapter regarding data analysis of the instrument developed.

Mechanics of Transcript Analysis

The methodology proposed by Belgrave et al. (2002), Bender and Ewbank (1994), Flick (2002), Gilgun (2004), Glaser and Strauss (1967), Hsieh and Shannon (2005), Miller and Fredericks (1999), Walker and Myrick (2006), and Yeh and Inman (2007) was used to guide the concept analysis and development of the grounded theory through dimensional analysis of the raw data. I read and listened to the raw data from the focus groups twice in entirety before a third review of the data. At this point, I placed the transcript into a two-column table. The left hand column was the transcript, the right hand column for notes and impressions. I placed each separate participant statement into a row. Additional nonverbal information to support or clarify the participant statement was added to the transcript (left hand) row, otherwise any impression or interpretation was reserved for the (right hand) content analysis row. I then began to look for particular patterns, themes, concerns or responses that were expressed (verbally and nonverbally) by the participants. I repeatedly read the narrative to look for concepts or themes that were more abstract or elusive than a simple count of words or repeated phrase. I noted the number of times a theme was mentioned by a group, or by all three groups, within the “incidence density” documentation.

The focus group data were evaluated with multiple readings of each group to determine the full disclosure of the group members on the concept of female sexual health and the preliminary themes to emerge from this repeated reading of the raw data. I gave the preliminary themes a descriptive label (see Chapter IV). I again read the transcript with the noted preliminary themes with the audio recording playing to

determine if potential subtle categories or subcategories might emerge based upon tone of voice or verbal context. These themes and subthemes, placed into an incidence density document, were examined for commonalities. I utilized inductive reasoning and common language usage to collapse the themes and subthemes into common terms (see Chapter IV). These subcategories were tallied and grouped under categories. Dominant themes began to emerge from the data and were noted to occur to the point of data saturation when they were easily recognized as having commonalities to other statements within and between groups, and/or they did not add further to the study findings.

Dimensional Analysis

The common themes and subthemes were then scrutinized. The goal of grounded theory is to conceptualize data and formulate a theory that is grounded in empirical evidence (Bonoliel, 1996). Dimensionality notes the attributes, context, processes, and meanings to address the complexity of a phenomenon (Kools et al., 1996) and goes beyond content analysis for grounded theory development because of the discovery of intricacies in meaning. As I analyzed and labeled the raw data, I designated themes and subthemes in order to allow me to continue with an analysis of the focus group transcript. This act of designation transforms the data from observations toward more abstract representations of the attribute and allows for both specificity and comparisons of concepts within the data (Kools et al., 1996). Saturation in grounded theory development occurs when no further information can be derived that is new from the analysis (Glaser & Strauss, 1967). In dimensional analysis a saturation point is achieved when the researcher perceives that major aspects of the phenomenon appear to be reflected and

repeated within the analysis and hence a *critical mass of dimensions* is achieved (Kools et al., 1996). At this point, the dimensions within the concept were fully emerged from the data, and the instrument was ready for development. (See Figure 6.)

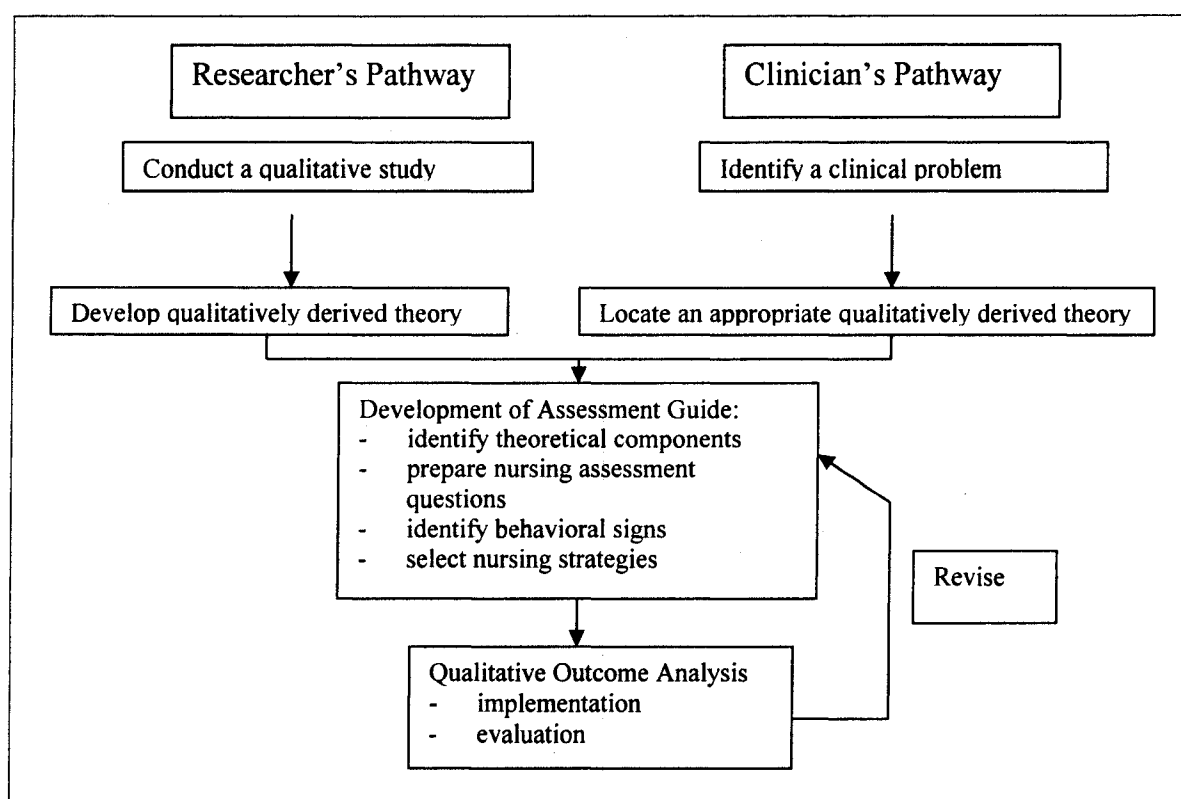


Figure 6. Overview of the process of developing and applying qualitative research to a clinical problem (Morse et al., 1998). The development of assessment guides from qualitatively derived theory.

Phase Two: Instrument Development and Testing

I utilized several sources in order to frame the instrument that would test the dimensions of female sexual health. Carmines and Zeller (1979), Creswell (2003), Daker-White and Crowley (2002), Dillman (2007), Durant and Carey (2002), Flocke (1997), Heiman (1976), Jones (2002), McHorney and Cohen (2000), Meston and Derogatis

(2002), Patton (2002), Pett et al. (2003), Picard and Jones (2005), Quirk et al. (2002), Sitzia (1999), Symonds et al. (2005), Taylor et al. (1994), Utian, MacLean, Symonds, Symons, Somayagi, and Sisson (2005), and notably Morse et al. (1998) were used for theoretical basis for instrument construction and formatting guides.

Instrument Development and Refinement

I developed a pilot instrument (Appendix E) utilizing the nine dimensions that emerged from the content analysis of the raw data. Additional questions placed within the pilot instrument were chosen based upon the need for clarification of dimension points, to note specific characteristics of the participants (such as demographics and relationship status), and to further define and describe possible assessment questions. The structure of the pilot instrument was framed based upon Dillman's (2007) recommended "Tailor Method." The instrument begins with clarification of the gender of the participant, and a request that the survey not be completed by a male. Demographic questions regarding the participant follow, noting age, race and ethnicity, educational background, and questions regarding hormonal status such as whether menopausal, whether ovaries remain. Sexual experience ranging from entirely heterosexual to entirely homosexual are noted. This particular question is worded in a manner similar to other previously tested instruments, such as the DSFI-I (Derogatis et al., 1976). Relationship status was assessed, whether past or current. The participants were asked to rate their personal level of sexual health, rate their ability to communicate their needs, and then asked questions related to the nine dimensions. See Chapter IV for a discussion on the nine dimensions. I mailed this pilot instrument to the 21 focus group participants who had provided their address labels at the

conclusion of the focus group sessions. I also mailed the pilot survey instrument to five sexology experts and two instrument development experts for their input regarding face validity and the wording of the questions. Addressed and stamped envelopes for the draft instrument critique were provided to my university mailbox. Input from these individuals was considered as the revised instrument was developed.

A 40-item instrument (Appendix F) was developed with the advice and input of the experts and focus group participants. The questions were framed in a neutral or positive fashion in order to not offend participants, or provide any sense of evaluative statements (Adams, DeJesus, Trujillo, & Cole, 1997; Clayton et al., 1997; Farber, 2003; Gerbert et al., 1999; Jones, 2002; Meston & Derogatis, 2002; Nusbaum et al., 2000). Some questions were framed in a response rank that was negative, in order to prevent individuals from answering questions without regarding their answer. The research goal was to inform the practice of health care providers. The assessment questions developed were empirically derived from listening to the voices of women, applying the dimensions learned into a usable framework within which other providers could listen to the voice of the patient, and to serve as a basis for implementing intervention strategies rather than determining a numerical measurement of a patient's state (Morse et al., 1998).

The instrument began with demographic questions. Participants were asked for information regarding their menstrual status (menopausal or not), presence of ovaries, and use of hormones. Participants were also asked to rate their level of sexual health, their ability to communicate their desires to others, and their ability to maintain safe sex practices.

The questions addressed the nine dimensions. Dimension one, “The Authentic Self,” was evaluated with questions 16, 19, 22, 30, 31, 32, and 34. Dimension two, “Communication on a deep and intimate level,” was evaluated with questions 16, 19, 20, 21, 22, and 25. Dimension three, “Emotional health,” was evaluated with questions 16, 19, 25, 26, 28, 31, and 32. Dimension four, “Frequency of sexual activity,” was evaluated with questions 23, 24, 25, 26, 31, 35, and 39a. Dimension five, “Presence of sexual pleasure or orgasm,” was evaluated with questions 22, 23, 28, 29, 31, 36, and 39b. Dimension six, “Relationship health,” was evaluated with questions 18, 19, 20, 27, 37, and 39c. Dimension seven, ‘Absence of discomfort’ was evaluated with questions 17, 26, 34, 38, and 39d. Dimension eight, “Significance of a positive health care provider relationship,” was evaluated with questions 34, 35, 36, 37, and 38. Dimension nine, “Sisterhood: Valued and appreciated for the journey,” was evaluated with question 33. See Chapter IV for a discussion on the emergence and definitions of the nine dimensions. See Appendix G, Table 3 for the placement of the dimensions within the survey instrument.

The instrument concluded with asking the participant to (a) provide input on how much they wish their health care provider to address sexual health issues, (b) rate the importance of addressing the FORD mnemonic, and (c) rank each aspect of the FORD mnemonic in its importance. Space was left for the participant to handwrite comments.

The instrument was typeset and printed into a four-page 8½ × 11 inch survey. It was sent to a random sample of 1,000 of the 2,032 female staff and faculty who are registered in the campus mail system of one Midwestern state university. Intercampus mail service was used to disperse the instruments to potential participants. A return

envelope noting my campus mail address and name was provided to enhance the anonymity of responses.

Instrument Analysis

Each returned survey was evaluated for usability. Only the surveys that answered positively to female gender were analyzed. The returned surveys numbered 247; 7 were not usable due to incomplete entry of data (4 were returned blank), providing an *n* of 240 (24% response rate). I entered data from the surveys into a personal computer using SPSS 11.0 series software. Data were then checked for accuracy using dual data entry, utilizing a second data entry person. This individual possesses data entry skills and has a graduate degree in education. If a discrepancy was noted, the numbered survey was retrieved and rechecked in entirety, as were the four surveys entered prior to and after that particular survey.

The pilot instrument was analyzed using the following sequence (Williams, 2003):

1. Descriptive analysis: describing the distribution and range of response to each variable.
2. Data were arranged into appropriate categories, such as age ranges, to enable a statistically meaningful comparison of the subgroups.
3. Nonparametric tests were performed to examine possible associations between variables.
4. The nine dimensions were evaluated for their correlation to each other.

5. The FORD mnemonic was evaluated for its correlation to the level of self-reported sexual health, and the relationships of the nine dimensions.

The research questions answered by this study and the methodology employed are as follows:

Explore the meaning of Female Sexual Health through identification of the attributes (dimensional analysis) of sexual health reported by women. This qualitative segment of the mixed methods analysis was approached with grounded theory development, dimensional analysis, and a comparison of findings to the prior literature.

What is the self-reported level of Female Sexual Health in a population of women? This was evaluated by examining frequencies. *Are there differences in the self-reported level of sexual health by age, race/ethnicity, education level, menopausal status, relationship status?* Nonparametric tests using Spearman's Rho test statistic were employed to address this research question.

Are the identified dimensions of Female Sexual Health correlated with overall self-reported level of sexual health? Correlations were calculated using Spearman's Rho (r_s). *Are there differences in the dimensions by age, race/ethnicity, education level, menopausal status, relationship status?* Nonparametric tests using Kruskal-Wallis (H) statistic were employed to address this research question.

Are the dimensions of Female Sexual Health correlated to each other? Correlation tests using Spearman's Rho (r_s) were used.

How do women rank four commonly perceived attributes of sexual health? This was evaluated by examining frequencies of different ranks and measures of central tendency. *Are there differences in four commonly perceived attributes of sexual health by*

age, race/ethnicity, education level, menopausal status, relationship status?

Nonparametric Kruskal Wallis (H) tests were employed to address this research question.

CHAPTER IV

RESULTS

This chapter includes the results of the two phases of the research study. Phase One results include results from the qualitative research study and the development of the nine discovered dimensions; Phase Two includes the results of the draft instrument evaluation and survey.

Phase One: Qualitative Research Results

Chapter II discusses the process and standards used for conducting and interpreting this qualitative research study. The theoretical models used to frame the questions and methods for data analysis are reviewed in Chapter III.

The focus groups were held in three different locations, convenient to the participants in the study (e.g., central to bus lines), after HSIRB approval was obtained and utilizing the IRB approved structure. The transcripts were evaluated using the methods described in the Chapter III. Through interpretation of these data, nine dimensions to the concept female sexual health emerged. The nine dimensions are: the authentic self, communication on a deep and intimate level, emotional health, frequency of sexual activity, presence of sexual pleasure, relationship health, absence of discomfort, significance of a positive health care provider relationship, and sisterhood: valued and appreciated for the journey.

This section of Chapter IV describes the process used to arrive at these dimensions as well as the qualitative findings in support of them. A usual presentation style of qualitative research is to merge discussions of method with discussions of results (Wolcott, 2002). While Chapter III reviews the theoretical underpinnings for this qualitative analysis, as a preamble to the results of the qualitative segment of this research, I will begin by discussing validity and reliability issues with respect to the findings.

Inherent Variability in Data

Focus group data, by nature, are variable. The goals of qualitative data analysis are often inductive; concepts are discovered and interpreted that are relevant to the participants in the study (Belgrave et al., 2002; Wolcott, 2001). In this regard, a common concept for data analysis in qualitative research is grounded theory, an intellectual process that is “built upon the assumption that knowledge is not static, people are undergoing change and context functions to facilitate, to hinder, and to influence human goals and social psychological processes” (Bonoliel, 1996, p. 416), as discussed in Chapter III.

Validity in Qualitative Research

The types of validity incorporated into qualitative research include the following: subjectivity and self-reflexivity, credibility and adequacy of data, data triangulation, interpretation of data, consequential validity, and transgressive validity (Yeh & Inman, 2007). Because the validity and reliability impact the reader’s interpretation of this study, specific results of this aspect relevant to the study are reviewed here. In Chapter III, I

discussed the process used for the development of grounded theory; here I review the aspects of validity in order to support my grounded interpretation of the results.

Subjectivity and self-reflexivity was addressed by examining my key biases prior to the commencement of the study. Before conducting the research, I had a bias toward noting that the mnemonic FORD would be a component of what the women discussed. I also recognized that my position in the community and comfortable role was as a Women's Health Nurse Practitioner, it would be difficult for me to be an objective focus group moderator. To inject my bias would possibly lead the groups in directions that would diminish the data. Toward that end, I spent 10 hours preparing the focus group moderator to lead the groups by discussing the orienting paradigm and requesting that she frame the questions in an objective manner. The same script for focus group questions (see Appendix D) was used in each group. As the observer to the focus groups, I did not interject any information a priori or guide the groups. The transcripts and content analysis were scrutinized to determine that the data accurately represented the reality of the participant and not that of the researcher. Experts in sexology also provided insight into questions on the draft instrument that presented an evaluative tone. Qualitative research is, by nature, the interpretation of information through the paradigm of the researcher. However, I did maintain some rigor to the process of developing the focus group questions and the product of the transcripts to limit as much bias as possible.

Credibility and adequacy of data was addressed by determining that data were collected until a saturation point was obvious in the content analysis of the transcript. It was determined that more focus group meetings or interviews would not add to the findings from the three focus groups when I began to find the same item label applying to

the transcripts from focus group two as had been determined with analysis of focus group one. No new items emerged from the analysis by the completion of focus group two's analysis—focus group three was found to reiterate the items brought forth in groups one and two, with some variations that related to relationship length. See Appendix G, Table 2 for transcript interpretation and the further discussion regarding the saturation of the data in this chapter.

Data triangulation occurred through a comparative analysis of the dimensions discovered in the focus group transcripts with what is published in literature about a women's health concept, and by the questions in the pilot and draft instruments. Further in this chapter, I review the nine dimensions that emerged from the data, and how each dimension is supported by what the focus group participants said and what prior research has suggested. Triangulation also occurs with the comparative results of the qualitative to quantitative data that follow (phase two).

The data were critiqued with repeated comparisons to identify any “discrepant or disconfirming evidence,” and categories were revised to reflect the participants' statements (Yeh & Inman, 2007, p. 389). Chapter III reviewed the process used to evaluate the raw data from the groups. Primarily the transcripts were repeatedly reviewed for overt and subtle inclusion in any category or subcategory. *Interpretation of data* was careful and rigorous. Following is the write-up of the data using a balance between the participants' words and my interpretation. This segment is also supported by the discussion chapter, which discusses further the dimensions that emerged from the analysis and how this compares to prior research about female sexual health. To support

interpretation of the data, I have included frequency information in the write-up to follow, and in Appendix G, Table 2.

Consequential validity is the extent to which research will function as a catalyst for social or political action. While the pragmatism of my research remains to be seen, I discuss potential contributions in Chapter V (Discussion). *Transgressive validity* speaks to the trustworthiness of the data and interpretation. Through the development and testing of the survey instrument, I have begun to apply transgressive validity to the new dimensions that have emerged. Post-doctoral research will also address this feature. I intend to further test the mnemonic as a rapid assessment instrument for use in primary care settings.

Phase one of the research addressed the following research question:

What is the meaning of the concept female sexual health to a group of women? Can attributes of sexual health be identified through dimensional analysis? Are there differences in the attributes by age, race/ethnicity, education level, menopausal status, relationship status?

Focus Group One: Ages 30–50

The first group of women was convened from the potential pool of participants in the business club, continuing education class, Bible study, and the social club. (See Chapter III for a discussion on the reason for selecting these social groups.) They met on December 8, 2006 at 5 p.m., ending their session at 6:30 p.m.; the setting is described in Chapter III.

Demographics

Seven women met at the first focus group. Their average age was 45.1, with a range of ages 37–57. (See Appendix G, Table 1: Participant Focus Group Information.) All of the women were white, none had solely a high school degree, 28.5% had a college degree, 57.1% were currently taking college courses, and 14.2% had a graduate degree (master's or doctorate). Their sexual orientation was 85.7% heterosexual and 14.2% homosexual (0% bisexual). Menopausal women comprised 14.2% of the group with none having had surgical removal of the ovaries and none having had surgical removal of the uterus. Their self-rated level of sexual health was 85% on average, with a range of 75% to 100%. Their average relationship length was 12.0 years, ranging from 1.3 to 25 years.

Focus Group Two: Ages 60 Plus

The second group of seven women was convened from the potential pool of participants in the business club, continuing education class, Bible study, and the social club. Chapter III describes the recruitment process and rationale for selecting these groups. They met on February 23, 2007 from 3:00 p.m. until 4:30 p.m.; the setting is described in Chapter III.

Demographics

Seven women met at the second focus group. Their average age was 68.1, with a range of 62–79 years. (See Appendix G, Table 1: Participant Focus Group Information.) All of the women were white, 14.2% had a high school degree, 28.5% had a college

degree (none currently taking college courses), and 57.1% had a graduate degree (master's or doctorate). All reported their sexual orientation to be heterosexual. Menopausal women comprised 100% of the participants, 42.8% had ovaries surgically removed and 42.8% had surgical removal of the uterus. Their self-rated level of sexual health was 87.8% on average, with a range of 70% to 95%. Their average relationship length was 34.5 years, ranging from 15 to 46 years.

Focus Group Three: College (Less than 30)

The third group of women was convened from the potential pool of participants in a continuing education class and from the mailbox drop of flyers on campus. See Chapter III for a discussion on the recruitment process and rationale for selecting this particular group. The group met on Friday, March 16, 2007, at noon and ended their discussion at 1:20 p.m.; the setting is described in Chapter III.

Demographics

Seven women met at the third focus group. Their average age was 23.8, with a range of 23–25 years. (See Appendix G, Table 1: Participant Focus Group Information.) All of the women were white, 14.2% had a high school degree, 57.1% had a college degree, 100% were currently taking college courses, and 28.5% had a graduate degree (master's or doctorate). All the women reported their sexual orientation as heterosexual. Menopausal women comprised 14.2% of the group, none having had surgical removal of the ovaries or uterus. Their self-rated level of sexual health was 87.1% average, with a

range of 50% to 100%. Their relationship length mean was 2.8 years, with ranges of 0 to 7 years.

Analysis of Transcripts (Raw Data)

Focus group one (middle age women) elicited 98 responses to the questions: 7 to “What does being sexually active mean to you?”; 7 to “How do you define sexual well being?”; 17 to “How does the understanding of your body fit into sexual health?”; 11 to “Is there anything that you would like to add with respect to sexual function as it affects your sense of well-being or your sense of health?”; 7 to “If you are uncomfortable with or have questions about your sexual health, how do you feel about asking your health care provider?”; 7 to “How does self-esteem contribute to how you feel about yourself sexually?”; 14 to “How necessary is it in your relationships to have sexual feelings in order to desire sexual activity?”; 6 to “How important is communication with your partner to your sexual health?”; 7 to “How important is your partner’s understanding of you as a whole person. How important is that to your sexual health? Your partner’s understanding of you as a whole person?”; 6 to “How are you able to be your authentic self with your partner?”; 2 to “Does your sense of being sexually healthy allow you to be authentic in the rest of your life?”; 7 to “Can you feel like you can be your authentic self with your partner if you are in a healthy relationship, but does having a healthy sexual relationship and feeling sexually healthy does that enable you to be an authentic person elsewhere in your life or if you are not feeling like you have good sexually health does that impede or somehow restrict your ability to be an authentic person in your life?”

Focus group two (over 60 year old women) elicited 132 responses to the questions: 23 to “What does being sexually healthy mean to you?”; 12 to “It sounds like in listening to you all that the emotional intimacy is so important. Is there anything about communicating in intimacy that are really important to you?”; 10 to “We have talked about intimacy and communication with your partner, how important is your partner’s understanding with you as a person important to your sexual health?; 16 to “Do you feel like you can be your authentic self when you are with your partner?”; 8 to “How does your self-esteem contribute to how you feel about yourself sexually? How your self esteem impacts how you feel about yourself sexually?”; 17 to “How necessary is it for you to have sexual feelings in order for you to desire sexual activity?”; 10 to “Looking at some of the social relationships that you have, in which roles of the social roles that you have, and there have been transitions as your children have grown older, in which roles are you most confident in—not as intimate partners, but the rest of you?”; 10 to “How do these roles impact your sense of sexual health outside your intimate relationships? Your roles as grandmother, learning new ways of getting around?”; 15 to “If you are having some discomfort or uncomfortable with some aspect of your sexual health, do you feel comfortable talking to your doctor about it?”; 6 to “How does access to a health care provider make you feel about your sexual health and I have already heard, ‘not comfortable I feel rushed,’ but how do you feel? Do you feel you have access?”; 5 to “Anything else you would like to share that we haven’t touched on?”

Focus group three (college age women) elicited 115 responses to the questions: 8 to “What does being sexually healthy mean to you? Because we hear about people being sexually unhealthy or having sexual dysfunction, but what does being sexually healthy

mean to you, not what somebody has told you, but what you think?"; 5 to "How do you define sexual well-being? We talked about being sexually healthy and now how would you define a state of when you are feeling that you have sexual well-being or maybe you don't? How would you define that?"; 7 to "In exploring this a little more, how much do your roles in society—students, partners, wives, girlfriends, mothers (for those of you who have children), how much do your roles in society impact your sexual well-being?"; 4 to "Which roles do you feel most confident in society?"; 9 to "So how then does this status, your talk about being students, working and feeling like you are between two worlds here—how does that impact your sexual health when you are in this period of transition?"; 3 to "How is your self-esteem affected by what happens to you and how does it affect how you feel about yourself sexually?"; 6 to "How necessary is it to have sexual feelings in order to desire sexual activity? Several of you have said it is the last thing you can think about when you come home and still have to study?"; 4 to "How does the past affect your present sexual health or sense of sexual well-being?"; 8 to "How important is the sense of emotional intimacy with your partner to sexual intimacy?"; 9 to "So how important is communication with your partner to your sexual health?"; 5 to "How important is your partner's understanding of you as a person to your sexual health?"; 5 to "So how are you able to be your authentic self with your partner? If you are not currently in a relationship, reflect back on one that you were in"; 15 to "How does an understanding of your body fit into your understanding of your sexual health?"; 3 to "So how do you define sexual function based on what you know along with what you have been taught?"; 6 to "Does an understanding of sexual function contribute to your sexual health and well-being?"; 10 to "What about if you look at yourself as a patient if

something is not working for you in your sexual health or something is not working as it should be, how would you feel about taking this concern to your health care provider?"; 8 to "How does just having access to a health care provider make you feel about your sexual health?"

Initial Categories and Subcategories

The transcripts yielded a total of 345 responses to the posed questions across the three groups. Chapter III reviewed the process used for this coding: the transcripts were reviewed twice as the recording was played, entered into a two-column multi-row table with the left hand column for the verbatim transcript and notes from the observations of nonverbal behaviors; the right hand column for the coding, assignment of categories, and other interpretive notes. The rows were for each participant's statement. At the third reading, particular patterns, themes, concerns, or responses that were expressed (verbally and nonverbally) by the participants were identified (termed a "summary statement or word") and totaled 681. These "summary words" were then scrutinized for common features, and categorized and subcategorized using inductive reasoning and common language usage. For example, from focus group two (the over 60 age group):

I think it is sort of a learned thing too, as you get older. It is learning how to accept your feelings and learning to accept who you are. For me, I didn't have any experience. I went into marriage as such a naïve person and to think that my generation was so naïve and that we ended up doing okay. It is a miracle that it lasted. I think for me, it was learning together and it was such an important thing. I think sexuality as a sexual expression does get better as you get older for all of the reasons that we talked about before. All of the pressures that we have or lack there of, and also learning how to respond and what is pleasurable and those types of things.

This particular statement was given the “summary statements” of: learning to accept feelings, learning to accept self, a positive relationship was learning together, sexuality is better with aging, pleasure is better with aging. The summary statements and words were then categorized into common language using inductive reasoning. The above statement was categorized into “self concept,” “self awareness,” “relationship growth,” “maturity,” and “pleasure.” The total number of categories at this stage of data analysis was 156.

Categories were derived from common usage for various terms and words. For example: a category derived from the transcript analysis was “stress impacts sexual function.” Nuances of this for subcategories were considered for “conflict,” “emotional stress,” “life pressures,” “physical fatigue,” and “time demands.” Frequency data were obtained noting how often the item occurred within and between the focus groups. The transcripts yielded four frequencies of the specific category “stress impacts sexual function.” The subcategories of “conflict” yielded 1 frequency, subcategory “emotional stress” yielded 2 frequencies, “life pressures” yielded 10 frequencies, “physical fatigue” yielded 4 frequencies, and “time demands” yielded 7 frequencies. See Appendix G, Table 2: Focus Group Transcript Theme Discovery. Preliminary coding of the transcripts resulted in a possibility of 156 total categories/items with which to label the responses. I arranged the categories into 76 categories with 80 subcategories and nuances, similar to the prior description of categorizing the items from the statement regarding “self concept,” “self awareness,” “relationship growth,” “maturity,” and “pleasure.” The transcripts then were submitted to a frequency count; the item total tally from each focus

group, total count of notations, and the themes noted to emerge from the analysis is presented in Appendix G, Table 2.

Dominant themes began to emerge from the data and were noted to occur to the point of data saturation when they were easily recognized as having commonalities to other statements within and between groups, and/or they did not add further to the study findings. It is important to note that by the time the content analysis of focus group three began, there was saturation of the categories. At this point, the transcripts did not elicit

the frequencies of occurrence. Alphabetical listing of the 156 labels (76 categories in column one, 80 nuances in column two) occurred. Focus Group One, Two, and Three tally results were noted in columns three, four, and five, respectively. The total occurrence tally held the sixth column space. This allowed for evaluation if a specific item or nuance occurred more commonly in one age group versus another, and to determine frequent occurrence of a specific item within the topics discussed. The New View paradigm was used to frame the questions for the focus groups, but was not used as the paradigm for content analysis; prior sexologic research dimensions were also not used as the paradigm for content analysis. Grounded theory format for qualitative research analysis indicates that the items are to emerge from the raw data, not be forced into specific terms and categories (Glaser & Strauss, 1967).

Collapse of the Categories

The transcripts were evaluated and each participant's statement was labeled. To initiate this labeling, I posed a question that seemed to be answered by the statement. For example, a participant in focus group one stated, "I would have to say for me, it is lack of inhibition. Just like being able to totally experience something and not feeling held back in any way. I think that just feels like that is what is healthy to me." This was labeled as "are you able to be open and honest." After the initial coding, the labels or nuances were assessed for common features. Using the prior example, after the second reading of the transcript this statement was labeled as "able to be open and honest." As the three focus group transcripts were evaluated, it was apparent that certain themes or dimensions were emerging from these 156 different labels. Collapsing of the categories (Glaser & Strauss,

1967) occurred as saturation of the data was realized and commonalities were observed.

Using the example above, the label of “being able to be open and honest” was placed into the “authentic self” theme (Figure 7).

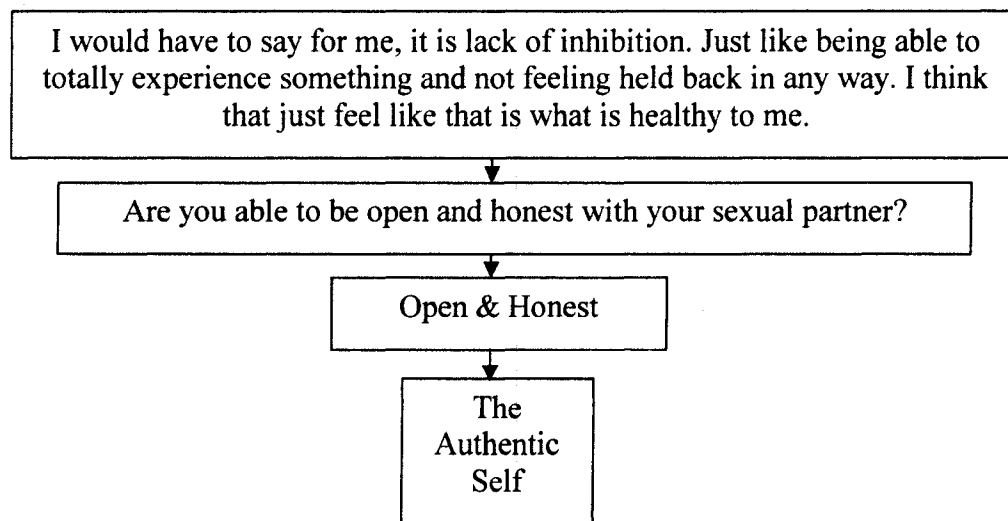


Figure 7. Collapse of statement to dimension.

The categories “authentic self,” “holistic self,” “important for me to claim myself as a sexual being and one with needs,” “journey: who I am in the moment,” “life,” “parenting,” “partner understands me, partner accepts me as a whole person,” “respect,” “self acceptance,” “self as me role,” and “role modeling” and their subcategories were evaluated to be representative of the dimension “*the authentic self*.” See section labeled “The Nine Dimensions” for further descriptors.

The categories “communication,” “in sync with partner,” “sharing of self freely,” and “time investment required for there to be a healthy sexual relationship” and their subcategories and nuances were evaluated to be representative of the dimension

“communication on a deep and intimate level.” See section labeled “The Nine Dimensions” for further descriptors.

The categories “anger,” “attraction must be present first before I can begin to share myself emotionally,” “body image,” “choice to claim health,” “comparison to other women,” “state of contentment,” “emotions,” “past experiences contribution,” “finding that male partners enjoy emotional intimacy,” presence of the state of “grief/tragedy,” “happiness,” “healthy feelings in self assessment,” “honesty,” “lack of inhibitions,” “feeling joy and fulfillment in everyday life,” the sense of “love—feeling loving and feeling loved,” “maturity” of the relationship(s), “sensitivity to partner needs,” “partner security,” refusing a partner who “wants only physical intimacy and not anything beyond sexual play,” “maintenance of privacy,” “respect for self,” presence of “romance,” “self awareness,” “placing self needs first,” “comfort and openness with the sexual self,” “stress impacts sexual function,” “time investment required in a relationship,” and that “role modeling occurs” were evaluated to be representative of the dimension *“emotional health.”* See section labeled “The Nine Dimensions” for further descriptors. Several of the categories, labels, nuances, and subcategories seemed to possibly fit into several themes. Returning to the prior example with the emerging theme of “authentic self,” the statement was interpreted to represent both “the authentic self” and “emotional health” and was tallied as such on the frequency table (Figure 8).

The categories “activity is part of a relationship,” “advances to partner,” “arousal,” “attraction to partner,” “moods linked to libido,” “hormonal link to sexuality,” references to “libido,” “lust” (as different from libido), “finding the partner attractive or likeable,” and “spontaneity,” and all the subcategories and nuances were evaluated by the

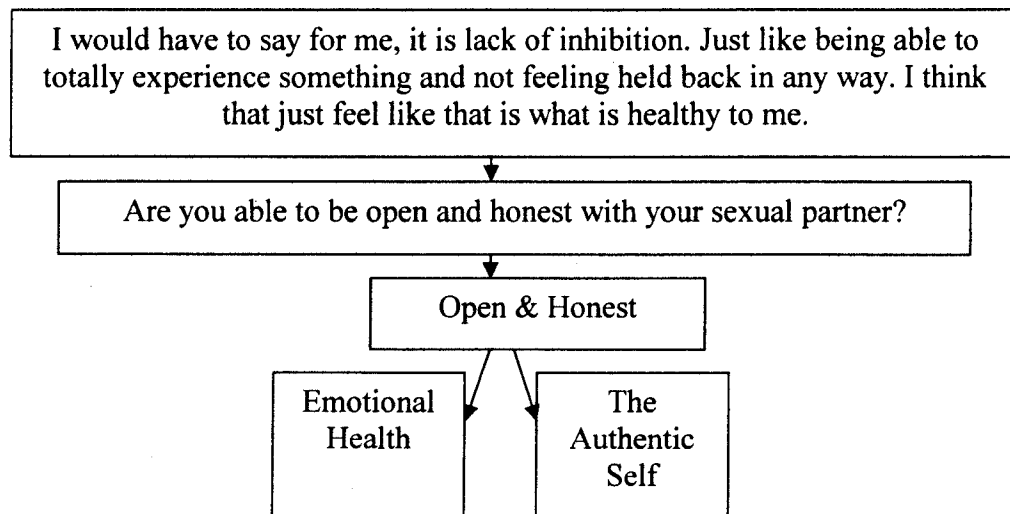


Figure 8. Collapse of statement to dimensions.

researcher to be representative of the dimensional theme *"frequency of sexual activity."*

See section labeled "The Nine Dimensions" for further descriptors.

The categories "body language: sexy play," "creativity" and "sexual fantasies," "hormonal link to sexuality," "lust as differs from libido or attraction to partner," "orgasm sexual pleasure or enjoyment," "I like my partner / find them attractive," "partner is sought for sexual play only and not needed for a companion," "romance," "satisfaction or satiety for sexual needs," "self pleasure or sexual fulfillment," "sexual activity outside of intercourse is acceptable and pleasurable," "spontaneity," "role modeling," and "technique" were evaluated by the researcher to be representative of the dimension *"presence of sexual pleasure."* See section labeled "The Nine Dimensions" for further descriptors.

The categories of "guilt sex done for partner benefit or to pacify partner," "intimacy with partner changes over time and this enhances sexual experience," "the

sense of feeling loving and feeling loved,” “maturity,” “openness with partner and with self,” “partner interest in self outside of sex—is my friend,” “partner awareness of needs,” “partner exhibits caring behaviors,” “partner security in the relationship,” “partner refused who will not go beyond the physical and only wants the sexual play,” “partner support,” “partner understands me as a whole person,” “relationship,” and “time investment is required for there to be a healthy sexual relationship” were evaluated to be representative of the dimension “*relationship health*.” This thematic dimension became a strong component of each focus group’s transcript and was discussed heavily by each participant in the study. The interpretation of this dimension and applicability to further studies are reviewed further in Chapter V: Discussion.

The categories of “body awareness (knowledge) and sex education,” “dysfunction (for self and for partner),” “maturity,” “STD awareness and avoidance,” “sense of safety with partner,” and “comfort and openness with sexual identity,” with subcategories and nuances were representative of the dimension “*absence of discomfort*.” See section labeled “The Nine Dimensions” for further descriptors.

The categories of “health care provider needs to be attentive to needs and importance of sexuality,” and “health care provider experience as positive and confidential” were evaluated by the researcher to be representative of the dimension “*significance of a positive health care provider relationship*.”

The categories of “comparison to other women,” “the joy of being a woman,” “friendships present and valued in life,” “the journey of who I am in the moment,” and “teaching others what is needed in a healthy relationship through role modeling” were

evaluated by the researcher to be representative of the dimension *“sisterhood: valued and appreciated for the journey.”*

As stated before in our example of how a specific participant’s input was labeled, categorized, and then assigned a theme, several categories and nuances fit several potential dimensions. As a further example of the thought process used to label, categorize, and tally results, the category “time investment is required for there to be a healthy sexual relationship” fit the dimensions of “communication on a deep and intimate level,” “emotional health,” “relationship health,” and “the authentic self.” Multiple categories and subcategories or nuances from one statement were often determined. A participant responding to the moderator posing “what does being sexually healthy mean to you” responded with “I would say it is respecting yourself, respecting your own body and not feeling any type of need of pleasing someone else.” This was categorized as “respect,” and “no need to please others/self needs primary.” These categories were then evaluated to belong to the dimensions of “emotional health” and of “authentic self.”

In response to the moderator question of “how do you define sexual well-being” an insightful response occurred that was placed into multiple categories, nuances, and subcategories. The participant said:

For myself, it is more a personal journey. With a history of sexual abuse as a kid, I had to be comfortable with the sexuality with myself and really identify what I wanted to be with, who I wanted to be with. I struggled with my sexual identity for years. I finally made a decision and stuck with it so sexual health and that type of thing was definitely something I had to address on my own before I could find the right partner and be able to identify and practice healthy sex with her.

Categories and subcategories that this response fit were “comfort with sexuality,” “comfort with sexual identity,” “comfort with self before seeking a partner,” “journey,”

“sexual identity comfort and openness,” “sharing of self freely,” and “relationship identity.” The dimensions to emerge from this categorization were evaluated to be: “the authentic self,” “emotional health,” and “absence of discomfort.”

The Nine Dimensions

The Authentic Self

Statements that indicated that women felt free to be themselves, no holds barred, free to express themselves emotionally, physically, and intellectually with others in their life experience were placed in the theme “the authentic self.” A participant from focus group one (middle aged women) said:

I think there is another element of me being able to look at myself in a mirror and I can be healthy about who I am right now and to say that I can love me for who I am right now and that is going to affect how I look at anyone else around. Whether it is male, female, husband, child and if I am crabby about things it is going to spill over to other things in my life. But if I am happy with me, granted things might work out. But if I am happy with who I am, where I am at in the process and love me for me, that is going to who I am right now.

Further in the conversations of the middle aged women’s focus group was the following statement:

You honor each other’s individuality. That is what is going to make the good sex, because you are honoring each other for who you are, so that is that wholeness. I think that might be the key and then to communication what those things are. They go hand-in-hand.

Another participant in focus group one felt that to define being authentic meant

Nothing unsaid and nothing undone. I was able to get it to a deeper level of communication with that person [a new love] and a deeper understanding of who he was and for him to have a deeper sense of who I was than in 31 years of marriage [prior love]. I think there is a part of me that the older I get, the less time

I have for the nonsense stuff. Age has lent some aspect of being authentic. I just don't have time not to be.

This participant verbalized that to be nonauthentic was to be nonsense. To be true to self and true to partners allowed her to share a deeper sense of who she was. Another participant also captured this same feeling when she expressed: "Don't you think that part of women's sexuality is that you have to be comfortable with yourself, because you cannot be comfortable with someone else until you are comfortable with yourself."

In response to the questions about authenticity, a woman in the over 60-year-old group said, "I think it builds a stronger multifaceted you, that directly impacts your sexual health. To me, those roles just become a part of you and make you a stronger person."

When the same questions about authenticity were posed to the college age women, the response was:

It takes time to establish that and show your authentic self and for you being able to fail in front of them and knowing that they are still there. It takes instances of that to realize that the person loves you unconditionally. It just takes time.

Another college age participant summed up her feelings about the importance of being authentic with their partner(s) as the following: "I am guilty of it. I have slept with people that did not know my authentic self at all and you get mad at them for it."

Communication on a Deep and Intimate Level

A recurring theme that occurred across all age groups was the importance of communication. Indeed, this topic alone elicited significant discussion. The transcripts were evaluated closely to separate out "relationship health" from "communication." Examples of statements that led to this dimension emerging from the data are:

We have found communicating not just about sexual things, but just communicate. When he came on board, I tell you, that was a turn on to me. I am telling you, because he was so willing to sit down and understand that was going on and you were willing to take the time and you were willing to figure this out with me, what do you want? I am yours! He was like, this was easy. But when you take the time to communicate about all the stuff, not just what I am feeling sexually, it is so important, that we can talk about the kids, we can talk about the budget, we can talk about things that are going on, sitting down with our calendars means so much to me, because we are trying to be on the same page. Communication is so huge. (from focus group one)

Other women in focus group one were quite adamant to support the following:

“You can’t really honor the whole me without being able to communicate.”

Participants in the college age group were able to differentiate that a relationship without communication is simply physical, those relationships that have communication have substance: “If you don’t communicate you do not get the emotional attachment which can then affect everything. . . . Or you just end up having a sexually-based relationship that has no other substance. That can leave you feeling empty.” The women in the over 60 age group were not differentiating in their responses relationship health from communication. Their responses could be indicative of the maturity of the relationship, and is discussed in Chapter V.

Emotional Health

Across all three age groups, the participants noted that it is important to be emotionally healthy when feeling sexually healthy. From focus group one:

If I feel good about myself, it is easier to feel good about my partner about sex and about sharing myself with my partner, because I feel good about myself. I think there are times when learning how to transition and this year especially making a transition between work and home. Finding that place to leave that mind there and transition into the happy me. I think it is a truly happy thing and it really is, but is getting to that place where the self-esteem is really good for me.

This participant found that when she was able to “transition into the happy me” that impacted her self esteem and translated into increased sharing with her partner.

Other women in focus group one responded that joy in one area of their life spilled over into others: “I think if you are to have joy, if there is some part of you that you are not feeling fulfilled, it is going to affect every other part of your body.”

This was echoed in focus group two, when reporting that how you feel about yourself and your relationships affects your sexuality:

I think that sexuality is more than sex. I think it is the whole makeup of how you relate to people both women and men and that I like to feel good about myself as a woman and not that I have to work harder because I am not a man and all of that. I hear a lot of my friends “man bashing” all of the time and I have never felt the need to bash men a lot. I grew up in a large family with brothers and sisters, so for me, sex is a big part of a relationship and there are ups and downs in it when you have been married 40 years and there are times when you don’t feel as good about each other or about yourself as you would like that can cause some problems in your sexuality.

The college age participants verbalized the importance of self-esteem, but from a slightly different paradigm. They equated a low self-esteem with unhealthy sexual behaviors:

I think a lot of times, but not specifically in school, when you have low self-esteem from something else you sometimes can practice unhealthy stuff—like looking for love in all the wrong places is so characteristic I think especially with girls in high school or early in college, because they do have low self-esteem. You are in college, you are in this new place and you think you are gaining the freshman 15, so you are going to go have sex with some football player who is going to use you, but you are going to feel better maybe for a day. And I think self-esteem probably has a lot to do with it, even though our schedules would not allow for something like that. Like, she said, low self-esteem when you do badly on a test you feel like crap, you think you are stupid and I am gaining weight from this program and I feel like crap and my butt is bigger than it used to be. You don’t feel like having sex if you feel fat. I think it has a big effect.

Frequency of Sexual Activity

When discussing frequency, the topic would include aspects of libido and desire.

From focus group one (the middle aged women):

I always feel like if I am not in the mood, I can get it going. You know, staying in the right frame of mind or putting myself in the right frame of mind. I know I love it and I enjoy it. Sometimes I find myself having a conversation with myself, ummm I am not really in the mood. I talk myself into getting in the mood and having all of these things to do and then just to let go and am always making the list, I have to return that, be here right now and enjoy and love and it is okay and I am going to share myself with my partner and share each other.

This particular participant's response was quite animated, which is hard to carry across in this transcript. She implied with her nonverbal behaviors and conversational tone a delight with sexual activity once the libido was revved up.

It was enlightening to hear the second focus group (over 60-year-olds) discuss the escalating desire for their partners:

The second marriage . . . I have to admit that it was pretty doggone nice in all kinds of ways. We were so together night and day, because he had retired, I had retired. He was 14 years older than I and definitely sexually active. And it was a joy. I mean there was never any problem. We didn't have kids, we were both retired, we traveled, we had new friends and so experiences can make a big difference. I actually enjoyed sex a lot more the second time around. Not that it was not as passionate or anything like that, but I was ready for it.

The women in focus group two acknowledged the change in hormonal surges (classified as lust in the transcript evaluation) but also verbalized the importance of intimacy despite a change in the physical drive: "I think sexual activity is very important in a marriage, but when the hormonal surges isn't there, there is the desire for that intimacy."

Focus group three, the college age participants, discussed that their libido was impacted by attraction to their partner, fatigue level, and how full that their schedule was. They acknowledged that their libido was an important part of feeling sexually healthy. “Another thing too is sometimes people just want it then and there and I just cannot go have sex on the staircase because I want to . . . technically, though I guess I really could.” Later on in the discussion, another participant acknowledged that her libido was lagging behind her partner, but she enjoyed having sex often:

I think that is the ideal, but it is not the reality. For me, sometimes I won't have sexual feelings but I will still have sex because I love him and because I need to fulfill his needs, and that is part of my role. It is great to always have sexual feelings, but that is just not going to happen and I am okay with it and I love him, so it works.

Presence of Sexual Pleasure

None of the focus groups specifically discussed physical pleasure using the term “orgasm.” It was often framed in words like “pleasing the partner” as noted in the following: “I like that word balance. That if you are in tune with each other or in sync. I will know what my partner wants and how to please him and he knows how to please me.”

A participant in focus group two verbalized the following when discussing her amusement at her physical pleasure derived from sexual activity:

It seems strange to me that I feel I enjoy sex. I have always enjoyed sexual relations with both of my husbands and I had not had any other experiences with any other men, but it is something that I am not sure is true of just my generation, or my age group or not, that is something that we never discussed outside of a relationship.

Another participant in focus group two (the over 60-year-olds) talked about missing physical pleasure from her relationship, and her statement to follow began a round of discussions on self loving/masturbation:

I certainly miss it, so I have learned to take care of myself. I think it is very important. I like to feel that is part of who I am and I thank God, this is wonderful that you have been able to give me this level of fulfillment that I can work it out by myself, so it works out just fine. I would feel that I was missing something. I would feel that if I couldn't get it from a husband or spouse that I am not willing to get it from someone else, I am just very happy that I can do it for myself. It is a blessing.

A respondent from focus group one replied to a question about sexual health that her pleasure came from a give-and-take relationship:

I think there is an aspect of giving from both parties. If I am so intent on just taking from the relationship under the umbrella of sexuality, then I am going to be frustrated and hurt, because I will not always get what I want maybe, but if I am in the mode of giving and what is pleasing for my partner, then there is a healthiness there that goes both ways.

The respondents from focus group three felt pleasure was possible once there was awareness of anatomy. "I think it is wanting to have sex and the difference between the want and being able to perform [achieve orgasm] is two big things that we have learned." Her fellow participant echoed this with "I think some girls and some guys do not know what a clitoris is. That is kind of the good spot to hit. When you find it, it is like, oh, yeah."

Relationship Health

Across all three focus groups, there was acknowledgement and affirmation of the importance of being in a healthy relationship. A woman in focus group one summed up what was reiterated over and over:

I know for me, that my husband's acceptance and his words of encouragement to me are so important and they help me so much. I think back over my journey and I was a whole lot [more] conservative when I was younger and I contribute a lot of that to my husband's acceptance of who I am and his loving me, encouraging me, and telling me that I look great, when I don't feel great or just saying words of love and encouragement that is kind of like, okay fine, let's just have fun in this journey and so he is a huge factor to where my healthy self-esteem is now. He could pull it right out from under me, he could, but I am not anticipating that and again it comes back to me encouraging and uplifting him and I get this wonderful thing in return, I do feel wonderful for him in turn, it is the couple, it is the journey together, but he is a huge factor in my self esteem.

Another response in focus group one verbalized the joy at finding out new and different things about her partner as the relationship matured: "Oh, my goodness, there are so many layers to both of us and we keep finding them." One of the other participants felt that relationship health meant being able to keep parts of yourself private and that a healthy relationship honors the desire to have some separateness:

I see boundaries as a picket fence that you need to hop across rather than a brick wall completely shutting people out. That you only convey that to someone that understands. I am willing to meet you there and about where the common ground is and I feel that I am being understood as a whole and then I can give of myself without feeling threatened or compromised in any way.

The women in focus group two, the mature women, verbalized repeatedly the importance of a growing and healthy relationship with their sexual partner. This response sums up many expressed feelings:

I think the actual sex is a small part of the relationship, an important part, but it is also the companionship and all that goes with that, so I am sure that we age with that waning there are other ways that you experience intimacy. Absolutely.

I found it interesting to compare the responses of focus group three (college age) with the predecessors, notably because of the brevity of their relationships. They would equate emotional intimacy with maturity of the relationship:

If I am not feeling loved by Josh or respect or if he is neglecting me, then the last thing I want to do is to have sex with him. So, I think it [emotional intimacy] is really important, and I will tell him that it is really important to me.

Participants in focus group three also equated being understood for the whole person with relationship maturity and health:

I think it is important for your partner to understand you as a whole so that they don't disassociate you with just the sex part—you have to be able to go out in public. It is not like just the sex in it. If your partner does not understand who you are, then why are you even having sex?

Absence of Discomfort

By and large, the three focus groups moved quickly away from a discussion regarding the dysfunctional aspects of sex, and talked about health in very positive terms: “Just a healthy respect for myself. Being healthy in my own skin” (from the first focus group).

A second group participant verbalized that for her, absence of discomfort or dysfunction meant that they were able to find other ways to enjoy physical intimacy despite a serious health issue that led to erectile dysfunction: “In my case, my husband had prostate cancer and they saved one nerve, but without medication it is difficult, but we have found other ways.”

The third focus group (college age women) was able to articulate that being sexually healthy (free of discomfort) meant free of emotional discomfort, along with being free of disease or disability:

I think being sexually healthy means having sex for the right reasons. I think along with that just having comfort in what you are doing—not feeling maybe guilt about what you are doing. Just feeling comfortable in your sexuality and knowing your own boundaries.

I also think being safe with it. You know like planned pregnancies, unplanned pregnancies and having sex with someone with the right timing and being safe and careful. . . . Probably doing it because you want to, not because you are feeling pressured or because your friends are or because everyone around you is—yes, a healthy reason for doing it.

Significance of a Positive Health Care Provider Relationship

Women from focus group one felt that a “good” health care provider was about how long the provider had been doing women’s health care: “It is who you find and how long they have been doing it and how well they have been doing what they are doing.” Others in this group felt it was about how they as patients related to their providers: “So how about we learn to interview our health care practitioners to see if they are meeting the needs that we would like to see.”

Women from the over 60 group (focus group two) verbalized that it was their right to demand help for sexuality:

I realize physicians run on a schedule, and they have X amount of time, but doggone it, you are talking about me and if I am paying for it and I have concerns on my mind that I want to discuss with you, and it takes a half hour to do it, too bad.

Another participant further defined what they needed from their provider or practitioner:

I think they have to do more than listen. They have to have the skills to know how to help you or what resources, that is what I am saying, I don’t think in sexual health so very many, but now you’re saying yours would? But in my experience there are not many who would feel comfortable if you would lay a question on them that they could respond to.

The participants in focus group three were in university courses in health care fields. Their responses were often from the point of a clinician seeking advice for other clinicians on how to care for women with sexual health needs differently:

In someone that has never gone to see a practitioner probably isn't going to want to make their first entrance with, I have something going on down there versus if you have a good relationship with a practitioner you are more likely just to make an appointment and go in, but if you don't have that relationship that would probably be really awkward and hard. How do you meet a new patient with this is my first visit and this is my intimate problem?

Sisterhood: Appreciation for the Journey

Most of the women's responses about this dimension emerged from discussions on understanding of their bodies, and how they learned about being healthy sexually: "I learned from my sister's friends and so I can talk to her and she talks with me freely" (from focus group one).

Across all focus groups, women expressed the value that relationships with other women brought to their world, and how those friendships enriched their lives: "I think with age comes a lot of wisdom and through having some of the good friendships that I have now, I have had several discussions similar to this with my friends and talking about authenticity."

Women from focus group one talked about how they felt the importance of maintaining their friendships, despite having a sexual partner:

Also, again, the older I get and the closer that I have friendships with my women friends, I really enjoy those friendships and I value them so much and I am not giving them up and I don't know, maybe I enjoy them too much.

And some women verbalized that they felt more intellectually and emotionally linked to their female friends: "I feel like I am more authentic outside of my relationship with him. I feel like I am more authentic with my parenting, with my work, with school, with my friends, because I do have the issues here."

Women in focus group two talked about the “sisterhood” dimension from the aspect of being role models to other women in their lives such as daughters and granddaughters:

I feel as I get older that the impact that all of us have as we season, of being role models. I don't think “Jo” realizes how much of a role model you are for so many people and your grandchildren too. I think that helps with self-esteem and probably helps to propel us into doing things that we wouldn't do, when we would just sit in a chair and feel sorry for ourselves today. I think that probably is a big role that we have now.

Some other women recognized that they were different with their female friends than they were with their sexual partners: “I was thinking that I really truly think I am my authentic self with my husband, but that is not the authentic self that I am with my women friends.”

The college age women saw their role as educators and guides for other women; I suspect a not uncommon occurrence for those in the health care fields: “A lot of women do not know their own anatomy.” They also expressed that helping other women understand their sexuality may have an impact upon some other dimensions of sexual health such as unplanned pregnancies or sexually transmitted infections:

Uneducated girls that are not ready are getting pregnant and I think it is like a vicious cycle. They are uneducated and they don't know very much about their self, sexuality or their bodies and they are going to have children and not educate them and it is just like this really vicious, vicious cycle.

Still others in the college age focus groups noted that part of being in the “sisterhood” was helping other women feel good about themselves as sexual creatures:

They teach you as a woman, that I have always felt embarrassed of my body. I am embarrassed that I am getting boobs and all that stuff. You shouldn't be embarrassed and maybe that is something that we need to take into account with girls that don't be embarrassed that you have huge boobs, which is fine. You are pretty.

Summary of Phase One

The research questions answered by Phase One of the study were: *What is the meaning of the concept female sexual health to a group of women? Can attributes of sexual health be identified through dimensional analysis? Are there differences in the attributes by age, race/ethnicity, education level, menopausal status, relationship status?*

The concept of female sexual health stems from a universal sentiment: a germane interest in a woman's authentic self promotes sexual health. Women also relied upon the presence of other women in their lives to enhance their sense of well-being, to mentor, or to turn to in need. A positive health care provider relationship was important as a supportive measure to the women in the focus groups. The women in the group of college age participants expressed more often statements regarding libido and pleasure; as the age of the participants matured, more comments were received about the quality of the relationship, and how important it was for their partner to respect themselves as authentic women.

What are the dimensions related to female sexual health to emerge from this analysis? Nine dimensions emerged from the analysis of the first phase. Female sexual health is made up of the dimensions "the authentic self," "communication on a deep and intimate level," "emotional health," "frequency of sexual activity," "presence of sexual pleasure," "relationship health," "absence of discomfort," "significance of a positive health care provider relationship," "sisterhood: valued and appreciated for the journey."

How does the FORD mnemonic relate to the dimensions discovered in the qualitative analysis? The FORD mnemonic was a part of the dimensions to emerge from

the analysis: F for “frequency of sexual activity,” O for “orgasm/presence of sexual pleasure,” R for “relationship health,” and D for “absence of discomfort.”

Phase Two: Instrument Development and Testing

Placing the Dimensions Into the Instrument

After the content analysis and an understanding of the dimensions to emerge from the transcript, writing the pilot instrument was completed. In preparation for this stage, I returned to the focus group transcript’s initial evaluation and the questions I had written previously to the typewritten comments (see focus group transcript analysis section). Using the prior example, to the participant’s statement of “I would have to say for me, it is lack of inhibition. Just like being able to totally experience something and not feeling held back in any way. I think that just feel like that is what is healthy to me,” I formed a question of: “Are you able to be open and honest with your sexual partner?” This question was not framed in a neutral manner. Other instruments for clinical research were reviewed (Frank-Stromberg & Olsen, 2004) for ideas on previously psychometric tested questions. As none were found specific to this item, a question was framed, “To what degree are you able to express yourself to your partner?” This question was critiqued by several individuals to be vague and not indicating the dimensions of “the authentic self” and “emotional health.” Dillman (2007) has several principles that assisted in the development of the questions for the draft instrument: use simple words, don’t be vague or lengthy, be specific, avoid bias, and avoid objectionable questions. Several potential questions were developed from this guidance. The draft instrument asks: “Using the

following scale: place an X on the line over the number rating your ability to communicate your desires and needs. To what degree are you able to express yourself with those whom you love?" "In general I feel that I am respected by my partner for who I am." "In general, I am able to communicate on an emotionally deep and intimate level with my partner when appropriate." The following schematic (Figure 9) demonstrates the process of developing the questions from the original transcript.

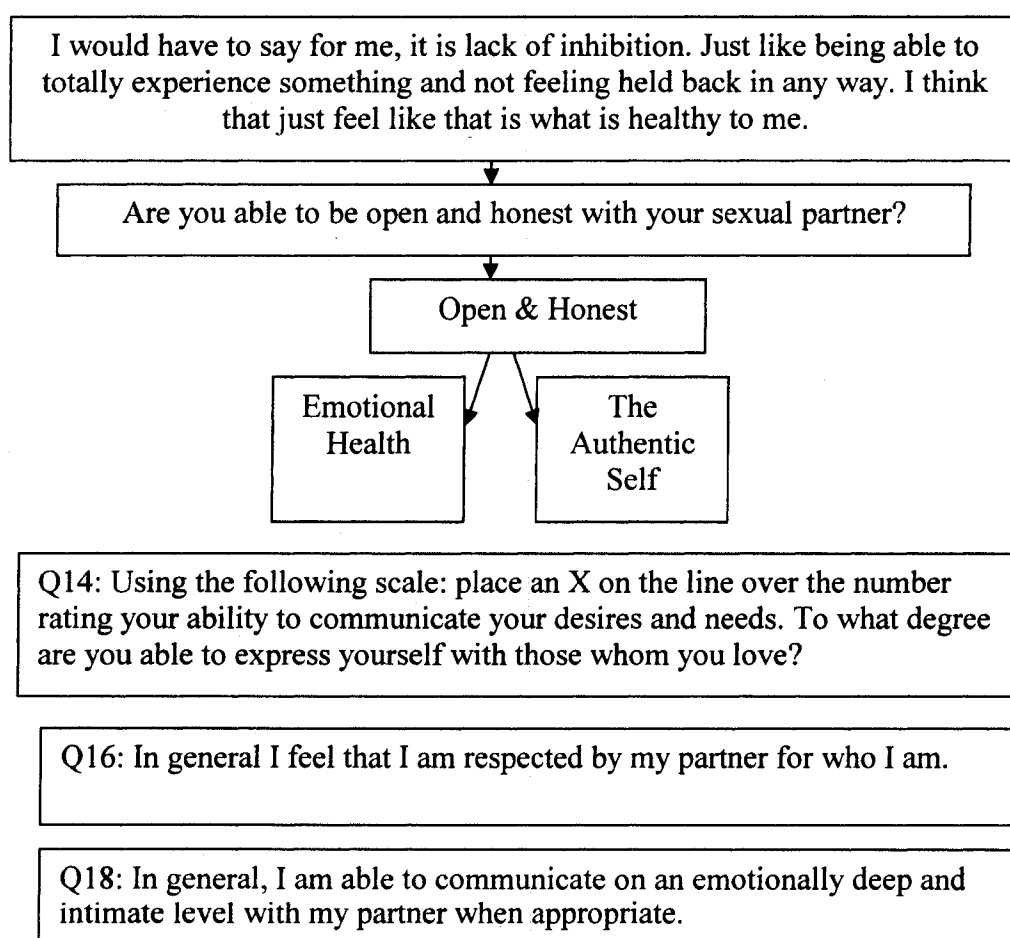


Figure 9. From statement to dimensions to questionnaire.

All of the dimensions were addressed by the pilot instrument using objective language and a visually appealing format (see Appendix E). The above process of reviewing the transcripts and notations, using the original questions and comments, and the terminology used in the focus groups (Frith, 2000) helped to frame the 37 pilot instrument questions.

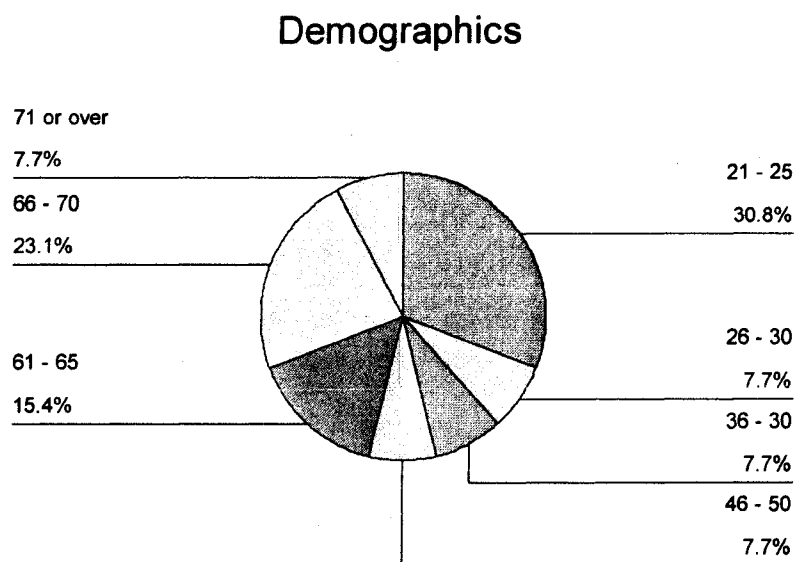
Testing the Pilot Instrument

The pilot instrument was reviewed by my dissertation chair for readability and consistency, then sent to the 21 focus group participants for their insight and further data collection. The draft instrument was also sent to experts for face validity insight. Dr. Laura Berman, Dr. Leonore Tiefer, Dr. Cindy Meston, and Dr. Hani Miletski were all sexology experts that offered to provide insight regarding the instrument. Dr. Nan Lackey, an expert in development and testing of instruments in health care research, also offered to provide insight into the instrument.

Test Results of the Pilot Instrument

Thirteen of the 21 (61.9%) surveys mailed were returned for analysis. Ages 21–25 had four (30.8%) respondents, one each (7.7%) in age categories 26–30, 36–40, 46–50, and 71 or over; two (15.4%) in ages 61–65; and three (23.1%) in ages 66–70 (Figure 10). All of the respondents answered “white” as race; eight (61.5%) answered “non Hispanic or Latino,” one (7.7%) responded as “multi-ethnic,” two (15.4%) were “other,” and two (15.4%) did not answer. Educational background was reported as two (15.4%) for “college in Technical or Associate’s degree,” two (15.4%) as “Bachelor’s degree,” six (46.2%) as “Graduate (Master’s or Doctorate) degree,” and three respondents (23.1%)

chose multiple answers (Figure 10). Seven women (53.8%) were “still menstruating”; six women (46.2%) were not. Of those women who were no longer cycling, three (23.1%)



Education Background Pilot Instrument Participants

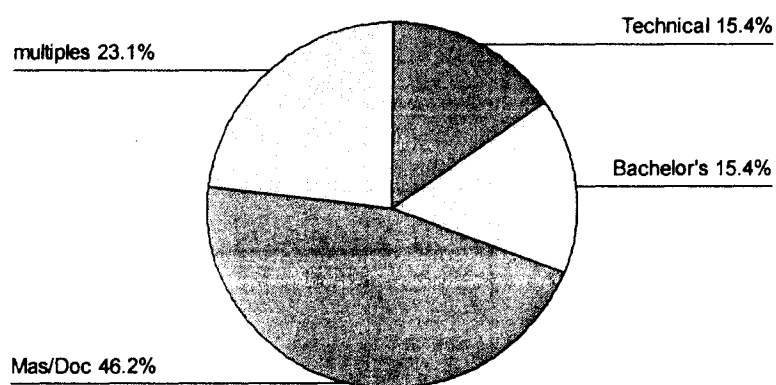


Figure 10. Demographics of pilot instrument participants (age, education).

had a “natural menopause” and three (23.1%) had a “surgical menopause”; one did not answer. Nine women (69.2%) had their ovaries; four (30.8%) had experienced oophorectomy. Sexual experience was noted as “entirely heterosexual” by twelve (92.3%) of the respondents, and “largely heterosexual but some homosexual experience” by one (7.7%). Eleven respondents (84.6%) were “currently in a sexual relationship” and two (15.4%) were not. Relationship length ranged from 6 months (one respondent) to 44 years (one respondent); two women (15.4%) had been in a 2-year relationship; one each (7.7%) responded with a relationship length of 2 years 6 months, 6 years, 24 years 10 months, 26 years, 33 years, 40 years, 43 years, and 44 years. Four women (30.8%) had been in a past sexual relationship, two (15.4%) had not, five (38.5%) did not answer, and two (15.4%) answered the question inappropriately. The past relationships varied in length from 4 years (15.4%) to 44 years (7.7%); one respondent had a past relationship of 9 years, one of 31 years, and one of 40 years.

The pilot group self-rated their personal level of sexual health in the range of 70 to 100%, with one (7.7%) at 70%, one (7.7%) at 80%, one (7.7%) at 85%, seven (53.8%) at 90%, and three (23.1%) at 100% sexual health levels (Figure 11).

The self-rating of the authentic self: the ability to express self to those who love you was rated in the range of 40 to 100%, with one (7.7%) respondent each answering 40%, 60%, 65%, and 70%. Three respondents (23.1%) self rated their authentic self at 80%, four (30.8%) at 90%, and one (7.7%) each at 93% and 100% (Figure 12).

“In general my relationship is a positive part of my life” was “strongly agreed” to by nine (69.2%) of the participants, two (15.4%) agreed with this statement, one (7.7%) was neutral, and one did not answer (Figure 13).

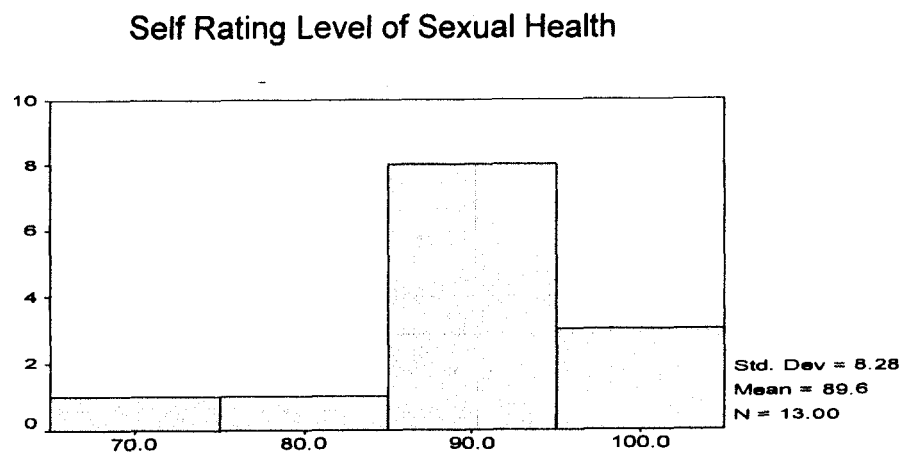


Figure 11. Draft instrument self rating female sexual health.

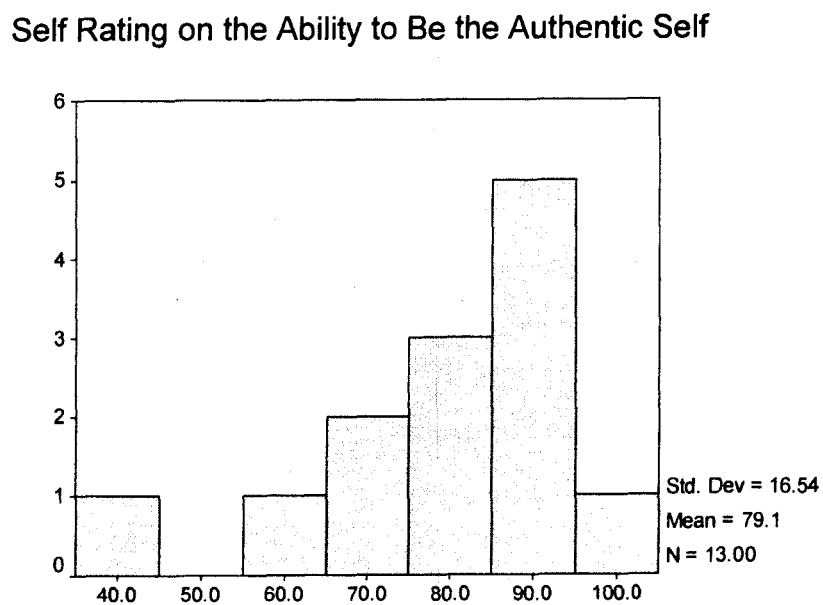


Figure 12. Draft instrument self rating the authentic self.

Relationship is a positive part of my life

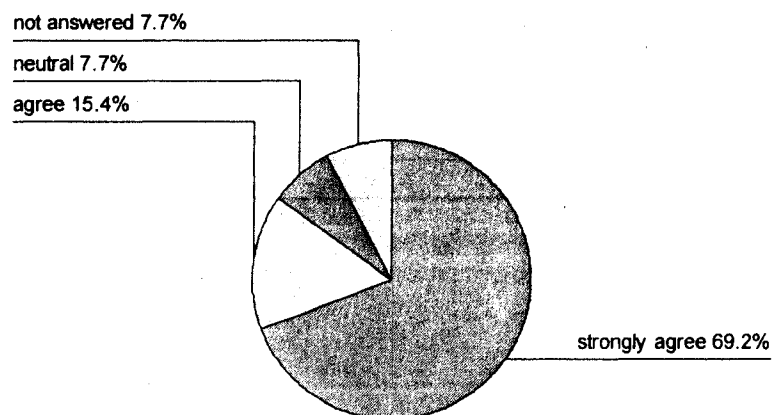


Figure 13. Draft instrument relationship rating.

“In general, I feel that I am respected by my partner for who I am” was “strongly agreed” to by eight (61.5%) of the participants, “agreed” to by three (23.1%), “disagreed” to by one (7.7%), and not answered by one. “In general I find it easy to communicate with my partner” was “strongly agreed” to by six (46.2%), “agreed” to by five (38.5%), “neutral” by one (7.7%), and not answered by one (Table 2). Five participants (38.5%) “strongly agreed” to the statement “In general I achieve emotional pleasure from my sexual relationship, four (30.8%) “agreed,” three (23.1%) were “neutral,” and one did not answer. “In general I am able to communicate on an emotionally deep and intimate level with my partner when appropriate” was “strongly agreed” to by six (46.2%), “agreed” to by five (38.5%), “disagreed” to by one (7.7%), and not answered by one (Table 2). Four women (30.8%) “strongly agreed” with the statement “In general, I am able to communicate my sexual needs to my partner,” eight women (61.5%) “agreed,” and one

did not answer. "In general, my partner and I are equally matched regarding the frequency of our desire for sexual intimacy" was "strongly agreed" to by one (7.7%), "agreed" to by eight (61.5%), "neutral" by three (23.1%), and not answered by one (Table 2). One (7.7%) felt that the "frequency of my sexual activity with a partner has been less than what I desired," ten (76.9%) felt the frequency was "as much as I desired," one (7.7%) felt frequency was "more than I desired" and one did not answer (Table 2).

Nine respondents (69.2%) strongly agreed to the statement that "in general, having my emotional needs met by my partner assists in arousing me for sexual intimacy," three (23.1%) agreed with that statement, and one did not answer (Table 2). Four respondents (30.8%) "strongly agreed" to the statement "in general, my desire for sexual activity is linked to my mood, eight (61.5%) "agreed" to the statement, and one did not answer. Six (46.2%) "strongly agreed" to the statement "in general, I have found that as a relationship matures, my sexual satisfaction increases," four (30.8%) "agreed," one (7.7%) was "neutral," one (7.7%) "disagreed," and one did not answer (Table 2). Six respondents (46.2%) "strongly agreed" to "I achieve physical pleasure from my sexual relationship," five (38.5%) "agreed," one (7.7%) was "neutral," and one did not answer (Table 2). All of the respondents agreed affirmatively to "I have a positive view of my self," with six (46.2%) "strongly agreeing" to the statement, and seven (53.8%) "agreeing" to the statement (Table 2).

Six (46.2%) women placed the "importance of sexual activity in their life" as "very important," four (30.8%) placed it as somewhat important, one each (7.7%) placed it in the categories "neither important nor unimportant," "somewhat important," and "not at all important" (Table 2). Nine women (69.2%) "strongly disagreed" that "emotional

Table 2

Pilot Instrument Results

Question	Response	Frequency	Percent
In general, my relationship is a positive part of my life.	Strongly agree	9	69.2
	Agree	2	15.4
	Neutral	1	7.7
	Not answered	1	
In general, I feel that I am respected by my partner for who I am.	Strongly agree	8	61.5
	Agree	3	23.1
	Disagree	1	7.7
	Not answered	1	7.7
In general, I find it easy to communicate with my partner.	Strongly agree	6	46.2
	Agree	5	38.5
	Neutral	1	7.7
	Not answered	1	7.7
In general, I am able to communicate on an emotionally deep and intimate level with my partner when appropriate.	Strongly agree	6	46.2
	Agree	5	38.5
	Disagree	1	7.7
	Not answered	1	7.7
In general, I am able to communicate my sexual needs to my partner.	Strongly agree	4	30.8
	Agree	8	61.5
	Not answered	1	7.7
In general, I have found that as a relationship matures, my sexual satisfaction increases.	Strongly agree	6	46.2
	Agree	4	30.8
	Neutral	1	7.7
	Disagree	1	7.7
	Not answered	1	7.7
In general, I achieve emotional pleasure from my relationship.	Strongly agree	5	38.5
	Agree	4	30.8
	Neutral	3	23.1
	Not answered	1	7.7
In general, I achieve physical pleasure from my relationship.	Strongly agree	6	46.2
	Agree	5	38.5
	Neutral	1	7.7
	Not answered	1	7.7
I have a positive view of my self.	Strongly agree	6	46.2
	Agree	7	53.8
Overall, how important a part of your life is your sexual activity?	Very important	6	46.2
	Somewhat important	4	30.8
	Neither important nor unimportant	1	7.7
	Somewhat not important	1	7.7
	Not at all important	1	7.7

Table 2—Continued

Question	Response	Frequency	Percent
In general, I am able to manage the stress or demands of my life.	Strongly agree	5	38.5
	Agree	7	53.8
	Neutral	1	7.7
I have a support system of other women in my life.	Strongly agree	9	69.2
	Agree	4	30.8
My HCP needs to be aware of the importance of sexuality in my overall health and well being.	Strongly agree	2	15.4
	Agree	9	69.2
	Disagree	2	15.4
How important is it for your HCP to discuss if you are satisfied with the FREQUENCY of your sexual activity?	This question is:		
	Very important to address	1	7.7
	Important to address	5	38.5
	Neutral about this question	6	46.2
	Not important to address	1	7.7
How important is it for your HCP to discuss if you are satisfied with the pleasure (ORGASM) you receive from your sexual activity?	This question is:		
	Very important to address	1	7.7
	Important to address	6	46.2
	Neutral about this question	4	30.8
	Not important to address	2	15.4
How important is it for your HCP to discuss if you feel your RELATIONSHIP is healthy?	This question is:		
	Very important to address	4	30.8
	Important to address	6	46.2
	Neutral about this question	2	15.4
	Not important to address	1	7.7
How important is it for your HCP to discuss if you experience any physical or emotional pain or distress in regards to your sexual activity?	This question is:		
	Very important to address	5	38.5
	Important to address	7	53.8
	Neutral about this question	1	7.7
	Not important to address		
	Not at all important to address		

pain or discomfort resulted from my sexual life,” three women (23.1%) disagreed, and one woman (7.7%) agreed. Nine women (69.2%) “strongly disagree” that “physical pain or discomfort resulted from my sexual life,” three women (23.1%) “disagreed,” and one woman (7.7%) agreed (Table 2).

Twelve of the respondents responded positively that they were “able to manage the stress or demands of their life,” five (38.5%) “strongly agreed” to this statement, seven (53.8%) “agreed,” and one respondent was neutral. All of the respondents “had a support system of other women (such as family or friends) in their life, nine (69.2%)” “strongly agreed,” and four (30.8%) “agreed” (Table 2).

“My health care provider or practitioner needs to be aware of the importance of sexuality in my overall health and well being” was strongly agreed to by two (15.4%), agreed to by nine (69.2%), and disagreed to by two (15.4%). The importance of the FORD mnemonic as a question for the HCP to address was evaluated by the respondents as follows (Table 2): five (38.5%) felt Frequency of sexual activity was important to address, one (7.7%) rated it very important to address, six (46.2%) were neutral, and one (7.7%) felt the HCP to discuss if they were satisfied with the FREQUENCY of sexual activity was “not” important to address. Six (46.2%) felt Orgasm was important for the HCP to address, one (7.7%) felt this question very important, four (30.8%) were neutral, and two (15.4%) felt “the HCP to discuss if they were satisfied with the pleasure (ORGASM) they receive from sexual activity” was not important to address. “How important is it for your HCP to discuss if you feel your RELATIONSHIP is healthy” was answered as “very important” by four (30.8%), “important” by six (46.2%), “neutral” by two (15.4%), and “not important” by one (7.7%). No one disagreed with “how important

is it for your HCP to discuss if you experience any physical or emotional pain/ distress,” five (38.5%) felt it was very important, seven (53.8%) felt it important to address, one (7.7%) was neutral.

Revision of the Pilot Instrument

Insight From the Focus Group Participants

Comments received from the focus group participants were regarding what else should be asked by health care providers. They follow:

03 “Addressing specific issues: vaginal dryness, impotence, changes due to aging, etc. Some people are hesitant to address these issues unless asked specific questions. It is easier to answer (and then discuss) specific questions, as opposed to answering a general question.”

05 “If there is more than one partner and why”

08 “I think the questions posed are important to ask”

10 “If you practice ‘safe’ sexual practices”

These comments (05 and 10) were then drafted into a question on the pilot instrument that asked the respondent to rate their ability to avoid sexually transmitted disease (Question 17). Respondents would mark a “0” if they did not practice safe sex (e.g., multiple partners, no use of barriers such as condoms/dams, partner at risk, or infrequent screening exams), and a “100” if they did practice safe sex (e.g., monogamy, use of condoms/dams, asking partner about risk, participating in frequent screening exams). The comment from respondent 03 was framed into a general question (number 8 on the pilot instrument) of “do you have a general medical condition that affects your sexual function?”

Insight From the Experts

Comments from Dr. Tiefer and Dr. Miletski were incorporated into the draft's revision into pilot instrument. Dr. Nan Lackey also offered insight into instrument development issues, and her suggestions were incorporated into the draft's revision into pilot instrument. The comments from Dr. Tiefer, a founder of the New View, are as follows:

1. I think people will be turned off by "a concept analysis"—better "a survey."
2. The age choices are too narrow. People will feel identified.
3. Q 5—why do you ask about menstruation but not about oral contraception? Q 7 why ask so specifically about ovaries if you don't ask other questions that pertain to reproductive or endocrine health. Q 7 seems odd in an otherwise psychological survey. Have you ever been pregnant? etc.
4. Q8 What does "sexual experience" mean in this question? Activity with a partner? Fantasy? We have learned that the two don't always go together.
5. Q9 Monogamous? what if you are sexual with more than one person more or less? What is "sexual relationship"? Is it having sex with a person? Is it committed?
6. Q13 What do you mean by "sexual health"? I have no idea how to answer this. Do I have any stds?
7. Q13 and 14. Once you've helped define sexual health, give some specificity to the endpoints ("e.g., if you feel very negative and full of despair about your level of sexual health, check 0")
8. Q33 Gynecologist? Primary care provider?
9. Q15-37 (except Q29). All these questions are framed in a positive way. The respondent has to indicate a "no" answer to challenge the premise of the question. Contrast your framing with these: I want my dr to respect my privacy and keep her curiosity about my sex life to herself; I don't think my partner understands me one single bit; My sexual relationship is the least important aspect of my primary relationship; etc. If all the questions

stay as you wrote them, the bias of the researcher comes thru—you believe in communication, respect, equal desire, getting needs met, etc etc etc. It's no longer a real inquiry but just a pop magazine thing.

The comments from Dr. Tiefer were valuable to gain insight into restructuring questions that would gather more data about women's sexual lives. Questions 5 (still menstruating) and 7 (presence of ovaries) were reframed as a result. The pilot instrument asks if women are still menstruating, if not—was it because of surgical or natural menopause, if they still have their ovaries, if a general medical condition exists to affect sexual function, and if hormones are used (either as contraceptive or replacement). Her comment about question 8 (sexual experience orientation) was changed to “sexual experience in activity or fantasy.” Her concern over question (draft) 9 was addressed by providing a box stating the respondent should answer questions based upon the relationship that they consider to be primary. Her concern over the matter of defining for the respondent the meaning of sexual health (draft questions 13 and 14) was addressed in the pilot instrument by a statement in the consent information page: “In 2002, the World Health Organization described sexual health in a holistic manner. The description of what women mean when they report sexual health needs further exploration and understanding” and by providing anchors to the self-rating on personal level of sexual health (pilot question 15). The respondent marks a “0” to represent that they feel very negative and full of despair about the level of their sexual health, and a “100” to represent that they feel very positive and satisfied about the level of their sexual health.”

Dr. Tiefer also advised that the questions should not lead the response. The wording of questions 15 through 37 on the draft instrument were changed in questions 18 through 38 on the pilot instrument. An example of this is the draft question 15, “in

general, my relationship is a positive part of my life” with item choices from strongly agree to strongly disagree with a choice for no opinion was reframed in the pilot instrument to read “In general, my relationship is:” and the respondent can choose from “a very positive part of my life” to “a very negative part of my life” with an option of “no opinion.”

Drs. Miletski and Lackey supported the rewording of the questions into more neutral ways. The pilot instrument was developed based upon the usability for the 13 focus group participants, the comments received from the experts, and my desire to have participants rank the FORD mnemonic for its importance to their overall sexual health and well-being. This aspect will answer the research question: *How do women rank four commonly perceived attributes of sexual health?*

Phase Two: Quantitative Research Results

Chapter III discussed the methods used to conduct the quantitative portion of this mixed method study. Section One of this chapter answered the first (qualitative) research question (*explore the meaning of female sexual health through identification of the attributes (dimensional analysis) of sexual health reported by women*); this section reports the results of research questions two through five using the revised survey results.

2. What is the self-reported level of female sexual health in a population of women?
 - a. Are there differences in the self-reported level of sexual health by age, race/ethnicity, education level, menopausal status, relationship status?

3. Are the identified dimensions of female sexual health correlated with overall self-reported level of sexual health?
 - a. Are there differences in the dimensions by age, race/ethnicity, education level, menopausal status, relationship status?
4. Are the dimensions of female sexual health correlated to each other?
5. How do women rank four commonly perceived attributes of sexual health?
 - a. Are there differences in four commonly perceived attributes of sexual health by age, race/ethnicity, education level, menopausal status, relationship status?

As mentioned in Chapter III, a revised survey was sent to 1,000 female faculty and staff of a Midwestern state university by campus mail. Of the 1,000 surveys, 244 were returned and 240 were usable for analysis. The four considered not usable were not completed (blank, $n = 3$) or the male gender box was checked ($n = 1$). Response rate was 24% and characteristics of the sample respondents are shown in Table 3.

Demographics of the Instrument Response

Characteristics of the respondents are as follows: The age range of the respondents was evenly distributed with 1.3% ages 18–20, 8.3% ages 21–25, 7.9% ages 26–30, 6.7% ages 31–35, 9.6% ages 36–40, 10.4% ages 41–45, 18.3% ages 46–50, 19.2% ages 51–55, 10.4% ages 56–60, 6.7% ages 61–65, and 0.8% ages 66–70 (Figure 14).

Racial characteristics were 87.5% white, 7.1% black or African American, 1.8% multiracial, 1.3% American Indian or Alaska Native, 0.8% Asian, and 0.4% Native Hawaiian or Pacific Islander (Figure 15). Ethnicity was 52.9% not Hispanic or Latino,

Table 3

Characteristics of Instrument Sample Respondents (n = 240)

Demographic	Frequency	Percent
<u>Age</u>		
18 – 20	3	1.3
21 – 25	20	8.3
26 – 30	19	7.9
31 – 35	17	7.1
36 – 40	22	9.2
41 – 45	25	10.4
46 – 50	44	18.3
51 – 55	46	19.2
56 – 60	25	10.4
61 – 65	16	6.7
66 – 70	2	.8
Over 70	0	
Total	239	99.6
Missing/not usable	1	
<u>Race</u>		
American Indian or Alaska Native	3	1.3
Asian	2	.8
Black or African American	17	7.1
Native Hawaiian or Pacific Islander	1	.4
White	210	87.5
Multiracial	4	1.7
Missing	3	1.3
Total	237	98.8
<u>Ethnicity</u>		
Hispanic or Latino	6	2.5
Not Hispanic or Latino	127	52.9
Multi-Ethnic	27	11.3
Other	37	15.4
Missing	43	17.9
Total	197	82.1
<u>Education</u>		
High School Graduate or Equivalent	41	17.1
Currently in College	23	9.6
College Graduate (Technical or Associate's)	28	11.7
College Graduate (Bachelor's)	42	17.5
College Graduate (Master's or Doctorate)	97	40.4
Missing	9	3.8
Total	231	96.3

Table 3—Continued

Demographic	Frequency	Percent
<u>Menopausal Status</u>		
Natural or spontaneous menopause	51	21.3
Surgical menopause (hysterectomy or ablation)	49	20.4
Missing (skip question)	139	57.9
Total	101	42.1
<u>Sexual experience in activity or fantasy</u>		
Entirely heterosexual	213	88.8
Largely heterosexual, but some homosexual experience	14	5.8
Equally heterosexual and homosexual	2	.8
Largely homosexual, but some heterosexual experience	2	.8
Entirely homosexual	4	1.7
Missing	3	1.3
Total	237	98.8
<u>Currently in a sexual relationship</u>		
Yes	196	81.7
No	43	17.9
Missing	3	1.3
Total	239	98.8
<u>Past sexual relationship</u>		
Yes	40	16.7
No	29	12.1
Missing (skip question)	111	46.3
Total	69	28.8

15% “other,” 11.3% multi-ethnic, and 2.5% Hispanic or Latino. Approximately 18% of the sample did not respond to the ethnicity question (Figure 16).

High school graduates comprised 17.1% of the sample, 9.6% were currently in college, 11.7% had a technical or associates college degree, 17.5% held a bachelor’s college degree, 40.4% had a master’s or doctorate degree, and 2.9% were not usable data either due to multiple choices checked or not answered (Figure 17).

Age of Participants

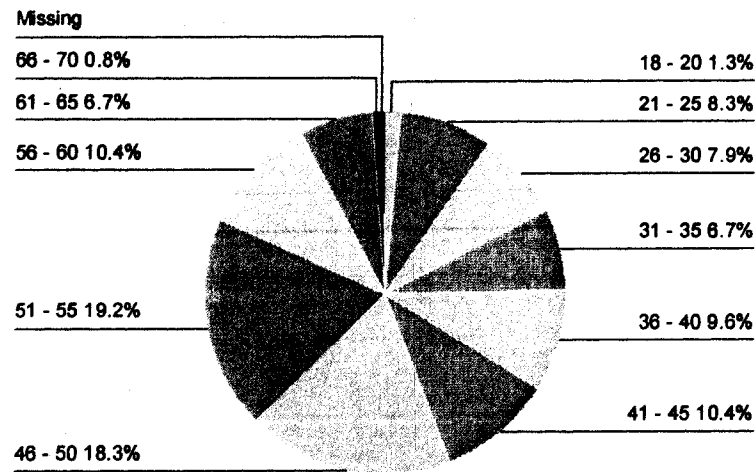


Figure 14. Age of participants.

Race of Participants

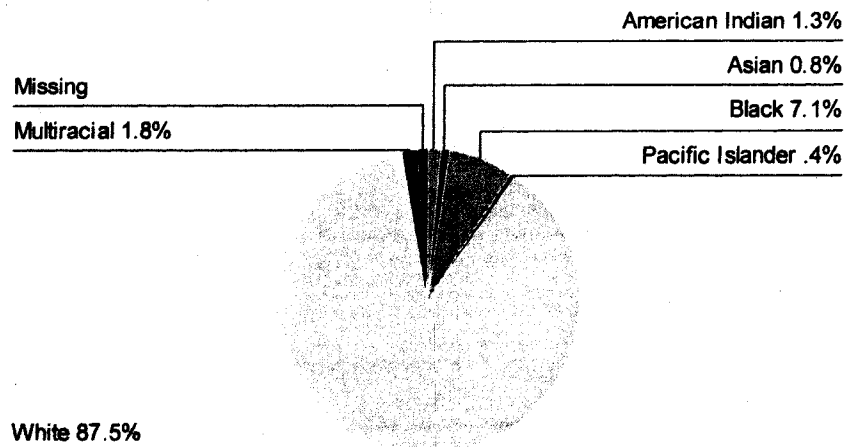


Figure 15. Race of participants.

Ethnicity of Participants

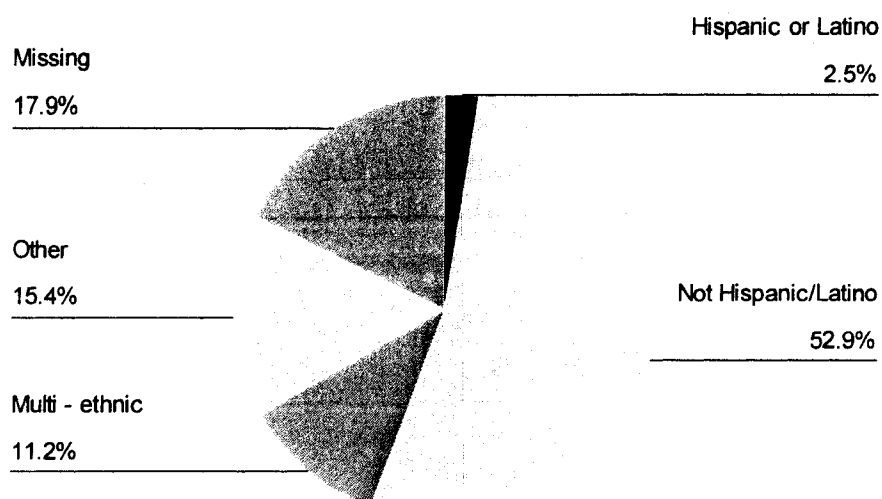


Figure 16. Ethnicity of participants.

Education of Participants

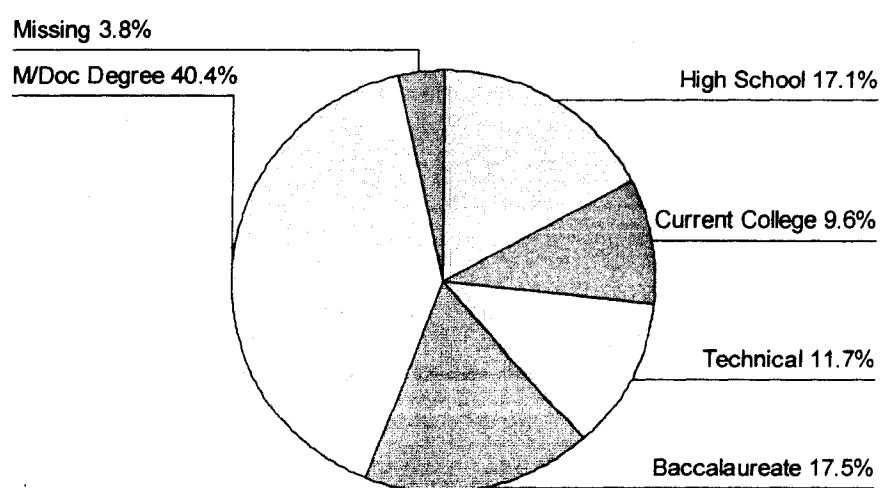


Figure 17. Education of participants.

In regards to the respondents' reproductive and sexual medical status, approximately 57% of the women were still menstruating, while 42% were not. Of the women who had no further menstruation, 21.3% responded it was due to a natural or spontaneous menopause and 20.4% due to a surgical menopause (hysterectomy or ablation). Both ovaries were still present in 80.8% of the women, one ovary present in 2.1% of the women, 8.8% of the women responded that they had had both ovaries removed. Responses from 93.8% indicated that they did not have a general medical condition affecting their sexual function, 5.8% responded that they did. Hormone replacement or contraception was not used by 71.3% of the respondents; hormonal contraceptives were used by 13.8%. Among the almost 14% that used hormone prescriptions, hormone replacement was used by 12.9%, and 0.4% of the respondents used over the counter herbal therapies for hormone support.

Sexual orientation in activity or fantasy was 88.8% heterosexual; 5.8% largely heterosexual, but some homosexual experience; 0.8% equally heterosexual and homosexual; 0.8% largely homosexual, but considerable heterosexual experience; 0.8% largely homosexual, but some heterosexual experience; and 1.7% entirely homosexual.

Current sexual relationship(s) was reported by 187 (81.7%) of the respondents. Length of the primary sexual relationship varied from 4 months to 44 years (Figure 18). Length of the current sexual relationship was less than 5 years for 22.9% of the respondents, 5–10 years for 19.7% of the respondents, 10–15 years for 14.9% of the respondents, 15–20 years for 8% of the respondents, 20–30 years for 14.9% of the respondents, 30–40 years for 17.6% of the respondents, while 1.6% had been in a relationship for over 40 years.

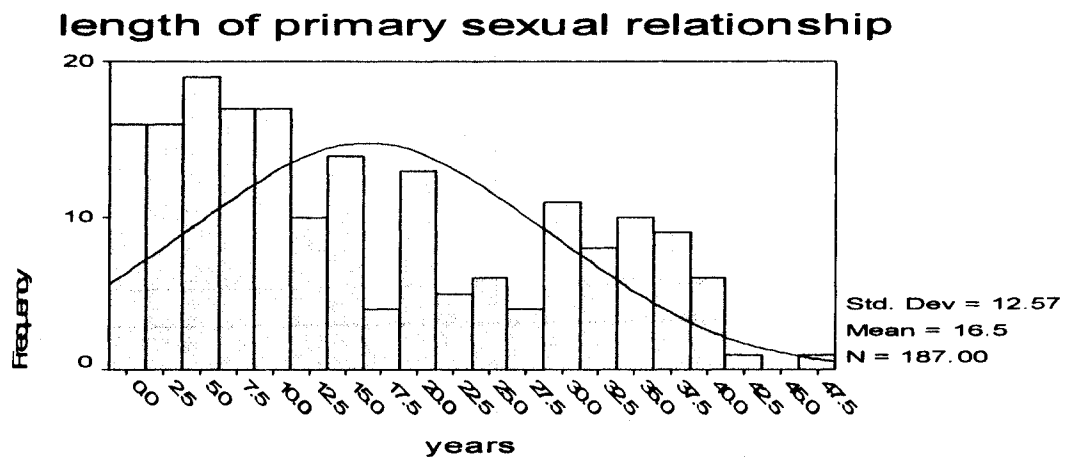


Figure 18. Length of primary relationship.

Past sexual relationships were reported by 131 (16.7%) of the respondents. The length of the prior sexual relationship varied from one month to 40 years; 55.7% had been in a relationship in the past for less than 5 years, 19.8% for 5–10 years, 5.3% for 10–15 years, 5.3% for 15–20 years, 10.6% for 20–30 years, and 6.1% for over 30 years. See Table 3 for a description of the instrument respondents.

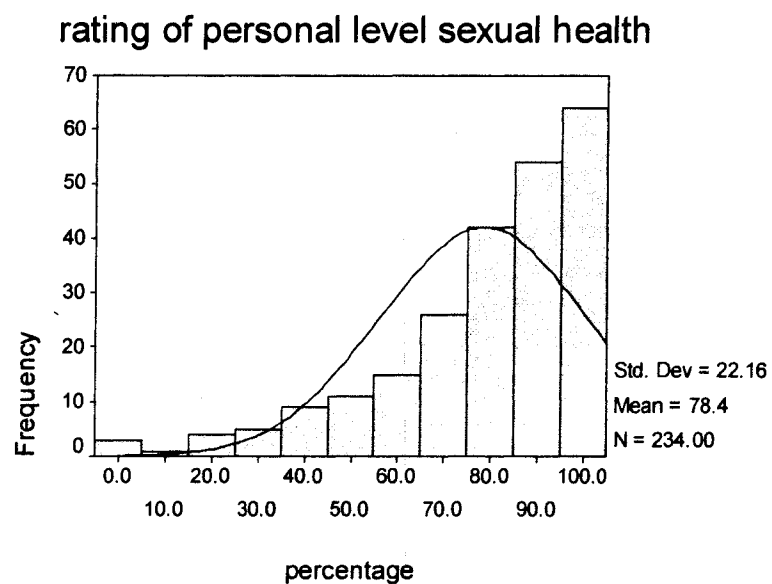
Research Question 2: What Is the Self-Reported Level of Female Sexual Health in a Population of Women?

On a scale of “0” to “100” the mean self-reported level of sexual health of the 234 responding to the question was 78.4 ($\sigma = 22.16$) with a median of 85.0 and a mode of 100 (Table 4). A histogram revealed that this variable was not normally distributed (Figure 19). Follow-up testing with Kolmogorov-Smirnov confirmed ($KS = .178$ (234 df), $p = .000$) that the distribution was not normal, so nonparametric tests were used for the comparisons by groups.

Table 4

Instrument Results

Self reported level of Female Sexual Health in a population of women <i>n</i> = 234	
Mean	78.43
Median	85.0
Mode	100
Standard Deviation	22.16
Minimum	0
Maximum	100

*Figure 19. Rating of personal level of sexual health.*

Research Question 2a: Are There Differences in the Self-Reported Level of Sexual Health by Age, Race/Ethnicity, Education Level, Menopausal Status, Relationship Status?

Rating of personal level of sexual health among groups was not different by age ($H(4) = 6.237, p = .182$), by race/ethnicity ($H(1) = .114, p = .736$), by education level ($H(3) = 1.507, p = .681$), by menopausal status ($H(1) = .216, p = .642$), or by relationship status ($H(1) = .071, p = .789$). See Table 5 for specific K-W test statistic findings.

Table 5

Kruskal-Wallis Test Statistics: Self-Rating of Female Sexual Health by Groups

Group	N	Mean Rank	Kruskal Wallis
<u>Age:</u>			
18 – 25	23	145.83	$H(4) = 6.237$ $p = .182$
26 – 35	35	105.29	
36 – 45	47	112.47	
46 – 55	86	119.95	
56 – 70	42	110.00	
Total	233		
<u>Race / Ethnicity:</u>			
All other races & ethnicities	117	118.97	$H(1) = .114$ $p = .736$
White non Hispanic	117	116.03	
Total	234		
<u>Education:</u>			
Less than or High School	39	114.58	$H(3) = 1.507$ $p = .681$
Currently in college or AD or technical degree	49	121.43	
Baccalaureate degree	41	105.38	
Graduate degree (Master or Doctorate)	96	111.31	
Total	225		
<u>Menopausal Status</u>			
Pre-menopausal	133	118.76	$H(1) = .216$ $p = .642$
Post-menopausal	100	114.66	
Total	233		
<u>Relationship Status</u>			
Yes, current sexual relationship	193	117.53	$H(1) = .071$ $p = .789$
No, not in a sexual relationship currently	40	114.44	
Total	233		

Research Question 3: Are the Identified Dimensions of Female Sexual Health Correlated With Overall Self-Reported Level of Sexual Health?

Dimension one: The Authentic Self (survey question 16) was statistically significantly correlated with self-reported level of Female Sexual Health, $r_s = .501$, $p < .0001$. This was a large effect size, based upon Cohen's effect size range of small .1 to .3, medium .3 to .5, and large over .5. See Figure 20 and Table 6.

Dimension two: Communication with the partner (Figure 21) on a deep and intimate level was correlated with self-reported level of Female Sexual Health, $r_s = .345$, $p < .001$ (statistical significance). This was a medium effect size (Table 7).

Dimension three: Emotional Health State (Figures 22 and 23) was evaluated with the personal view of self (survey question 30) and the general ability to manage the stress or demands of life (survey question 32). There was a relationship between the rating of personal level of sexual health and the personal view held of self, $r_s = .177$, $p < .001$. There was a relationship between the rating of personal level of sexual health and the ability to manage the stress of life, $r_s = .191$, $p = .004$. These were both small effect sizes. There was a relationship also found between the personal view held of self and the ability to manage the stress of life, $r_s = .298$, $p < .001$, a medium effect size based upon Cohen's range (Table 8).

Dimension four: Frequency of Sexual Activity desired and achieved (F) was evaluated with the libido match (Figure 24) between self and partner (survey questions 23). There was a relationship between the rating of personal level of sexual health, and

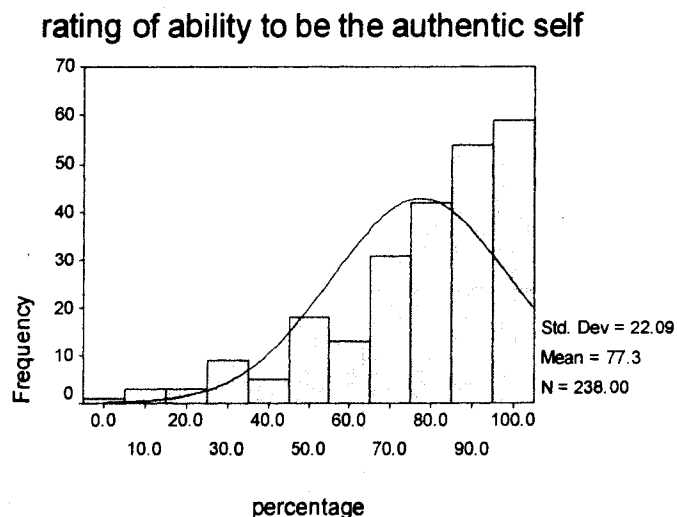


Figure 20. Rating of ability to be the authentic self.

Table 6

Dimension One: The Authentic Self

Dimension 1: The Authentic Self			
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.		
Question 16	Rate your ability to communicate your desires and needs. To what degree are you able to express yourself with those who you love? "0" representing that you are not at all able to communicate your desires and needs. "100" representing that you are able to express yourself to those who you love.		
Spearman's rho		Rating of personal level of sexual health	Rating of ability to be the authentic self
Rating of personal level of sexual health	Correlation Coefficient	1.000	.501
	Sig. (2-tailed)		<.001
	N	234	233
Rating of ability To be the authentic self	Correlation Coefficient	.501	
	Sig. (2-tailed)	<.001	
	N	233	

level of communication with my partner

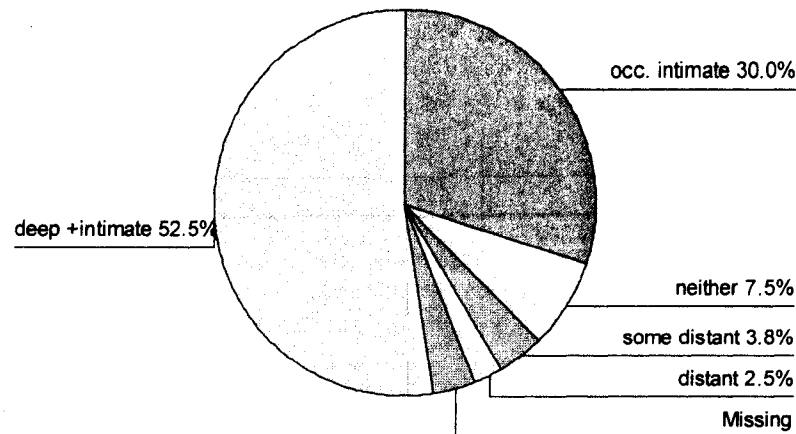


Figure 21. Level of communication with my partner.

Table 7

Dimension Two: Communication With the Partner on a Deep and Intimate Level

Dimension 2: Communication with the partner on a deep and intimate level			
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.		
Question 21	In general, the communication with my partner is: emotionally deep and intimate when appropriate (5), occasionally intimate (4), neither intimate or distant (3), somewhat distant (2), emotionally distant and not ever deep (1).		
Spearman's rho		Rating of personal level of sexual health	Communication depth and intimacy
Rating of personal level of sexual health	Correlation Coefficient	1.000	.345
	Sig. (2-tailed)		<.001
	N	234	226
Communication depth and intimacy	Correlation Coefficient	.345	1.000
	Sig. (2-tailed)	<.001	
	N	226	234

Personal View Held of Self

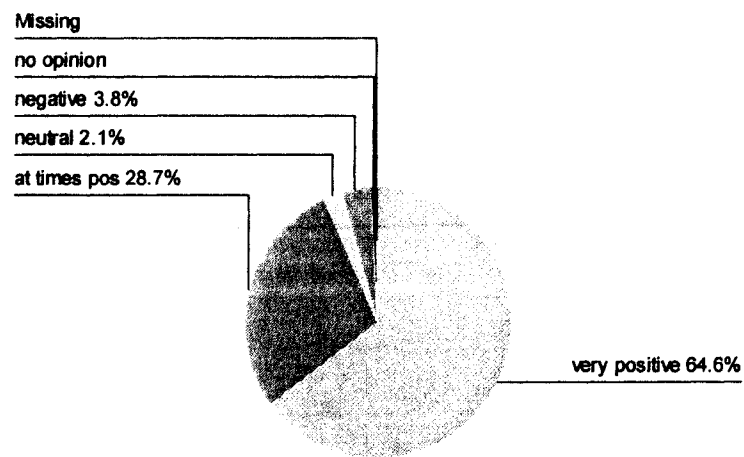


Figure 22. Personal view held of self.

Generally Able to Handle Stress

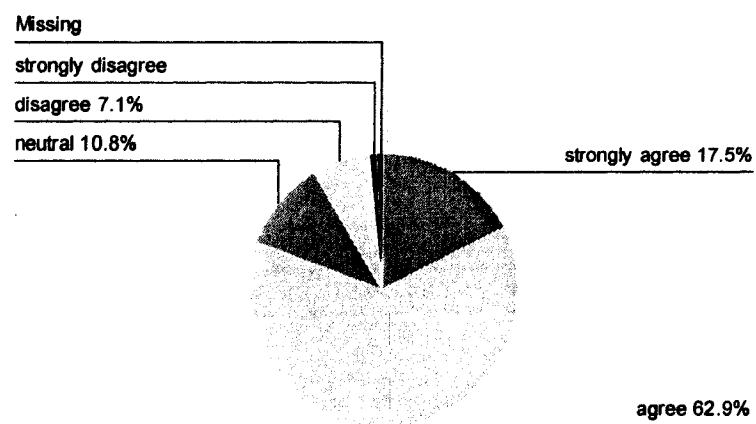


Figure 23. Generally able to handle stress.

Table 8

Dimension Three: Emotional Health State

Dimension 3: Emotional Health State				
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.			
Question 30	The personal view I hold of myself is generally: very positive (5), at times positive (4), neutral (3), usually negative (2), generally very negative (1).			
Question 32	In general, I am able to manage the stress or demands of life: strongly agree (5), agree (4), neutral (3), disagree (2), strongly disagree (1)			
Spearman's rho		Rating of personal level of sexual health	Personal view held of self	Ability to manage the stress of life
Rating of personal level of sexual health	Correlation Coefficient Sig. (2-tailed) N	1.000 234	.177 .007 233	.191 .004 232
personal view held of self	Correlation Coefficient Sig. (2-tailed) N		1.000 234	.298 <.001 237
ability to manage the stress of life	Correlation Coefficient Sig. (2-tailed) N			1.000 234

the libido match between self and partner, $r_s = .360$, $p < .001$, a medium (Cohen's) effect size (Table 9).

Dimension five: Presence of Sexual Pleasure (O) was evaluated with receiving emotional pleasure (survey question 28) (Figure 25) and receiving physical pleasure and no discomfort (survey question 29) (Figure 26). There was a relationship between the rating of personal level of sexual health, and the emotional pleasure received from the

libido match between self and partner's libido

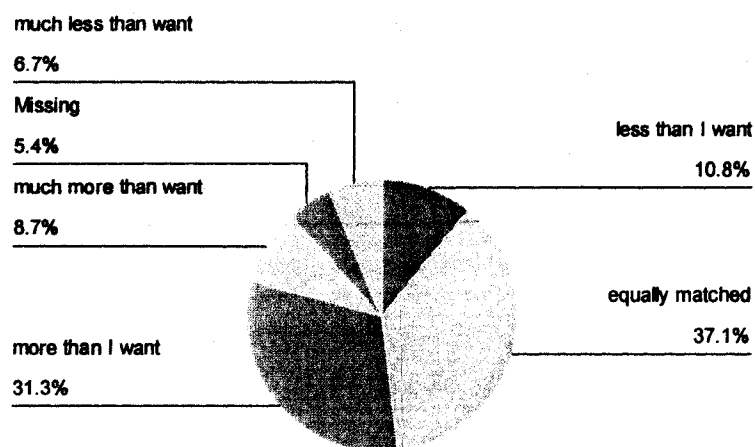


Figure 24. Match between self and partner's libido.

Table 9

Dimension Four: Frequency of Sexual Activity Desired and Achieved (F)

Dimension 4: Frequency of Sexual Activity desired and achieved (F)			
Question 15		Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.	
Question 23		In general, the match between my libido (desire for sexual intimacy and/ or activity) and that of your partner is: much less than what I desire as my partner's libido is much less than my own (1), somewhat less than what I desire as my partner's libido is less than my own (2), equally matched as my partner's libido and mine are equal most of the time (3), somewhat more than what I desire as my partner's libido is more than my own (2), much more than what I desire as my partner's libido is quite more than my own (1).	
Spearman's rho		Rating of personal level of sexual health	Libido match between self and partner
Rating of personal level of sexual health	Correlation Coefficient	1.000	.360
	Sig. (2-tailed)		<.001
	N	234	222

sexual relationship and emotional pleasure

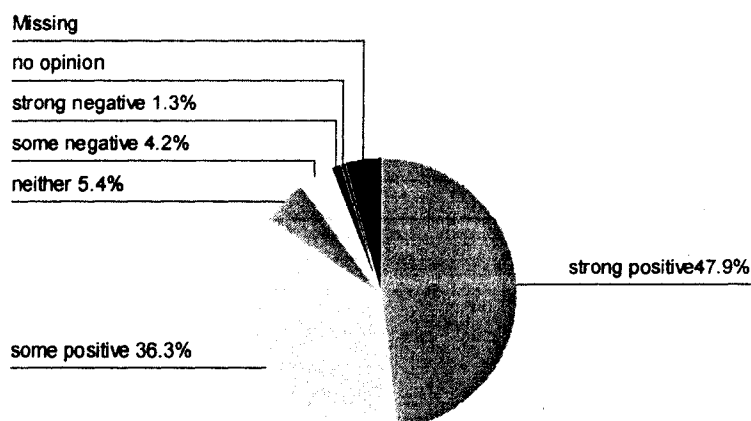


Figure 25. Sexual relationship and emotional pleasure.

sexual relationship and physical pleasure

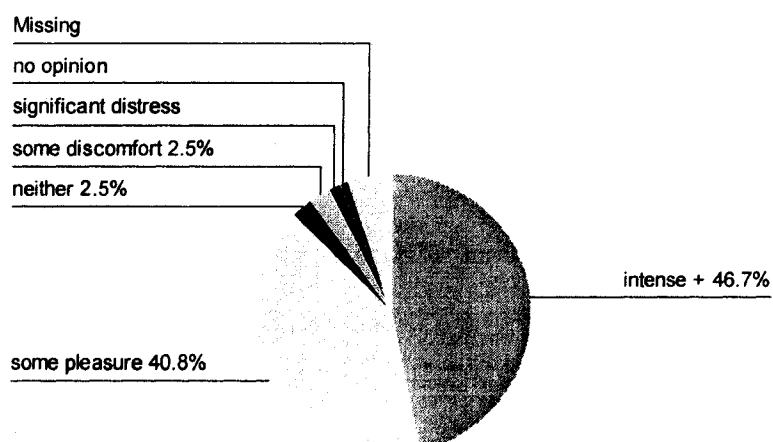


Figure 26. Sexual relationship and physical pleasure.

sexual relationship, $r_s = .325$, $p < .001$. There was a relationship between the rating of personal level of sexual health, and the physical pleasure received from the sexual relationship, $r_s = .418$, $p < .001$. There also was a relationship between the emotional

pleasure and the physical pleasure in the relationship, $r_s = .443, p < .001$. All of the correlations were a medium (Cohen's) effect size (Table 10).

Table 10

Dimension Five: Presence of Sexual Pleasure (O)

Dimension 5: Presence of Sexual Pleasure (O)				
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.			
Question 28	In general, from my sexual relationship I achieve: strong emotional pleasure (5), some emotional pleasure (4), neither pleasure or displeasure (3), some emotional displeasure (2), strong emotional displeasure (1).			
Question 29	In general, from my sexual relationship I achieve: intense physical pleasure (5), some physical pleasure (4), neither pleasure or displeasure (3), some physical discomfort (2), significant physical discomfort (1).			
Spearman's rho		Rating of personal level of sexual health	Emotional pleasure	Physical pleasure
Rating of personal level of sexual health	Correlation Coefficient Sig. (2-tailed) N	1.000 234	.325 <.001 223	.418 <.001 220
Emotional pleasure	Correlation Coefficient Sig. (2-tailed) N		1.000 228	.443 <.001 225
physical pleasure	Correlation Coefficient Sig. (2-tailed) N			1.000 225

Dimension six: Health State of the Relationship (R) was evaluated with the general perceived positive or negative aspects of the relationship in the woman's life (survey question 18) (Figure 27) and the respect felt from the partner (survey question 19)

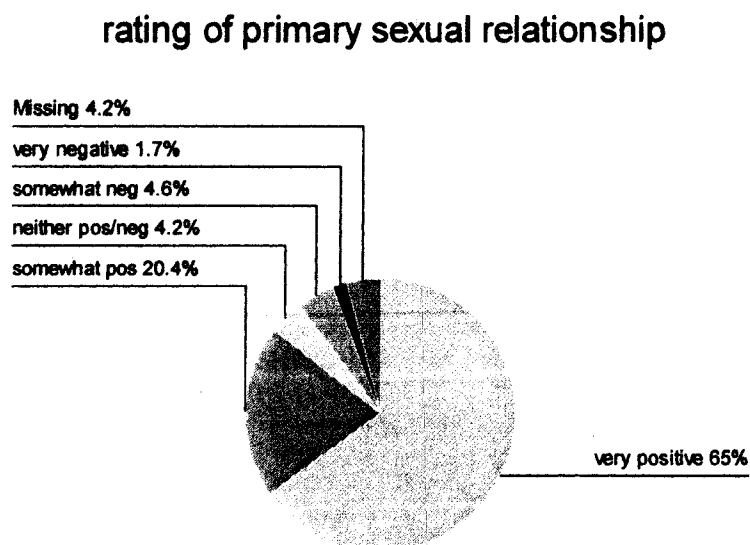


Figure 27. Rating of primary sexual relationship.

(Figure 28). There was a relationship between the rating of personal level of sexual health, and the evaluation of the relationship as a positive aspect of life, $r_s = .323, p < .001$, a medium effect size. There was a relationship between the rating of personal level of sexual health, and the degree of respect received from the partner, $r_s = .258, p < .001$, a small effect size. There was a relationship also between the relationship evaluation and the degree of respect felt to be received from the partner, $r_s = .577, p < .001$, a large effect size (Table 11).

Dimension seven: Absence of Emotional or Physical Discomfort (D) was evaluated with a “0” to “100” scale rating the ability to avoid disease and participate in health screenings (survey question 17) (Figure 29), and receiving pleasure and no discomfort from the sexual relationship (survey question 29) (Figure 30). A statistically significant relationship was not found between the rating of personal level of sexual

Respect Felt from Partner

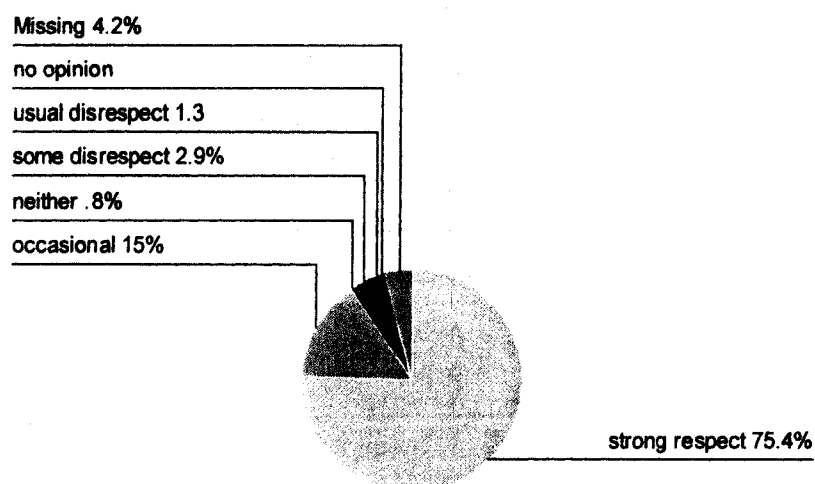


Figure 28. Respect felt from partner.

health, and the practice of safe sex and health maintenance exams. There was a relationship between the rating of personal level of sexual health, and the physical pleasure received from the sexual relationship, $r_s = .418$, $p < .001$, a medium (Cohen's) effect size. A statistically significant relationship was not found between the practice of safe sex and health maintenance practices and the presence of physical pleasure (Table 12).

Dimension eight: Significance of a Positive Health Care Provider Relationship was evaluated with addressing the approach desired from the women from the health care practitioner regarding sexuality (survey question 34). There was no relationship between the rating of personal level of sexual health and the significance of the health care provider's approach to sexuality, $r_s = .026$, $p = .642$ (Table 13). See Table 14 for

participant responses to the question regarding what women want from their health care provider's evaluation of their sexual health.

Table 11

Dimension Six: Health State of the Relationship (R)

Dimension 6: Health State of the Relationship (R)				
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.			
Question 18	In general, my relationship is: a very positive part of my life (5), a somewhat positive part of my life (4), neither positive or negative (3), a somewhat negative part of my life (2), a very negative part of my life (1).			
Question 19	In general, I feel that I am: strongly respected by my partner for who I am (5), occasionally respected by my partner for who I am (4), neither respected or disrespected by my partner (3), somewhat disrespected (2), usually disrespected (1).			
Spearman's rho		Rating of personal level of sexual health	Relationship evaluation	Respect from partner
Rating of personal Coefficient level of sexual health	Correlation	1.000	.323	.258
	Sig. (2-tailed) N	234	<.001 225	<.001 224
Relationship evaluation Coefficient	Correlation		1.000	.577
	Sig. (2-tailed) N		230	<.001 228
Respect from partner Coefficient	Correlation			1.000
	Sig. (2-tailed) N			229

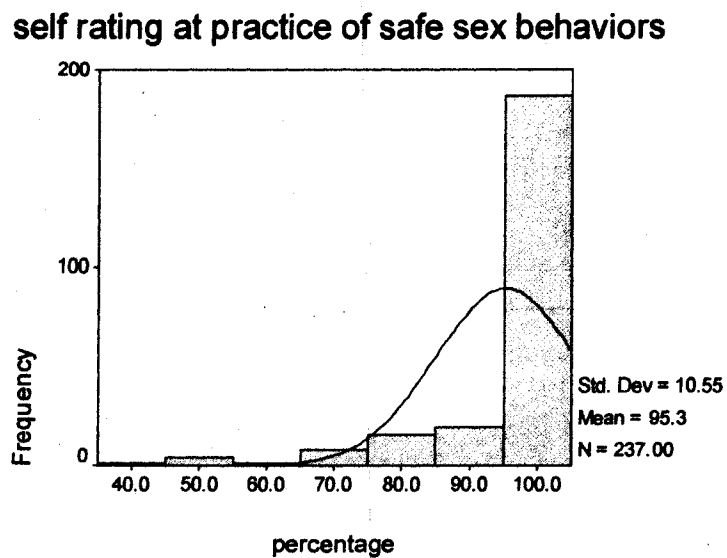


Figure 29. Ability to practice safe sex behaviors.

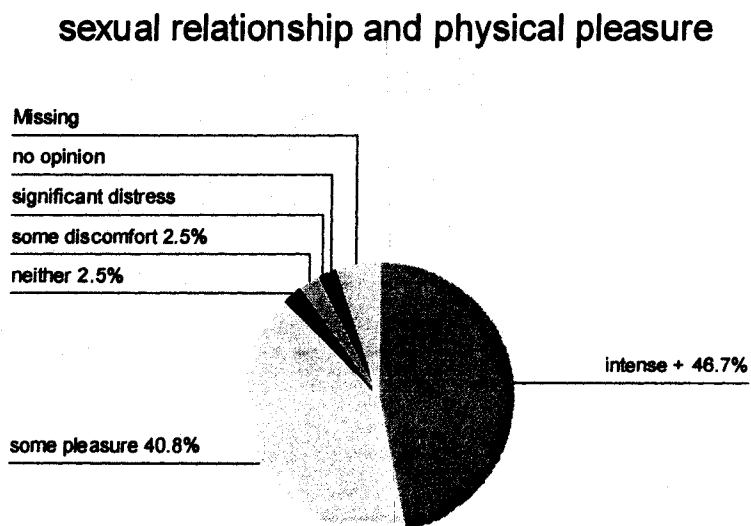


Figure 30. Sexual relationship and achievement physical pleasure.

Table 12

Dimension Seven: Absence of Emotional or Physical Discomfort (D)

Dimension 7: Absence of Emotional or Physical Discomfort (D)				
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.			
Question 17	Using the scale, rate your ability to avoid STD. "0" indicates that you do not practice safe sex practices. "100" indicates that your practice safe sex at all times and participate in frequent screening exams.			
Question 29	In general, from my sexual relationship I achieve: intense physical pleasure (5), some physical pleasure (4), neither pleasure or displeasure (3), some physical discomfort (2), significant physical discomfort (1).			
Spearman's rho		Rating of personal level of sexual health	Safe sex and health maintenance practices	Physical pleasure
Rating of personal level of sexual health	Correlation Coefficient Sig. (2-tailed) N	1.000 234	.003 .968 232	.488 <.001 220
Safe sex and health maintenance practices	Correlation Coefficient Sig. (2-tailed) N		1.000 237	-.057 .400 223
Physical pleasure	Correlation Coefficient Sig. (2-tailed) N			1.000 225

Table 13

Dimension Eight: The Significance of a Positive Health Care Provider Relationship

Dimension 8: The Significance of a Positive Health Care Provider Relationship			
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.		
Question 34	I want my HCP to have the following approach to my sexuality: I want my HCP to respect my primacy and not ask about my sexuality (1), I want my HCP to only ask about my sexuality if I bring up a problem to them (2), I am neutral about my health care provider asking questions about my sexuality as it impacts my overall health and well being (4).		
Spearman's rho		Rating of personal level of sexual health	HCP approach to sexuality significance
Rating of personal level of sexual health	Correlation Coefficient	1.000	.026
	Sig. (2-tailed)		.642
	N	234	230

Table 14

I Want My Health Care Provider to Have the Following Approach to My Sexuality

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
I want my HCP to respect my privacy and not ask about sexual activity	6	2.5	2.5	2.5
I want my HCP to only ask about my sexuality if I bring it up	63	26.3	26.5	29.0
I am neutral about my HCP asking questions about my sexuality	40	16.7	16.8	45.8
I want my HCP to ask me questions about my sexuality as it pertains to my overall health.	127	52.9	53.4	99.2
No opinion or don't know	2	.8	.8	100.0
Total	238	99.2	100.0	
Missing Not usable data	2	.8		
Total	240	100.0		

Dimension nine: Sisterhood was evaluated with the presence of a support system of other women (Figure 31). There was a relationship between the rating of personal level of sexual health, and the “sisterhood” or presence of other females in her life, $r_s = .154$, $p = .019$, a (Cohen’s) small effect size (Table 15).

support system of other women (sisterhood)

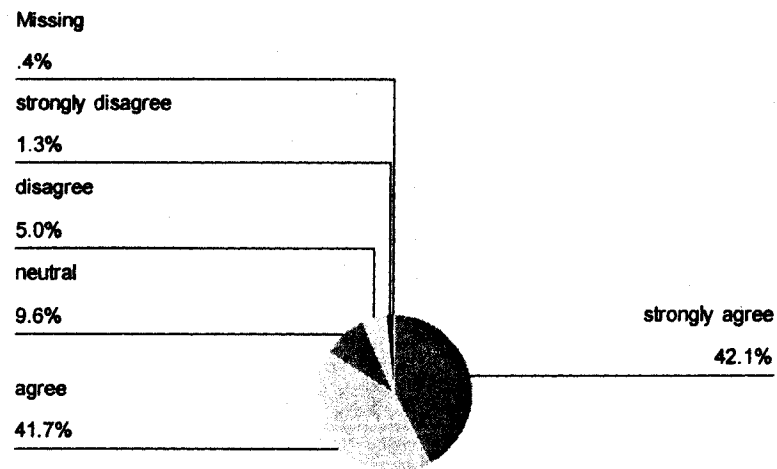


Figure 31. Support system of other women (sisterhood).

Table 15

Dimension Nine: Sisterhood

Dimension 9: Sisterhood			
Question 15	Using the scale, rate your personal level of sexual health. "0" representing you feel very negative and full of despair about your level of sexual health. "100" representing that you feel very positive and satisfied about your level of sexual health.		
Question 33	I have a support system of other women such as family or friends in my life: strongly agree (5), agree (4), neutral (3), disagree (2), strongly disagree (1).		
Spearman's rho		Rating of personal level of sexual health	Sisterhood
Rating of personal level of sexual health	Correlation Coefficient	1.000	.154
	Sig. (2-tailed)		.019
	N	234	233

Research Question 3a: Are There Differences in the Dimensions by Age, Race/Ethnicity, Educational Level, Menopausal Status, Relationship Status?

Dimension one: The Authentic Self did not demonstrate a statistically significant difference by groups (Table 16) of age ($H(4) = 2.905, p = .574$), by race/ethnicity ($H(1) = .049, p = .825$), by education level ($H(3) = 1.057, p = .787$) by menopausal status ($H(1) = .025, p = .874$), or by relationship status ($H(1) = 1.119, p = .290$).

Dimension two: Communication with the partner on a deep and intimate level was not different between groups (Table 17) by age ($H(4) = 4.186, p = .381$), by race/ethnicity ($H(1) = .613, p = .434$), by education level ($H(3) = .033, p = .998$) by menopausal status ($H(1) = .001, p = .253$), or by relationship status ($H(1) = .253, p = .615$) to a statistically significant degree.

Dimension three: Emotional Health State and the personal view of self did not differ between groups (Table 18) by age ($H(4) = 8.909, p = .063$), by race/ethnicity ($H(1) = .090, p = .764$), by education level ($H(3) = .751, p = .861$) by menopausal status ($H(1) = 1.881, p = .170$), or by relationship status ($H(1) = .113, p = .737$) to a statistically significant degree. The Emotional Health State and the ability to manage the stress in life did not differ between groups by age ($H(4) = 9.239, p = .055$), by race/ethnicity ($H(1) = .461, p = .497$), by education level ($H(3) = .575, p = .902$) or by relationship status ($H(1) = .529, p = .467$) to a statistically significantly degree. It differed by menopausal status ($H(1) = 4.907, p = .027$) and this difference reached statistical significance.

Dimension four: Frequency of Sexual Activity desired and achieved (F) differed (Table 19) by age groups ($H(5) = 18.794, p = .002$). Mann-Whitney U tests were used to follow up this finding. A Bonferroni correction was applied and so all effects are reported

Table 16

Kruskal-Wallis Test Statistics: Dimension One of Female Sexual Health by Groups

Dimension One	Group	N	Mean Rank	Kruskal - Wallis
The Authentic Self	<u>Age:</u>			$H(4) = 2.905$, $p = .574$
	18 – 25	23	140.57	
	26 – 35	36	119.40	
	36 - 45	47	117.63	
	46 – 55	90	117.49	
	56 – 70	41	111.43	
	Total	237		
	<u>Race / Ethnicity:</u>			$H(1) = .049$, $p = .825$
	All other races and ethnicities			
	White non Hispanic	119	118.53	
	Total	119	120.47	
		238		
	<u>Education level:</u>			$H(3) = 1.057$, $p = .787$
	Less than or High School	40	111.81	
	Currently in College or AD/technical	51	120.62	
	Baccalaureate	41	120.17	
	Graduate Degree (Master or Doctorate)	97	111.18	
	Total	229		
	<u>Menopausal Status:</u>			$H(1) = .025$, $p = .874$
	Pre-menopausal	136	119.60	
	Post-menopausal	101	118.19	
	Total	237		
	<u>Relationship Status:</u>			$H(1) = 1.119$, $p = .290$
	Yes, in a current sexual relationship	196	121.13	
	No, not currently in relationship	41	108.82	
	Total	237		

Table 17

Kruskal-Wallis Test Statistics: Dimension Two of Female Sexual Health by Groups

Dimension Two	Group	N	Mean Rank	Kruskal - Wallis
Communication with the partner on a deep and intimate level	<u>Age:</u>			$H(4) = 4.186, p = .381$
	18 – 25	21	133.36	
	26 – 35	36	111.00	
	36 – 45	46	105.96	
	46 – 55	88	121.22	
	56 – 70	40	111.46	
	Total	231		
	<u>Race / Ethnicity:</u>			$H(1) = .613, p = .434$
	All other races and ethnicities	119	119.00	
	White non Hispanic	112	112.81	
	Total	231		
	<u>Education level:</u>			$H(3) = .033, p = .998$
	Less than or High School	39	112.86	
	Currently in College or AD/technical	49	111.03	
	Baccalaureate	41	111.83	
	Graduate Degree (Master or Doctorate)	93	111.03	
	Total	222		
	<u>Menopausal Status:</u>			$H(1) = .001, p = .972$
	Pre-menopausal	131	115.62	
	Post-menopausal	99	115.34	
	Total	230		
	<u>Relationship Status:</u>			$H(1) = .253, p = .615$
	Yes, in a current sexual relationship	195	116.34	
	No, not currently in relationship	35	110.83	
	Total	230		

Table 18

Kruskal-Wallis Test Statistics: Dimension Three of Female Sexual Health by Groups

Dimension Three	Group	Variable 1 Personal view held of self		Variable 2 Able to manage stress in life		Kruskal - Wallis	
		N	Mean Rank	N	Mean Rank	Var 1	Var 2
Emotional Health State	<u>Age:</u>					$H(4)=$	$H(4)=$
	18 – 25	23	123.04	23	117.37	8.909,	9.239
	26 – 35	36	100.71	35	105.77	$p =$	$p =$
	36 - 45	47	107.23	47	116.37	.063	.055
	46 – 55	89	125.76	89	114.62		
	56 – 70	42	131.30	43	142.57		
	Total	237		237			
	<u>Race / Ethnicity:</u>					$H(1)=$	$H(1)=$
	All other races and ethnicities	119	118.38	119	122.10	.090,	.461,
	White non Hispanic	119	120.62	119	116.90	$p =$	$p =$
	Total	238		238		.764	.497
	<u>Education level:</u>					$H(3)=$	$H(3)=$
	Less than or High School	41	112.57	41	113.89	.751,	.575,
	Currently in College or AD/ technical	50	110.91	49	118.43	$p =$	$p =$
	Baccalaureate	41	114.21	42	118.45	.861	.902
	Graduate Degree (Master or Doctorate)	97	118.47	97	112.24		
	Total	229		229			$H(1)=$
	<u>Menopausal Status:</u>					$H(1)=$	$H(1)=$
	Pre-menopausal	136	114.61	135	111.65	1.881,	4.907
	Post-menopausal	101	124.92	102	128.73	$p =$	$p =$
	Total	237		237		.170	.529,
	<u>Relationship Status:</u>						$p =$
	Yes, in a current sexual relationship	195	119.58	194	117.69	$H(1)=$.467
	No, not currently in relationship	42	116.31	43	124.90	.113,	
	Total	237		237		$p =$	
						.737	

Table 19

Kruskal-Wallis Test Statistics: Dimension Four of Female Sexual Health by Groups

Dimension Four	Group	N	Mean Rank	Kruskal - Wallis
Frequency of Sexual Activity Desired and Achieved	<u>Age:</u>			$H(4) =$
	18 – 25	21	151.33	18.731,
	26 – 35	34	121.79	$p = .001$
	36 – 45	47	86.19	$F(4.222) = 5.182,$
	46 – 55	86	115.13	$p = .001$
	56 – 70	39	118.13	
	Total	227		
	<u>Race / Ethnicity:</u>			$H(1) =$
	All other races and ethnicities	116	110.05	1.012,
	White non Hispanic	111	118.13	$p = .314$
	Total	227		
	<u>Education level:</u>			$H(3) =$
	Less than or High School	39	112.04	.274,
	Currently in College or AD/technical	50	106.89	$p = .965$
	Baccalaureate	38	107.29	
	Graduate Degree (Master or Doctorate)	91	110.77	
	Total	218		
	<u>Menopausal Status:</u>			$H(1) =$
	Pre-menopausal	129	114.86	.061,
	Post-menopausal	98	112.87	$p = .806$
	Total	227		
	<u>Relationship Status:</u>			$H(1) =$
	Yes, in a current sexual relationship	192	110.67	2.816,
	No, not currently in relationship	34	129.47	$p = .093$
	Total	226		

at a (.05/5) .01 level of significance. There was an age difference for libido match between self and partner, $F(4.222) = 5.182, p = .001$, with the statistical significance between the 36–45 year olds and the 18–25 year olds . There were no statistically significant group differences on Dimension (F) by race/ethnicity ($H(1) = 1.012, p = .314$), education level ($H(3) = .274, p = .965$), menopausal status ($H(1) = .061, p = .806$), or relationship status ($H(1) = 2.816, p = .093$).

Dimension five: Presence of Sexual Pleasure (O) and emotional pleasure did not demonstrate group differences (Table 20) by age ($H(4) = 6.327, p = .176$), race/ ethnicity ($H(1) = .697, p = .404$), education level ($H(3) = 5.395, p = .145$) menopausal status ($H(1) = .271, p = .603$), or relationship status ($H(1) = .129, p = .719$). The Presence of Sexual Pleasure (O) and physical pleasure differed between groups by age ($H(4) = 10.578, p = .032$), Mann-Whitney U tests were again used to follow up this finding. A Bonferroni correction was applied and so all effects are reported at a (.05/5) .01 level of significance. After using the Bonferroni correction, no statistically significant difference between groups were found. The Presence of Sexual Pleasure (Dimension 5) and physical pleasure was not different by race/ ethnicity ($H(1) = 1.532, p = .216$), education level ($H(3) = 7.717, p = .052$) menopausal status ($H(1) = 2.396, p = .122$), or relationship status ($H(1) = .066, p = .798$).

Dimension six: Health State of the Relationship (R) and rating of the sexual relationship as a positive part of life was not different (Table 21) between groups by age ($H(4) = 5.543, p = .236$), race/ ethnicity ($H(1) = .976, p = .323$), education level ($H(3) = 2.389, p = .496$), or menopausal status ($H(1) = 1.223, p = .269$); however, it differed by relationship status ($H(1) = 15.709, p < .001$). Mann-Whitney U tests were used to follow

Table 20

Kruskal-Wallis Test Statistics: Dimension Five of Female Sexual Health by Groups

Dimension Five	Group	Variable 1 Emotional Pleasure		Variable 2 Physical Pleasure		Kruskal - Wallis	
		N	Mean Rank	N	Mean Rank	Var 1	Var 2
Presence of Sexual Pleasure	<u>Age:</u>						
	18 – 25	21	134.40	21	139.50	H(4)= 6.327	H(4)= 10.578,
	26 – 35	35	101.57	34	108.84	p = .146	p = .032
	36 - 45	46	103.45	46	114.61		F(10,2
	46 – 55	87	119.89	85	117.26		14) =
	56 – 70	39	116.40	39	91.17		1.276,
	Total	228		225			p= .245
	<u>Race / Ethnicity:</u>						
	All other races and ethnicities	116	111.26	113	108.23	H(1)= .697,	H(1)= 1.532,
	White non Hispanic	112	117.85	112	117.81	p= .404	p= .216
	Total	228		225			
	<u>Education level:</u>						
	Less than or High School	39	100.18	38	107.42	H(3)= 5.395,	H(3)= 7.717,
	Currently in College or AD/ technical	48	120.23	47	119.59	p= .145	p= .052
	Baccalaureate	41	122.30	41	122.76		
	Graduate Degree (Master or Doctorate)	92	104.54	91	97.99		
	Total	220		217			
	<u>Menopausal Status:</u>						
	Pre-menopausal	130	112.23	128	117.67	H(1)= .271,	H(1)= 2.396,
	Post-menopausal	97	116.37	96	105.60	p= .603	p= .122
	Total	227		224			
	<u>Relationship Status:</u>						
	Yes, in a current sexual relationship	192	114.60	189	112.93	H(1)= .129,	H(1)= .066,
	No, not currently in relationship	35	110.69	35	110.20	p= .719	p= .798
	Total	227		224			

Table 21

Kruskal-Wallis Test Statistics: Dimension Six of Female Sexual Health by Groups

Dimension Six	Group	Variable 1 Relationship a positive part of life		Variable 2 Respect felt from partner		Kruskal - Wallis	
		N	Mean Rank	N	Mean Rank	Var 1	Var 2
Health State of the Relationship	<u>Age:</u>						
	18 – 25	21	125.83	21	122.38	$H(4)=$ 5.543, $p=$.236	$H(4)=$ 10.065, $p=$.039 $F(1,227)$ $= 19.079$ $p < .001$
	26 – 35	35	166.94	35	115.00		
	36 - 45	46	105.17	46	96.86		
	46 – 55	88	122.80	87	123.22		
	56 – 70	40	104.63	40	114.11		
	Total	230		229			
	<u>Race / Ethnicity:</u>						
	All other races and ethnicities	117	111.99	118	111.81	$H(1)=$.976, $p=$.323	$H(1)=1.$ 121, $p=$.290
	White non Hispanic	113	119.13	111	118.39		
	Total	230		229			
	<u>Education level:</u>						
	Less than or High School	39	100.56	39	106.40	$H(3)=$ 2.389, $p=.496$	$H(3)=$ 3.298, $p=.348$
	Currently in College or AD/ technical	48	115.55	49	102.66		
	Baccalaureate	41	116.74	41	115.98		
	Graduate Degree (Master or Doctorate)	93	110.49	92	115.17		
	Total	221		221			
	<u>Menopausal Status:</u>						
	Pre-menopausal	130	118.47	130	113.74	$H(1)=$ 1.223, $p=.269$	$H(1)=$.216, $p=.642$
	Post-menopausal	99	110.44	99	116.65		
	Total	229		229			
	<u>Relationship Status:</u>						
	Yes, in a current sexual relationship	194	121.08	194	119.96	$H(1)=$ 15.709 $p < .001$ $F(10,$ 214) = 1.276, $p=.245$	$H(1) =$ 17.661, $p < .001$ $F(10,$ 214) = 1.276, $p=.245$
	No, not currently in relationship	35	81.31	34	83.37		
	Total	229		228			

up this finding. A Bonferroni correction was applied and so all effects are reported at a $(.05/2) .025$ level of significance. The Health State of the Relationship (R) and physical pleasure did not demonstrate a difference by race/ ethnicity ($H(1) = 1.121, p = .290$), education level ($H(3) = 3.298, p = .348$) or menopausal status ($H(1) = .216, p = .642$). The Health State of the Relationship (R) and physical pleasure differed by age ($H(4) = 10.065, p = .039$, and relationship status ($H(1) = 17.661, p < .001$). Mann-Whitney U tests were used to follow up this finding. A Bonferroni correction was applied and so all effects are reported at a $(.05/5) .01$ level of significance. After applying a Bonferroni correction, none of these findings were statistically significant.

Dimension seven: Absence of Emotional or Physical Discomfort or Distress (D) and rating of the ability to avoid an STD was not different between groups (Table 22) by age $H(4) = 8.995, p = .061$, race/ethnicity $H(1) = .114, p = .736$, or menopausal status $H(1) = 2.166, p = .141$. However, this correlation was different to a statistically significant degree by education level $H(3) = 8.226, p = .042$ and relationship status $H(1) = 8.697, p = .003$. Absence of Distress and physical pleasure from relationship was not different between groups by race/ethnicity $H(1) = 1.532, p = .216$, education $H(3) = 7.717, p = .052$, menopausal status $H(1) = 2.396, p = .122$, or relationship status $H(1) = .066, p = .798$. However, absence of distress and physical pleasure did differ between groups by age $H(4) = 10.578, p = .032$.

Table 22

Kruskal-Wallis Test Statistics: Dimension Seven of Female Sexual Health by Groups

Dimension Seven	Group	Variable 1 Ability to avoid STD		Variable 2 Physical pleasure from relationship		Kruskal - Wallis	
		N	Mean Rank	N	Mean Rank	Var 1	Var 2
Absence of Emotional or Physical Discomfort or Distress	<u>Age:</u>						
	18 – 25	23	90.09	21	139.50	$H(4)=8.995$, $p=.061$	$H(4)=10.578$, $p=.032$
	26 – 35	36	114.38	34	108.84		
	36 – 45	47	119.02	46	114.61		
	46 – 55	89	122.63	85	117.26		
	56 – 70	41	128.49	39	91.17		
	Total	236		225			
	<u>Race / Ethnicity:</u>						
	All other races and ethnicities	118	123.52	113	108.23	$H(1)=.114$, $p=.736$	$H(1)=1.532$, $p=.216$
	White non Hispanic	119	114.52	112	117.81		
	Total	237		225			
	<u>Education level:</u>						
	Less than or High School	40	108.57	38	107.42	$H(3)=8.226$, $p=.042$	$H(3)=7.717$, $p=.052$
	Currently in College or AD/ technical	51	110.60	47	119.59		
	Baccalaureate	41	100.72	41	122.76		
	Graduate Degree (Master or Doctorate)	96	124.93	91	97.99		
	Total	228		217			
	<u>Menopausal Status:</u>						
	Pre-menopausal	135	114.17	128	117.67	$H(1)=2.166$, $p=.141$	$H(1)=2.396$, $p=.122$
	Post-menopausal	101	124.28	96	105.60		
	Total	236		224			
	<u>Relationship Status:</u>						
	Yes, in a current sexual relationship	195	123.09	189	112.93	$H(1)=8.697$, $p=.003$	$H(1)=.066$, $p=.798$
	No, not currently in relationship	41	96.65	35	110.20		
	Total	236		224			

Dimension eight: Significance of a Positive Health Care Provider Relationship was not different between groups (Table 23) by age ($H(4) = .903, p = .924$), race/ethnicity ($H(1) = .246, p = .620$), education level ($H(3) = 7.334, p = .062$) menopausal status ($H(1) = .930, p = .335$), or relationship status ($H(1) = .683, p = .409$).

Dimension nine: Sisterhood was not different between groups (Table 24) by age ($H(4) = 2.795, p = .593$), education level ($H(3) = 5.439, p = .142$) menopausal status ($H(1) = .360, p = .548$), or relationship status ($H(1) = 2.667, p = .102$). Sisterhood was different between groups by race/ ethnicity ($H(1) = 6.595, p = .010$), Mann-Whitney U tests were used to follow up this finding. A Bonferroni correction was applied and so all effects are reported at a $(.05/2) .025$ level of significance. After applying the Bonferroni correction, none of the findings were statistically significant.

Research Question 4: Are the Identified Dimensions of Female Sexual Health Correlated to Each Other?

Correlations between the nine dimensions were examined (Table 25). See Appendix G, Table 4 for specific numeric values. Statistically significant findings in the correlations ($p < .001$) were noted for the pairs of dimensions marked with an asterisk.

Large effect sizes were noted for the correlations of Dimension One: The Authentic Self to Dimension Two: Communication on a deep and intimate level, and for Dimension Two to Dimension Five: Presence of Sexual Pleasure (O), also for Dimension Two to Dimension Six: Relationship Health. Medium effect sizes were noted for the correlations of Dimension One: The Authentic Self to Dimension Six: Relationship Health, for The Authentic Self to the Dimension Seven: Absence of Discomfort or

Table 23

Kruskal-Wallis Test Statistics: Dimension Eight of Female Sexual Health by Groups

Dimension Eight	Group	N	Mean Rank	Kruskal - Wallis
Significance of Positive Health Care Provider Relationship	<u>Age:</u>			$H(4) = .903$, $p = .924$
	18 – 25	23	115.37	
	26 – 35	36	126.46	
	36 – 45	47	116.47	
	46 – 55	87	117.29	
	56 – 70	42	115.38	
	Total	235		
	<u>Race / Ethnicity:</u>			$H(1) = .246$, $p = .620$
	All other races and ethnicities	118	116.58	
	White non Hispanic	118	120.42	
	Total	236		
	<u>Education level:</u>			$H(3) = 7.334$, $p = .062$
	Less than or High School	39	94.46	
	Currently in College or AD/ technical	50	110.20	
	Baccalaureate			
	Graduate Degree (Master or Doctorate)	42	115.26	
		96	123.36	
	Total	227		
	<u>Menopausal Status:</u>			$H(1) = .930$, $p = .335$
	Pre-menopausal			
	Post-menopausal	136	121.18	
	Total	99	113.63	
		235		
	<u>Relationship Status:</u>			$H(1) = .683$, $p = .409$
	Yes, in a current sexual relationship	193	116.51	
	No, not currently in relationship	42	124.86	
	Total	235		

Table 24

Kruskal-Wallis Test Statistics: Dimension Nine of Female Sexual Health by Groups

Dimension Nine	Group	N	Mean Rank	Kruskal - Wallis
Sisterhood	<u>Age:</u>			$H(4) = 2.795$, $p = .593$
	18 – 25	23	123.70	
	26 – 35	36	116.83	
	36 – 45	47	132.29	
	46 – 55	89	114.13	
	56 – 70	43	116.63	
	Total	238		
	<u>Race / Ethnicity:</u>			$H(1) = 6.595$, $p = .010$
	All other races and ethnicities	120	130.55	
	White non Hispanic	119	109.37	
	Total	239		$H(3) = 5.439$, $p = .142$
	<u>Education level:</u>			
	Less than or High School	41	111.49	
	Currently in College or AD/ technical	50	132.42	
	Baccalaureate			
	Graduate Degree (Master or Doctorate)	42	104.50	
		97	113.24	
	Total	230		$H(1) = .360$, $p = .548$
	<u>Menopausal Status:</u>			
	Pre-menopausal			
	Post-menopausal	136	121.64	$H(1) = 2.667$, $p = .102$
	Total	102	116.65	
		238		
	<u>Relationship Status:</u>			
	Yes, in a current sexual relationship	195	116.34	
	No, not currently in relationship	43	133.81	
	Total	238		

Table 25

Correlation of the Dimensions to Each Other

Dimensions to Correlate		Correlation r_s	p (2 tailed)	Effect Size
One: Authentic Self	Two: Communication on a deep and Intimate Level	.513	<.001*	Large
	Three: Emotional Health State	.235 .173	<.001* .008	Small
	Four: Frequency of Sexual Activity (libido) (F)	.199	.003	Small
	Five: Presence of Sexual Pleasure (O)	.426 .389	<.001* <.001*	Medium
	Six: Relationship (R)	.296 .328	<.001* <.001*	Medium
	Seven: Absence of Discomfort or Distress (D)	.389 (Q29 – not Q17)	<.001*	Medium
	Nine: Sisterhood	.228	<.001*	Small
Two: Communication on a deep and Intimate Level	Three: Emotional Health State	.187 (Q30 – not Q32)	.004	Small
	Four: Frequency of Sexual Activity (libido) (F)	.232	<.001*	Small
	Five: Presence of Sexual Pleasure (O)	.524 .305	<.001* <.001*	Large
	Six: Relationship (R)	.569 .530	<.001* <.001*	Large
	Seven: Absence of Discomfort or Distress (D)	.305 (Q29 – not Q17)	<.001*	Medium
	Nine: Sisterhood	.136	.040	Small
	Three: Emotional Health State	.139 .178	.036 .008	Small
Three: Emotional Health State	Six: Relationship (R)	.158 (Q19 not Q18 and only to Q30 not 32)	.017	Small
	Seven: Absence of Discomfort or Distress (D)	.193 (Q17 to Q30) .142 (Q17 to Q32) .178(Q29 to Q30)	.003 .030 .008	Small
	Nine: Sisterhood	.205 .241	.001 <.001*	Small

Table 25—Continued

Dimensions to Correlate		Correlation r_s	p (2 tailed)	Effect Size
Four: Frequency of Sexual Activity (libido) (F)	Five: Presence of Sexual Pleasure (O)	.353 .228	<.001* <.001*	Medium
	Six: Relationship (R)	.260 (Q18 not Q19)	<.001*	Small
	Seven: Absence of Discomfort or Distress (D)	.228 (Q29 not Q17)	.001	Small
Five: Presence of Sexual Pleasure (O)	Six: Relationship (R)	.462 (Q18 to Q28)	<.001*	Medium
		.257 (Q18 to Q29)	<.001*	
		.362 (Q19 to Q28)	<.001*	
		.216 (Q19 to Q29)	<.001*	
	Seven: Absence of Discomfort or Distress (D)	.153 (Q17 to Q28)	.021	Small
		.468 (Q29 to Q28)	<.001*	
	Nine: Sisterhood	.176 (Q29)	.008	Small
Six: Relationship (R)	Seven: Absence of Discomfort or Distress (D)	.200 (Q17 to Q19)	.002	Small
		.257 (Q29 to Q18)	<.001*	
		.216 (Q29 to Q19)	.001	
Seven: Absence of Discomfort or Distress (D)	Nine: Sisterhood	.176 (Q29 not Q28)	.008	Small
Eight: Significance of a Health Care Provider Relationship	Not correlated to any dimension (not statistically significant)			

Note. Effect sizes are Cohen's: small = .1 – .3, medium = .3 – .5, large = >.5

Distress; medium effect sizes were also noted for Dimension Two (Communication) to Dimension Seven (Absence of Discomfort or Distress). Dimension Four (Frequency of Activity) had a correlation with a medium effect size to Dimension Five (Presence of

Pleasure); Dimension Five (Pleasure) had a medium effect size of Dimension Six (Relationship Health) and Dimension Seven (Absence of Discomfort). The remainder of the Dimensions noted above in Table 25 had a small effect size on the other dimensions. The Dimensions representing the FORD mnemonic showed the strongest effect size to each other, along with the Authentic Self Dimension.

Research Question 5: How Do Women Rank Four Commonly Perceived Attributes of Sexual Health?

The role of relationship (R) was ranked as first (Figure 34) in importance ($n = 236$, $\mu = 1.49 \pm .71$, minimum 1, maximum 4). Having a sexual relationship that was free of distress or discomfort (D) was ranked as second (Figure 35) in importance ($n = 235$, $\mu = 2.09 \pm 1.10$). The presence of pleasure (O) was ranked as third (Figure 33) in importance ($n = 236$, $\mu = 2.61 \pm .68$) and libido (frequency/F) was ranked as least (Figure 32) in importance ($n = 236$, $\mu = 3.60 \pm .70$) (Table 26).

Research Question 5a: Are There Differences in Four Commonly Perceived Attributes of Sexual Health by Age, Race/Ethnicity, Educational Level, Menopausal Status, Relationship Status?

The attribute of Frequency (F) did not differ (Table 27) between groups by age ($H(4) = 4.233$, $p = .375$), race/ethnicity ($H(1) = 2.604$, $p = .107$), education level ($H(3) = 4.297$, $p = .231$) menopausal status ($H(1) = .007$, $p = .935$), or relationship status ($H(1) = .277$, $p = .633$). The attribute of Orgasm (O) did not differ between groups by age ($H(4) = 5.872$, $p = .209$), race/ethnicity ($H(1) = .671$, $p = .413$), education level ($H(3) = .356$, $p = .949$) menopausal status ($H(1) = .283$, $p = .595$), or relationship status ($H(1) = 3.054$,

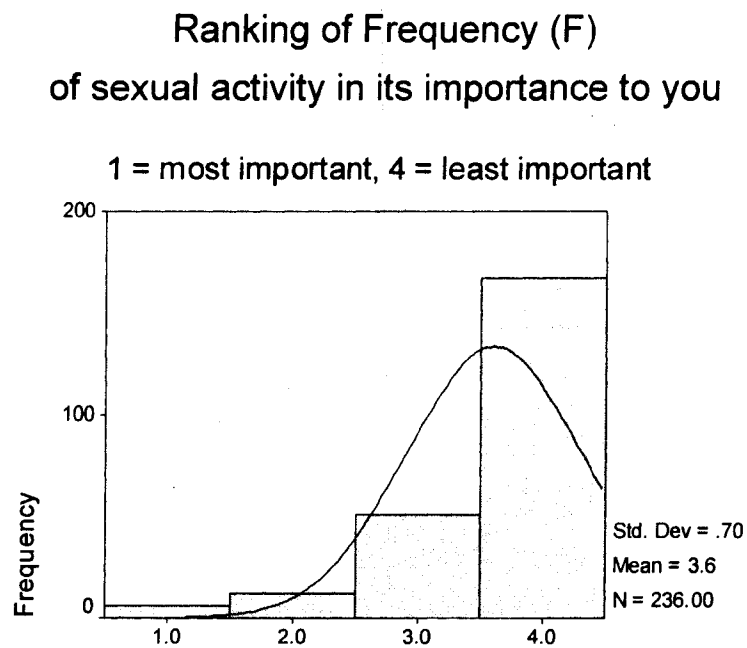


Figure 32. Ranking of frequency (F) and importance.

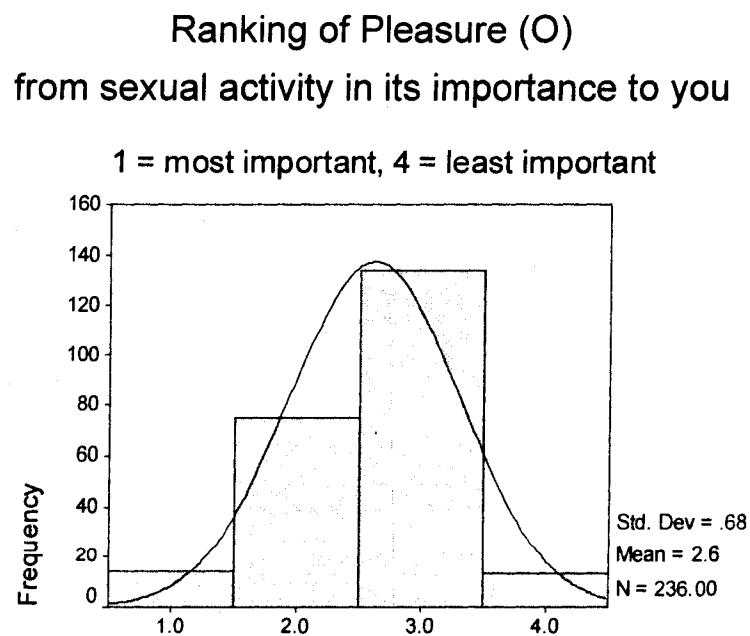


Figure 33. Ranking of orgasm (O) and importance.

Ranking of Relationship (R) health and well-being in its importance to you

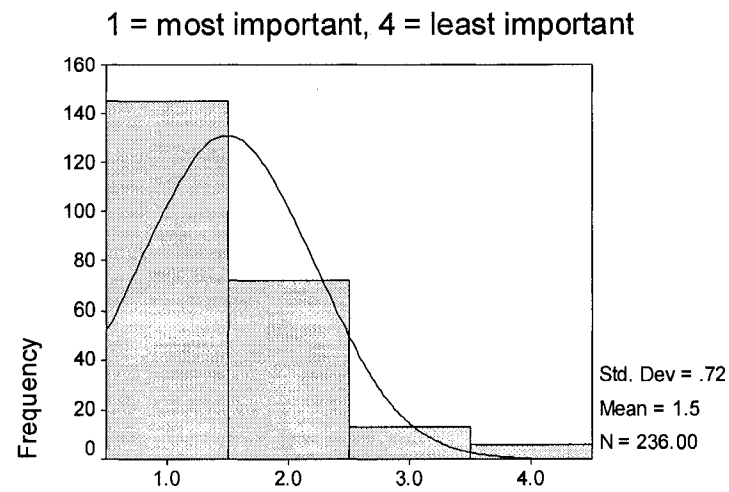


Figure 34. Ranking of relationship (R) and importance.

Ranking of Discomfort (D) absence in its importance to you

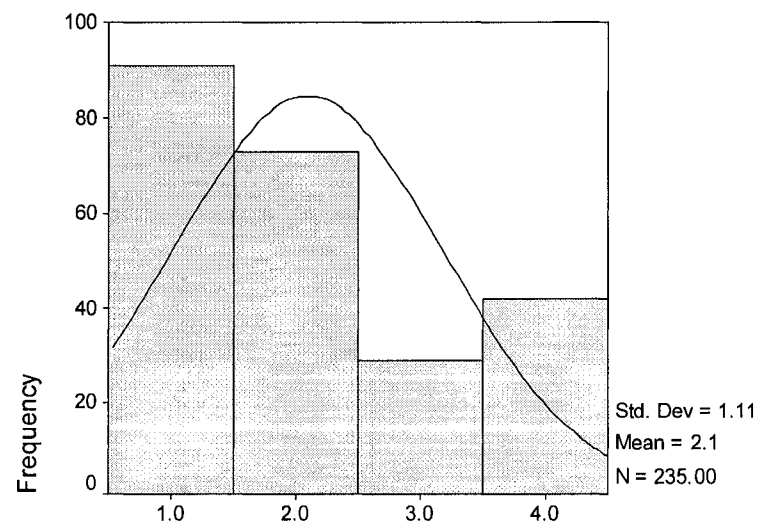


Figure 35. Ranking of discomfort (D) and importance.

Table 26

Ranking of the FORD Mnemonic

	Frequency (F)	Orgasm (O)	Relationship (R)	Discomfort (D)
<i>N</i>	236	236	236	235
Mean	3.60	2.61	1.49	2.09
Median	4.0	3.0	1.0	2.0
Mode	4.0	3.0	1.0	1.0
Standard deviation	.704	.683	.718	1.11
Minimum	1	1	1	1
Maximum	4	4	4	4
25 th %	3.14	2.08		1.16
75%		3.29	1.96	2.96

$p = .081$). The attribute of Relationship (R) did not differ between groups by age ($H(4) = 5.229, p = .265$), race/ethnicity ($H(1) = .006, p = .939$), education level ($H(3) = .955, p = .812$) menopausal status ($H(1) = .664, p = .415$), or relationship status ($H(1) = .456, p = .500$). The attribute of Absence of Distress/Discomfort (D) did not differ between groups by age ($H(4) = 6.801, p = .147$), race/ethnicity ($H(1) = .936, p = .333$), education level ($H(3) = .216, p = .975$) or menopausal status ($H(1) = .227, p = .634$) There was a statistically significant association by relationship status ($H(1) = 8.366, p = .004$). Mann-Whitney U tests were used to follow up this finding. A Bonferroni correction was applied and so all effects are reported at a $(.05/4) .0125$ level of significance. This represents a statistically significant finding between relationship status and the ranking of disease or

discomfort in its importance to the respondent; those not in relationships rated this differently than those who were in a relationship currently.

Table 27

Rank Differences for Four Commonly Perceived Attributes of Sexual Health

	Frequency		Orgasm		Relationship		Discomfort	
Groups	N	Mean Rank	N	Mean Rank	N	Mean Rank	N	Mean Rank
Age								
18 – 25	23	132.26	23	137.80	23	110.57	23	105.52
26 – 35	36	116.72	36	103.97	36	130.50	36	116.24
36 – 45	46	107.71	46	125.21	46	110.85	46	134.62
46 – 55	87	116.34	87	112.93	87	124.09	87	119.90
56 – 70	43	125.80	43	121.71	43	106.85	42	101.42
Total	235		235		235		234	
Kruskal-Wallis								
Chi-square	4.233		5.872		5.229		6.801	
df	4		4		4		4	
Asymp.Sig.	.375		.209		.265		.147	
Race/ Ethnicity								
All other races and ethnicities	117	112.74	117	115.25	117	118.21	116	122.13
White Non Hispanic	119	124.17	119	121.70	119	118.79	119	113.97
Total	236		236		236		235	
Kruskal-Wallis								
Chi-square	2.604		.671		.006		.936	
df	1		1		1		1	
Asymp.Sig.	.107		.413		.939		.333	
Education level								
< or grad HS	40	99.09	40	118.10	40	113.95	40	
AD/Technical	50	113.93	50	114.48	50	107.36	49	
Bachelor's	41	117.02	41	114.68	41	115.77	41	
Graduate	96	118.96	96	111.75	96	116.72	96	
Total	227		227		227		226	

Table 27—Continued

	Frequency		Orgasm		Relationship		Discomfort	
Groups	<i>N</i>	Mean Rank	<i>N</i>	Mean Rank	<i>N</i>	Mean Rank	<i>N</i>	Mean Rank
Kruskal-Wallis								
Chi-square	4.297		.356		.955		.216	
df	3		3		3		3	
Asymp.Sig.	.231		.949		.812		.975	
Menopausal								
No	135	117.75	135	116.20	135	120.67	135	119.2
Yes	100	118.33	100	120.43	100	114.39	99	2
Total	235		235		235		234	115.16
Kruskal-Wallis								
Chi-square	.007		.283		.664		.227	
df	1		1		1		1	
Asymp.Sig.	.935		.595		.415		.634	
Relationship								
Yes	193	117.21	193	121.20	193	116.80	192	123.2
No	42	121.62	42	103.27	42	123.51	42	0
Total	235		235		235		234	91.46
Kruskal-Wallis								
Chi-square	.227		3.054		.456		8.366	
df	1		1		1		1	
Asymp.Sig.	.633		.081		.500		.004	

CHAPTER V

DISCUSSION

The meaning of the concept female sexual health was discovered in this study through a dimensional analysis and grounded theory development. The nine dimensions to emerge from the qualitative study were emotive and physiologic. They consisted of the authentic self, communication on a deep and intimate level, emotional health, frequency of sexual activity, presence of sexual pleasure, relationship health, absence of discomfort or distress, significance of a positive health care provider relationship, and sisterhood—valued and appreciated for the journey. The nine dimensions were further examined in a population of women with an instrument developed for this purpose and eight of the nine dimensions were found to correlate positively to self-reported levels of sexual health. As mixed methods were used to analyze the concept of female sexual health, I will present a discussion on the nine dimensions blending the two analyses.

Research question 1: *What is the meaning of the concept female sexual health to a group of women? Can attributes of sexual health be identified through dimensional analysis? Are there differences in the attributes by age, race/ethnicity, education level, menopausal status, relationship status?*

The concept of female sexual health stems from the expressed sentiment that women value relationship with their partner, and also relied upon the presence of other women in their lives to enhance their sense of well-being, to mentor or to turn to in need.

Communication with their partner on a deep and intimate level was important to overall sexual health, as was a sense of emotional health. A positive health care provider relationship was reported as important by the focus group participants as a supportive measure.

The Nine Dimensions

Being an *authentic self* was a dimension of the overall concept of sexual health. This dimension could be argued to represent a concept in and of itself. Being authentic means to be able to present your self without reservation to others, to feel comfortable with the person you have become, and to feel that your life journey has developed within a rich cadre of experience (Sheldon, Ryan, Rawsthorne, & Hardi, 1997; Tracy & Tretheway, 2005). To become authentic indicates a personal maturity and confidence in the person you have become (Diehl, Hastings, & Stanton, 2001; Sheldon et al., 1997; Tracy et al., 2005). Women in the focus groups indicated that being authentic was important for overall sense of well-being and for their level of sexual health with their partner, and that this was linked to the importance of their partner respecting and valuing their true self. This dimension is seen to be consistent with Maslow's (1943, 1954) hierarchical theory of needs, and is similar to the level of self-actualization and high level emotional needs. The Authentic Self dimension correlation to self-reported level of sexual health indicated a large effect (Cohen's) size, and was one of the dimensions that correlated to each of the other dimensions, except for the health care provider dimension.

Large to moderate effect sizes were also noted for the correlations of the FORD mnemonic, and I present my discussion regarding these dimensions next.

Frequency of sexual activity as a dimension was reported to mean the desire for sexual activity, the ability to respond to libido, and the connection of the woman's libido to that of her partner. The women in the focus groups indicated that desire for sexual activity with their partner was indicative to them of being healthy. They did not express that arousal was a necessary predecessor to libido, but did indicate that if their relationship was a healthy one, they were more responsive to their libido or their partner's advances for sexual activity. Women reported sexual frequency satisfaction despite hormone status or relationship status. This may indicate that a woman's libido is perceived to be satisfactory despite endocrine support or absence of a partner. As mentioned previously, a poor libido in women is considered to contribute to relationship brevity or discord (Kaschak et al., 2001); pharmaceutical companies are investigating the impact of interventions to improve sexual desire in women (Hicks, 2005). Further exploration of libido in women may validate what was found in this study: that perceived state of satisfaction with frequency relates to overall sexual health, not altered desire states. This dimension was called "frequency" as it seemed to reflect response to partner along with response to own libido in the participants. This dimension of frequency is consistent with Brölde's (2000) health theory regarding perception of wellness and sociologic function somewhat, but also is consistent with Basson's (2000) conceptual model of sexual health incorporating desire. Correlation of frequency of sexual activity to self-reported level of sexual health indicated a moderate effect size, and frequency was correlated to several other dimensions with a moderate effect size correlation to orgasm (pleasure), a small effect size correlation to relationship and lack of distress. Frequency of sexual activity was the lowest rank in importance to the surveyed women regarding the

FORD mnemonic. This dimension, which represents libido, is an indicator of sexual health and well-being in male patients (Seftel, 2004) and is one of the diagnostic categories (APA, 2006) for sexual dysfunction. Further studies into the dimensions and the differences between genders may elicit more information about this interesting finding.

The presence of *sexual pleasure (orgasm)* was a domain of overall sexual health. Women participants expressed that they enjoyed their sexual lives and that this was important to them; no differences existed between groups based upon age or menopausal status or relationship status. Finding pleasure in physiologic function also fits into a more holistic view of health, and seems to combine Brölde's (2000) constructs of perceived state of wellness and physiologic function. That the women surveyed did not rate sexual pleasure higher than relationship health or lack of discomfort was interesting and bears further study. It perhaps represents that women gain more emotional pleasure (emotional health) and sense of satisfaction (authentic self) from their sexual relationship or sexual activity than they experience physical pleasure. This also affirms the statements of the sexologists reviewed prior that physical pleasure does not seem to be the primary motivator for women in their sexual lives (Basson, 2000; Berman & Bassuk, 2002; Kaplan, 1974b; Kinsey et al., 1953; Masters & Johnson, 1966; Maurice, 1999; Westheimer & Lopater, 2005). Kinsey (Kinsey et al., 1953) noted in his studies the presence of sexual activity when orgasm occurred. The women in this study ranked pleasure above frequency, and behind relationship health and lack of distress as third in importance in their sexual health achievement. Pleasure (the FORD O) had a medium effect size correlation to self-reported level of sexual health for these women, and a

moderate effect size correlation to the relationship health (FORD R) and absence of distress (FORD D).

Relationship health was expressed by the women in the qualitative study and the survey instrument as a dominant component of overall sexual health. It validates my belief that there are more emotive and sociologic constructs to health than simply physiologic function. Marital therapy and relationship interventions for those couples and individuals in crisis will often address the role of sexual activity in overall relationship health (Westheimer & Lopater, 2005), and this study validates that for women relationship health and satisfaction was associated with their overall perceived state of sexual well-being. Future studies on relationship health as a separate concept of “health” may find that there are social functions, perceived state of wellness, and physiologic functions to this dimension. It is certainly feasible that communication and partner respect for the authentic self contribute to this dimension, and therefore all three are interrelated to overall sexual health in women. This dimension is consistent with Brölde’s (2000) concept of health incorporating sociologic function as one domain. The women in the survey noted a correlation of relationship health to self-reported level of sexual health (moderate effect size); they ranked this to be the most important of the FORD mnemonic to their overall sense of sexual health. Relationship health had a moderate effect correlation to the authentic self and pleasure, a large effect size correlation with communication with the partner being deep and intimate, a moderate effect correlation to the authentic self and pleasure, and a small effect correlation with emotional health and the FORD F (frequency). It was interesting that women felt this was the primary issue that their HCPs should address in their assessments. Taking this message to HCPs that

women's sexual health may be related to relationship health more than libido or pleasure could encourage the providers to look at sociologic constructs of health outside of the physiologic domains.

Absence of distress or discomfort did emerge as a dimension of the concept sexual health from the grounded theory development. This is consistent with the medical definition of health as absence of disease, and is also consistent with Brülde's (2000) definition of health being inclusive of absence of disease or distress. Women in the focus groups felt this was an issue of import in their overall sexual health and well-being, women in the instrument testing also indicated that this was an area they felt comfortable having their healthcare provider address. Some of the respondents indicated that they would be uncomfortable having their HCP discuss sexual health issues unless they brought up a complaint. This bears further analysis as health care practitioners strive to address women's health issues in the primary care setting. The ICD codes for billable diagnoses indicate that personal complaint must accompany pathology for use of these terms in the clinical setting (APA, 2006; WHO, 1992); preliminary information from this study indicates that some women feel uncomfortable going beyond personal distress complaints in the clinical setting. It would be interesting to note if the respondents would feel comfortable having their health care provider routinely ask about sexual health from the medical view, e.g., "Are you experiencing any discomfort or distress in your sexual function?" instead of asking patients to self-rate their sexual health and if they are pleased with sexual function (more positive terminology). Absence of distress correlations had a moderate effect size with the authentic self, communication, and pleasure and a small effect size with emotional health, frequency, and relationship health dimensions. It was

ranked by the women surveyed as number two in order of importance of the FORD mnemonic.

Communication on a deep and intimate level also emerged from the dimensional analysis as an attribute or domain of female sexual health. The participants expressed that it was important to them that their partner be able to listen to them, to share their lives verbally and emotionally, and to trust that the communication was valued by their partner. To communicate deeply, a woman needs to feel that her expressed thoughts are respected and heard. This contributed to overall sense of sexual health by improving the social function of the relationship in emotional support, and mirrors a concept of health that incorporates emotive and sociologic components. This dimension is consistent with sociologic function (Brülde, 2000) as a dimension of health, and sociological principles of intimate communication being essential for relationship health (Tiefer, 2006b; Westheimer & Lopater, 2005). Communication as a dimension correlated to the authentic self, pleasure, and relationship health dimensions with a large effect size, to absence of distress with a moderate effect size, and to emotional health, frequency, and sisterhood dimensions with a small effect size. Perhaps teaching appropriate communication techniques to women who are dissatisfied with the level of their sexual health, or to their partners, would be found in further studies to enhance their sexual lives.

Emotional health as a dimension contributes to overall sexual health as a concept. To be emotionally healthy is a similar concept to being the authentic self, and may need to be explored further to see if these are different dimensions or part of the same dimension. The women in this study indicated that emotional health meant to feel well about themselves, to feel that they had something to offer their partner and their world.

When the women reported an emotionally diminished mood or a lower self-esteem this impacted their reported sexual health state rating. This dimension contributes to understanding that a woman's overall health is not limited to physical well-being and instead is made of emotive or psychological constructs. It also is a dimension that mirrors Brülde's (2000) theory of health, with perception of wellbeing a component. Emotional health had a small effect size on the other dimension correlations to authentic self, communication, pleasure, relationship health, absence of distress, and sisterhood. I would suggest that this dimension be examined further as possibly a separate and only minimally related dimension of overall sexual health; as this was an exploratory study, further implications of this finding of a small effect size with emotional health to authentic self could not be examined further.

In this study, women expressed enjoyment of relationships with each other (the *sisterhood* dimension) and with their sexual partner. This is consistent with the WHO (1946, 2002) definition of health, indicating that health is not just physiologic, but also emotional and functional. It is also consistent with Brülde's (2000) theory of health indicating that sociologic function is a component of wellbeing. Further studies on this dimension could address the impact of adding supportive relationships to women's overall health and well-being. It would also be enlightening to investigate whether men feel the same need to be in a relationship with other men to enhance their sense of sexual health. Also, this should be evaluated in other groups that are not predominantly heterosexual; does the sisterhood dimension apply to women with same gender relationships? This dimension correlated to the dimensions of authentic self, communication, emotional health, pleasure, and absence of distress with a small effect

size, and correlated to level of sexual health with a small effect size. There was not a large effect size in correlation to overall female sexual health in this study for the population surveyed.

The *presence of a positive health care provider experience* emerged as a dimension from the focus group analysis, but was not validated as a correlate of sexual health with the survey instrument. It is possible that this concept emerged from the qualitative study because there were specific questions in the New View, and thus focus groups, regarding this, that I am a health care provider of women's services, or that several of the participants in the focus groups were studying the health care fields. It is also possible that this is not a separate dimension to overall physical health and emotional health by women utilizing a HCP who helps them with their health promotion efforts. Further testing regarding the gender of HCP to patient may indicate that this is a component of the sisterhood dimension, or of general health management.

Summation of Findings Within the Dimensions

Compared to women who reported lower levels of female sexual health, women in the sample who reported that their sexual health was higher were more likely to report that their authentic self was developed and supported, that they communicated well and deeply with their partner, that they were emotionally healthy, that their libido was matched to the partner, that they received emotional and physical pleasure from their relationship, and that they had women friends and family to rely upon for emotional support. The only dimension discovered during the qualitative study that was not upheld in the quantitative survey was importance of a positive HCP relationship. As stated

previously, this may be due to the population of study in the focus groups, or it may be due to other factors not addressed by the survey such as the gender and age of health care provider to patient.

Ranking of the FORD Mnemonic

An objective of this study was to evaluate my rapid assessment instrument for the clinical setting—the FORD mnemonic. The dimensions representing the four aspects of FORD (frequency/libido, orgasm/pleasure, relationship health, and lack of discomfort) emerged from the qualitative analysis and were tested further with the survey instrument by having the participants rank in importance four dimensions (the FORD mnemonic) of female sexual health. The dimension with the highest ranking was relationship health (R), followed by absence of distress (D), pleasure or orgasm (O), and in fourth place frequency or libido (F). Level of sexual health or the dimensions noted to comprise the concept FSH generally did not differ by age, race/ethnicity, education level, menopausal status, or relationship status. However, there was a difference between age groups in regards to frequency of sexual activity or libido, with the greatest difference noted between ages 18–25 and ages 36–45. Libido was found to more strongly correlate to sexual health rating in the younger age group than the 36–45 year old group. By group comparisons regarding relationship status also affected relationship health ratings (those not in a relationship rated their relationship health lower). This finding is congruent with common sense, that relationship health is rated lower if someone is not in a relationship, but could be examined further in future studies. Race/ethnicity affected the sisterhood dimension correlation to female sexual health, with those in non-White Hispanic or other

ethnicities reported a stronger correlation between sisterhood and sexual health. Further evaluation of the sisterhood domain with health should be undertaken in more racially and ethnically diverse populations than this exploratory study.

In summary, the top five effect sizes for the correlations to self-reported level of sexual health, and for correlations to each other were the dimensions of authentic self, and the FORD mnemonic: frequency of sexual activity desired and achieved, orgasm or pleasure received from sexual activity, relationship health, and absence of distress in sexual health.

The Ford Theory Is Emerging

When analyzing this information, I began to see that sexual health has several levels. In evaluation of the transcripts, I began to envision a hierarchical system (Figure 36) very similar to Maslow's (1943, 1954, 1968) Hierarchy of Needs. At the beginning of their sexual lives, women build a base of response to their libido and need for pleasure.

They are beginning to develop a sense of themselves, but are also establishing a knowledge base that incorporates how to be in relationship with their partner and with others. As they mature, emotional health and the ability to communicate on a deep and intimate level are developed. Of note is that this maturity is not reflected in chronological age, but represents emotional maturity. Relationships with the partner and with others, including other women support this journey. A higher degree of sexual health is achieved with the development of the authentic self that is acknowledged and respected by the partner. It is built upon a base of comfort with their libido level and their recognition

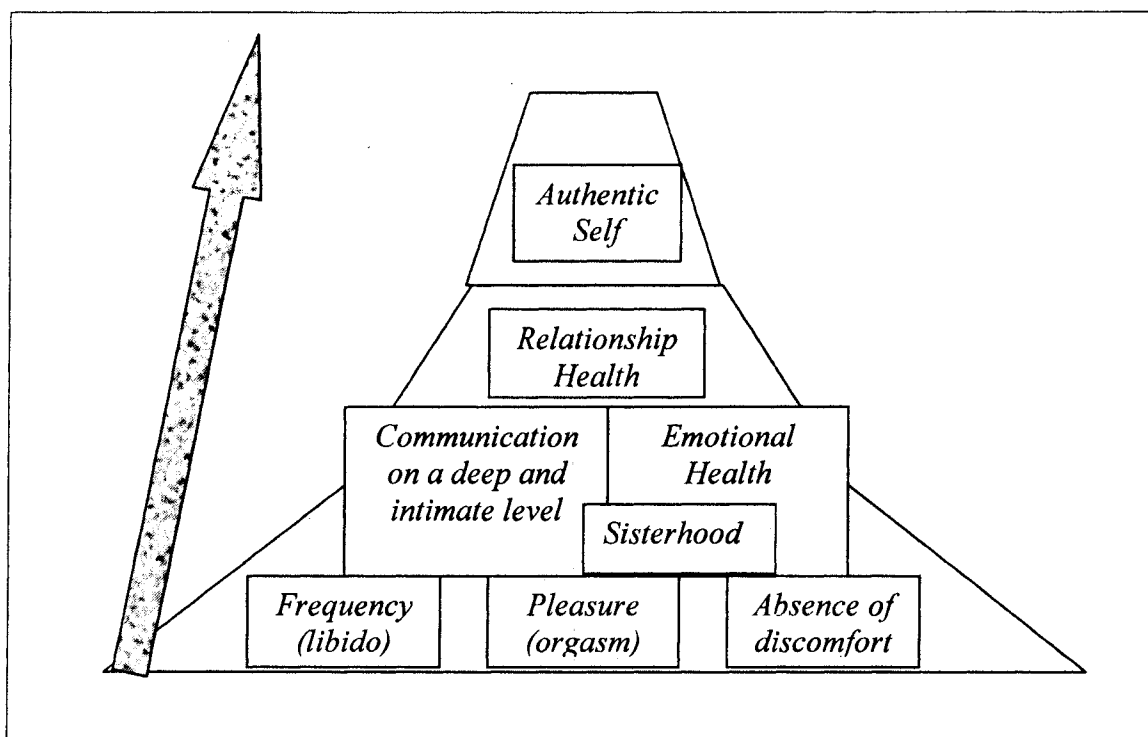


Figure 36. Schematic representation of the theory to emerge from this study.

of emotional and physical pleasure that can be received from a partner, and freed from physical or emotional distress—women become content and secure in their sexual lives. This preliminary schema bears further evaluation in more diverse populations.

Conclusions Looking Back to Original Stated Problems

A problem noted and reviewed in Chapters I and II is that women's sexual health as a concept warranted further study and investigation. In order to recognize dysfunction, to treat this, or to support sexual health in women, I have argued that providers of women's health care must understand what is healthy sexual function outside of disease prevention (medical) terms—what are the emotive and sociologic constructs of this

concept. Little research exists in this field (Anastadias et al., 2002; Berman & Bassuk, 2002; Berman & Goldstein, 2002). This was an exploratory study, and as such the emerging theory bears continued exploration and comparison to what is known about the dimensions of sexual health: libido, desire, quality of life, distress. As stated earlier in this chapter, the nine dimensions to emerge from the qualitative segment of this study should continue to be evaluated for a separate or distinct property versus a true domain of the concept of sexual health.

It is understood that women's receptivity and sexual seeking behavior may not have a physiologic basis (Basson, 2000; Berman & Bassuk, 2002; Masters & Johnson, 1966; Westheimer & Lopater, 2005). This differs from the male model of sexology. Sexual dysfunction is the lack of ability to become aroused or achieve physical pleasure from sexual activity and can signify vascular disease or other pathophysiology in men. This does not appear to be so with women overall (Sutherland & Althof, 2004) or those in this study.

Women reported a high level of sexual health despite not being in a current sexual relationship. They reported that frequency (libido) and pleasure from sexual activity was less important than relationship health. Psychosocial impact of sexual desire disorders in women indicates that sexual dysfunction is a component of mental distress and relationship conflict (Kaschak & Tiefer, 2001). The findings in this study that higher levels of emotional health and relationship integrity were associated with higher levels of self-reported sexual health support this theory.

Brölde's (2000) concept of health as being comprised of physiologic function, perceived state of wellness, social function, and absence of distress is similar to the

analysis and grounded theory of female sexual health to emerge from this study. Women noted that physiologic function was important to sexual health through the results for frequency and orgasm. Perceived state of wellness was supported as a component of sexual health as shown by the results for authentic self, emotional health, and lack of distress. Social function level was correlated to sexual female health as shown in results for relationship health, communication on a deep and intimate level, and sisterhood, and finally, the absence of distress indicated a higher perceived level of sexual health.

What Do Health Care Providers Need to Know?

Health care providers need to regard their patient's health state in part from the patient's view. In order to incorporate sexual health assessment into a holistic evaluation and management strategy, the HCP should be aware of the components that affect sexual receptivity and satisfaction in women. Women will often not broach subjects of arousal, libido, orgasm, or sexual problems with their health care practitioner (Heiman & Meston, 1997). HCPs do not consistently screen female patients for sexual health issues as part of routine health maintenance examinations (Anastadias et al., 2002; Berman & Bassuk, 2002; Berman & Goldstein, 2002). This may be in part due to discomfort on the part of the provider or that women are reluctant to bring up the issue for fear of being misunderstood. This research study found that for the population studied, women do not highly report a desire for questions regarding their sexual lives to come from their HCP unless it is a concern on her part.

As noted in the review of the literature, the general consensus is that female sexual health does not seem to fit the male model, nor does sexual function necessarily

indicate the same thing in women that it does in men (Maurice, 1999). The male model that is focused upon structure (erection and ability to copulate) and function (satisfactory orgasm) does not appear to apply to women (Anastadias et al., 2002; Berman & Bassuk, 2002; Berman & Goldstein, 2002). This study was also consistent with this viewpoint.

What health care providers need to know is that women's sexual health evaluation is better addressed from a holistic paradigm that incorporates social function (relationship health), perceived state of wellness (authentic self), physiologic function (libido and pleasure), along with absence of disease or dysfunction or distress.

Unique Strengths of This Study

This research differs from the reviewed prior approaches because I listened to the voices of women to understand and generate a theory about the dimensions and constructs of healthy sexuality. Kinsey (Kinsey et al., 1953) purposely sought individuals for his research who had a sexual cathexis or did not represent societal norms. This research differs in that the focus groups sought individuals who claimed sexual health; the instrument for outcome analysis asked for a self-rating on the level of sexual health, and incorporated more emotive and sociologic constructs than designating a sex act as satisfactory if orgasm was achieved. This research differs from the work of Masters and Johnson (1966), Basson (2000), and Kinsey et al. (1953) in that women were encouraged to provide a definition of sexual health—and to base their responses to the research questions upon this self-definition. The age categories spread from age 18 to age 70 contributed to the strength of this study, and differed from the prior work of Masters and Johnson (1966), and that of Kinsey et al. (1953).

There is a need to understand what the concept female sexual health means in order to accurately evaluate a woman. Prior evaluative instruments and surveys focused upon dysfunction or were tested in men with limited applicability to female patients (Meston & Derogatis, 2002; Symonds et al., 2005; Taylor et al., 1994). This study cannot be compared to prior research on instrument development and testing because of the different construct of “health” being addressed, rather than “distress” or “dysfunction.” The correlations of the dimensions to the self-reported level of sexual health should be examined further in more diverse groups of women than this limited population of women studied. This is preliminary data, and the moderate to large effects of four commonly perceived attributes of sexual health, the FORD mnemonic, also bears further evaluation in more diverse groups of women for the potential development of a rapid assessment mnemonic for HCPs.

Consequential validity, the extent to which the research will function as a catalyst for action, remains to be seen. Postdoctoral testing of the dimensions and the FORD mnemonic as a rapid assessment device is planned for the years following completion of doctoral study. I hope to bring to light aspects of sexual health that may not have been considered before, notably the dimension of the authentic self being correlated so strongly (Cohen’s large effect size) to reported levels of sexual health in women. If this continues to be validated in further research, future endeavors to help women achieve satisfactory sexual health levels may need to include actions that support the development of the authentic self.

Implications

This mixed methods analysis of the concept of female sexual health has several implications for current theory and practice. First of all, use of the grounded theory approach continues to be a useful endeavor in qualitative research. Through application of this theoretical model, a theory emerged from dimensional analysis of the data. Another contribution of this study is for HCPs to begin to understand the concept of sexual health in women, and to support the development of a rapid assessment device such as the FORD mnemonic for use in the health care setting. Self-rating scales have been suggested as a reliable assessment tool (Durant & Carey, 2002; Farber, 2003).

The research hypotheses that the nine dimensions of sexual health discovered in the qualitative analysis would be correlated with self-reported sexual health was supported for all except one dimension: that of the HCP relationship. HCP relationship was not associated with FSH. Possible reasons for this limited support to the hypothesis may include that the focus group questions, being derived from the New View theory, supposed that this was a theoretical construct of sexual health in women. Another possible reason for this limited support is that the women in the focus groups may have offered this information because of awareness that I was a HCP, or that they were studying the health care field (in the instance of the college age women).

Limitations

Limitations of this study that may affect the validity or the generalizability of the results include that it is limited to a demographic of women in a Midwestern college

town, predominantly sampled from a university setting, and the majority of respondents were highly educated and White non-Hispanics. Kinsey's and Masters' and Johnson's sentinel studies also had a limited demographic to Caucasian women, Masters' and Johnson's studies were limited to a higher educated woman, also. It should also be noted that sexual health as a concept comes from a personal definition and application of this construct. How sexual health is interpreted in a woman's life is linked to her emotional health and relationship integrity. Reliance upon self-reports regarding emotive and sociologic constructs may further limit the validity or generalizability of the results.

Both a strength and a weakness of this study is that it was exploratory study using mixed methods. Although it did contribute to the rich data obtained, and the "thick descriptions" of the concept from the analysis, the concept of sexual health is very complex, and may not have been fully explored in this preliminary analysis. The study of health, of sexual health, and of emotive constructs warrants full and in depth analysis of perceptions. As such, this study's primary strength was to listen to the voices of women and to develop a theory, grounded within a qualitative study with rigor and analyzed critically for dimensions to emerge. The dimensions were further tested using a survey developed for that purpose; as such the results are specific to the theory that was developed. This enhances the richness of the results and contributes to the understanding of a complex concept in women's health.

Future Work

Recommendations for future research would include further testing of the dimensions, specifically the FORD mnemonic that emerged as a component of sexual

health for women. The mnemonic could be tested in men to determine if there were gender differences in ranking. It would also further the science of understanding female sexual health to have men rate their relationship health, authentic self, ability to communicate with their partner, and emotional health and compare men's answers with the results of this study. A high percentage of this sample was White, non-Hispanic, heterosexual and had graduate degrees. Further testing should occur in different racial, ethnic, socioeconomic, intellectual, and sexual orientation groups.

Summative Statements

This study has implications for professional practice. Information about what women feel their HCP should know or address regarding their sexual lives may serve to educate health practitioners about female sexuality. The dimensions to emerge from the analysis may be tested further by developing a rapid assessment device, such as the FORD mnemonic, and educating HCPs on its use and application in daily primary care practice. Certainly educating HCPs on a basic understanding of the complex meaning of women's sexual health may contribute to more comprehensive evaluation and intervention of female clients under their care. Information about the lack of many between group differences is also helpful to inform the practice of a provider and to encourage cultural competence.

The information may resonate in the lives of women. Sexual health may be enhanced by understanding the basic underlying message to the dimensions: a genuine interest in a woman's authentic self promotes sexual health.

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Appendix A
Human Subjects Institutional Review Board
Letter of Approval

WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: October 4, 2006

To: Marie Gates, Principal Investigator
Zoann Snyder, Co-Principal Investigator
Laura Ford, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

A handwritten signature in cursive script that reads "Amy Naugle".

Re: HSIRB Project Number: 06-08-18

This letter will serve as confirmation that your research project entitled "The Development and Testing of an Instrument to Measure Female Sexual Health" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: October 4, 2007

Walwood Hall, Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276

Appendix B
Recruitment Flyer

RECRUITMENT FLYER

Western Michigan University, Department of Interdisciplinary Health Studies
Principal Investigator, Marie Gates, PhD, RN
Co-Principal / Student Investigator, Laura Ford, MS, RNC, CNP
The Development and Testing of an Instrument to Measure Female Sexual Health

Doctoral student Laura Ford, MS, RNC, CNP invites you to participate in a focus group to discuss the concept "Female Sexual Health." Ms. Ford seeks participants who are female, and who have no issues or complaints with their sexual function. Compensation for your time and participation will be provided, and your responses will be kept strictly confidential and anonymous. If you are interested in learning more about participating in this research study – please contact Ms. Ford on the following phone number: (269) 330 0471. You may also send an inquiry to Ms. Ford at LakeView Family Care, 52375 Main Street, Mattawan MI 49071.

Appendix C
The New View Theory

THE NEW VIEW THEORY

Women's Sexual Problems: A New Classification

Source: Kaschak, E., & Tiefer, L. (Eds.). (2001). *A New View of Women's Sexual Problems*. New York: Haworth Press.

I. SEXUAL PROBLEMS DUE TO SOCIO-CULTURAL, POLITICAL, OR ECONOMIC FACTORS

- A. Ignorance and anxiety due to inadequate sex education, lack of access to health services, or other social constraints:
 - 1. Lack of vocabulary to describe subjective or physical experience.
 - 2. Lack of information about human sexual biology and life-stage changes.
 - 3. Lack of information about how gender roles influence men's and women's sexual expectations, beliefs, and behaviors.
 - 4. Inadequate access to information and services for contraception and abortion, STD prevention and treatment, sexual trauma, and domestic violence.
- B. Sexual avoidance or distress due to perceived inability to meet cultural norms regarding correct or ideal sexuality, including:
 - 1. Anxiety or shame about one's body, sexual attractiveness, or sexual responses.
 - 2. Confusion or shame about one's sexual orientation or identity, or about sexual fantasies and desires.
- C. Inhibitions due to conflict between the sexual norms or one's subculture or culture of origin and those of the dominant culture.
- D. Lack of interest, fatigue, or lack of time due to family and work obligations.

II. SEXUAL PROBLEMS RELATING TO PARTNER AND RELATIONSHIP

- A. Inhibition, avoidance, or distress arising from betrayal, dislike, or fear of partner, partner's abuse or couple's unequal power, or arising from partner's negative patterns of communication.
- B. Discrepancies in desire for sexual activity or in preferences for various sexual activities.
- C. Ignorance or inhibition about communicating preferences or initiating, pacing, or shaping sexual activities.
- D. Loss of sexual interest and reciprocity as a result of conflicts over commonplace issues such as money, schedules, or relatives, or resulting from traumatic experiences, e.g., infertility or the death of a child.
- E. Inhibitions in arousal or spontaneity due to partner's health status or sexual problems.

III. SEXUAL PROBLEMS DUE TO PSYCHOLOGICAL FACTORS

- A. Sexual aversion, mistrust, or inhibition of sexual pleasure due to:
 - 1. Past experiences of physical, sexual, or emotional abuse.
 - 2. General personality problems with attachment, rejection, co-operation, or entitlement.
 - 3. Depression or anxiety.
- B. Sexual inhibition due to fear of sexual acts or of their possible consequences, e.g., pain during intercourse, pregnancy, sexually transmitted disease, loss of partner, loss of reputation.

IV. SEXUAL PROBLEMS DUE TO MEDICAL FACTORS

Pain or lack of physical response during sexual activity despite a supportive and safe interpersonal situation, adequate sexual knowledge, and positive sexual attitudes.

Such problems can arise from:

- A. Numerous local or systemic medical conditions affecting neurological, neurovascular, circulatory, endocrine or other systems of the body;
- B. Pregnancy, sexually transmitted diseases, or other sex-related conditions.
- C. Side effects of many drugs, medications, or medical treatments.
- D. Iatrogenic conditions.

Appendix D

Question Framework for Focus Groups

QUESTION FRAMEWORK FOR FOCUS GROUPS

ICE BREAKER:

Hi. If any of you know each other in another setting, please do not refer to her by her real name. What we say here stays in the room other than has been designated by Laura Ford.

I am going to supply you with some scratch paper as you may want to jot down your ideas or concerns as we go along. Even though I will be asking questions and probing some of your answers, I want you to keep your focus on talking to one another, not to me or to Laura Ford who is the invisible woman now.

In order to get to know one another just a bit, I would like for you to briefly share something about yourself that you think is important for us to know.

Q: What does being sexually healthy mean to you?

Q: How do you define sexual well-being?

All too often women's sexual health isn't discussed openly and within the medical field it may only be addressed in the negative, such as dysfunctional.

Probes:

A: Aspects of Medical or Health Issues:

- 1) How does **an understanding of your body** fit into your understanding of sexual health?
- 2) **How do you define sexual function?**
- 3) Does an **understanding of sexual function** contribute to your sexual health and wellbeing?
- 4) When you are uncomfortable with an aspect of your sexual health – **how do you feel about taking this concern to your health care provider?**
- 5) **How does access to a health care provider** make you feel about your sexual health?

B: Aspects of Sociocultural or Political or Economic Factors

- 1) How much do **your roles in society** impact your sexual function? For example – does your role as a daughter or as a mother affect your sexual function? Other roles?
- 2) **In which roles are you most confident in** your world?
- 3) **How do these roles impact** your sexual health?
- 4) How does **the ability to express yourself** on an emotional level or intellectual level in your day to day life impact your sexual health?

C: Aspects of Psychosexual Factors

- 1) How does **self esteem** contribute to how you feel about yourself sexually?
- 2) How necessary is it to have **sexual feelings in order to desire** sexual activity?
- 3) How does **the past** affect your present sexual health?

D: Aspects of Sexual Partners and Relationships

- 1) How important is a sense of **emotional** intimacy with your partner to **sexual** intimacy?
- 2) How important is **communication with your partner** to your sexual health?
- 3) How important is your partner's **understanding of you** as a person to your sexual health?
- 4) How are you **able to be your authentic self** with your partner?

Appendix E
Pilot Instrument

PILOT INSTRUMENT

Western Michigan University, Department of Interdisciplinary Health Studies
Co-Principal / Student Investigator, Laura Ford, PhDc, RN, CNP
Co-Principal Investigator/ Dissertation Chair, Amy Curtis, PhD

Dear Potential Participant:

Your name has been randomly selected from a mailing list for inclusion in a research study on a newly developed instrument to evaluate or assess female sexual health. The purpose of this study is to discover what the concept 'female sexual health' means to women. There are no right or wrong answers. You are being asked to complete the questions as completely and honestly as possible. A return envelope is included for your reply. By returning this survey to the researcher in the enclosed stamped and addressed envelope, you imply your consent to use the answers provided as research data regarding the concept of Female Sexual Health. Please do not note on the survey your name or address in order to maintain the anonymity of your response.

In order to participate in this survey you must be a female. If you are not a female please do not complete the survey.

You may choose to not answer the survey, or to refuse to answer any question without prejudice, penalty, or risk of any loss of service you would otherwise have. You may choose to contact the Primary (Doctoral Student) Investigator Laura Ford (269.330.0471) should questions or problems arise. You may also contact the Chair of the Human Subjects Institutional Review Board (269.387.8293) or the Vice President for Research (269.387.8298) if questions or problems arise during the course of the study. This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

Thank you for agreeing to participate in pilot testing a new survey instrument.

In 2002, the World Health Organization described sexual health in a holistic manner. The description of what women mean when they report sexual health needs further exploration and understanding. Toward that end, this doctoral research is focused upon two general goals: to listen to women regarding sexual health, and to develop an instrument or question format for health care practitioners to use to address and assess women's sexual health in a clinical setting.

Please consider offering your views on this important subject. Your responses are anonymous and will contribute to the study on this important part of life.

This survey will take 10 minutes of your time to complete.
To participate in this study, you should be female.

Your gender is:

- ☐ Female
☐ Male → ↓

Do not complete the survey if you answered yes to Male.

1. Your age is:

- | | | |
|-------------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> 20 or less | <input type="checkbox"/> 36 – 40 | <input type="checkbox"/> 56 - 60 |
| <input type="checkbox"/> 21 – 25 | <input type="checkbox"/> 41 – 45 | <input type="checkbox"/> 61 - 65 |
| <input type="checkbox"/> 26 – 30 | <input type="checkbox"/> 46 – 50 | <input type="checkbox"/> 66 - 70 |
| <input type="checkbox"/> 31 – 35 | <input type="checkbox"/> 51 – 55 | <input type="checkbox"/> 71 or over |

2. What is your race?

- ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Multiracial

3. What is your ethnicity?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Multi-ethnic |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Other: _____ |

4. What is your educational background?

- ☐ less than High School
☐ High School Graduate or equivalent
☐ Currently in college
☐ College Graduate (Technical or Associate's Degree)
☐ College Graduate (Bachelor's)
☐ College Graduate (Master's or Doctorate)

5. Are you still menstruating / having your cycle or period?

- ☐ Yes → ↓
 If yes, skip question 6 and go to question 7
☐ No

6. If you have stopped menstruating, was it because of:

- ☐ natural or spontaneous menopause (stopped period on my own)
☐ surgical menopause (hysterectomy or ablation)
☐ I don't know

7. Do you still have your ovaries?

- ☐ Yes, I have both of my ovaries
☐ Yes, I have one ovary
☐ No, I have had my ovaries removed surgically
☐ I don't know

8. Mark the box that corresponds to the statement that best describes your sexual experience.

- ☐ Entirely heterosexual
- ☐ Largely heterosexual, but some homosexual experience
- ☐ Largely heterosexual, but considerable homosexual experience
- ☐ Equally heterosexual and homosexual
- ☐ Largely homosexual, but considerable heterosexual experience
- ☐ Largely homosexual, but some heterosexual experience
- ☐ Entirely homosexual

9. Are you currently in a sexual relationship?

☐ Yes → ↓

☐ No → go to question 11.

10. If yes to #9: How long have you

been in this relationship? _____ years

_____ months go → question # 13.

11. Have you ever been in a sexual relationship (past)?

☐ Yes → ↓

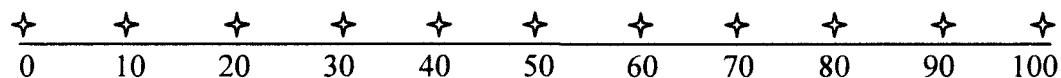
☐ No → if no, go to question 13.

12. If yes to # 11: How long was your

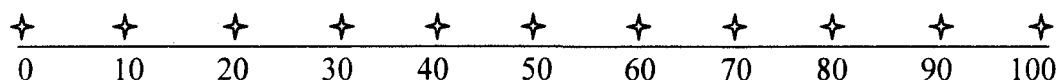
primary prior sexual relationship? _____ years

_____ months

13. Using the following scale: place an **X on the line over the number rating your personal level of sexual health.**



14. Using the following scale: place an **X on the line over the number rating your ability to communicate your desires and needs. To what degree are you able to express yourself with those whom you love?**



The following questions relate to the relationship that you described in the above questions. It is the relationship that you consider to be your primary sexual relationship, either currently or in the past. If you are in a current relationship, please answer considering that relationship. If you had a past relationship, please answer questions based upon the experience you consider to be your primary past sexual relationship. **If you answered 'no' to current or past relationships, please skip this section of the survey (questions 15 – 26).**

15. In general, my relationship is a positive part of my life.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

16. In general, I feel that I am respected by my partner for who I am.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

17. In general, I find it easy to communicate with my partner.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

18. In general, I am able to communicate on an emotionally deep and intimate level with my partner when appropriate.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

19. In general, I am able to communicate my sexual needs to my partner.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

20. In general, my partner and I are equally matched regarding the frequency of our desire for sexual intimacy:

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

21. In general, the frequency of my sexual activity with a partner has been:

- ☐ less than what I desired
☐ as much as I desired
☐ more than I desired
☐ no opinion or don't know

22. In general, having my emotional needs met by my partner assists in arousing me for sexual intimacy.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

23. In general, my desire for sexual activity is linked to my mood.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

24. In general, I have found that as a relationships matures, my sexual satisfaction increases.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

25. In general, I achieve emotional pleasure from my sexual relationship.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

26. In general, I achieve physical pleasure from my sexual relationship.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

This section may be answered regardless of your 'yes' or 'no' response to the question about the presence of a sexual relationship in your life.

27. I have a positive view of my self.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

28. Overall, how important a part of your life is your sexual activity?

- | | |
|--|---|
| <input type="checkbox"/> not at all important | <input type="checkbox"/> somewhat important |
| <input type="checkbox"/> somewhat not important | <input type="checkbox"/> very important |
| <input type="checkbox"/> neither important nor unimportant | <input type="checkbox"/> no opinion or don't know |

29. In general, I experience emotional pain/ discomfort as a result of my sexual life.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

30. In general, I experience physical pain / discomfort as a result of my sexual life.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

31. In general, I am able to manage the stress or demands of my life.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

32. I have a support system of other women (such as family or friends) in my life.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

Questions 33 to 38 are regarding your health care provider and their assessment.

33. My health care provider / practitioner needs to be aware of the importance of sexuality in my overall health and well being.

- ☐ strongly agree
- ☐ agree
- ☐ neutral
- ☐ disagree
- ☐ strongly disagree
- ☐ no opinion or don't know

34. How important is it for your health care provider / practitioner to discuss if you are satisfied with the frequency of your sexual activity?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

35. How important is it for your health care provider / practitioner to discuss if you are satisfied with the pleasure you receive from your sexual activity?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

36. How important is it for your health care provider / practitioner to discuss if you feel your relationship is healthy?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

37. How important is it for your health care provider / practitioner to discuss if you experience any physical or emotional pain / distress?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

38. What additional questions should a health care provider / practitioner ask you about your sexual health?

Thank you for your time and opinion!

Please return completed survey in the addressed and posted envelope promptly to:

Laura Ford, PhDc, RN, CNP
 Doctoral Student – PhD Program Interdisciplinary Health Studies
 Mail Stop 5379
 Western Michigan University
 1903 W. Michigan Avenue
 Kalamazoo, MI 49008 – 5379

15 June 2007

Appendix F
Survey Instrument

SURVEY INSTRUMENT

Western Michigan University, Department of Interdisciplinary Health Studies
Co-Principal / Student Investigator, Laura Ford, PhDc, RN, CNP
Co-Principal Investigator/ Dissertation Chair, Amy Curtis, PhD

Dear Potential Participant:

You have been invited to participate in a research project entitled "Female Sexual Health: A Concept Analysis." Your name has been randomly selected from a mailing list of Western Michigan University faculty, staff, and emeriti for inclusion in a research study on a newly developed instrument to evaluate or assess female sexual health. The purpose of this study is to discover what the concept "female sexual health" means to women. There are no right or wrong answers. You are being asked to complete the questions as completely and honestly as possible. A return envelope is included for your reply. By returning this survey to the researcher in the enclosed campus mail envelope, you imply your consent to use the answers provided as research data regarding the concept of Female Sexual Health. Please do not note on the survey your name or address in order to maintain the anonymity of your response. The campus mail envelope will be destroyed once returned to the student investigator to maintain the anonymity of your survey response.

In order to participate in this survey you must be a female. If you are not a female please do not complete the survey.

You may choose to not answer the survey, or to refuse to answer any question without prejudice, penalty, or risk of any loss of service you would otherwise have. You may choose to contact the Primary (Doctoral Student) Investigator Laura Ford (269.330.0471) should questions or problems arise. You may also contact the Chair of the Human Subjects Institutional Review Board (269.387.8293) or the Vice President for Research (269.387.8298) if questions or problems arise during the course of the study. This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

Thank you for agreeing to participate in pilot testing a new survey instrument.

In 2002, the World Health Organization described sexual health in a holistic manner. The description of what women mean when they report sexual health needs further exploration and understanding. Toward that end, this doctoral research is focused upon two general goals: to listen to women regarding sexual health, and to develop an instrument or question format for health care practitioners to use to address and assess women's sexual health in a clinical setting.

Please consider offering your views on this important subject. Your responses are anonymous and will contribute to the study on this important part of life.

This survey will take approximately 10 minutes of your time to complete.

Your gender is:

- ☐ Female
☐ Male → Do not complete the survey if you answered yes to Male.

1. Your age is:

- ☐ Less than 18 → do not complete the survey if you are a minor.
☐ 18 – 20 ☐ 31 – 35 ☐ 46 – 50 ☐ 61 – 65
☐ 21 – 25 ☐ 36 – 40 ☐ 51 – 55 ☐ 66 – 70
☐ 26 – 30 ☐ 41 – 45 ☐ 56 – 60 ☐ over 71

2. What is your race?

- ☐ American Indian or Alaska Native ☐ Native Hawaiian / Pacific Islander
☐ Asian ☐ White
☐ Black or African American ☐ Multiracial

3. What is your ethnicity?

- ☐ Hispanic or Latino ☐ Multi – ethnic
☐ Not Hispanic or Latino ☐ Other: _____

4. What is your educational background?

- ☐ less than High School
☐ High School Graduate or equivalent
☐ Currently in college
☐ College Graduate (Technical or Associate's Degree)
☐ College Graduate (Bachelor's)
☐ College Graduate (Master's or Doctorate)

5. Are you still menstruating / having your cycle or period?

- ☐ Yes →
 If yes, skip question 6 and go to question 7
☐ No

6. If you have stopped menstruating, was it because of:

- ☐ natural or spontaneous menopause (stopped period on my own)
☐ surgical menopause (hysterectomy or ablation)
☐ I don't know

7. Do you still have your ovaries?

- ☐ Yes, I have both of my ovaries ☐ No, I have had my ovaries removed surgically
☐ Yes, I have one ovary
☐ I don't know

8. Do you have a general medical condition that affects your sexual function?

- ☐ No, I do not have a medical condition that affects my sexual function.
- ☐ Yes, I feel my condition _____ affects my sexual function.

9. Please note the current use of hormones, either in hormonal contraceptive or replacement:

- ☐ I am not taking any hormones, either for contraception or replacement.
- ☐ I am taking a hormonal contraceptive. Name if known: _____
- ☐ I am taking hormone replacement. Name if known: _____
- ☐ I do not know if I am taking a hormone replacement.
- ☐ I am using an over-the-counter herbal for my hormone support.
- ☐ I am using an over-the-counter herbal but I don't know if it affects my hormone levels.

10. Mark the box that corresponds to the statement that best describes your sexual experience (activity or fantasy).

- ☐ Entirely heterosexual
- ☐ Largely heterosexual, but some homosexual experience
- ☐ Largely heterosexual, but considerable homosexual experience
- ☐ Equally heterosexual and homosexual
- ☐ Largely homosexual, but considerable heterosexual experience
- ☐ Largely homosexual, but some heterosexual experience
- ☐ Entirely homosexual

11. Are you currently in a sexual relationship?

- ☐ Yes →
- ☐ No → go to question 13.

12. If yes to #9: How long have you been in your current primary sexual relationship? _____ years
 _____ months go → question 15.

13. Have you ever been in a sexual relationship (past)?

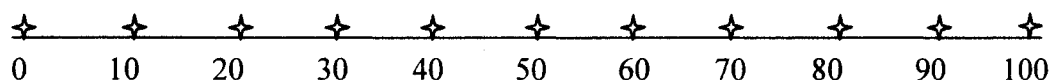
- ☐ Yes →
- ☐ No → if no, go to question 15.

14. If yes to # 11: How long was your primary prior sexual relationship? _____ years
 _____ months

15. Using the following scale: place an ☐ on the line over the number rating your personal level of sexual health.

'0' represents that you feel very negative and full of despair about your level of sexual health.

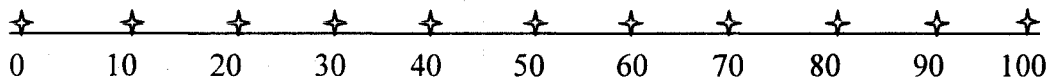
'100' represents that you feel very positive and satisfied about your level of sexual health.



16. Using the following scale: place an ☐ on the line over the number rating your ability to communicate your desires and needs. To what degree are you able to express yourself with those whom you love?

'0' represents that you are not at all able to communicate your desires and needs.

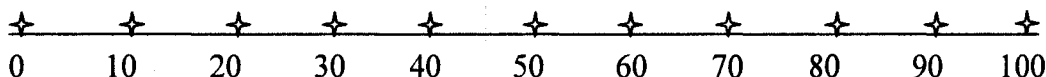
'100' represents that you are easily able to express yourself to those whom you love.



17. Using the following scale: place an ☐ on the line over the number rating your ability to avoid sexually transmitted disease.

'0' represents that you do not practice safe sex (e.g. multiple partners, no use of barriers such as condoms/ dams, partner is a risk, or do not have frequent screening exams).

'100' represents that you do practice safe sex at all times (e.g. monogamy, use of condoms/ dams, ask partner about risk, participate in frequent screening exams).



The following questions relate to the relationship that you described in the above questions. It is the relationship that you consider to be your **primary sexual relationship**, either currently or in the past. If you are in a current relationship, please answer considering that relationship. If not and you have had past relationship(s), please answer questions based upon the experience you consider to be your primary past sexual relationship.

If you answered 'no' to current and past relationships, please skip this section of the survey (questions 18 – 29) and go to question 30.

18. In general, my relationship is:

☐ a very positive part of my life.

☐ a somewhat positive part of my life.

☐ neither positive or negative.

☐ a somewhat negative part of my life.

☐ a very negative part of my life.

☐ no opinion or don't know

19. In general, I feel that I am:

- ☐ strongly respected by my partner for who I am
- ☐ occasionally respected by my partner for who I am.
- ☐ neither respected or disrespected by my partner for who I am.
- ☐ somewhat disrespected by my partner for who I am.
- ☐ usually disrespected by my partner for who I am.
- ☐ no opinion or don't know

20. In general, I find it hard to communicate with my partner.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

21. In general, the communication with my partner is:

- ☐ emotionally deep and intimate when appropriate.
- ☐ occasionally intimate.
- ☐ neither intimate or distant.
- ☐ somewhat distant.
- ☐ emotionally distant and not ever deep.
- ☐ no opinion or don't know

22. In general, I am able to communicate my sexual needs to my partner.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

23. In general, what is the match between your libido (desire for sexual intimacy and/or activity) and that of your partner?

- ☐ much less than what I desire: my partner's libido is much less than my own
- ☐ somewhat less than what I desire: my partner's libido is less than my own.
- ☐ equally matched: my partner's and mine libido are equal most of the time
- ☐ somewhat more than what I desire: my partner's libido is more than my own.
- ☐ much more than what I desire: my partner's libido is quite more than my own

24. In general, the frequency of my sexual activity with a partner has been:

- | | |
|---|---|
| <input type="checkbox"/> less than what I desired | <input type="checkbox"/> more than I desired |
| <input type="checkbox"/> as much as I desired | <input type="checkbox"/> no opinion or don't know |

25. In general, having my emotional needs met by my partner assists in arousing me for sexual intimacy.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

26. In general, my desire for sexual activity is linked to my mood.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

27. In general, I have found that as a relationship matures:

- ☐ my sexual satisfaction decreases
- ☐ my sexual satisfaction does not change with the maturity of the relationship
- ☐ my sexual satisfaction increases
- ☐ no opinion or don't know

28. In general, from my sexual relationship I achieve:

- | | |
|--|---|
| <input type="checkbox"/> strong emotional pleasure | <input type="checkbox"/> some emotional displeasure |
| <input type="checkbox"/> some emotional pleasure | <input type="checkbox"/> strong emotional displeasure |
| <input type="checkbox"/> neither pleasure or displeasure | <input type="checkbox"/> no opinion or don't know |

29. In general, from my sexual relationship I achieve:

- | | |
|--|--|
| <input type="checkbox"/> intense physical pleasure | <input type="checkbox"/> some physical discomfort |
| <input type="checkbox"/> some physical pleasure | <input type="checkbox"/> significant physical discomfort |
| <input type="checkbox"/> neither pleasure or displeasure | <input type="checkbox"/> no opinion or don't know |

This section may be answered regardless of your 'yes' or 'no' response to the question about the presence of a sexual relationship in your life.

30. The personal view I hold of myself is:

- | | |
|--|---|
| <input type="checkbox"/> generally very positive | <input type="checkbox"/> usually negative |
| <input type="checkbox"/> at times positive | <input type="checkbox"/> generally very negative |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

31. Overall, how important a part of your life is your sexual activity?

- | | |
|--|---|
| <input type="checkbox"/> not important at all | <input type="checkbox"/> somewhat important |
| <input type="checkbox"/> not very important | <input type="checkbox"/> very important |
| <input type="checkbox"/> neither important nor unimportant | <input type="checkbox"/> no opinion or don't know |

32. In general, I am able to manage the stress or demands of my life.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

33. I have a support system of other women (such as family or friends) in my life.

- | | |
|---|---|
| <input type="checkbox"/> strongly agree | <input type="checkbox"/> disagree |
| <input type="checkbox"/> agree | <input type="checkbox"/> strongly disagree |
| <input type="checkbox"/> neutral | <input type="checkbox"/> no opinion or don't know |

Questions 34 to 39 are regarding your health care provider / practitioner and their assessment or approach to you.

34. I want my health care provider / practitioner to have the following approach to my sexuality:

- ☐ I want my health care provider to respect my privacy and not ask about my sexuality.
- ☐ I want my health care provider to only ask about my sexuality if I bring up a problem to them.
- ☐ I am neutral about my health care provider asking questions about my sexuality.
- ☐ I want my health care provider to ask me questions about my sexuality as it impacts my overall health and well being.
- ☐ no opinion or don't know

35. How important is it for your health care provider / practitioner to discuss if you are satisfied with the frequency of your sexual activity?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

36. How important is it for your health care provider / practitioner to discuss if you are satisfied with the pleasure you receive from your sexual activity?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

37. How important is it for your health care provider / practitioner to discuss if you are satisfied with the health of your primary sexual relationship?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

38. How important is it for your health care provider / practitioner to discuss if you experience any physical or emotional pain / distress?

- ☐ This issue is very important to address
- ☐ This issue is important to address
- ☐ I am neutral about the importance of this issue
- ☐ This issue is not important to address.
- ☐ This issue is not at all important to address.
- ☐ no opinion or don't know

39. Please rank each of the following items from top to bottom with regard to the amount of importance these items have to your overall general sexual health. Please rank all four items from 1 to 4 giving a '1' to the issue that is of most importance to you and a '4' to the issue that is of least importance to you..

- _____ a. Frequency of sexual activity
- _____ b. Ability to achieve pleasure from sexual activity/ intimacy
- _____ c. Relationship health and wellbeing
- _____ d. Having no disease and discomfort

40. What additional questions should a health care provider / practitioner ask you about your sexual health?

Thank you for your time and opinion!

Please return completed survey in the addressed and posted envelope promptly to:

Laura Ford, PhD, RN, CNP
 Doctoral Student – PhD Program Interdisciplinary Health Studies
Mail Stop 5379
 Western Michigan University
 1903 W. Michigan Avenue
 Kalamazoo, MI 49008 – 5379

1 July 2007

Appendix G

Tables

Table 1: Focus Group Participant Information

Demographic	Focus Group 1	Focus Group 2	Focus Group 3
Number (n)	7	7	7
Age (mean and range)	45.1 mean (range 37 – 57)	68.1 mean (range 62 – 79)	23.8 mean (range 23 – 25)
Self rated level of sexual health (mean and range)	85.0 mean (range 75 – 100)	87.85 (range 70 – 95)	87.14 mean (range 50 – 100)
Educational Background:			
High School		1 (14.2%)	1 (14.2%)
Current College	4 (57.1%)	0	0
Baccalaureate	2 (28.5%)	2 (28.5%)	4 (57.1%)
Graduate	1 (14.2%)	4 (57.1%)	2 (28.5%)
Sexual Orientation:			
Heterosexual	6 (85.7%)	7 (100%)	7 (100%)
Homosexual	1 (14.2%)	0	0
Bisexual	0	0	0
Currently in relationship:			
Yes	6 (85.7%)	6 (85.7%)	5 (71.4%)
No	1 (14.2%)	1 (14.2%)	2 (28.5%)
Relationship length	12.01 (range 1.3 – 25 years)	34.53 (range 15 – 46 years)	2.9 years (range 0 – 7 years)
Menopausal?			
Yes	1 (14.2%)	7 (100%)	1 (14.2%)
No	5 (71.4%)		6 (85.7%)
Surgical Removal of Uterus?			
Yes	0	3 (42.8%)	0
No	7 (100%)	3 (42.8%)	7 (100%)
Surgical Removal of Ovaries?			
Yes	0	3 (42.8%)	0
No	7 (100%)	4 (57.1%)	7 (100%)

Table 2: Focus Group Transcript Theme Discovery

A		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Activity is part of a relationship		1	1	2	4	Frequency of sexual activity
	Activity is part of just being human			2	2	
Advances to partner		1	1		2	Frequency of sexual activity
Anger		1			1	Emotional health
Arousal		1	1	2	4	Frequency of sexual activity
	Arousal tied to emotions and physical problems	2		2	4	
	Mind can control arousal state	2		2	4	
Attraction must be present first before I can begin to share myself emotionally.				2	2	Emotional health Frequency of sexual activity
Authentic self		13	4	3	20	The authentic self
	Honor / recognition of	4		3	7	
	Development of		1	2	3	
	Partner helps me achieve the authentic self	5			5	
B		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Body awareness (knowledge) and sex education		4		9	13	Absence of discomfort
	Accuracy concern					
	Bodily function comfort (I can fart)			3	3	
	Reproductive organ appreciation	2		3	5	
	Reproductive organ function	4		3	7	
	Hormone balance function	2			2	
	Optimum performance	3		2	5	
Body Image		6	1	3	10	Emotional health
Body language: sexy play			1		1	Presence of sexual pleasure
C		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Choice to claim health (point of view)		1			1	Emotional health

Communication (free)		10	5	3	18	Communication on a deep and intimate level
	Communication (I feel that my voice is respected by my partner)	3			3	
	Communication is intimate and deep (emotional)	5	1	3	9	
	Communication of sexual needs to partner	2	1	2	5	
Comparison to other women		2	2		4	Sisterhood Emotional health
	Fitting into the 'norm' of society	1	1	1	3	
Conception: planning for			2	1	3	
Contentment		2	1	2	5	Emotional health
	With self	2	1	1	4	
	With partner	1	1	1	3	
Creativity		1			1	Presence of sexual pleasure
	Fantasies	1			1	
D		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Dysfunction		1			1	Absence of discomfort
	Working with partner's dysfunction		2	1	3	
E		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Emotion		4	3		7	Emotional health
	Emotional link to physical state	5		1	6	
	Moods link to libido	3		3	6	Frequency of sexual activity
Experience (differs from maturity)						The authentic self
	Past experiences can impact current sexual choices : positive			2	2	Emotional health
	Past experiences can impact current sexual choices: negative			2	2	Emotional health
F		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Female issues: the 'joy' of being a woman			1	2	3	Sisterhood
	Viva la difference		1	2	3	
	Have found that male partners have enjoyed emotional intimacy			3	3	Emotional health

Frequency		4	1		5	Frequency of sexual activity
	Of sexual activity			1	1	
	Attitude about sexual frequency			1	1	
	Grieve loss of sexual relationship when lose partner		2		2	
Friendships present and valued in life		2	1		3	Sisterhood
G		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Grief / tragedy			2		2	Emotional health
Guilt sex (done for partner benefit or to pacify partner for covering a wrong)				2	3	Relationship health
H		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Happiness		1			1	Emotional health
Health care provider needs to be attentive to needs and importance of sexuality		6	14	5	25	Significance of a positive health care provider relationship
	HCP experience needs to be positive	6	2	5	13	
	HCP experience needs to be confidential and private			4	4	
	Insurance concerns		2		2	
Health – maintenance of health screenings, well woman examinations				2	2	
Healthy feelings – self assessment		1			1	Emotional health
Holistic self: physical, psychological, spiritual, social		1	4	1	6	The authentic self
Honesty: no holding back of self		5	2	2	9	Emotional health
Hormonal link to sexuality		3	3		6	Frequency of sexual activity Presence of sexual pleasure

I		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Important for me to claim myself as a sexual being and one with needs			4	2	6	The authentic self
Inhibitions (lack of) = healthy		3		1	4	Emotional health
Intimacy with partner changes over time and this enhances sexual experience			1	1	2	Relationship health
	Intimacy is different than function	1	1	4	6	
J		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Journey: who I am in the moment		6	1		7	Sisterhood The authentic self
K		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
L		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Libido		4	2	3	9	Frequency of sexual activity
	Aware of link of libido to arousal and intimacy	2	3	2	7	
	able to talk self into receptivity when libido is lacking	1	1	2	4	
Life			3	2	5	Emotional health The authentic self
	Feeling joy and fulfillment in everyday life	3	4		7	
	Role outside of sexual partner / self	1	10	1	12	
Love (sense of feeling loving and feeling loved)		2	2	2	6	Relationship health Emotional health
Lust (differs from libido / attraction to partner)		2	2	4	8	Presence of sexual pleasure Frequency of sexual activity
M		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Maturity (time)		3	10	1	14	Emotional health Relationship health Absence of discomfort
Mutuality	(consideration of)	1	5	2	8	Relationship health
	Mutual give and take	3		1	4	
	Mutual pleasure	5		1	6	

	Mutual uplifting and encouragement	1			1	
	Mutual respect		2		2	
	In sync with partner	5	1		6	Communication on a deep and intimate level
N		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
O		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Open with partner/self (differs from vulnerable?)			1		1	Relationship health
Orgasm – sexual enjoyment/pleasure		1	4	6	11	Presence of sexual pleasure
	I must find pleasure in order to desire sexual activity	1	1		2	
P		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Parenting			2	1	3	The authentic self
Partner interest in self outside of sex (is my friend)		1	1		2	Relationship health
	Interest in my partner's life outside of sex					
Partner <u>awareness</u> (needs) [communication is under 'C']		1		2	3	Relationship health
	I am sensitive to my partner needs	1	1	1	3	Emotional health
	I know what my partner needs		4	1	5	
	My partner is sensitive my needs / boundaries	3	5		8	Relationship health
	Partner awareness that life demands affect my sexual expression			2	2	
Partner exhibits <u>caring</u> behaviors (e.g. encouragement)		1	2		3	Relationship health
	Partner adoring behaviors					
	Partner sharing in life experiences – e.g. travel or other interests – is a <u>companion</u>	1	5		6	
	Partner participating in home life	2	2		4	

I like my partner/ find them attractive.		2	1		3	Presence of sexual pleasure Frequency of sexual activity
	Physical attraction differs from feeling connected to my partner.					
Partner <u>security</u> in relationship (partner feels secure)		1			1	Emotional health Relationship health
Partner is sought for sexual play only and not needed for a companion				3	3	Presence of sexual pleasure
	Partner is refused who will not go beyond the physical and only wants the sexual play			1	1	Emotional health Relationship health
Partner <u>support</u>		1	1		2	Relationship health
	Partner support through a crisis	1	2		3	
Partner <u>understands me</u> as a whole person		2	6	3	11	Relationship health
	Partner accepts me as a whole person	2	1	3	6	Authentic self
	Partner supports me as an authentic person / supports my self development	1	1	1	3	The authentic self
Patience - waiting		2			2	
Privacy maintenance		1	1		2	Emotional health
Q		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
R		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Relationship [differs from partner issues and from communication issues]						Relationship health
	Authentic (actualized and achieving full potential)	2	4	2	8	
	Connection (emotional)	2	1	4	7	
	Determined to be healthy / positive	1		2	3	
	Growth (mutual) and Deepens	3	8	2	13	
	Identity	2	9		11	

	Perseverance		2	1	3	
	Respect	3	1	1	5	
Relaxation				1	1	Emotional health
Respect		2		1	3	Emotional health The authentic self
	Respect for self needs	3			3	
	Respect for partner's needs	2	2	2	6	
Romance		2	1	1	4	Emotional health Presence of sexual pleasure
S		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
STD: knowledge, awareness, avoidance		2		3	5	Absence of discomfort
Safety (sense of safe with partner)		1		1	2	Absence of discomfort
Satisfaction / satiety for sexual needs			1		1	Presence of sexual pleasure
Self Awareness		2	1	2	5	Emotional health
	Self concept (global) comfort	4	2	7	13	
	Self discovery (self actualization)	3	3	3	9	
	Empowerment		2		2	
	Self exploration of sexual response to discover how to train or respond to a partner	4		2	6	
Self esteem (see body image)		5	5	6	16	Emotional health
	Self acceptance / self talk	3	3	1	7	The authentic self
	Self integrity	1		1	2	
	Self sufficiency / self confidence	2	7	2	11	
	Self worth	2	2		4	
Self – 'me' (role)		2	3		5	The authentic self
Self needs primary (placing own needs first) [selfish]		1	1	3	5	Emotional health
Self pleasure/ sexual fulfillment	(self loving)		3		3	Presence of sexual pleasure
	No regrets			3	3	
Sexual activity outside of intercourse is acceptable and pleasurable (cuddling)		3	2		5	Presence of sexual pleasure

Sexual identity: comfort and openness		3	2		5	Absence of discomfort Emotional health
Sharing of the self freely		1			1	Communication on a deep and intimate level
Sisterhood (lived experience of women's lives)		8	6	1	15	Sisterhood
Spontaneity			1	1	2	Frequency of sexual activity Presence of sexual pleasure
Stress impacts sexual function		2	1	1	4	Emotional health
	Conflict		1		1	
	Emotional stress			2	2	
	Life pressures	5	3	2	10	
	Physical fatigue	1	1	2	4	
	Time demands	2	2	3	7	
T		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Teaching others what is needed in a healthy relationship (role modeling)		2	4	5	11	Sisterhood Emotional health The authentic self Presence of sexual pleasure
Technique		1			1	Presence of sexual pleasure
Time investment is required for there to be a healthy sexual relationship		2		3	5	Communication on a deep and intimate level Emotional health Relationship health The authentic self
U		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Unhealthy sexual behaviors linked to emotions / mood		1			1	Emotional health
V		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Vulnerability		2			2	Emotional health
W		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
X		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Y		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis
Z		FG 1	FG 2	FG 3	Total	Themes to emerge from analysis

Table 3: The Dimensions and Placement into the Pilot Instrument

Dimension one:	The Authentic Self
Dimension two:	Communication on a deep and intimate level.
Dimension three:	Emotional Health
Dimension four:	Frequency of sexual activity
Dimension five:	Presence of sexual pleasure
Dimension six:	Relationship health
Dimension seven:	Absence of discomfort
Dimension eight:	Significance of a positive health care provider relationship
Dimension nine:	Sisterhood: valued and appreciated for the journey

Question	One	Two	Three	Four	Five	Six	Seven	Eight	Nine
16	X	X	X						
17							X		
18			X		X	X	X		
19	X	X	X			X			
20		X							
21		X							
22	X	X	X		X				
23				X	X				
24				X					
25		X	X	X		X			
26	X		X	X			X		
27					X	X			
28			X		X		X		
29					X		X		
30	X		X						
31	X		X	X	X				
32	X		X						
33	X								X
34							X	X	
35				X				X	
36					X			X	
37						X		X	
38							X	X	
39a				X					
39b					X				
39c						X			
39d							X		

Table 4: Results of Dimension Correlation

Correlations of the Nine Dimensions to each other														
		1:	2:	3:		4: F	5: O		6: R		7: D		8	9
	Q15 FSH	Q16	Q21	Q30	Q32	Q23	Q28	Q29	Q18	Q19	Q17	Q29	Q34	Q33
Q15 FSH r_s sig. (2) N	1.000 234													
Q16 r_s sig. (2) N	** .501 .000 233	1.000 238												
Q21 r_s sig. (2) N	** .345 .000 226	** .513 .000 230	1.000 231											
Q30 r_s sig. (2) N	** .177 .007 233	** .235 .000 237	** .187 .004 229	1.000 238										
Q32 r_s sig. (2) N	** .191 .004 232	** .173 .008 236	** .091 .171 229	** .298 .000 237	1.000 238									
Q23 r_s sig. (2) N	** .360 .000 222	** .199 .003 226	** .232 .000 226	.007 .922 225	.037 .585 225	1.000 227								

		1:	2:	3:	4: F		5: O	6: R		7: D		8	9
	Q15 FSH	Q16	Q21	Q30	Q32	Q23	Q28	Q29	Q18	Q19	Q17	Q29	Q34
Q28	**	**	**	*	.117	**	1.000						
r_s	.390	.426	.524	.139	.077	.353	1.000						
sig. (2) N	.000	.000	.000	.036	.077	.000	228						
	223	227	227	227	227	223							
Q29	**	**	**	**	.050	**	**	1.000					
r_s	.488	.389	.305	.178	.050	.228	.468	1.000					
sig. (2)	.000	.000	.000	.008	.458	.001	.000						
N	220	224	224	224	224	220	225	225					
Q18	**	**	**		.095	**	**	**	1.000				
r_s	.323	.296	.569	.100	.095	.260	.462	.257	1.000				
sig. (2)	.000	.000	.000	.131	.151	.000	.000	.000					
N	225	229	229	228	229	225	227	224	230				
Q19	**	**	**	*	.059	.129	**	**	**	1.000			
r_s	.258	.328	.530	.158	.059	.053	.362	.216	.577	1.000			
sig. (2)	.000	.000	.000	.017	.374	.000	.000	.001	.000				
N	224	228	228	227	227	225	226	223	228	229			
Q17				**	*		*			**			
r_s	.003	.108	.055	.193	.142	-.039	.153	-.057	.061	.200	1.000		
sig. (2)	.968	.098	.411	.003	.030	.559	.021	.400	.356	.002			
N	232	237	229	236	235	225	226	223	228	227	237		
Q29	**	**	**	**	.050	**	**	1.000	**	**			
r_s	.488	.389	.305	.178	.050	.228	.468	1.000	.257	.216	-.057	1.000	
sig. (2)	.000	.000	.000	.008	.458	.001	.000		.000	.001	.400		
N	220	224	224	224	224	220	225	225	224	223	223	225	
Q34													
r_s	.032	-.015	.108	.073	.024	-.051	.083	.101	.056	.004	-.090	.101	1.000
sig. (2)	.630	.818	.105	.268	.714	.451	.216	.133	.404	.946	.170	.133	
N	230	235	228	234	234	224	225	222	227	226	234	222	236
Q33	*	**	*	**	**			**				**	
r_s	.154	.228	.136	.205	.241	-.016	.013	.176	-.002	.032	.020	.176	.102
sig. (2)	.019	.000	.040	.001	.000	.808	.851	.008	.970	.630	.763	.008	.120
N	233	237	230	238	238	226	228	225	229	228	236	225	235
													1.000
													239

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