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Validation of a brief French version of the sexual anxiety scale

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Although sexual anxiety (SA) is associated with significant sexual and relationship difficulties, to date, we lack brief scales to adequately assess SA. The aim of the present study was to develop a brief and reliable French version of the Sexual Anxiety Scale (SAS) that can be used to screen the manifestations of SA and their severity. A community sample (n = 576) was recruited to investigate the reliability and validity of the brief form of the scale (SAS-BF). Confirmatory factor analysis was performed on the original three-factor model (SAS) and on the new, four-factor SAS-BF. Its convergent validity was tested with theoretically relevant correlates (e.g., anxiety, sexual satisfaction). The SAS-BF yielded strong psychometric properties in terms of factor structure and reliability, and was reasonably correlated with associated variables. SAS-BF can be considered a valid short scale to assess SA in studies where a brief form of the questionnaire is desirable or during clinical screening with patients experiencing variable levels of SA.

KEYWORDS: Brief questionnaire, erotophobia, factor analysis, sexual anxiety, validation

Difficulties with sexual functioning represent a common experience in adulthood (Graham et al., 2020; Lewis et al., 2010) and have been associated with lower sexual and relationship satisfaction, self-esteem, and quality of life (Flynn et al., 2016; Nappi et al., 2016). Sexual anxiety is defined as the tendency to experience worrisome thoughts, discomfort, fear, or avoidance when exposed to sexual contexts or cues (Fisher et al., 1988; Snell et al., 1993). In the current article, sexual anxiety (SA) is employed as an umbrella term for related conditions: sexual aversion (Crenshaw, 1985), sexual phobia (Kaplan, 1987), and erotophobia (Fisher et al., 1988).

Prevalence data suggest that SA is far from uncommon, even though epidemiological data are lacking. In a large internet survey (n = 4,147) about sexual health among a representative sample of adults (19–69 years of age) in the Netherlands, 30% of respondents had experienced SA at some point in their lives and about 4% met diagnostic criteria for Sexual Aversion Disorder (a recurrent and acute form of anxiety toward sexuality; Bakker & Vanwezenbeek, 2006). A more recent population-based study (n = 8,000), which focused on a representative sample of the Dutch population (aged 15–71 years), suggested that women are twice as likely to experience persistent SA (4.5%) when compared to men (2.4%; Kedde, 2012). Regarding sexual functioning, SA is associated with experiencing more sexual dysfunctions (e.g., difficulties related to sexual desire or pain during sexual intercourse; Brassard et al., 2015; Nelson & Purdon, 2011), increased sexual distress (Dang et al., 2018), and lower sexual satisfaction (Bigras et al., 2017; Fallis et al., 2011). SA is also related to poorer body image (Carter et al., 2020; La Rocque & Cioe, 2011) and lower sexual self-esteem (Brassard et al., 2015; Snell et al., 1993). Higher levels of SA are negatively correlated with risky sexual behaviours (Lafortune et al., 2020; Lewis et al., 2006) and sexual compulsivity (Efrati & Mikulincer, 2018). Moreover, the signs and symptoms of each individual with SA are distributed along a continuum ranging from lesser to greater severity; in severe form of SA, sexual stimuli may cause symptoms of extreme anxiety/panic, such as palpitations, shortness of breath, or nausea (Brotto, 2010). Although SA is associated with significant sexual and relational distress (Dang et al., 2018), measures of SA are currently limited and short scales to adequately assess SA are lacking, thus reflecting the need to develop measures meant to accurately screen manifestations of SA and its impacts on sexual satisfaction and functioning (Borg et al., 2014).

Sexual Anxiety Scale

Several scales have been developed to assess anxious or phobic responses to sexual cues (e.g., Fallis et al., 2011; Fisher et al.,

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1988; Janda & O'Grady, 1980; Snell et al., 1993) or SA-related behaviours (e.g., sexual avoidance; Katz et al., 1989). However, many existing measures show conceptual and methodological shortcomings. For example, some only cover SA in the general sense without addressing its specificities to certain aspects of sexuality (e.g., "I am anxious when I think about the sexual aspects of my life"; Snell et al., 1993). Others appear outdated considering socio-cultural shifts (e.g., attitudes towards premarital sex; Janda & O'Grady, 1980; Katz et al., 1989) or conjointly assess SA and other constructs such as attitudes towards homosexuality and sexual behaviours deviating from penile-vaginal intercourse (e.g., "If I found that a close friend of mine was a homosexual, it would annoy me"; Fisher et al., 1988). The Sexual Anxiety Scale (Fallis et al., 2011) offers the advantage of being better adjusted to current socio-cultural realities (e.g., online pornography, diversity of sexual preferences and behaviours) and of capturing different manifestations of SA in a broad range of sexual situations (e.g., nudity, masturbation, sexual communication, sexual practices, sexual health messages). This 56-item self-report questionnaire assesses erotophilia-erotophobia on a continuous scale, from the tendency to respond to sexual situations with positive affects and approach behaviours in terms of erotophilia, to the tendency to respond to sexual situations with negative feelings of anxiety, discomfort, and avoidance in the case of erotophobia (Fisher et al., 1988). The items and structure of SAS were established based on the Sexual Opinion Survey (Fisher et al., 1988), a classic measure of erotophilia/erotophobia. The SAS comprises 3 subscales: (1) solitary and impersonal sexual expression, which consists of pornographic and erotic material, masturbation, and display of affection (23 items; e.g., "Using sex toys, such as a vibrator, when I am alone"); (2) exposure to information, or the giving or receiving of information of a sexual nature (14 items; e.g., "Being exposed to information about sexually transmitted infections"); and (3) sexual communication and openness to consensual sexual activity (16 items; e.g., "Discussing my sexual fantasies with my partner"). Respondents rate their degree of discomfort with a list of sexually relevant situations or stimuli on an 11-point Likert scale ranging from 0 (*extremely pleasurable*) to 100 (*extremely discomforting*) and a sum is computed with lower scores representing greater erotophilia and higher scores representing greater erotophobia.

The SAS demonstrated satisfactory psychometric properties. The original validation study (Fallis et al., 2011) showed a three-factor solution accounting for 49.5% of the variance, excellent internal consistency ($\alpha > .96$) and high test-retest reliability ($r = .87$, $p < .01$). Other studies also showed satisfactory internal consistency ($\alpha > .96$; Jayne, 2019; Nelson & Purdon, 2011) and construct validity was supported through correlations with sexual functioning and sexual satisfaction (Fallis et al., 2011; Nelson & Purdon, 2011; Rye et al., 2015). Discriminant validity was supported through non-significant or weak correlations (ranging from .04 to .16) with measures of depression, anxiety, and neuroticism (Fallis et al., 2011).

Certain limitations, however, pertain to the SAS in its original form. Firstly, careful examination reveals that Factor 1 (23 items) contains distinct latent constructs (i.e. exposure to pornographic/erotic material, masturbation/sexual exploration and impersonal sexual experiences), suggesting that subdividing this factor could yield a stronger statistical model. Secondly, the SAS is lengthy (56 items) with somewhat redundant items. The use of brief scales is highly recommended both in clinical settings for quick screening purposes as well as in research, notably to maintain motivation when data collection involves numerous scales (Bőthe et al., 2020; Godbout et al., 2016). From the targeted respondent perspective, completing long questionnaires about sexuality can represent significant exposure to sexual cues, leading to elevated distress among people with SA which may result in higher dropout rates. From the clinicians' standpoint, notably by those working in the public sector where resources are often limited (e.g., high workload, limited time), it is necessary for evidence-based assessment to use tools with established reliability and validity metrics, that are straightforward and brief to administer (Beidas et al., 2015). Thirdly, there are no papers detailing the factorial structure of the SAS following a Confirmatory Factor Analysis. It is thus essential to develop a brief version of the SAS where each factor is comprised of a parsimonious selection of items per construct. Nevertheless, the SAS offers an adequate basis to develop a brief scale assessing SA, since it is based on a solid theoretical background (Fisher et al., 1988), provides a multidimensional screening of domains in which SA manifests, and demonstrates strong psychometric qualities across several original studies.

Research Aims and Hypotheses

The aim of the present study was to develop a brief and reliable scale that could assess different dimensions and manifestations of SA through the Sexual Anxiety Scale (SAS; Fallis et al., 2011), based on Fisher and colleagues' (1988) well-known theoretical framework on SA. To achieve this, the first objective was to test a French translation of the original three-factor structure of the SAS (French SAS) in a French-Canadian sample issued from the general population. The second objective was to develop and test a brief form of the SAS (e.g., by eliminating redundant items) and compare its factorial structure (SAS-BF), internal consistency, and construct and discriminant validity (through relationships with variables associated with SA in previous studies). We hypothesized that: (1) higher SA would be negatively correlated with sexual satisfaction, sexual self-esteem, and sexual compulsivity, and positively associated with other measures of SA; (2) the SAS would be weakly or *non-significantly associated* with measures of nonspecific anxiety and neuroticism, suggesting that the total SAS score would not directly reflect general anxiety symptoms or emotional instability; (3) total and subscales scores of the original SAS would be strongly correlated with the corresponding scales of the SAS-BF. Considering previous studies on SA (e.g. Bigras et al., 2017; Kedde, 2012), gender differences were also explored for the SAS-BF total and subscale scores and the aforementioned correlates.