CENTRE FOR EMOTIONAL HEALTH
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Critical Flaws in the Female Sexual Function Index and the International Index of Erectile Function

What was the aim?
We wanted to determine if the Female Sexual Function Index (FSFI) and the International Index of Erectile Function (IIEF) accurately measure all the dimensions of sexual dysfunction for which they are used.

The FSFI and IIEF are the most widely used self-report measures to diagnose sexual dysfunction in clinical practice and research. The FSFI, is a19-item measure that has been cited in over 1500 articles, and measures the six key dimensions of sexual function in woman: desire, arousal, lubrication, orgasm, satisfaction and pain. However, the measure was originally designed to identify arousal disorders only. This raises questions around the validity of the measure for other domains of sexual dysfunction.

The IIEF is a 15 item measure, cited in over 2700 articles, and measures five domains of male sexual function including desire, erectile function, orgasmic function, intercourse satisfaction, and overall satisfaction. However, the IIEF was also designed to measure arousal disorders; specifically, erectile dysfunction. Again, the validity of the measure across the other domains is questioned.

How did we do it?
A total of 518 sexually active Australian adults completed an online survey, of which 65% were female. The median age group of respondents was 25 to 34 years, but the sample included adults ranging in age from 18 to 65 years. Women completed the FSFI and men completed the IIEF. We analysed their responses in the context of the existing literature to determine whether the FSFI and IIEF provided reliable and valid measurement of sexual dysfunctions.

What did we find?
Both the FSFI and IIEF had clear measurement flaws. The FSFI provided poor measurement of sexual desire in particular, because it used an over-simplified definition of female sexual desire, and only asked two broad and vague questions about how desire was experienced. There were no apparent problems with the brief orgasm and pain scales, but measuring physiological sexual arousal using self-report methods for women has been shown to be inaccurate. For men, only the erectile function subscale of the IIEF provided reliable and valid information. The desire scale performed very poorly in statistical tests, and the orgasmic function scale does not provide clinically useful information.

What does this mean in practice?
We encourage researchers and clinicians to assess whether using either of these measures are appropriate on a case-by-case basis; the measures are most suitable when sexual arousal or erectile function are the outcomes of interest. Specifically, the FSFI should not be used to measure sexual desire, and clinicians and researchers should familiarise themselves with the conceptual issues surrounding self-report measurement of physiological sexual arousal for women. We also recommend that the desire and orgasmic functions subscales of the IIEF should not be used if low

desire, premature ejaculation or delayed ejaculation are variables of interest; and that the Sexual Health Inventory for Men (which is comprised of the erectile function items from the IIEF) should replace the IIEF in all future research.

Citation Details

Forbes, Miriam K., Baillie, Andrew J., Schniering, Carolyn A. Critical Flaws in the Female Sexual Function Index and the International Index of Erectile Function, *The Journal of Sex Research*, Vol. 51, Iss. 5, 2014