

Validation of the McCoy Female Sexuality Questionnaire in an Italian Sample

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This article presents the result of a study that translated into Italian and validated the McCoy Female Sexuality Questionnaire (MFSQ) on an Italian sample. The questionnaire was first administered to a sample of 240 Italian women (age range, 18–65 years) recruited from a gynecology clinic. A principal component analysis identified 2 factors: *sexuality* (9 items) and *partnership* (5 items). Both factors showed an adequate inter-item reliability (Cronbach's α of .88 and .75, respectively). The validity of the Italian MFSQ was then tested by administering the questionnaire to a sample of 16 women with sexual dysfunction and 46 control women. Sexual dysfunction diagnoses were assessed through a semi-standardized interview based on the *DSM-IV-TR* diagnoses for Female Sexual Arousal Disorder, Female Orgasmic Disorder, Dyspareunia, and Hypoactive Sexual Desire Disorder. A discriminant validity test showed significant differences between women with and without female sexual dysfunction. These results indicate that the translated version of the MFSQ is a reliable and valid measure of sexual dysfunction among Italian women. The results also indicated a difference in factor structure between the Italian and the original version of the MFSQ, which warrants further investigation.

KEY WORDS: culture; psychometrics; female sexuality; assessment.

INTRODUCTION

The majority of the questionnaires currently used to assess sexuality in women have been developed and standardized on the U.S. population (for a review, see Davis, Yarber, Bauserman, Schreer, & Davis, 1998). When researchers from other countries decide to conduct a study on sexuality, these measures are translated into the target language and administered to the non-English speaking sample. Often, these studies do not provide complete psychometric information on the translated questionnaires (e.g., Nathorst-Böös & Hammar, 1997).

The decision not to standardize and validate a translated questionnaire is based upon the assumption that the constructs of sexuality underlying the original questionnaire are unaffected by culture. The indifference toward the role of culture in sexuality is reflected in the low percentage (7.3%) of articles published in *Archives of Sexual Behavior* and *Journal of Sex Research* between 1971 and 1995 that considered ethnicity a relevant variable (Wiederman, Maynard, & Fretz, 1996). However, culture has been shown in the literature to impact sexual attitudes and sexual behaviors (e.g., Meston, Trapnell, & Gorzalka, 1998; Okazaki, 2002; Tsui, 1985). In particular, studies have shown that African American women report higher levels of sexual satisfaction compared to Caucasian women when socioeconomic status is controlled for (Cain, Johannes, & Avis, 2003; Henderson-King & Veroff, 1994; Oggins, Leber, & Veroff, 1993). Women from Hispanic, Anglo-American, and bicultural backgrounds reported a strong relation between passionate love and marital

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satisfaction that was not observed in Caucasian couples (Contreras, Hendrick, & Hendrick, 1996). A study by Meston et al. (1998) found that differences in certain sexual attitudes between Canadians from Asian and from European ancestry diminished according to length of exposure to North American culture. Because significant differences in sexuality have been observed between subcultures that coexist in the same country, it is feasible that sexual differences may be even more salient in populations with different ethnic backgrounds, and living in different countries. Therefore, the lack of information on the psychometrics of translated questionnaires could be a serious limitation to our investigation of sexuality in different cultures.

The primary purpose of this study was to validate the McCoy Female Sexuality Questionnaire (MFSQ; McCoy & Matyas, 1996) for an Italian sample. The MFSQ was selected because of its extensive use among women from different cultures (French: Limouzin-Lamothe, Mairon, Joyce, & Le Gal, 1994; Swedish, Norwegian, and Danish: Nathorst-Böös & Hammar, 1997), and because of its wide use for the assessment of sexual functioning associated with hormonal fluctuation due to treatments (e.g., oral contraceptive or hormone replacement therapy) or natural biological rhythms (e.g., menopause). The focus on a questionnaire highly associated with biological aspects of sexuality was chosen in an attempt to tap into aspects of sexuality that may be less affected by cultural differences. The Danish, Norwegian, and Swedish translations of the MFSQ used only a portion (7–9) of the original 19 items, and have been used to compare results from women in the three different countries (Nathorst-Böös & Hammar, 1997). Unfortunately, researchers have not provided information on the rationale behind item selection. The selected items included questions about frequency of orgasm, pain, arousal, and sexual thoughts or fantasies. One of the questions that has been consistently eliminated from the translations pertains to the need for manual stimulation or stimulation of another type (mechanical vibrations) at the time of the orgasm.

STUDY 1

Method

Participants

The sample consisted of 245 Italian women, ages 18–65 years ($M = 36.31$, $SD = 12.7$), recruited from an obstetric and gynecology clinic in a middle-sized town in Italy. Potential participants were given a brief explanation of the study while in the waiting room prior to

their gynecological visit. Women interested in the study returned the questionnaires completed, whereas women who refused to participate returned the questionnaires blank. Participants' reasons to schedule appointments at the clinic included routine visits (approximately 58%), checkup visits for oral contraceptive treatment (approximately 20%), or visits for hormone replacement therapy (HRT; approximately 21%). Two percent ($n = 5$) of the participants did not return the completed questionnaire; therefore, the analysis was conducted on data from 240 participants.

A total of 80.4% of the participants ($n = 193$) reported coming from a medium social economic status, whereas 4.2% ($n = 10$) reported a medium-low to low status, and 19% ($n = 37$) reported medium-high to high status. Of the 240 women in the study, 50.8% ($n = 122$) were in a cohabiting sexual relationship, 45.8% ($n = 110$) were in a sexual relationship but did not cohabit, and 3.3% ($n = 8$) were not in a sexual relationship. Of the women without a partner, only one woman reported engaging in sexual activities during the prior month. Sexual activities were loosely defined as any sensual or sexual activity with a partner or alone, including kissing, petting, masturbation, and intercourse. Among women in a relationship, the average duration of the relationship was 11 years ($SD = 11.23$). Nineteen percent ($n = 46$) of the participants completed middle school education, 42.7% ($n = 102$) completed high school, and the remaining 38.1% ($n = 91$) completed college. A total of 206 (85.8%) women reported that they had engaged in some sexual activity with their partner during the preceding 4 weeks and only 19 (7.9%) women reported they masturbated during the previous 4 weeks. It should be noted that 67 (27.9%) women refused to answer the question about masturbation.

Only women who reported sexual activity in the previous 4 weeks were included in the analysis. This criterion is consistent with that used in a number of recent validation studies on sexuality questionnaires (for a review, see Meston & Derogatis, 2002). Although excluding women who have not been sexually active in the previous 4 weeks may limit the generalizability of the results, it is not possible to assess problems with sexual arousal and orgasm if the woman has not participated in sexual activities. Relying on memories of sexual activities that occurred more than 4 weeks prior to the interview can also be problematic given the lack of accuracy in recalling events that are far removed from the present. It is feasible that excluding women who have not engaged in sexual activities during the prior month may have selectively excluded women with low sexual desire. However, it should also be noted that frequency of sexual activities

is often associated with elements other than the woman's levels of sexual desire. Women engage in sexual activities because they desire to feel emotional closeness, to please their partners, to express feelings of love, or because they may feel afraid that their partners will leave them (Meston, 2003). In the present study, 35 (14%) of the 240 women did not engage in sexual activity during the previous month.

Measures

Eighteen of the original nineteen items of the MFSQ are scored on a 7-point Likert scale and one item asks for frequency of intercourse. Seventeen items are grouped into five factors derived from a principal component analysis and two items were added at a later time to measure "attractivity." The five factors comprise: *sexual interest* (4 items), *satisfaction with frequency of sexual activity* (3 items), *vaginal lubrication* (3 items), *sex partner* (3 items), and *orgasm* (4 items). Items 1–11 can be answered by both sexually active and nonactive women, whereas items 12–19 pertain exclusively to women who have engaged in vaginal intercourse. The percentage of variance in the questionnaire explained from the five factors was 23.1, 11.1, 8.3, 7.7, and 7.3, respectively. The 2-week reliability for the MFSQ measured with Pearson r has been shown to range between .69 and .95 (average $r = .83$; Dennerstein, Anderson-Hunt, & Dudley, 2002; McCoy & Matyas, 1996). The internal consistency measured with Cronbach's α has also been shown to be adequate ($\alpha = .76$; McCoy, 2000).

After translating the MFSQ into Italian, an English-speaking Italian, naïve to the questionnaire, translated the scale back into English. This is known as the "back translation" method that is used to protect the questionnaire's face validity during the process of translation. The back-translation was discussed with N. McCoy, who suggested several modifications to ensure the retention of the questionnaire's original meaning.⁴

Procedure

Potential participants were recruited from the waiting room of a gynecological clinic in a medium-sized Italian town. Women were informed about the study and given the opportunity to participate if they expressed interest. After completing a confidential questionnaire composed of demographics and the MFSQ, participants were given the opportunity to ask questions and provide feedback on the clarity of the MFSQ items. Finally, participants were debriefed and thanked for their time.

Results

Because the purpose of Study 1 was to evaluate whether the dimensions of the original MFSQ could be generalized to an Italian sample, we conducted a confirmatory principal components analysis with Oblimin rotation on all items. The results did not appear to support this factor structure because 13 of the 19 items showed a loading $>.30$ on two or more factors. The total percentage of variance accounted for by the five factors was 63.4. The five factors accounted for 34.1, 10.7, 7.1, 6.3, and 5.2% of variance.

To identify a factor structure that had fewer cross factor loadings, a new exploratory principal component analysis was conducted on the 19 items. This second analysis identified four factors that had an eigenvalue >1.0 . These four factors cumulatively explained 58% of the variance. In this factor structure, 10 items showed high cross factor loadings ($>.30$). Items were deleted on the basis of the following statistical and clinical criteria: (1) the item showed a loading $>.30$ on two or more factors and (2) participants' feedback at the end of the questionnaire identified the item to be confusing. According to these criteria, four items were eliminated from the questionnaire (Items 3, 6, 16, and 17). Items 6 and 17 asked about lubrication, which participants reported was difficult to evaluate unless they felt it created a problem in their sexuality. Item 3, which asked about sexual fantasies, was also reported to be a difficult construct for Italian women to report because of feelings of embarrassment, guilt, and/or unfamiliarity with the concept. Item 16, which asked about using manual or vibratory stimulation, was deleted because it was noted to be an unfamiliar concept to the participants. Item 12 (frequency of intercourse) was also eliminated because the presence of that item was associated with the cross loading of three other items.

The third principal components analysis identified a two-factor structure: *sexuality* and *partnership* (Table I). The two factors explained 53% of variance (42.0 and 11.2% for *sexuality* and *partnership*, respectively), as compared to the 58% explained by the factor structure that included all items. The results of this principal component analysis were considered superior to the two previously presented because, in addition to accounting for a high percentage of the scale's variance, only one item had a loading $>.30$ on more than one factor. The two factors showed an adequate inter-item reliability with Cronbach's $\alpha = .88$ for the sexuality factor and $.75$ for the partnership factor.

Because participants recruited for the study arrived at the clinic for different reasons (e.g., routine examination

⁴The Italian translation of the MFSQ is available from the first author.

Table I. Factor Loadings for the Italian MFSQ Computed with Principal Component Analyses

Item	Loading	
	1	2
Factor 1 (sexuality)		
1. How enjoyable has sexual activity been for you?	.841	.072
2. How do you feel about the present frequency of your sexual activity?	.476	.050
4. How excited or aroused have you been during sexual activity (for instance increased heartbeat/flushing/heavy breathing, etc.)?	.766	.093
5. How would you describe your level of sexual interest (i.e., sex drive) during the past 4 weeks?	.855	-.111
7. How sexually attractive do you feel you are?	.641	-.159
13. How enjoyable has sexual intercourse been for you?	.776	.119
14. How often have you had an orgasm during sexual intercourse?	.744	-.028
15. On the average, how pleasurable were the orgasm(s) you have had during sexual intercourse?	.791	.014
18. How often have you had pain during sexual intercourse?	.314	.189
Factor 2 (partnership)		
8. How sexually attractive do you feel you are to your primary sexual partner?	.168	.476
9. How often has your satisfaction from sexual activity decreased because your partner has not had enough sexual interest in you?	-.140	.883
10. How satisfied are you with your primary partner as a lover?	.481	.470
11. How satisfied are you with your primary partner as a human being/friend?	-.028	.656
19. How often have you been prevented from having sexual intercourse because your partner could not achieve or maintain an erection?	.081	.701

or checkup for hormonal treatment), we conducted an exploratory analysis on potential differences in MFSQ factors between the premenopausal women coming for an oral contraceptive checkup visit versus routine clients, and between the menopausal women (follicle stimulating hormone >10 iu/l) seeking an HRT checkup visit versus routine clients. Means on the two factors for the sexually active women, and for menopausal and non-menopausal women are shown in Table II. Women not clearly assigned to the menopausal or non-menopausal group were excluded from these analyses ($n = 9$). Two t -test analyses showed no significant differences on the two factors between premenopausal routine clients and oral contraception clients, and between menopausal women seeking HRT and routine visits.

STUDY 2

Study 2 was designed to examine the discriminant validity of the Italian MFSQ.

Method

Participants

A total of 68 sexually active women were recruited from the same gynecological clinic as that used in Study 1. In this study, only participants who were currently

in a relationship were asked to complete the questionnaires. Recruitment took place over a 2-month period. Women were administered a semi-structured *DSM-IV-TR* clinical interview in order to establish whether they met criteria for a sexual dysfunction. Six participants did not return the completed questionnaires; hence, analyses were conducted on data from 62 participants. Sixteen women met criteria for one or more sexual disorder and comprised the dysfunctional sample; 46 women did not meet criteria for any sexual disorder and comprised the control sample. Participant characteristics are reported in Table III. The two groups were comparable in annual income, education, marital status, and number of children. Women diagnosed with sexual dysfunction were 8.2 years older ($t[60] = -2.38, p < .05$) and, not surprisingly, reported less frequent sexual activity as compared to women with no sexual dysfunction.

Measures

Measures included the Italian version of the MFSQ, and a number of questions designed to diagnose sexual dysfunction according to the *DSM-IV-TR* criteria. The questions were conducted during a face-to-face interview conducted by a trained interviewer.⁵ These questions were mostly open ended questions such as, "How satisfied

⁵Questions are available from the first author.

Table II. Means and SDs for McCoy Female Sexuality Questionnaire Factors

	Factors	
	Sexuality	Partnership
Sexually active (<i>n</i> = 208)		
<i>M</i>	43.81	29.50
<i>SD</i>	11.0	5.1
<i>Premenopausal</i>		
Routine visit (<i>n</i> = 120)		
<i>M</i>	44.4	29.9
<i>SD</i>	11.0	4.1
Contraceptive visit (<i>n</i> = 48)		
<i>M</i>	46.3	30.0
<i>SD</i>	10.5	5.8
<i>Menopausal</i>		
Routine visit (<i>n</i> = 16)		
<i>M</i>	42.5	27.1
<i>SD</i>	8.1	9.3
HRT visit (<i>n</i> = 47)		
<i>M</i>	40.3	28.8
<i>SD</i>	11.6	4.4

Note. Range of scores for *sexuality factor*, 9–63; range for *partnership factor*, 5–35. No significant differences between groups of menopausal or premenopausal women.

are you with your sexuality?"; "Are you currently experiencing any concern with your level of desire? How satisfied are you with your sexual arousal? How satisfied are you with your orgasms? Do you experience any pain during vaginal intercourse with your partner?" Because of potential differences in the way Italian women define their sexuality from the definitions provided by the *DSM-IV-TR*, interviewers asked participants to explain their definition of sexual desire and arousal. At times, participants would describe their sexual arousal as a form of desire. This condensing of desire and arousal has also been noted among North American women. Indeed, in the validation of the Female Sexual Function Index, a factor analysis combined items about desire and arousal under the same factor (Rosen et al., 2000). Prompts to assess presence of distress because of these conditions were also used during the interview. Additional questions were asked to provide a quantitative measure of the disorders. These questions, based on a reference point of the past 4 weeks, were as follows: "How many times in a typical week do you feel sexual desire?" (desire); "What percentage of time do you experience pain during vaginal penetration?" (pain); "What percentage of time do you have problems achieving orgasm during sexual activity with your partner?" (orgasm); and "What percentage of time do you have difficulty becoming sexually aroused during sexual activity with your partner?" (arousal).

Procedure

Potential participants were approached similarly to Study 1. Those participants who were interested in the study returned the completed questionnaire to the researchers and were administered the semi-structured *DSM-IV-TR*-based interview previously described. All interviews were conducted in a private room in the gynecological clinic. Only 6 (8%) of the 69 women approached during the recruitment refused to participate in the study. Participants were informed about confidentiality at the beginning of the interview and were debriefed and thanked for their time at the end of the interview. The interviewers were two trained graduate students in clinical psychology. The training consisted of 5 hr of practice interviews with an expert interviewer who had interviewed over 500 women with sexual dysfunction in the United States during the prior 2 years. Each interviewer also observed three interviews conducted by the expert, and the expert observed one interview conducted by each of the interviewers.

Results

Given that women with and without sexual dysfunction showed a significant age difference, age was included as a covariate in a set of two ANCOVAs used to assess differences between women with and without a sexual dysfunction. The results of the ANCOVAs showed that women diagnosed with sexual dysfunction scored significantly lower than women with no diagnosis of sexual dysfunction on both factors of the MFSQ. Women with a sexual dysfunction scored significantly lower in sexuality ($M = 36.2$) and partnership ($M = 20.9$) as compared to healthy control women ($M = 48.7$ and $M = 24.8$ for sexuality and partnership, respectively). The effect size for the sexuality and the partnership factors were -8.96 and -0.95 , respectively. A logistic regression was conducted to assess the probability that scores on the two factors predicted the diagnosis of sexual disorder. The presence of a sexual disorder assessed during the interview was dummy coded as 1 and no sexual dysfunction was coded as 0.

The results from this model showed that the *sexuality* factor significantly predicted sexual dysfunction, whereas the *partnership* factor was not useful in predicting a diagnosis of sexual dysfunction ($Wald = 0.63$, $p = .43$). The coefficient for *sexuality* was negative and statistically significant at $p < .001$ ($Wald = 10.34$). An increase of one standard unit in the *sexuality* factor was equal to an increase in 10.98 times in likelihood to be diagnosed with

Table III. Characteristics of Participants Diagnosed with Female Sexual Dysfunction (FSD) and Controls

	FSD (<i>n</i> = 16)		Controls (<i>n</i> = 46)		<i>ES</i>	<i>t</i> (<i>df</i>)
	<i>M</i>	<i>SEM</i>	<i>M</i>	<i>SEM</i>		
Age	44.7	3.2	36.48	1.5	2.94	-2.69 (60)*
Frequency sexual activity (month)	3.3	3.6	8.6	6.2	-1.06	3.24 (60)***
Sexual variables						
Desire ^a	4.0	0.5	5.5	0.3	-0.75	2.43 (60)*
Arousal ^b	45.6	8.5	20.5	3.7	0.90	3.14 (60)***
Orgasm ^c	53.1	9.7	17.6	3.8	0.85	5.88 (60)***
Pain ^d	44.4	9.9	6.6	1.9	0.77	5.70 (60)***
	<i>n</i>	%	<i>n</i>	%		χ^2 (<i>df</i>)
Social economic status						5.43 (2)
€15,000	3	18.8	2	4.3		
€15,000–€ 50,000	13	81.3	37	80.4		
€50,000	0	0.0	7	15.2		
Marital status						2.96 (4)
Married	11	68.8	24	52.2		
Uncommitted relationship	5	31.3	17	37.0		
Dating	0	0.0	2	4.3		
Single	0	0.0	3	6.5		
Children (% yes)	10	62.5	22	47.7		1.02 (1)

^aDesire: "How many times in a typical week do you feel sexual desire?"

^bArousal: "What percentage of time do you have difficulty becoming sexually aroused during sexual activity with your partner?"

^cOrgasm: "What percentage of time do you have problems achieving orgasm during sexual activity with your partner?"

^dPain: "What percentage of time do you experience pain during vaginal penetration?"

p* < .05. **p* < .001.

a sexual dysfunction. The overall model was significant at *p* < .001 level according to the model χ^2 statistics. The model predicted 87.5% of the people diagnosed with a sexual dysfunction correctly. The McFadden's *R*² was .45.

DISCUSSION

This study was conducted to validate the translated version of the MFSQ on a sample of Italian women. A principal component analysis revealed that the factor structure of the original questionnaire did not adequately fit the data collected from an Italian sample. A two-factor solution identified by principal component analysis provided the best factor solution. The two factors were labeled *sexuality* and *partnership*. A discriminant validity test showed that women with sexual dysfunction scored significantly lower on both factors as compared to women with no diagnosis of sexual dysfunction. Moreover, a logistic regression showed that the *sexuality* factor significantly predicted diagnosis of sexual dysfunction.

It is important to note that although the Italian version of the MFSQ was able to differentiate between women with and without sexual dysfunction, the principal

component analysis did not support the multiple factors that are associated with the domains of desire, arousal, orgasm, and pain. Rather, the factor solution supported a two-factor structure where all dimensions of sexuality (desire, orgasm, arousal, pain, and satisfaction) were combined together and distinct from items pertaining to the woman's partner. There are several viable explanations for this finding. First, the lack of distinction between these sexual domains may reflect inadequate translation of the questionnaire. Problems with translation can lie either in the inaccuracy of the word choice (the translation is no longer asking about the same constructs) or the inability of the words to depict the same concepts (the words are correct but the constructs are different). In this study, we adopted the back-translation method to minimize the risk of an inaccurate translation of the text.

It is difficult to assess whether the translation addressed the same constructs as that in the original questionnaire because words may have different meanings across cultures. One way to overcome this limitation is by conducting qualitative studies on Italian women and developing questionnaires based on the language used by Italian population. The hypothesis that the constructs behind the Italian MFSQ may be different from the

constructs behind the original MFSQ is partly supported by the lower correlations between the answers to the interview and the MFSQ scores specific to the dimensions of desire and arousal. Comparatively, the correlations between the interview and the MFSQ scores on pain and orgasm constructs were higher. Pain and orgasm were more tangible aspects of sexuality and their definition was associated with a specific bodily experience that may be easier to translate than concepts of desire and arousal.

A second explanation for the difference in factor structure between the Italian MFSQ and the original MFSQ may relate to sampling differences between that used by McCoy and Matyas (1996) and that used in this investigation. The original MFSQ was administered to North American university students between the ages of 18 and 26, whereas the present study administered the Italian MFSQ to a sample of women between the ages of 18 and 65 who were attending a gynecology clinic. Although it is feasible that a sample of Italian university students may have provided a factor structure more similar to that of the original MFSQ, it is unclear why age differences between samples would differentiate women who do and do not distinguish between the various stages of the sexual response underlying the original MFSQ domains.

Of course, the difference in factor structure between cultures may also indicate that aspects of sexuality based on a North American sample simply do not adequately reflect the sexual experience of Italian women. In fact, the model used to understand female sexuality may not even be an adequate depiction of the sexual experience of North American women. Traditionally, questionnaires for the assessment of sexual functioning have been based on a linear model of sexual responding first proposed by Masters and Johnson (1966), in which desire precedes arousal that precedes orgasm. Recently, a consensus panel of experts on women's sexuality provided evidence that women's sexual experiences may not occur in this hypothesized linear sequence (Basson et al., 2004). Additionally, researchers are raising the question whether it is even possible to assess a sexual dysfunction without taking into consideration cultural, relational, and individual characteristics (Tiefer, 2001). Future studies should focus on using a combination of qualitative and quantitative methodologies to study sexuality in the Italian population with the aim to develop culture appropriate theories and measurements (for a review, see Rellini & Muller, 2003). In conclusion, the two-factor Italian MFSQ adequately discriminates between women with and without sexual dysfunction; however, further research is needed to clarify the nuances among dimensions of sexual desire, arousal, satisfaction, and orgasm among Italian women.

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