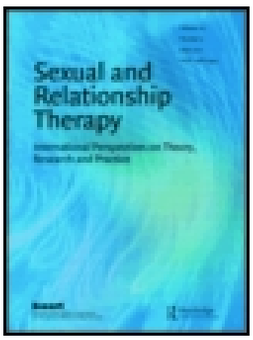

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The Sex Positivity Scale: a new way to measure sex positivity as a trait

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ABSTRACT

Sex Positivity as a construct has garnered much attention in recent years - in the media, with global policy, and in research endeavors. This research aims to provide a measure that can evaluate levels of sex positivity for use in research and clinical work. An examination of the literature discovered several commonalities related to the traits of sex positivity, which informed the initial item pool. 521 participants provided data for the initial analysis, which utilized Classical Test Theory to provide evidence of validity and reliability for a stable scale. The final structure of The Sex Positivity Scale was shown to be a valid and reliable measure with three subscales (Behaviors and Attitudes, Talking about Sex/Communication, Knowledge and Beliefs) and one aggregate total score. The measure itself is comprised of 27 items on a Likert scale, and can be utilized in a variety of contexts.

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KEYWORDS
Sex positivity; sexual health; scale construction; psychometrics; classical test theory

Lay summary

This paper outlines the creation of a test to determine a person's level of sex positivity—that is, the amount of general positive or affirmative beliefs and actions towards human sexuality, sexual expression, and sexual rights.

There are many definitions of sex positivity as a way of being, or traits a person may embody, and many that include aspects of how to treat others and care for the health of your body. Carol Queen has utilized a definition of sex positivity that embodies a social constructivist approach which evolved out of the feminist body-positive movement. In her 1997 book, *Real live nude girl, Chronicles of sex-positive culture*, she spoke of sex positivity as:

> … a simple yet radical affirmation that we each grow in our own passions on a different medium, that instead of having two or three or even half a dozen sexual orientations, we should be thinking in terms of millions. 'Sex positive' respects each of our unique sexual profiles, even as we acknowledge that some of us have been damaged by a culture that tries to eradicate sexual difference and possibility. Even so, we grow like weeds. (p. 30)

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Emily Nagoski takes a similar approach in her definition of sex positivity, while incorporating the physical body into the definition, "the radical, all-inclusive belief that each person's body belongs to that person." (Nagoski, 2019, p. 104) An additional definition of sex positivity comes from the researchers Williams, Prior, and Wegner who stated in their 2013 article that sex positivity can be described as,

> being open, communicative, and accepting of individual's difference related to sexuality and sexual behavior… a sex-positive approach is about allowing for a wide range of sexual expression that takes into account sexual identities, orientations, and behaviors; gender presentation; accessible health care and education; and multiple important dimensions of human diversity. (p. 273).

Among the definitions above one thing remains constant—the constant idea that nothing may define for a person what their body is for, what pleasure is acceptable or OK, and/or how a person lives their sexual life is up for judgment. This makes the development of a scale that assess how sex positive a person is rather difficult—as researchers we are walking a thin line between judging what is sex positive, and what is not. However, we utilized these three definitions in conjunction with concepts of sexual health to guide our conceptualization of how to ask about sex positivity, along with how to consider whether a person can report 'traits' of sex positivity in an objective measure.

Sexual health as part of sex positivity

The World Health Organization (WHO) and World Association for Sexual Health both agree that sexual health as a construct is a pivotal component deeply connected with sex positivity (World Association for Sexual Health, 2014; World Health Organization, 2006). In fact, the WHO defines sexual health as including a "positive and respectful approach to sexuality and sexual relationships…" (WHO, 2006).

Utilizing the previous definitions of sex positivity and sexual health, the link is shown that with increased sex positivity, sexual health attitudes and adherence increase as well. The two are intrinsically linked yet measuring and assessing them are a more complicated matter. Sexual health has typically been measured through adherence to decreased sexual risk activities, increased awareness and knowledge, and overall outcomes associated with biosocial health. However, sex positivity has often been measured more so with a dichotomous erotophobic vs. erotophilic construct. This research aims to provide evidence for a more comprehensive measure of sex positivity—that will be able to be linked more closely with sexual health outcomes.

Sexual health and advocacy programs that foster a positive, nonjudgmental environment have been shown to have stronger outcomes in preventing unplanned pregnancy, decrease risk of contracting or spreading sexually transmitted infections, and increase personal mental health outcomes (e.g. Aparicio et al., 2018; Chan et al., 2016; Chandra-Mouli et al., 2015; Msetfi et al., 2018; Svanemyr et al., 2015; WHO, 2017; Wilson et al., 2018; Woodford et al., 2015). Therefore, it stands to reason that sexual health as a construct is something closely linked with sex positivity. The two components deserve to be measured for various reasons within mental health,

biological and medical health, and for the wellbeing of populations within the realm of the public health sphere.

Sex positivity in mental health as a component of sexual health

The importance of researching sex positivity is made further evident because of its several beneficial uses in therapy. Sex plays a significant role in mental health and is often necessary to discuss when working with couples or individuals. However, it is not uncommon for clinicians to experience discomfort when discussing sex with their clients (Cruz et al., 2017). In some cases, the disclosure of a sexual problem is not expected by the therapist and can lead to clinical errors in treatment if the therapist becomes uncomfortable. Clients recognize the therapist's discomfort and become less willing to be open with disclosing their problems, thereby creating a major difficulty in treatment (Walters & Spengler, 2016) This exemplifies the need for sex-positive therapists; it is essential for clients to discuss sexual matters without feelings of judgement from the therapist for therapy to be successful (Cruz et al., 2017). There has been a call in the literature for master's and doctoral counseling programs, as well as couple and family therapy programs, to incorporate sex positivity into their training curricula when learning about human sexuality and sex therapy (Burnes et al., 2017; Dermer & Bachenberg, 2015).

The need for discussion about sex often occurs when clients experience sexual dysfunctions. Sexual dysfunctions are not variances in sexual behaviors or orientation (which are accepted in sex positivity), but problems that prevent couples or individuals from having orgasms or satisfying sexual experiences. Anxiety is often a major factor in sexual dysfunctions (Niak, 2017). Treatment models have been developed for sexual dysfunction that focus on treating anxiety through the use of sex-positive techniques often applied in sex therapy. Such a model is exemplified by Kimmes et al. (2015) in the treatment model they adapted from the Masters and Johnson (1970) Sensate Focus Model. This particular model involves partners learning their own and each other's bodies by touch while being guided by the therapist. Mindfulness techniques are also taught during the process to alleviate discomfort. The overall goal of the model is to help couples create a sex-positive, judgement-free environment to relieve anxiety about having sex. A therapist using this model needs to be comfortable when guiding a couple through such intimate practices, making it necessary for the therapist to identify as and utilize a sex positive approach.

A recent case study by Baggett et al. (2017) found that the inclusion of sex-positive techniques typically used in sex therapy proved very useful in the assessment and treatment of female survivors of sexual trauma. Having a sex-positive therapist can allow the sexual trauma survivor to learn or reacquaint themselves with a model of healthy sexuality, which they may not experience otherwise. Sex-positive therapists can also create a safe space for dialogue on boundaries, pleasure, and other topics that can be difficult for a sexual trauma survivor to discuss (Baggett et al., 2017). Sex-positivity is also being implemented into therapy with transgender individuals. Spencer and Vencill (2017) created a group therapy curriculum for transfeminine clients that focused on alleviating gender dysphoria by enhancing sexual self-esteem. The sex-positive curriculum aimed to increase the individuals' comfort with their

bodies (including genitalia) as well as their sexuality. Therapists who hold sex positive beliefs and attitudes and rely on a sex positive therapeutic approach can provide an empowering outcome for clients through providing a paradigm shift from erotophobic beliefs endorsed by what is sexually accepted within society (Burnes et al., 2017). Although existing research is limited on client outcomes from therapists who utilize a sex positive approach, it can be theorized from previous studies that therapists who endorse sex positive beliefs promote sexual diversity and inclusivity of sexual expressions that vary from the norm which can be empowering and validating for clients (Williams et al., 2016).

Measuring sex positivity

Currently, there are a number of scales that measure sexual *attitudes* (see: Blanc et al., 2018; Fisher et al., 1988; Gilbert & Gamache, 1984; Hendrick & Hendrick, 1987; Hendrick et al., 2006; Hudson et al., 1983; Reiss, 1964) and even more that address sexual attitudes in relation to specific factors (such a religiosity, see: Victor et al., 2015; Young et al., 2015). Several of these scales include items that are important to measure sex positivity, such as opinions on same-gender relationships and various sexual activities. However, the majority of scales are a minimum of thirty years old and are missing crucial elements that are considered necessary to modern sex positivity. They also do not include positivity as a construct directly - instead focusing on behaviors, or beliefs.

In many of the current scales on sexual attitudes, they will focus on one aspect of sex positivity but not include others. One such example would be the Sexual Opinion Survey (Fisher et al., 1988). This scale focuses on opinions towards erotica, pornography, and masturbation, and is used for measuring an individual's level of erotophobia or erotophilia. While acceptance of an individual's erotophilia would be considered an element of sex positivity- as sex positivity is non-judgmental of an individual's sexual autonomy (Ivanski & Kohut, 2017) - this one component would not able to determine whether or not an individual would actually be considered sex-positive, as it does not address an individual's opinions of others' sexual variations without it being seen as a detrimental effect on one's own eroto-philia/phobia. The same would be true for the Premarital Sexual Permissiveness Scales (Reiss, 1964), which only focuses on sexual attitudes for premarital, heterosexual couples. Lack of inclusivity and sex diversity in the Premarital Sexual Permissiveness Scales (Reiss, 1964) prevent this scale from measuring one's acceptance toward sexual attractions and identities that very from societal norms.

Sex positivity as a construct

It is necessary to create a scale that can determine the level sex positivity among people due to the impact of sex-positive aspects on society and the wide range of benefits regarding promoting non judgement and sexual diversity. Sex positivity is multifaceted, and several key features are currently understudied. The purpose of this study was to create a scale that could measure some of these key features and evaluate its psychometric properties. Scales previously discussed measure various

components of sex positivity but there is not an existing scale that measures how these different components interact with each other and impact individual's sex positive attitudes. Three components that were considered crucial to sex positivity were studied: (1) sexual behaviors and activities, (2) feelings about communicating or talking about sex, and (3) beliefs, exploration, and knowledge about sex.

Doing sex positively

Sexual behaviors and activities have been studied and discussed in previous literature (see: Blanc et al., 2018; Fisher et al., 1988; Gilbert & Gamache, 1984; Gray et al., 2019; Laner et al., 1978; Twenge et al., 2015). However, sexual behaviors and activities are still necessary to include in this study because of its major influence in sex positivity. Sex positivity involves sexual autonomy, meaning that it is up to the individual to decide what kind of sexual expression is right for them, and the acceptance of others to do the same (Williams et al., 2013). For the purpose of our study, endorsing one's own and other's sexual autonomy was measured through questioning what types of behaviors the participant found acceptable for themselves and others to engage in.

Positive sex talk

Communication about sex is a major missing element of current sexual attitudes scales. In scales that do implement communication, they are typically tailored for communication between partners (e.g. The Dyadic Sexual Communication Scale, Catania, 1986). This is necessary, as communication about sex has a strong association with sexual and relationship satisfaction (Mark & Jozkowski, 2013). While this is important in sex positivity, communication about sex outside of sexual and romantic relationships also plays a role in determining if an individual is sex positive. This would include an individual's comfort with discussing sex with people other than their partners, such as friends or family members, as well as willingness to ask questions about sex. Communication about sex in public, or questioning if sex is a taboo subject, are also key components, and were necessary items to include in the scale.

Internal ideologies of sex

Beliefs, exploration, and knowledge about sex are crucial elements about sex positivity that are currently understudied. While some studies have covered the topic of beliefs about sex (e.g. Hendrick & Hendrick, 1987), fewer have covered sexual exploration (e.g. Fishers et al., 1988), and studies covering an individual's knowledge of sexual diversity and inclusivity are even harder to come by. Sexual exploration of one's sexual identity, attractions, and consensual activities that differ from the norm have not always been accepted within society and could be a reason for the lack study about exploration and knowledge. This has been true even amongst the LGBTQ + community (Queen & Comella, 2008). Society sees sex positivity (and therefore, sexual exploration) as something dangerous because it celebrates sexual diversity and inclusivity. Traditionally endorsed and internalized sex negative attitudes made it necessary for these topics to be covered in the scale.

Purpose of this study

This study aims to create a scale that measures sex positivity as a construct, privileging sexual health and incorporating components of behaviors, beliefs, and communication aspects. Our overarching research question was, *What does a valid and reliable scale that provides information about levels of sex positivity (through the lens of sexual health and positive interaction) look like?* In constructing this scale, we hope to create a measure that can start being used in clinical mental health, public health/biomedical, and research settings.

Methods

In order to create the Sex Positivity Scale, a list of qualifying characteristics of sexual health and sexual positivity—heavily influenced by current literature (e.g. Baggett et al., 2017; Cruz et al., 2017; Ivanski & Kohut, 2017) and professional policy or political statements (e.g. Feminist Campus, 2020) was utilized. Ideological stances and position statements from international (WHO, 2019; World Association for Sexual Health, 2014) and national sexual health or sex therapy, and sexology organizations (e.g. Auteri, 2015) were also considered when the initial pool of items were developed. From these various publications, many commonalities existed, covering areas such as beliefs, values, behaviors, thoughts, and experiences. Overlapping concepts were matched up and combined via face value vocabulary and grammatical construction; and unique components were identified. An initial pool of 30 items that appeared to exemplify what current literature and statements of sex positivity is as a construct were created, and then re-formulated into a Likert scale for evaluation.

In order to validate the scale, Internal Review Board approval (from the first author's host institution at the time) was granted to conduct a survey study online; collecting the responses of any consenting adult (18+ years of age) from around the United States in English. The only exclusionary criteria included was if the person was not able to legally provide consent, e.g. if they person was under 18 years of age, and/or was unable to cognitively process and agree to the terms. The survey was conducted using Qualtrics online software and was advertised through Facebook and Instagram social media platforms, sent via direct email to listservs of national organizations related to sex and sexuality, and was distributed to other mental health providers to send along tertiary networks. The survey was only given in the English language, therefore participants had to be proficiently literate in English in order to read and complete the survey.

Survey instruments

There was a standard demographic survey included which asked for characteristics of the sample population related to social location and contextual factors of their lives. The Sexual Opinion Scale (Gilbert & Gamache, 1984) was utilized as a base measure to determine levels of erotophibia vs erotophilia. The measure was initially proven well validated in development, having a cronbach's alpha of .90, split-half reliability of .77. Additionally, a principal component analysis of the measure resulted in four subscales (open sexual display, sexual variety, homoeroticism, and undefined),

and an overall scale measuring dichotomous erotophobia—erotophilia (Gilbert & Gamache).

To measure the sample's general state of psychological health, the Outcome Questionnaire 10.2 (OQ; Lambert et al., 1998) was distributed. The OQ was developed from the longer, Outcome Questionnaire 45 by the same authors as a way to more briefly measure the overall level of distress in a person's life. The measure is 10 items, and is scored on a likert scale where higher scores indicate higher levels of distress in life. The OQ has been used in several studies, showing evidence of acceptable reliability and validity (e.g. Seelert et al., 1999). The Big Five Inventory (John et al., 1991) was utilized in an effort to determine if any personality constructs were connected with sex positivity and for additional validation of the measure of sex positivity. The Big Five Inventory is considered a well researched scale with acceptable ranges of validity, having a chronback's alpha in studies randing from .79 to .88. Finally, the newly developed sex positivity scale was presented and answered by participants, based on the items initially developed as mentioned previously.

Results

Participants

The survey was active for a total of 6 months, during which time it gathered a grand total of 781 responses, of which 521 were usable. Data was initially reduced by examining completion rate - those with more than 10% of data missing (n = 260) were removed. This left the final usable data set of n = 521. Of those cases with less than 10% of data missing (not systematic), data points replaced with scale mean (this occurred only 5 times in the data set). It was determined that this first test of the Sex Positivity Scale would include primarily classical test theory analysis of the data; gathering evidence for validity and reliability. Before we began the analysis, we also examined the data for basical statistical assumptions, outliers, and normality. An analysis of the pairwise plots indicated linearity and homoscedasticity of continuous variables, and no significant skewness was found—thefore, no data cleaning or transformative methods were employed. STATA IC 16 (StataCorp, 2019) was utilized to analyze the data.

Demographics

There were 521 total participants in this study. Of which, 61% made less than $75,000 a year, and 62% were less than 40 years of age. The majority of participants were non-Hispanic/Latino Whites (74.4%) living in the Southeast (41.2%), though participants were found across all regions of the United States. The participants were mostly female (50.9%) and 18 to 29 years old (41.9%). The majority were heterosexual (72.1%) and in monogamous, committed relationships (64.5%). The participants were mostly full-time employees (42.4%) with an associate degree or higher (57.2%). The majority of participants were Christian (61.5%), either in a specific denomination or non-denominational. Participants also most frequently reported identifying as a Democrat (39.2%) and liberal (31.9%). More detailed demographics are provided in Table 1.

Table 1. Sample demographics – only endorsed items represented (N = 521).

Demographic Category	*n*	% of Total	Demographic Category	*n*	% of Total
Age Ranges			Income		
18–23	*133*	26	> $34,999	*159*	30.6
24–34	*132*	25	$35,000–49,999	*62*	11.9
35–50	*129*	25	$50,000–74,999	*95*	18.3
51–80	*127*	24	$75,000–99,999	*85*	16.4
Ethnicity			$100,000+	*118*	22.7
Asian Culture	*13*	2.5	Region of the US		
African American	*58*	11.2	Northeast	*63*	12.4
Latino/a	*18*	3.5	Midwest	*135*	26.4
Mixed Ethnicities	*36*	6.9	Southeast	*211*	41.1
White	*387*	74.4	Southwest	*39*	7.7
Religion			West Coast	*61*	12
Agnostic	*81*	15.9	Employment		
Atheist	*46*	9.1	Full or Part Time	*277*	53.1
Baptist	*39*	7.7	Student	*109*	21
Catholic	*64*	12.6	Retired	*38*	7.3
Christian (General)	*160*	31.5	Political Affiliation		
Education			Democrat	*204*	39.2
High School Diploma	*200*	38.4	Republican	*92*	17.7
Associate's Degree	*53*	10.2	No Party / Unaffiliated	*146*	28.0
Bachelor's Degree	*110*	21.1	Did not answer	*79*	15.1
Advanced Degree	*135*	25.9	Gender Identity		
Sexual Orientation			Agender	*2*	.4
Asexual	*13*	2.5	Female	*265*	50.9
Bisexual	*57*	10.9	Gender Queer	*3*	.6
Gay	*20*	3.8	Intersex	*1*	.2
Heterosexual	*375*	72	Male	*232*	44.5
Lesbian	*11*	2.1	Non-Binary	*6*	1.2
Pansexual	*20*	3.8	Transgender	*9*	1.7
Queer/Questioning/Fluid	*20*	3.8	Other/Not Listed	*3*	.6
Other/Missing	*5*	1			

Table 2. Big Five Inventory & Outcome Questionnaire 10.2 tabulations.

	This Sample		Comparison*	
	M	σ	M	σ
BFI – Extraversion	3.21	.85	3.24	.90
BFI – Agreeableness	3.89	.59	3.82	.68
BFI – Conscientiousness	3.69	.66	3.72	.71
BFI – Neuroticism	2.98	.87	3.13	.86
BFI – Openness	3.82	.56	3.89	.69
OQ 10.2 α = .894	13.92	7.24	13	7.05

*Comparison Data for BFI from Srivastava et al. (2003); for OQ 10.2 from Seelert et al. (1999).

Big Five Inventory & Outcome Questionnaire 10.2 as providing characterological traits

The Big Five Inventory (John et al., 1991) does not have a strict guideline for interpreting results; however, the developers frequently point to a large data set they collected in 1999, published in 2003, of early and middle adulthood populations. This data set is used for a simple comparison for this study. The Outcome Questionnaire 10.2, does in fact have 'cut off' and normed ranges for interpretation (Lambert et al., 1998). In Table 2 below, the data from this population is displayed, along with comparison ranges for the Big Five Inventory.

The data from the BFI and OQ10.2, indicate that the sample is similar to the overall general US Population characteristics reported elsewhere. All means for this

sample, compared with previously published data are within one standard deviation (both original development, and this sample standard deviation) for analysis. This is another factor to indicate that the sample is adequate for comparison to the general US Population.

Analysis & psychometric properties of the sex positivity scale

Initial exporatory structure

The Sex Positive Scale was analyzed using Classical Test Theory properties—establishing a factor structure through an exploratory Parallel Analysis (Monte Carlo simulation), which provided an idea of how many factors were possible in the data. The Parallel Analysis indicated that there was sufficient data provided and ligned around three factors of viable information provided (95% confidence interval, 1,000 random generated data sets; O'Connor, 2000). In addition, the parallel analysis showed three factors with eigenvalues above corresponding eigenvalues created through randomly ordered data (raw data eigenvalues [percentile random data eigenvalue]: 7.34 [1.54], 2.86 [1.45], 2.25 [1.39]).

Reliability estimates and stabilization

In the original scale, there was a total of 30 items that were initially tested. Of the 30, when four items were included with analysis they destabilized the factor structure and decreased the overall reliability of the measure. One of those four, "*I believe I am a sex positive person*" destabilized the entire factor structure; the statistical software was unable to find convergence as the single item accounted for a vast amount of variance. When the item was removed, the scale stabilized. The decision was made to keep the item as a stand-alone 'screen' question at the beginning of the measure, as it had significantly high relationships with the final factors and was theoretically significant.

Three more items were removed, as they provided no information and decreased overall reliability. Those items included: "I am comfortable in my own sexual identity," "I am aware of, and use protection (such as condoms, dental dams, birth control, etc.) to safeguard my partner and I's health," and "I get tested for sexually transmitted infections regularly." Once these four items were removed, the scale was found to have a stable factor structure of three loading categories, and reliability remained constant (Cronbach's Alpha levels: scale A "Behaviors & Attitudes" = .832; scale B "Talking about Sex, Communication" = .832; scale C "Personal Beliefs, Knowledge, and Exploration" = .788; overall total scale = .865). The three subscales and overall scale were also highly correlated with one another, all showing signs of significant relationships of moderate-high strength, as displayed in Table 3.

Stablization of structure

A final exploratory factor analysis (maximum likelihood) was conducted between the three categories discovered in the parallel analysis. The restricted Principal Component Analysis indicated that a three-factor model was appropriate (KMO = .870, Chi-Square = 4536.72, df = 300, Sig. .000); lambda estimates of the model

Table 3. Exploratory factor structure & item metrics.

New Item Number	Original Item Number	Factor 1 λ = 6.69 α = .832	Factor 2 λ = 2.69 α = .832	Factor 3 λ = 2.21 α = .788	M	σ	Cronbach's α if item Deleted
1	25	.711			4.03	1.25	.806
2	26	.699			4.30	1.01	.806
3	23	.692			3.77	1.40	.815
4	21	.637			4.27	.961	.810
5	22	.633			4.41	.924	.813
6	27	.612			4.57	.755	.818
7	4	.605			3.48	1.37	.825
8	12	.592			4.61	.822	.826
9	11	.499			4.26	1.04	.818
10	28	.467			4.62	.836	.826
11	14		.795		4.00	1.15	.796
12	13		.758		3.90	1.14	.791
13	16		.756		3.32	1.29	.817
14	15		.682		2.67	1.38	.797
15	24		.596		3.76	1.22	.821
16	17		.590		4.60	.692	.826
17	20		.573		3.94	1.16	.821
18	18		.495		4.09	1.07	.827
19	2			.697	4.47	.978	.764
20	5			.690	4.55	.724	.737
21	6			.659	4.55	.759	.744
22	9			.629	4.45	.824	.751
23	1			.569	4.76	.665	.772
24	10			.554	4.52	.883	.776
25	7			.530	4.77	.570	.774
26	8			.421	4.75	.607	.795

indicate that the first factor was the strongest (λ_1 = 6.69), while the remaining two factors were relatively close (λ_2 = 2.69 & λ_3 = 2.21)—also indicating that very little information would be provide beyond three factors. Table 3, below, shows all final factor loading weights.

Final structure determination with confirmatory factor analysis

Maximum likelihood estimate was utilized to estimate model parameters of the three factor structure identified earlier in the exploratory factor analysis. Goodness of fit indicators were estimated with root mean square error of approximation (RMSEA = .05, 90% CI ≤ .06), standardized root mean square residual (SRMR = .06), comparative fit index (CFI = .91), and Tucker-Lewis Index (TLI = .90). All indicators were within acceptable to close-fit ranges (Hu & Bentler, 1999; Kline, 2016) (Table 4).

Other validity estimates

Validity of the scale was determined through comparative relationships, including face/content validity (established through the design of the measure using empirical research, statements, and policies from leading global organizations), divergent validity (correlations with non-related scales), and convergent validity (correlation with the sexual opinion scale, one of the only sex positivity-related scales to date). Correlations between the new Sex Positivity Scale total score and the Big Five Inventory Neuroticism Subscale as well as the overall Outcome Questionnaire 10.2

Table 4. Confirmatory factor analysis – unstandardized and standardized loadings for three factor model.

		FACTOR 1 Behavior		FACTOR 2 Communication		FACTOR 3 Beliefs	
New Item Number	Original Item Number	UNST	STAND	UNST	STAND	UNST	STAND
1	25	1.0^* 73.8	.65*				
2	26	.87* 13.17	.70*				
3	23	.89* 11.81	.52*				
4	21	.73* 11.32	.62*				
5	22	.66* 10.68	.58*				
6	27	.59* 11.68	.64*				
7	4	.74* 8.78	.44*				
8	12	.59* 10.83	.58*				
9	11	.62* 9.48	.49*				
10	28	.48* 9.10	.47*				
11	14			1.0^*	.81*		
12	13			.93*	.76*		
13	16			1.0*	.73*		
14	15			.81*	.55*		
15	24			.69*	.53*		
16	17			.45*	.61*		
17	20			.64*	.51*		
18	18			.57*	.50*		
19	1					1.0^*	.46*
20	2					1.55*	.49*
21	5					1.84*	.72*
22	6					1.84*	.75*
23	9					1.83*	.68*
24	7					.92*	.50*
25	8					.55*	.28*
26	10					1.24*	.43*

Note: ^ indicates that the standard error was not estimated. * Indicates signifance at p < .001. *z* scores reported below coefficient. χ^2 (290) = 704.01.

Table 5. Internal scale correlations and final psychometrics (n = 521).

Item/Area	1	2	3	4	M	σ	α
1. I believe I am a sex positive person.	1.0						
2. Subscale: Behavior	.412* .000	1.0			42.32	6.67	.832
3. Subscale: Communication	.553* .000	.341* .000	1.0		30.28	6.24	.832
4. Subscale: Beliefs	.515* .000	.347* .000	.397* .000	1.0 .000	36.77	3.91	.788
Total Scale	.651* .000	.788* .000	.787* .000	.684* .000	109	12.94	.865

* indicates significance at p < .001.

score were identified as a means to determine divergent validity. Pearson correlation coefficients between the scales were insignificant (SPS—BFI-N: $r(520) = .016$, $p = .723$; SPS—OQ 10.2: $r(520) = -.083$, $p = .070$) and for divergent validity analysis, indicating that the scale did not measure similar constructs. For the comparison with a similar construct, the Sexual Opinion Scale, there was a significant medium-strong relationship between the variables, $r(520) = .662$, $p = .000$—this indicates that the scales measure similar constructs, providing evidence for convergent validity. Table 5, below, provides Pearson Correlation coefficients between subscales and screening questions (all highly significant, p < .001 with moderate-high relationships) as well as the final scale psychometrics.

Discussion

The purpose of this study was to create and examine a measure of sex positivity as a trait, taking into account the various definitional components of the term from global representations. Generally, it was assumed that the scale would be able to differentiate between those who were sex positive, and those who were not. Overall, the initial psychometric properties of the Sex Positivity Scale demonstrated construct validity and internal consistency; this extended to the three subscales that emerged from examining the data. Based on this preliminary study, it can be stated that the Sex Positivity Scale can cautiously be used within research, clinical work, biomedical and public health settings to gather more information about a person's self-reported sex positivity.

Possibly one of the more interesting findings from this study, was the overwhelming amount of information provided by a single question, "I believe I am a sex positive person." This was not anticipated as part of the study variables and theoretical assumption but does coincide with previous literature on the general impact of self-perception on sex positive attitudes and beliefs. As such, and as described, this item was unable to fit within a specific factor or subscale, as it loaded too strongly with the concepts being measured—and so was relegated to being an initial 'screening' type question on its own at the beginning of the questionnaire. However, it should be noted that if the question was removed from the questionnaire overall, the three other factors still loaded within similar ranges and the overall reliability and validity of the scale itself did not decrease to below satisfactory or acceptable levels. This indicates that the item, while very important and providing a lot of information, does not provide a majority or even the most information—instead, the item enhances the scale overall when included as a separate from the three subscales component.

Psychometric reporting & scoring

The final version of the Sex Positivity Scale was determined to have a total of 26 items, three subscales, and a single screener question to start. To score the scale: Sum items 1–10 for subscale 1, "Behaviors & Attitudes about Sex"; Sum items 11–18 for subscale 2, "Talking about Sex & Communication"; Sum items 19–26 for subscale 3, "Personal Beliefs, Knowledge & Experiences." Reverse score items #3, 7, & 15. To interpret raw data scores, caution is advised. This is an initial study, without the extensive research necessary to determine final cut-off points. However, with moderation, a summed score of: M = 42 M, $\sigma = \pm 7$ for factor 1, M = 30, $\sigma = \pm 6$) for factor 2, M = 37, $\sigma = \pm 4$) for factor 3, and M = 109, $\sigma = \pm 13$) for total scores may be used to describe participant characteristics—higher scores indicating more sex positivity traits. The first item at the top of the scale, "I believe I am a sex positive person" should be used for discussion (in a therapy, qualitative research, or educational context), or used as a potential covariate/control in research studies. It is not included in the total score.

Implications

This new scale has significant implications in several fields, including mental health, biomedical/public health, and research efforts. As one of the first measures of its

kind to provide information about sex positivity as a construct, this scale can be used in research projects considering sexual health, human behavior, beliefs around typically difficult topics to discuss, or psychological constructs associated with sexuality. The scale is general enough to provide information for a single component, sex positivity, and also provide information on the components that contribute to and create sex positivity as a construct. Additionally, the strong evidence provided in this initial research for the validity and reliability of the scale demonstrates the usability of the measure in various types of studies and clinical settings.

As mentioned previously, sex and sexuality difficulties are a major presenting problem reported at the start of therapy. Prior to this scale being developed, there were very few measures to examine issues of sexuality outside of identity, satisfaction, behaviors or activities, or risk issues (typically all measured with different scales). While all of these areas are important to assess in sex therapy, focusing purely on the presenting problem can be less than helpful for many therapists; in therapy it is important to get at underlying characteristics and beliefs of the person you are working with. This scale provides information for therapists and counselors to start a discussion about sex with their clients from a positive place, considering how sex can be a good thing—or examining why it is thought of as a bad thing for their clients.

The breakdown into the three subscales, Behaviors & Attitudes, Talking about Sex & Communication, and Personal Beliefs, Knowledge and Experiences, can provide significant amounts of information for the therapist in assessing the client, as well as provide information for the biomedical, public health, or researcher professionals to understand the components of sex positivity for a person. Questions about sexual health can be helpful for gathering information related to risk, which will enable to medical or public health officials to engage in educational opportunities with patients/clients. Many people typically do not have the sexual health education background to be able to combat some of the significant social stigma, bias, and myths that circulate around sex and sexuality.

Social discourses focused around the promulgation of myths and false information can lead to higher rates of sexually transmitted diseases, mental health concerns associated with negative beliefs or sexual experiences, and overall discontentment. Using a scale such as this one to evaluate and then provide correct and helpful information, along with privileging the space to create a positive experience (deconstructing the feelings of awkwardness or appropriateness) of discussing the topic can lead to more supportive outcomes for adherence to medical treatments, lower risk-taking behavior, and increased acceptance of self.

Lastly, it can be difficult to expect clients to be comfortable openly discussing sex and sexuality when therapists hold sex negative attitudes. Therapists are not exempt from harmful messages regarding sex and sexuality that are propagated by society. Using this scale to assess therapist sex positive attitudes is a great tool for therapists to rely on identifying their implicit and explicit sex negative beliefs that could potentially harm clients. Locating where oneself stands with sex positive attitudes and beliefs can act as a great tool for therapists to conceptualize which areas they need to work on with regard to unlearning socialized sex messages and/or integrating more sex positive narratives. Therapists who hold sex positive beliefs are more likely to promote inclusivity around relationship structures, ie. consensually

non-monogamous relationships, and sexual attractions, ie. the kink community, that defer from socially accepted norms (Burnes et al., 2017). As previously mentioned, there has been a call within the literature for the need to incorporate sex positivity into training curriculum for counselors, as well as couple and family therapists (Burnes et al., 2017; Dermer & Bachenberg, 2015). Masters and doctoral clinical training programs can use the Sex Positivity Scale as a tool for teaching student therapists how their own sex positivity is influential when working with clients and trying to incorporate a sex positive therapeutic approach. The Sex Positivity Scale can be used to further research how therapists' sex positive beliefs and attitudes impacts sex therapy outcomes. Examining if therapists who rely on sex positive practices, like cultivating non-judgmental attitudes and inclusivity regarding sex and sexuality, will enrich existing literature on how self-of-the-therapist sex positive beliefs impacts treatment of clients with presenting sexual dysfunctions, sexual exploration, and general sexual topics.

Limitations

The study was completed with a number of items initially developed by the first author through examination of literature. Additional items were developed from definitional characteristics provided by worldwide organizations or other public media that discussed sex positivity. Additionally, other scales considering erotophilia/phobia (such as the Sexual Opinion Survey) and sexual activity were examined for consideration of item modification for inclusion. Overall, the items on The Sex Positivity scale were created by a single person, and so are inherently tainted with bias.

The study participants skewed significantly toward white (75% of sample), employed (53% of sample), well educated (46% had bachelor or higher), and middle-upper class (57% made an annual income of more than $50,000 per year). This is not an accurate representation of any nation's average population, and so with this scale, while showing significant evidence of reliability and validity—should be interpreted with caution when consider more diverse samples.

Another limitation of the study was the method of data collection. Virtually all participants accessed and used the internet, and either a computer, phone, or tablet to take the study. This limited the reach of the project to only those who have these items, the internet, or access to areas where these luxuries are available. While convenient and easily able to be completed in this manner, future research should examine further characteristics of samples such as rural/urban location, environmental factors such as access to resources—and, in attempting to get better samples, engage in a more clustered or stratified recruitment strategy.

Conclusion

The Sex Positivity Scale is one of the first of its kind to measure Sex Positivity as a construct. Previous scales have attempted to develop similar instruments, focusing primarily on a dichotomy of erotophobia or erotophilia (polarized ends of a limited spectrum). However, by incorporating sexual health components as exemplified through internationally endorsed contemporary beliefs of what sexual health and sex positivity

is, a more accurate and encompassing questionnaire was developed. This included elements of measurement around Behaviors and Attitudes, Talking about Sex, and Personal Beliefs—something not generally incorporated into a single scale. Through a Classical Test Theory Psychometric Analysis, the Sex Positivity Scale showed evidence of strong validity and reliability with a medium-large sized sample that had some characteristics representative of typical US samples; albeit skewed toward the majority.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Appendix

Sex Positivity Scale

Name: _____Date: _____

Directions: Please answer all questions as honestly as possible, thinking about your views, thoughts, beliefs, and/or actions related to sex and sexuality. Go with your first, gut reaction.

First, please answer the following:
I believe I am a sex positive person.
Completely Disagree Disagree Neither Disagree nor Agree Agree Completely Agree

	Item	*Completely Disagree*	*Disagree*	*Neither Disagree nor Agree*	*Agree*	*Completely Agree*
1.	The number of sex partners a person has is not a determinant of their moral purity.	1	2	3	4	5
2.	Erotica (video, audio, written, spoken, performed, etc.) is an acceptable form of sexual expression.	1	2	3	4	5
3.	Sexual activity should be reserved for people in a committed, romantic relationship.	1	2	3	4	5
4.	I do not judge others for their sexual behaviors or desires.	1	2	3	4	5
5.	I do not judge others for their sexual attraction.	1	2	3	4	5
6.	Just because I am not aroused by a specific sexual activity, does not make it "wrong."	1	2	3	4	5
7.	If I were propositioned for sex with a person who did not identify with the gender I am typically sexually attracted to, I would be upset.	1	2	3	4	5
8.	There is no one "right" way to have sex.	1	2	3	4	5
9.	The definition of "sex" is individual to each person.	1	2	3	4	5
10.	Sexual health is a basic human right.	1	2	3	4	5
11.	I am comfortable talking about sex with friends.	1	2	3	4	5
12.	I am comfortable talking about sex in public.	1	2	3	4	5
13.	If I have a question about sex, I am comfortable asking someone about it.	1	2	3	4	5
14.	I am comfortable talking about sex with family.	1	2	3	4	5
15.	I think talking about sex is an awkward experience, no matter who I am talking to.	1	2	3	4	5
16.	I am not ashamed to talk to my doctor about sex issues.	1	2	3	4	5
17.	Sex is not a taboo subject for discussion.	1	2	3	4	5
18.	I am comfortable talking about sex in private.	1	2	3	4	5
19.	I believe that a healthy sex life is important to everyone.	1	2	3	4	5
20.	I like to learn new things about sex.	1	2	3	4	5

(*Continued*)

	Item	Completely Disagree	Disagree	Neither Disagree nor Agree	Agree	Completely Agree
21.	I like to learn new things about what I enjoy with sex.	1	2	3	4	5
22.	I am willing to try new things sexually, as long as it is not illegal.	1	2	3	4	5
23.	I believe sex is a good thing.	1	2	3	4	5
24.	Sex should be enjoyed by all people.	1	2	3	4	5
25.	I believe it is important to know about my partner's beliefs and thoughts related to sexual activity.	1	2	3	4	5
26.	I always ensure consent prior to sexual activity with a partner.	1	2	3	4	5