Departamento de Sociologia

Sexual dysfunctions and sexology: social constructions, personal meanings and medicalization of sexuality

Violeta Sabina Niego Perestrelo de Alarcão

Tese especialmente elaborada para obtenção do grau de

Doutor em Sociologia

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Dezembro, 2015

À minha filha Pilar, o tesourinho que revolucionou a minha vida.

Ao meu amor de e para sempre, por acreditar e amar mais do que sou.

À minha família, pelo apoio e amor incondicionais.

A quem perdi, mas me acompanha sempre.

Gracias a la vida que me ha dado tanto.
Me dio dos luceros que, cuando los abro,
Perfecto distingo lo negro del blanco,
Y en el alto cielo su fondo estrellado
Y en las multitudes el hombre que yo amo.

Gracias a la vida que me ha dado tanto.
Me ha dado el oído que, en todo su ancho,
Graba noche y día grillos y canarios;
Martillos, turbinas, ladridos, chubascos,
Y la voz tan tierna de mi bien amado.

Gracias a la vida que me ha dado tanto.
Me ha dado el sonido y el abecedario,
Con él las palabras que pienso y declaro:
Madre, amigo, hermano, y luz alumbrando
La ruta del alma del que estoy amando.

Gracias a la vida que me ha dado tanto.
Me ha dado la marcha de mis pies cansados;
Con ellos anduve ciudades y charcos,
Playas y desiertos, montañas y llanos,
Y la casa tuya, tu calle y tu patio.

Gracias a la vida que me ha dado tanto.
Me dio el corazón que agita su marco
Cuando miro el fruto del cerebro humano;
Cuando miro el bueno tan lejos del malo,
Cuando miro el fondo de tus ojos claros.

Gracias a la vida que me ha dado tanto.
Me ha dado la risa y me ha dado el llanto.
Así yo distingo dicha de quebranto,
Los dos materiales que forman mi canto,
Y el canto de ustedes que es el mismo canto
Y el canto de todos, que es mi propio canto.

Gracias a la vida que me ha dado tanto.

Violeta Parra, Gracias A La Vida

Like Viagra, this book has been a collaborative endeavor.

Loe M. (2004) *The rise of Viagra: how the little blue pill changed sex in America.*

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Nenhum projeto é possível sem a generosa colaboração dos informantes, neste caso, homens e mulheres adultos que aceitaram falar sobre sua sexualidade e também partilhar as suas representações da sexualidade; e também os especialistas em sexologia e sexualidade em Portugal, que num gesto de cooperação académica contaram os seus percursos e discutiram temas da sua especialidade. É em primeiro lugar a todos os participantes que devo retribuir com a produção científica de resultados que espero merecedora do seu apoio. Apesar de não terem sido identificados, espero que pelo menos em parte se identifiquem com o que é escrito.

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apoio nesta tese, como em tudo o resto, pela (part)*ilha encantada* que torna a minha vida mais rica e mais feliz cada dia que vai passando.

Esta tese foi o meu reencontro com a sociologia, e o seu útil diálogo com a epidemiologia, e reforçou a minha vontade de continuar a articular os saberes de ambas para melhor estudar as questões de género, saúde e sexualidade.

DECLARAÇÃO

De acordo com o artigo 35º das Normas Regulamentares Gerais dos Doutoramentos da Universidade do ISCTE-IUL, aprovadas pelo Despacho n.º 9887/2011 do Reitor do ISCTE-IUL e no Regimento do Conselho Científico do ISCTE-IUL, esta dissertação assume a forma de uma compilação de artigos, englobando uma introdução alargada e um conjunto coerente e relevante de trabalhos de investigação submetidos para publicação em revistas com comités de seleção de reconhecido mérito e indexadas em bases internacionais.

A autora declara que foi responsável pela conceção e delineamento do estudo, recolha de dados, análise e interpretação dos resultados, assim como pela redação, submissão e revisão dos manuscritos dos artigos enviados para publicação.

Violeta Sabina Niego Perestrelo de Alarcão

Setembro, 2015

STRANGE, YOU SAY. A woman has written a book about Viagra. I wonder how she got interested in that…

Loe M. (2004: 1) *The rise of Viagra: how the little blue pill changed sex in America.*

ABSTRACT

In contemporary constructions of sexuality, the discourses and practices of medicine and clinical psychology occupy a primary role. They contribute to the origin of new normative approaches to sexuality, focused on the issue of good sexual functioning. However, despite the growing attention that sexuality is receiving, the study of the social construction of sexual dysfunction remains incipient, especially in a national context.

Overall, the results of this thesis, which integrates two studies with mixed methodologies, are presented in the form of four scientific publications.

The first article aims to contribute to the discussion of how beliefs regarding sexuality and gender affect the categorization of sexual function as either natural or pathological.

The second article provides a view of the dynamics of changing sexual behavior, showing a "model of human sexuality" consisting of four types: *rigid conservative, attenuated traditional, adaptive progressive,* and *confluent transformative*.

The third article seeks to explore how the growing plurality of sexual scripts affects gender order through the meanings created from personal experiences in everyday life, focusing on representations of sexual problems.

Finally, the fourth article analyzes how Portuguese sexologists integrate their professional role in the vast multidisciplinary field of sexual health, providing an overview of the emergence of sexology as *scientia sexualis* in Portugal.

Preceding the four articles, there is an introduction that frames sexuality in the light of two fundamental debates: the medicalization of sexuality and growing individualization in contemporary Western societies.

Keywords: *sexuality; medicalization; sexual dysfunctions; sexual scripts; sexology*.

RESUMO

Nas construções contemporâneas da sexualidade, os discursos e as práticas da medicina e da psicologia clínica ocupam um papel principal. Estão na origem das novas abordagens normativas à sexualidade, centradas na questão do bom funcionamento sexual. Porém, apesar da crescente atenção que a sexualidade tem merecido, o estudo da construção social das disfunções sexuais mantem-se incipiente, sobretudo no contexto nacional.

Globalmente, os resultados desta tese, que integra dois estudos com metodologias mistas, são apresentados sob a forma de quatro publicações científicas.

O primeiro artigo visou contribuir para a discussão acerca da forma como as crenças relativas à sexualidade e género condicionam a categorização da função sexual em natural ou patológica.

O segundo artigo forneceu um olhar sobre as dinâmicas de mudança dos comportamentos sexuais, apresentando um "modelo da sexualidade humana" composto por quatro tipos: *rígido conservador*, *tradicional atenuado*, *progressivo adaptativo*, e *confluente transformativo*.

O terceiro artigo procurou explorar como é que a crescente pluralidade de scripts sexuais afeta a ordem de género, através dos sentidos que se tecem a partir das experiências pessoais no quotidiano, com enfoque nas representações sobre os problemas sexuais.

Por fim, o quarto artigo analisou como é que os sexólogos portugueses integram o seu papel profissional no vasto campo multidisciplinar da saúde sexual, fornecendo uma visão global da emergência da sexologia enquanto *scientia sexualis* em Portugal.

A preceder os quatro artigos há uma introdução que enquadra a sexualidade à luz de dois debates fundamentais: a medicalização da sexualidade e a individualização crescente nas sociedades ocidentais contemporâneas.

Palavras-chave: *sexualidade; medicalização; disfunções sexuais; scripts sexuais; sexologia.*

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Chapter II

> *Sociologists care about normal. We care about how individuals internalize society's norms; how normality and abnormality are defined, and by whom; how and why particular social groups and individuals are sanctioned for being different from the norm; how social norms shift in relation to historical, economic, political and cultural change; and how social norms reflect and perpetuate social inequalities. So when a product appears or an event occurs that pushed us to reflect upon, and maybe even change, our collective conceptions of "normal", sociologist take notice.*

Loe M. (2004: 19) *The rise of Viagra: how the little blue pill changed sex in America.*

INTRODUCTION

First, this is a sociological study on sexual dysfunctions, the physical changes of sexual functioning with social meaning, in Portugal. The work developed and presented here is therefore an attempt to deepen a sociological analysis of the social construction and personal significance of this problem. More specifically, this research has an object that unfolds in two parts, one on social actors and the other on fields, both under the perspective of the medicalization and moralization of sexuality.

This introduction is divided into six sub-points: the research roadmap; the thesis roadmap; thesis problems; the conceptual framework, research questions, and methodology; the general discussion of the results presented in the four articles; and implications and future directions.

The four chapters following this general framing introduction are empirical chapters in which four studies are presented. All of these chapters are based on papers published or accepted for publication.

In **Article 1** (Alarcão, Machado, & Giami, 2015), the differences between the responses to the Indexes of Sexual Function and the responses to a self-report question about sexual problems are discussed in light of the evolution of the concept of sexual health, changes in the definitions of sexual dysfunction, and the use of sexual function indexes in research and clinical practice. In this first chapter, an approach focused on the sociology of diagnosis by analysis of qualitative interviews makes it possible to discuss the reality of suffering, the legitimacy of the diagnosis and the therapeutic intervention, and the role of illness in the construction of rupture and the role of rupture in the construction of the illness.

In **Article 2** (Alarcão, Virgolino, Roxo, Machado, & Giami, 2015), we focus our analysis on the discussion of the growing individualization process in Western societies, particularly on notions of intimacy and sexuality, seeking to articulate in the discussion the notions of power and gender. We have searched for the meanings assigned to intimate relationships, sexual satisfaction, and equality. In the discourse of respondents, we have searched for continuities and changes that may help us understand the process of modernization and adaptation in a context where modernized social and intimate relationships, the characteristics of a new social time, are built. The permanence of gender inequality has led us to question the usefulness and timeliness of the concept of the sexual double standard. This

concept, created by Reiss (1964), refers to a set of social norms that govern the practice of different sexual behaviors for each gender, with men being granted greater sexual freedom than women.

In **Article 3** (Alarcão, Roxo, Virgolino, & Machado, 2015), we have explored how men experience the loss of sexual function, which modifications are introduced in sexual intercourse and in their experiences of masculinity and sexuality, and which strategies and resources are mobilized. To that end, we have attempted to conduct an analysis of the condition of the "impotent" man and study the manner in which men address the inability to maintain an erection and to satisfactorily perform sexual acts. In other words, how do men reconcile the dominant conception of sexual intercourse and internalize their inability to maintain an erection and perform in a sexual relationship in their actions and thoughts? The constraints that produce the masculine sexed body and what meanings they produce for gender and sexuality are also studied. Is the loss of erectile function always viewed the loss of masculinity? The utility of the concept of biographical rupture in capturing the diversity of experiences of illnesses and disabilities in modern Western societies and in identifying the different types of biographical narratives of decline, progress or morality should also be highlighted.

Finally, in **Article 4** (Alarcão, Beato, Almeida, Machado, & Giami, 2015), sexuality is no longer studied as the locus of the processes of individualization and is analyzed as a domain of scientific knowledge. The empirical data result mainly from the exploitation of material collected through in-depth interviews with a large number of experts on sexology, especially with regard to their perceptions of the meaning of sexology as a profession. The point of departure of this analysis is knowing whether sexology, in contemporary Portugal, is an activity or an emerging profession/semi-profession. However, the central question becomes the discussion of the social relevance, both real and symbolic, of the emerging profession of sexologist.

Research roadmap

The study of sexual dysfunctions, particularly the paradigmatic case of erectile dysfunction, allows a glimpse into contemporary Portuguese society in which sexual problems are constructed by both men and women with and without sexual difficulties and their possible partners, in addition to professional groups such as doctors, sexologists, the pharmaceutical industry, and marketing. In this manner, the axes of analysis are developed, on one hand, around

the contemporary discussion on individualization in the sense of "institutionalized individualism" (Beck & Beck-Gernsheim, 2002), the "reflexive modernization" of all spheres of social life (Beck, Giddens, & Lash, 2000), and of the "untraditionalization" of the values and ways of experiencing intimate relationships in the family, in the couple, and in social networks (Bauman, 1992, 1995, 2000, 2001; Beck & Beck-Gernsheim, 2002; Giddens, 1991, 1992, 2002; Jamieson, 1999). On the other hand, the axes are formed around the discussion of the so-called process of the "medicalization of sexuality", which includes, in a structural and dynamic approach, the organization of knowledge, social organizations, the organization of professions and the actors involved, and subjectivities. This set comprises what Foucault (1976) called the "device of sexuality". The analysis of the "medicalization of sexuality" is also critical to contextualize the emergence and the constitution of the field of sexology, in addition to the professional activity of the sexologist (Giami, 2007, 2009; Rohden, 2009, 2012; Russo, 2013; Tiefer, 1996; Weeks, 2002). Indeed, the increasing medicalization of the field of sexology is associated with the strengthening of sexology, intensified by the formulation and commercialization in the 1990s of the newly created "pill of love", Viagra, and by the fact that some sexual behaviors and states are defined as "health problems" that require medical and/or pharmaceutical intervention (Loe, 2004b; Marshall, 2002; Wentzell, 2013b).

As Meika Loe (2004b) demonstrates in her work on how the medical breakthrough of sildenafil citrate (Viagra) changed the meaning of sex in United States, the medicalization of impotence existed before Viagra; however, medical and biotechnological hegemony, the aging population, changes in gender roles, and recent political movements contributed to this cultural phenomenon. In this manner, its commercialization and the discussion of sexual problems represent an opportunity to study the construction of social norms, ideals, and expectations. In addition to the discussions surrounding sexual "normality" and functionality, this opportunity also presupposes a questioning of the definitions of masculinity and femininity, "normal" sexuality, "normal" aging, "normal" treatments, etc., and a reflection on how these discussions and definitions are built and the role of institutions, social groups, and individuals in this definitional process.

In a recent essay on Portuguese sexuality, in which an overview of the main changes in the field of sexuality is presented, Sofia Aboim (2013: 11) states: "In recent decades, few things have changed so radically as the ways of talking about sexuality and of living a sex life". Sexuality is thus described by the author as perhaps "one of the best examples that we could raise to think about the changes that have marked Portuguese society in recent decades" (2013: 15). However, the topic of sexuality remains little studied in Portugal. The Portuguese context,

by combining diversified practices of intimacy and sexuality with the continuity in various social sectors of traditional gender relations, is potentially rich for producing a better understanding of the changes in contemporary Western societies. In her analysis of the transformations of conjugality, Anália Torres also reports that changes in Portuguese society follow a particular rhythm. In addition to the fact that changes have become more visible later than in other countries, "certain atavisms still stand, are renewed, and traditions are even reinvented in a blend that is sometimes difficult to discern" (2001: 1).

The study of sexual dysfunctions, and sexuality in general, represents an open door for social theory. As stated by the pioneers of the sociological approach to sexuality, John Gagnon and William Simon (1973), sexuality articulates three dimensions of social life – the social structure, intersubjective relations, and the reflexivity of the self – which together constitute a very complex form, anchored in the body. Gagnon and Simon are responsible for claiming that the definition of sexuality is socially constructed, but they do not investigate how the idea of sexuality emerges. This aspect is central in the work of Foucault (1976). From a Foucaultian perspective, it is also important to understand why sexology and sexual therapy emerge, why sexuality and sex are discursively defined as problematic, and why they are viewed as something in need of therapy. Why is there a centrality of sex? Why is there the discursive social objective of sexual performance and satisfaction? How are the parameters of what is and is not sexual satisfaction and achievement defined, and how do individuals internalize them from the perspective of their health and personal fulfillment?

Indeed, this investigation represents both a challenge, due to the complexity of the topic, and an attempt to incorporate some of the most important contributions of existing studies, at the national and international levels, in a constantly evolving field of knowledge that is always intra- and interdisciplinarity, simultaneously seeking an innovative and comprehensive view. Its realization was a long process, neither linear nor continuous, but was developed throughout my professional career.

Indeed, in 2004, I had the opportunity to be hired as a researcher to coordinate the fieldwork for the project *Prevalence of male sexual dysfunction and andropause - A cross-sectional study*, financed by the Foundation for Science and Technology (Fundação para a Ciência e a Tecnologia) (POCTI/ESP/45965/2002), under the supervision of Prof. Alberto Galvão-Teles, one of the leaders of sexology in Portugal. This participation in epidemiological investigation sparked my interest in the study of sexuality, which was not exhausted with the completion of the project and the dissemination of key results (Teles, Carreira, Alarcão, Aragues, Lopes, Mascarenhas, & Costa, 2008), and it stirred my curiosity and motivated the

search for sociological problems in this area. In this manner, the two studies that were being designed in parallel to respond to the main emerging research issues and which received the acceptance and institutional support of the research unit to which I belonged – the Institute of Preventive Medicine and Public Health, Faculty of Medicine, University of Lisbon (Instituto de Medicina Preventiva e Saúde Pública da Faculdade de Medicina da Universidade de Lisboa) – were addressing, on one hand, the identification and comprehension of the diversity of representations and experiences of sexual problems in both men and women and, on the other hand, the characterization of the emergence of the field of sexology and the profession of sexologist in Portugal.

The first study included broader clinical research designed to evaluate the profile and characteristics of users and the effectiveness of treatment for sexual dysfunction in the context of primary health care, and it had the support of the Merck Sharp and Dohme Foundation and a research prize from the AstraZeneca Foundation to study the association of cardiovascular disease with sexual dysfunction. Actually, this area has recently been the target of new approaches and medical appropriations, specifically in cardiology (Hall, Shackelton, Rosen, & Araujo, 2010).

The second study was made possible by a collaboration with the *Institut National de la Santé et de la Recherche Médicale* (INSERM-France) through Professor Alain Giami, who provided the research protocol and data collection instruments used in the study "Profession - Sexologist in Europe (Euro sex)" for adaptation and implementation in Portugal. The study of sexology as a science and profession can provide a window for observing the manner in which sexuality has been addressed. Investigating sexology as a scientific field of knowledge, practice, and profession makes it possible to deconstruct the social and culturally specific definitions of correct and incorrect, including gender and homosexuality.

The combination of these two studies resulted in a large data set, specifically for the intended sociological undertaking, resulting in the submission of eight scientific articles, of which four have been selected for inclusion in this dissertation.

Thesis roadmap

This thesis, in the form of a compilation of articles, aims to contribute to the development of the sociological investigation of sexuality in Portugal, particularly with regard to intimacy and the individualization of sexual trajectories, and the "medicalization of sexuality" and the

"medicalized construction of sexuality". An innovative research was developed, at the level of theoretical conceptualization and methodological design, to achieve a comprehensive view and to avoid a partial and fragmentary approach to sexuality.

In Portugal, the sociological approach to sexuality was delayed, and its formalization as a disciplinary field in addition to gender by the Portuguese Association of Sociology (Associação Portuguesa de Sociologia), a scientific and professional association that is highly respected at the national and international levels, occurred in 2011. This institutional recognition reveals the growing relevance that these thematic areas have been acquiring in Portuguese sociology. The comprehension of the sociological phenomena related to sexuality and gender presents a clear link to other variables and fields of study. In this manner, and avoiding the reductionist nature of any attempt at defining this field, it is important to briefly trace its roots, noting that as in other areas of knowledge, the field of *Sexuality and Gender* is large, complex, and in a continual process of construction and negotiation. In the national context of recent sociological research, in our view, six major themes should be emphasized; these themes are linked to each other and to other fields of expertise, including the sociology of health, the sociology of emotions, and the sociology of families and life course:

1. Sexual behaviors – in the context of HIV/AIDS – as in the international trends, sexuality surveys have made it possible to explore the normative references of the Portuguese and the different sexual morals in different social contexts, in particular sexual initiation; contraceptive methods; attitudes in the face of HIV/AIDS; what is prohibited in sexuality; and what is permitted (Aboim, 2012; Amaro, Dantas, & da Cunha Teles, 1995; Amaro, Frazão, Pereira, & da Cunha Teles, 2004; Ferreira & Cabral, 2010; Maia & Ferreira, 2014; Pais, 1998);

2. Sexual life cycle and sex education – with an emphasis on studies on young people and teenagers – in an analysis that is simultaneously inter- and intra-gender in terms of differences in sexual paths and the practices and meanings that involve them (Ferreira, 2011; Marques, 2014; Pais, 1998, 2012; Pereira, 2012; Vasconcelos, 1998; Vieira, 2012; Vilar, 2002);

3. Sexuality, partnership, and fertility – sociologists linked to the area of family and gender have studied the changes in the structures of the contemporary family, the reconciliation of work and family life, prenuptial relations, and the choice of spouses, divorce, and reproductive decisions, but little is known about intimacy and sexuality (Aboim, 2011; Almeida, Vilar, André, & Lalanda, 2004; Guerreiro, Caetano, & Rodrigues, 2014; Torres, 2001; Wall, Aboim, & Cunha, 2010);

4. Sexuality, intimate life transformations, and processes of individualization in modernity – recently, some studies have emerged around new forms of experiencing sexuality, love, and marriage as dimensions of the process of social change and the configuration of new regulatory guidelines (Aboim, 2010; Freire, 2007, 2010; Neves, 2013; Policarpo, 2011, 2014);

5. Representations and experiences of intimacy and sexuality – including studies on gender violence and prostitution – indications that social equality was imposed as a key principle in intimate and sexual relationships. Unequal relationships or those based on a strong social distance, such as prostitution and also traditional heterosexual relationships, are understood as forms of social domination and violence (Barroso, 2007; Casimiro, 2011; Coelho, 2009; Lisboa, Vicente, Carmo, Nóvoa, & Barros, 2006; Oliveira & Coelho, 2010; Salvado, 2013; Stecanela & Ferreira, 2009);

6. Gender, identity, and sexuality – where queer studies stands out. The internal thematic diversity within this expanding sub-theme must be stressed because it ranges from studies on family models and family and interpersonal relations to different identity positioning depending on sexual orientation and/or gender identity, including bisexual and transgender identities, passing through activism and sexual citizenship (Brandão & Machado, 2012; Machado & Brandão, 2013; Saleiro, 2002, 2014; Santos, 2006, 2013a, 2013b).

Additionally, the contributions and articulations of anthropology (Almeida, 2000, 2006, 2009), communication sciences (Cascais, 2004, 2006), and psychology (Alferes, 1997; Amâncio, 1994; Carneiro & Menezes, 2006; Moita, 2006) must also be noted.

Thus, for this research, important "empty" spaces in the national sphere would be the study of **professional groups in the field of sexuality** and the **medicalization, unmedicalization, and remedicalization of sexuality**. To date, the "sexologist profession" has not been studied in Portugal, and the inherent interdisciplinarity of the studies of sexuality and the multidisciplinarity of the professionals of the field represent a real challenge to the sociology of professions and the sociology of knowledge.

Indeed, sexology has been being presented as a discipline that remains in the process of self-definition and that combines the inheritance of various scientific fields, specifically those of the health and behavioral sciences. Sexology's manifest function addresses sexuality, whereas its latent function is similar to that of religion and medicine, that is, establishing sexual rules and boundaries and defining right and wrong (Guasch, 1993). In this sense and as argued by Béjin (1982b), the scientific power of contemporary sexologists, first, relies on the agreement on a definition of "sexual health" and, then, holds to the fact that they have been able to impose their definition of a common goal for sexual acts, the "legitimate means" for

achieving this goal, and the recognition of their competence in the definition, correction, and prevention of sexual deviation. The conceptions of sexual health result in political compromises and occur in the public health culture and practice of each country (Giami, 2002). Additionally, the recognition of sexology as a scientific discipline and of sexologists as a professional group must be investigated within sociocultural, political, economic, and historical contexts (Giami, 2012).

Thesis Problematics

Sexuality has been addressed from the most varied perspectives, scientific and political, including anthropology (Heilborn, 1999; Herdt, 1999; Malinowski & Ellis, 2005; Mead, 1985; Parker, 2009); biomedical and psychological investigations of sexual response (Basson, 2001; Kaplan, 1974; Masters & Johnson, 1970; Masters, Johnson, & Kolodny, 1985); feminist studies (Jackson & Scott, 2010b; Kaschak & Tiefer, 2001; Potts, 2002; Rubin, 2011); queer theory (Butler, 1990; Jagose, 1996; Seidman, 1996; Weeks, 2002); history (Ariès & Béjin, 1984; Bullough, 1994; Chaperon, 2004, 2007; Duby & Ariès, 1991; Foucault, 1976; Lantéri-Laura, 1994; Laqueur, 1992); philosophy (Soble, 1987); psychology (Freud, 1996; Lacan, Mitchell, & Rose, 1985); and sociology (Connell, 1987; Gagnon & Simon, 1973; Giami, 1991, 2004; Giddens, 1992; Irvine, 2005; Jamieson, 1999; Kimmel & Plante, 2004; Laumann, 1994; Leridon & Bozon, 1993). Different approximations and approaches originate from different interpretations of what sexuality is, and they show that sex is not a consistent or universal category but rather is cultural and historically constituted.

The sociological understanding of sexuality (or sexualities) makes it possible to better understand the society in which we live because discourses on sexuality are inherently discourses that concern something beyond sex: they are also about gender, power, symbolism, identity, etc. (Pais, 1998). In the words of José Machado Pais (1998: 408):

> "(…) *love is a game – it is said – but it is also an exercise of power guided by the knowledge and feelings of others, which Sociology must explore. What are the sexualities of sexuality and the loves of love in their conjugal plurality? These are relevant issues since behaviors and family lifestyles, including attitudes regarding sexuality and intimate relationships, constitute one important dimension of the process of social change in recent decades, playing a strategic role in setting new*

> *normative guidelines that tend to crystallize into new forms of experiencing sexuality, love, and marriage".*

In this manner, the analysis of the ideas, sexual behavior, social movements, and historical processes associated with sexuality and gender allows not only the identification of their intellectual, cultural, and political roots but also the evaluation of their evolution and contradictions over the course of the 20th and 21st centuries (Giami & Hekma, 2015).

Indeed, sexuality in the 20th century has suffered an increasing level of interference from medicine, and the rupture between sex and reproduction has made possible the emergence of new forms of relationships and the legitimation of a pleasure-oriented sexuality. Sexuality has become more emancipated and emancipatory, but the main change is the social acceptance of a sexuality focused on pleasure and the more varied ways of attaining it (Loyola, 2003).

From the emergence of sexology to the new approaches of sexuality

In the mid-19th century, before a *scientia sexualis*, the desire to control reproductive behavior appeared, and it became one of the conditions for the emergence of sexuality as a field of knowledge. Pedagogy, psychiatry, psychology, hygienism, medicine, and early sexology all have in common the search for controlling individual behavior based on the definitions of the normal and the pathological. The new disciplines are therefore the creators of bodies of knowledge, experts, and the new attitudes of individuals. The first science of sexuality begins in this manner as an attempt at the general medicalization of behaviors. The first modern sexology focuses its concern on threats to a so-called normal sexuality, i.e., reproductive sexuality. From venereal diseases, the great fear of the 19th century, it extends to perversions, i.e., non-reproductive sexual practices (masturbation, homosexuality, bestiality, and "heterosexuality" without the intention of reproduction) (Giami, 1999).

For Béjin (1982a), sexology had two births. The first birth was in the second half of the 19th century, in 1844 and 1886, with two studies with the same title, *Psychopathia sexualis*, by Henrich Kann and Kraaft Ebing. The second sexology was born in the 1920s with the work conducted by Wilhelm Reich on the function of the orgasm, continued later by Alfred Kinsey.

"Proto-sexology" was focused on venereal diseases, the psychopathology of sexuality, and eugenics. At that time, the medicalization of homosexuality, or "inversion" as it was called, was part of a political struggle and a movement of "sexual reform" that was concentrated in Germany and had Kraaft Ebing, Havelock Ellis, Magnus Hirschfield, and Albert Moll, among

others, as prominent figures. The passage from the 19th century to the 20th century marked a shift in the approach to sexuality. It occurred through a medical discourse and under a biological/scientific rationality, as opposed to a legal or religious discourse, with the sexualities that are peripheral to the couple and to the family beginning to be explained (Russo, Rohden, Torres, & Faro, 2009).

The contributions of Sigmund Freud, the founder of psychoanalysis, related to infantile sexuality, the sex object, homosexuality, fetishism, and sadomasochism, present in his 1905 work "Three essays on the theory of sexuality", illustrate the plasticity of the scientific object of sexuality (Jackson & Scott, 2010b).

In 1906, Iwan Bloch became known as the father of sexology when he assigned the term (*Sexualwissenschaft*) to the theoretical-scientific study of sexuality, and Berlin became the birthplace of sexology and the center of the production and dissemination of knowledge on the subject (Irvine, 2005; Russo, 2013). During the first two decades of the 20th century, magazines, companies, and scientific meetings dedicated to sexology emerged, and the seeds of sexology as a science were sown. In 1908, Magnus Hirschfeld, who is regarded as the precursor of the sexual revolution, advocating political and sexual equality for men and women and the protection of the rights of homosexuals (Jaspard, 2005), edited the Journal of Sexology (*Zeitschrift Für Sexualwissenschaft*), one of the first scientific journals in sexology, which then acquired the status of science in the academic area. In 1913, Bloch founded the first society of sexology, the Medical Society of Sexology and Eugenics (*Arztliche Gesellschaft fur Sexualwissenschaft und Eugenik*). Additionally, in 1919, Hirschfeld created the first Institute for Sexology as an interdisciplinary research center in the fields of sexual biology, sexual pathology, sexual sociology, and sexual ethnology, showing the inter- and multidisciplinary characteristics of sexuality. In 1921, Hirschfeld convened the first congress of sexology in history (Dose, 2003).

During the Nazi period, German sexologists were persecuted, and European sexology in general was affected by World War II (Haeberlé, 1981; Irvine, 2005; Russo, 2013).

After World War II, a rebirth of sexology in the United States occurred due to the efforts of Alfred Kinsey. By virtue of their two large studies, Kinsey and his collaborators contributed to the non-medical investigation of sexuality. There is, in this second sexology, a double decentralization: a geographical change and the transformation of the object of attention, which shifts from "perversions" to "normal" sexuality (Russo, 2013).

Alfred Kinsey was one of the key promoters of the modernization of sexuality after World War II. The works conducted by Kinsey present a critique of American sexual morality,

based on the contradictions between the sexual behaviors identified by his research and the laws in force in certain American states (Giami, 1991; Robinson, 1976). .

The rebirth of sexology was thus marked by controversy on the issue of sexuality, both due to the results of the Kinsey reports (regarding masturbation and extramarital and homosexual relations) and due to the growing transformations in traditional gender roles. The difficulty in legitimating sexology also remained linked to the ambivalences and stigmas of sexuality (Irvine, 2005).

As Russo explains (Russo, 2013) in his discussion on the movements of *scientia sexualis*, in this period, two parallel paths are designed: on the one hand, a "psycho-medicalization" of sexuality and, on the other hand, an intense politicization of sexuality by racial and countercultural movements.

Indeed, the modern study of sexuality was dominated by the medical practice until Alfred Kinsey, who was determined to make the study of sex a science and developed his scientific method, reviewing the foundations of the taxonomy, the sampling and interviewing processes, and statistical analysis and the validity of the data (Bullough, 1994; Irvine, 2005). The results of his work challenged many widely held beliefs about sexuality, including the belief that women were not sexual, and his work contributed to both the feminist and the gay/lesbian liberation movements (Bullough, 1998; Irvine, 1990). The implications of Kinsey's research on women are controversial (Bancroft, 2004). Despite the fact that he rejected a cultural analysis suggesting that women are sexually socialized differently from men, he assumed the importance of equality in marriage and challenged the primacy of the penis and sexual intercourse as a source of pleasure for women (Irvine, 2005).

Despite their devotion to the scientific method, sex therapists William Masters and Virginia Johnson consolidated the alignment of sexology with medicine and appealed to the power of the medical profession. For Masters and Johnson, sexuality was largely biological and instinctual, and with their concept of the human sexual response cycle (HSRC), they asserted the similarity between women and men as a major theme of 20th-century sexology. The publication of *Human Sexual Inadequacy* in 1970 was a landmark for sexology. It served as a guidebook for practitioners and provided scientific legitimation to the new field of sex therapy (Irvine, 2005; Tiefer, 2006). Sex therapist Helen Kaplan broadened the field of sex therapy, reconceptualized Masters and Johnson's HSRC, and developed "the new sex therapy", which represented a synthesis of the therapeutic traditions of behaviorism and psychoanalysis. Kaplan, together with Masters and Johnson, represented the leaders among the scientifically oriented sexologists (Irvine, 2005).

Furthermore, by the late 1960s, more humanistic sexologists, based on human experience as the foundation of their practices, evolved from the tradition of Masters and Johnson in reaction to the empirical approach to sexuality. Sex therapy as a humanistic enterprise influenced some contemporary sexologists, specifically Leonor Tiefer (2006) and the New View of Women's Sexual Problems, an educational campaign dedicated to challenging the post-Viagra medicalization of sexual problems that incorporates some humanistic elements, and others, such as Kleinplatz (2012).

A major change in sex research starting in the last part of the 20th century was in fact the contribution from previously silent disciplines, such as history and sociology, making the sex research agenda come to be more influenced by external forces than by those who regarded themselves as sex researchers (Bullough, 1994). Indeed, rethinking sexuality as a social rather than a natural or psychological phenomenon emerged from social constructionist perspectives in the 1960s, with their roots in phenomenological and interactionist sociology, John Gagnon and William Simon's sexual scripting theory being the first to be fully developed (Gagnon & Simon, 1973; Gagnon, 1975, 1990).

The confluence of these new views on sexuality with the emergent feminist and gay movements in the West challenged the power of sexology to define the normative parameters of sex and gender, offering alternative views on sex and gender grounded in people's own experiences and within a sociopolitical context that especially considered the power inequalities between men and women, the concepts of maleness and femaleness, masculinity and femininity. They disrupted scientific sexology's strategy for professionalization and the internal self-definition of sexology (Irvine, 2005; Jackson & Scott, 2010b). Considering its general theory, methods, and empirical research support, the field's lack of definition and the insufficiency of its boundaries emerged (Bancroft, 2009; Tiefer, 2006, 2012).

In recent developments in biomedical and clinical research on the sexual function of men and women, the term sexuality is increasingly less used, having been replaced by the expressions of sexual function and sexual health (Giami, 2002). The concept of "sexual function" emerges in opposition to the concept of "reproductive function" and becomes a marker of "phallic sexual performance" (Calasanti & King, 2005) that is focused on genital functionality and the imperative of penetration, in a unique biomedical model throughout the lifespan (Ménard, Kleinplatz, Rosen, Lawless, Paradis, Campbell, & Huber, 2015).

Inspired by George Canguilhem's (1978) critique of 19th century biomedicine, Stephen Katz and Barbara Marshall (2004) state that the emergence of the binary of functional/dysfunctional replaced the binary of normal/pathological. Canguilhem demonstrates

that the binary of normal/pathological re-creates scientific perceptions of health and illness, leading to an era of standardization therapy. Katz and Marshall argue that the normal and the pathological were assimilated and overcome by a new biosocial binary grid – the functional and the dysfunctional – with a greater explanatory power due to recent social transformations.

While medical definitions of sexual difficulties, and their interventions, are based on an understanding of a "universal body", that is, a body that is essentially biological and that transcends culture and history, within a categorization of normal and pathological, empirical studies show that in some cases, the experiences and perspectives of men (Loe, 2004b; Potts, Gavey, Grace, & Vares, 2004; Wentzell, 2013b) and women (Cacchioni, 2007; Hinchliff, Gott, & Wylie, 2012; Loe, 2004a; Potts, Gavey, Grace, & Vares, 2003) challenge the biomedical model of sexuality. The study of individuals' representations of sexual dysfunctions and the identification and understanding of their distance to scientific or professional definitions are therefore crucial (Bancroft, Loftus, & Long, 2003; Brotto, Heiman, & Tolman, 2009; Mitchell, Wellings, & Graham, 2012).

Conceptualizations of sexuality as an eminently social phenomenon

In his work *The History of sexuality* (1976), the French philosopher and historian Michel Foucault constructs a new hypothesis concerning human sexuality. His thesis is that in the Western world, in the 18th and 19th centuries, the identity of people begins to be increasingly linked to their sexuality. Foucault challenges the "repressive hypothesis", based on the idea that Western society repressed sexuality from the 17th century to the mid-20th century, arguing that in reality, the discourses concerning sexuality proliferate during this period. Indeed, the author states that from that moment, experts began to study sexuality in a scientific manner, classifying the various types of sexuality with the intention of knowing the "truth" about sex. According to Foucault, sexuality is historically and discursively constructed through power relations. For Foucault, there is no essential human quality that is suppressed or liberated, and what actually exists are ideas on sexuality translated into words – discourses. The history of sexuality in the West is actually the history of the discourses on sexuality. For Foucault, power and knowledge imply each other: there is no power relationship without the constitution of a field of knowledge, nor is there a knowledge that does not simultaneously assume or establish power relations. In this way, and in the words of author (Foucault, 1978: 53):

> *"(...) for two centuries now, the discourse on sex has been multiplied rather than rarefied; and that if it has carried with it taboos and prohibitions, it has also, in a more fundamental way, ensured the solidification and implantation of an entire sexual mosaic. Yet the impression remains that all this has by and large played only a defensive role. By speaking about it so much, by discovering it multiplied, partitioned off, and specified precisely where one had placed it, what one was seeking essentially was simply to conceal sex: a screen-discourse, a dispersion-avoidance."*

Foucault's theory of the abandonment of the "repressive hypothesis" has led to an intense intellectual debate surrounding the concept of "sexual revolution". In a contemporary interpretation of this problem, we can affirm, through Giami and Hekma (2015), that Foucault, through his concept of the "device of sexuality", introduced key concepts for understanding different forms of sexual repression. In this manner, the absence of repression at the level of discourse does not cancel the different forms of selective repression that occur at the level of behavior. These forms of repression might actually have contributed to the construction of contemporary sexualities.

Foucault's *History of Sexuality* is certainly one of the most famous and influential social constructionist texts in the study of human sexuality, widely used and critically discussed (Giami, 2005; Jackson & Scott, 2010b; Morrow, 1995). Since his work, sexuality has begun to be understood as being produced and reinvented by institutions with the power of classification, regulation, and separation between the normal and the deviant. In sociology, both sexuality and gender are now understood as socially constructed and regulated through a range of contexts and institutions, specifically with important contributions from the two sociological frameworks that have most influenced the study of human sexuality, symbolic interactionism and scripting theory (Irvine, 2003; William Simon & Gagnon, 2003), within the broad paradigm of social constructionism (Berger & Luckmann, 1966).

Foucault, along with other social constructionist authors such as John Gagnon and William Simon, was responsible for emphasizing the ways in which sexuality is socially and discursively constructed, contesting the ideas of a biological sexual instinct that is nature-based and repressed by society, according to the model developed by Freud.

The sociology of sexuality owes much to two American sociologists, Gagnon and Simon, who began working together in the 1960s and were the first to question all forms of biological determinism, developing a unique approach to sexuality (Jackson & Scott, 2010a).

In 1973, they published the reference work *Sexual Conduct: The Social Sources of Human Sexuality*. These two researchers introduced the concept of sexual scripts, which are "scripts" or "scenarios" that guide the actions and mental sexual behavior of individuals, who adapt them to the social norms of a particular culture. Thus, they defined the *enjeu* of a sociology of sexuality by demystifying the field of sexuality and addressed sexual facts as any other social fact. In this manner, the theatrical metaphor of the script appeared for the comprehension of sexual behavior in the wider scenario of social life, in a rupture with the static model of human behavior, and in a global context of changing cultures.

The investigations of these two collaborators at the Kinsey Institute in Bloomington, Indiana, were not immediately followed. Initially, their investigations were not as widely known as the studies by Masters and Johnson, and they did not raise the same theoretical and intellectual debate as the writings of Foucault. Feminist studies and queer studies, which, in the United States, greatly contributed to relocating the investigation of sexuality out of its "clinical ghetto", only belatedly showed interest in these two investigators, who intended to go beyond the development of a sociography of sexuality and sought the construction of a sociological theory of sexuality to explain the origins and modes of operation within the framework of a theory of action and interaction (Bozon & Giami, 1999).

Scripting theory, developed by Simon and Gagnon in the 1970s, has long proven to provide a useful framework for understanding sexual roles in the context of social change and concurrent levels of individualization (William Simon & Gagnon, 2003). Accordingly, the majority of sexual and intimate behaviors in heterosexual relationships tends to follow a prescribed social script that reflects the cultural norm (Longmore, 1998). Scripts are important determinants of individuals' sexual beliefs and behaviors that operate on cultural, intrapsychic, and interpersonal levels, in the sense that each level dynamically influences the others (Gagnon, 1990; Simon & Gagnon, 1986). For this reason, there can be areas of discontinuity between the mainstream norms of the cultural scenarios and the dyadic or individuals scripts of gendered behavior.

The individualization processes operating in contemporary societies illustrate a great level of complexity and diversity in the context of intimate relationships. More recent sociologies of intimacy, for example, by Beck, Giddens, and Butler, emphasize reflexivity, viewing the self as a product of socially located biographies (Jackson & Scott, 2010b). However, to perceive reflexivity as symptomatic of freedom from constraint, as do Giddens (Giddens, 1991, 1992) and Beck and Beck-Gernsheim (Beck & Beck-Gernsheim, 2002), can be misleading. As Gagnon and Simon demonstrate, sexual conduct is socially meaningful, and

the sense we make of embodied experience is always mediated through the scripts that are available to us. Although reflexivity is fundamental for social being, social divisions and inequalities impact reflexive processes and capacities. If the variety of cultural scenarios available have increased the range of resources for sexual self-making, then the cultural resources are not the same for everyone, and the relationship between the cultural scenarios and individual lives is mediated through interpersonal and intrapsychic scripting (Jackson & Scott, 2010a).

Indeed, another central legacy of Gagnon and Simon's work is that sexual expression, whether highly conventional or extravagantly unconventional, is always embedded in wider patterns of sociality. Therefore, sexuality should not be treated as a special area of life and must be located within the everyday of social life, entangled with other non-sexual aspects of life (Jackson & Scott, 2010a).

Butler highlights that the performance of social life can be viewed as heteronormatively ordered, and she presents a deconstruction of the "compulsory order of sex/gender/desire" that was critical of the normalization of heterosexuality processes (Butler, 1990). Indeed, in Jackson and Scott's words (2010b: 76): "If we are serious about analysing sexuality as socially constructed, or prevailing patterns of intimate relationships as products of a particular society and culture, then heterosexuality, so central to both, must become an object of scrutiny".

In contemporary societies, there are several ways to describe the roles that sexuality plays in the life and to identity the formation of individuals. In all cases, however, it is important to avoid considering sexuality as an autonomous function that would, in itself, have an indisputable and objective existence (Gagnon, 1990; Bozon, Giami, 1999).

> *For many years, we have all been living in the realm of Prince Mangogul: under the spell of an immense curiosity about sex, bent on questioning it, with an insatiable desire to hear it speak and be spoken about, quick to invent all sorts of magical rings that might force it to abandon its discretion.*
>
> Foucault M. (1978[1976]: 77) The History of Sexuality.

Conceptual framework, research questions, and methodology

Although, internationally, evidence has already been accumulated concerning sexuality and sexual problems with proposals that stand as alternatives to the biomedical model-based studies of sexuality (Cacchioni, 2007; Hinchliff, Gott, & Wylie, 2012; Loe, 2004b; Potts, Grace, Gavey, & Vares, 2004; Wentzell, 2013b), national studies that have focused on this issue are scarce (Ferreira & Cabral, 2010). Therefore, scientific knowledge based on a global and unified sociological approach is lacking. The challenge of this dissertation has been to develop theoretical knowledge that is empirically supported and that shows that social construction and the personal meaning of sexual problems, and the paradigm of erectile dysfunction, are engines that transform sexuality and intimacy.

The central thesis of this investigation is that *the process of modernization and individualization in Portuguese society in recent decades influenced social representations and the experiences of sexuality of men and women, and simultaneously, the manner in which sexuality is categorized and experienced has an impact on the process of the individualization and democratization of the society.*

Thus, the central object of this investigation is to understand *what are the meaning and the subjective experiences of sexuality, in general, by focusing on the study of sexual problems, and specifically the case of erectile dysfunction, as a paradigm for understanding the negotiations in defining masculinity as a response to social needs, physical constraints, and medical resources.*

In the context of the changes in sexuality and intimacy that have occurred in the modern process of individualization, the double standard and the rigidity of traditional sexual morality have yielded to an "attenuated double standard" (Vasconcelos, 1998) that shows greater acceptance of diverse behaviors and is less differentiated in terms of gender and closer to the "confluent love" (Giddens, 1992). There is also a positive appreciation of sexual satisfaction as a component of intimate relationships and as a normative ideal in contemporary societies. Furthermore, in the context of the medicalization of sexuality and with the replacement of the

normal/pathological binary by the functional/dysfunctional binary (Katz & Marshall, 2004), the individual has become an active participant, committed to the pursuit of functionality.

Following the feminist analysis, which has focused on criticizing the exploitation of male-centric versions of sex, particularly the need to attain orgasm via penetration, we retain the concept of *heteronormativity* and question the biomedical model's capacity to explain the dynamics and diversity of normative and non-normative sexualities (Jackson, 2008). Heterosexual hegemony (or heteronormativity) is a contemporary name for the historical device of sexuality as a set of requirements on which social processes of regulation and control are founded. The concept has been used to criticize a dichotomous system of categorization that directly links social behavior and self-identity with the individual's genitalia and the exploitation of traditional norms of sex, gender identity, gender role, virility, and femininity. The diversity of sex lives, life circumstances (the attention attributed to the variables of age, socioeconomic status, religion, and ethnicity), and questions of power also gain central importance in feminist theories.

Inserted in these processes of change, the studies that integrate this work seek to understand and describe the relationship between the social and the cultural construction of sexual dysfunctions, and of erectile dysfunction in detail, and the dominant conception of sexual intercourse, proposing an in-depth analysis of the concept of "sexual dysfunction" and the notion of "sexual intercourse", crossing different discourses on sexuality, including the discourses of sexology (**Figure 1**).

The originality and innovative character of this work are present, on one hand, in the mixed theoretical and methodological approach and, on the other hand, in the integration of the study of the field of sexology in Portugal and the analysis of the impact of Viagra and the pharmaceutical industry in the current discourse on sexuality, both male and female (Loe, 2004a; A. Potts, Gavey, Grace, & Vares, 2003).

Finally, there is the social relevance of this work: borrowing the words of Plummer, "studying sexualities for a better world". Indeed, in Plummer's (2008) mapping and analysis of ongoing and future areas in the study of sexualities, we highlight the following for their relevance:

1. The inter-sectional challenges of feminism and LGBT/Queer movements, providing insightful critiques;

2. The continuing role of AIDS/HIV in stimulating research, politics, and worldwide debates concerning the meaning of sexualities and the nature of sexual acts;

3. The problematization of "heterosexuality", assumed and taken for granted in much early research;

4. The concern with both the performativity, i.e., the doing of gender, and the nature of sexualities, removing a broad essentialism from the study of the sexual;

5 A focus on issues of power and sex, especially on human sexual rights as "the sexual citizenship debates" (Plummer, 2004).

The thesis was designed to address two central objectives: **understanding and sociologically interpreting the feelings of loss/decrease of sexual function among men**, especially focusing the social sphere; and discussing the social relevance of the profession of sexologist while **mitigating the lack of information on the field of sexology in Portugal,** both as a science and as a profession.

The thesis and the research design were guided by the starting issues stated below.

How are the definitions of sexual dysfunctions made? Which actors have a role in this process?

What can sexual problems tell us about the continuities and changes in sexuality in terms of gender and social conditions?

What meanings do men and women attribute to the sexual problems in their lives?

What can the analysis of the emergence of Viagra explain about the process of the medicalization of sexuality?

What is the presence of Viagra, and other treatments for sexual problems, in Portuguese bedrooms, and which differences originate in the representations of sexuality and gender?

What are the representations of sexology experts in Portugal with regard to sexuality, gender differences, and sexual problems?

When attempting to answer these and other questions, several answers (and new questions, as well) were possible, reflecting the existing diversity in the sexuality of the Portuguese.

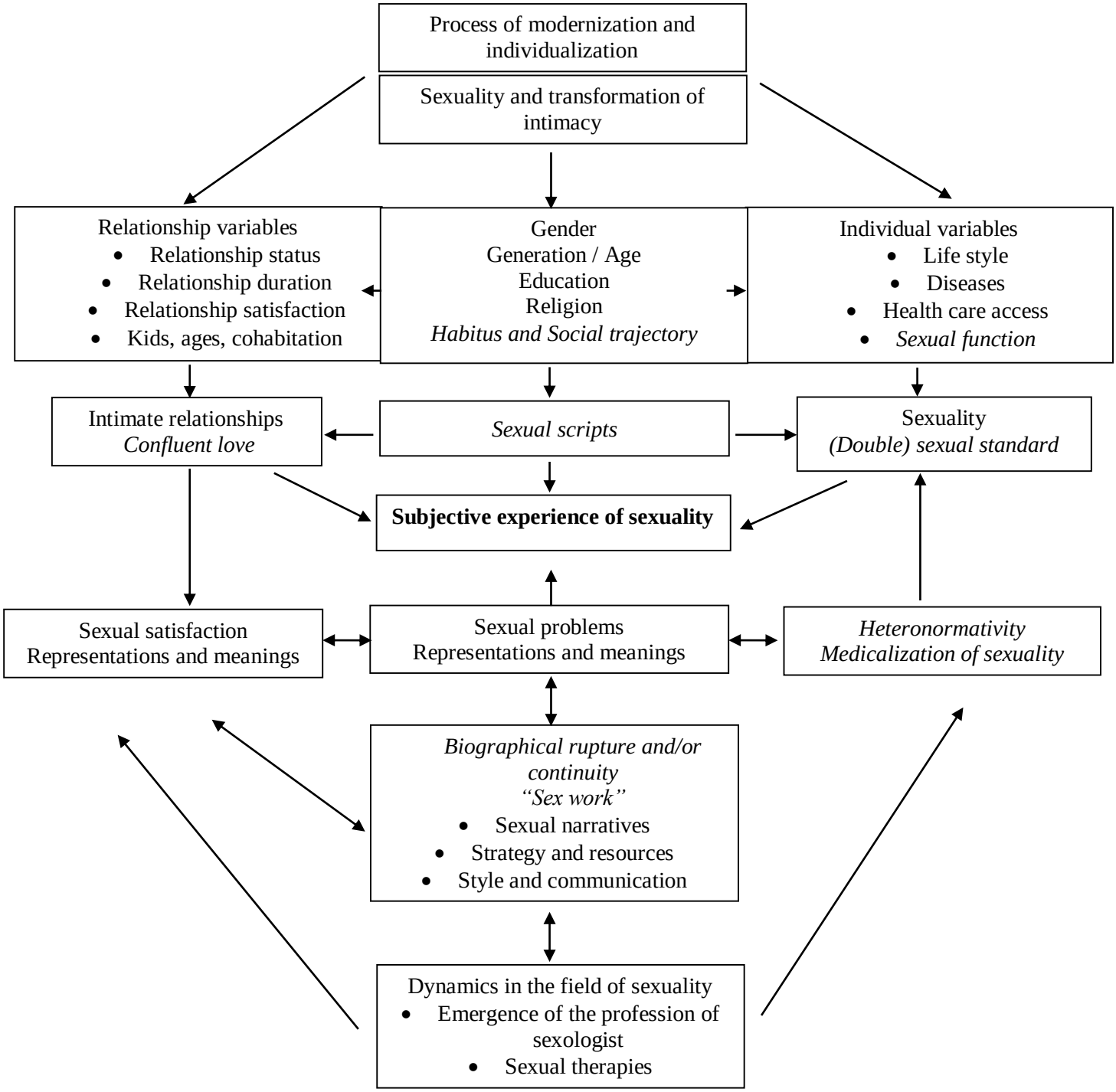

Figure 1. Conceptual framework

These general and initial questions were later implemented in different general research objectives, each corresponding to an empirical study.

1) Discuss disagreements on the definitions of sexual function by focusing on medicalization and socially constructed gender effects through the framework of the sociology of diagnosis and sexual scripting theory;

2) Identify and explore the variety of responses to dominant sexual scripts in Portugal by identifying different frequencies of or intensities for heterosexual relations, different forms of relationships between genders, and different representations of sexual satisfaction;

3) Investigate how men's and women's experiences and representations of sexual problems are shaped by sociocultural factors and how sexual problems are socially constructed by individuals and their intimate relationships;

4) Understand and interpret the different modes of commitment to a larger professional identity as sexologists in Portugal and produce knowledge about the meanings attributed to sexology.

Bearing in mind the general objectives of this work, a multi-methods approach was implemented, given that the actual combination of qualitative and quantitative approaches allows a better understanding of the research problems (Creswell & Clark, 2011). The investment in methodological plurality aims to develop a comprehensive understanding of male and female experiences of sexuality and intimacy with two benefits: an increase in the completeness of the results, enabling the discovery of patterns and the relationship between variables, and the strengthening of the understanding of the experiences and sexual representations, by means of the participants' own narratives.

The "arrival" at the problem of the social construction and personal meaning of sexual dysfunctions initially presupposed the existence of a research design that would allow one to capture the complexity and interconnectedness of this phenomenon. Qualitative methods were used for a cultural understanding, but a mixed approach was necessary so that the two main studies covered in this research could reach the social "diagnosis" of sexual dysfunctions (**Figure 2**). With this articulation, it was thus possible to obtain an in-depth examination of the personal and social meanings of sexual problems and their historical, social, medical, and cultural evolution. An extensive methodological explanation is not included here, given that in each of the dissertation's constituent articles, the methodology is presented in detail.

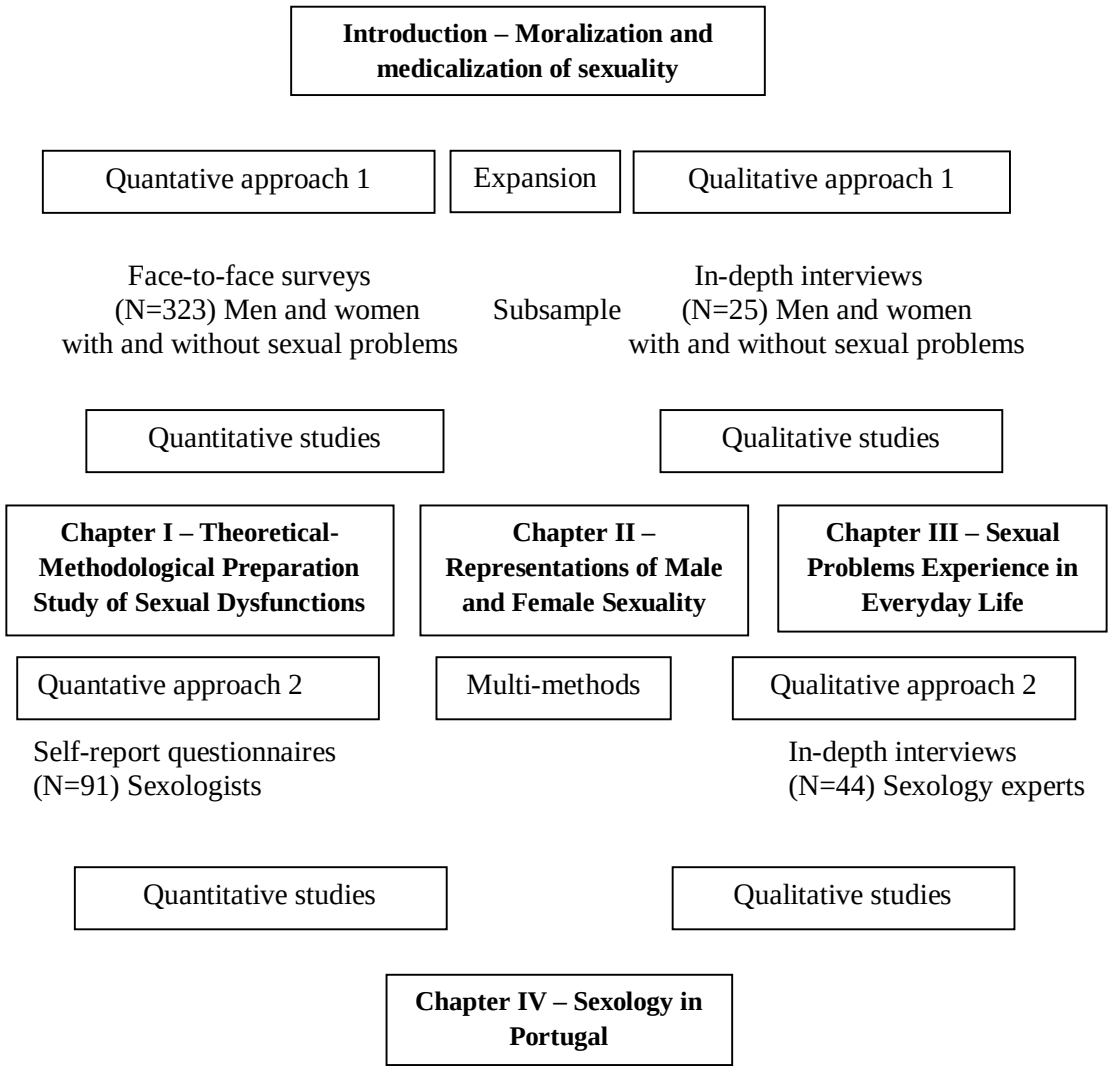

Figure 2. Structure of research – methodological contours

General discussion of the results presented in the four articles

The thesis was conceived with the purpose of contributing to improving the scientific knowledge about sexual dysfunction, with a particular focus on the social sphere, and the dynamics of the formation of the field of sexology in Portugal.

The general research objectives were defined as follows: *1) discussing the controversies on the definitions of sexual function by focusing on medicalization, moralization, and socially constructed gender effects; 2) identifying and exploring the variety of responses to dominant sexual scripts in Portugal through the discussion of sexuality in its ever changing reality; 3) investigating how men's and women's experiences and representations of sexual problems are shaped by sociocultural factors and how sexual problems are socially constructed by individuals and their intimate relationships; and 4) analyzing the peculiarities of the scientific and professional organization of Portuguese sexology through Portuguese sexologists' self-descriptions and reflections on this ongoing process.*

Given that the results are presented in the following chapters, independently in the four scientific articles, in this section, the aim is to perform an integrated discussion, to highlight the most significant research contributions, articulating the main results with the literature in this area, and to indicate possible starting points for future research.

Summary of the findings

The key findings of **Article 1** (Alarcão, Machado, & Giami, 2015) illustrate that individuals not only challenge concepts of illness and the diagnoses and treatments of sexual dysfunction but also construct sexual problems based on their impacts in everyday life:

- Sexual dysfunctions are not self-evident disorders discovered through the value-neutral methods of a scientific sexology but rather are socially constructed as problems with reference to "hegemonic masculine" standards and patterns of normal sexual functioning and interaction in Portugal, as in other countries (Fishman & Mamo, 2001; Giami, 2007; Morrow, 1994; Rohden, 2009; Rohden & Russo, 2011).
- Although sexual problems can be a relevant constraint in intimates' lives, the results seem to indicate the existence of alternative models to the biomedical definition, classification, and treatment of sexual problems that should be taken into consideration.

- The data also appear to indicate gender differences; women's views on sexual problems are slightly more challenging of the biomedical model. Nevertheless, both genders' sexual stories complicate the medical model of sexuality, which is in line with previous international findings (Potts, Gavey, Grace, & Vares, 2004).

Article 2 (Alarcão, Virgolino, Roxo, Machado, & Giami, 2015) highlights that there are different ways of perceiving sexuality, depending on gender, age, education, religion, and relationship and sexual satisfaction:

- The key outcomes of this research reinforce the evidence of increasingly egalitarian sexual scripts among men and women and highlight age and educational differences (Crawford & Popp, 2003). These findings may be related to the fact that in sexual life, as elsewhere, those who are more privileged have more choices and more opportunities to explore different sexual lifestyles, with age and life-course variations also becoming part of the sexual landscape (Jackson, 2008).
- The results extend the evidence on gendered sexual scripts through participants' sexual stories of both continuity with traditional sexual scripts and change in these scripts, corroborating the findings of Masters and collaborators (2013).
- Both distinctive beliefs and experiences among men and women and across genders were found, indicating potentially emerging transgressive heterosexual practices (Beasley, 2011). In these terms, heterosexuality, far from being a static and unchanging standard, reflects broader changes in dialogue with other spheres of social life (Jackson, 2008; Jackson & Scott, 2010b; Beasley, 2011).

The major findings of **Article 3** (Alarcão, Roxo, Virgolino, & Machado, 2015) reveal that the physical, relational, affective, and moral problems that men undergo with changes in sexual function may be viewed not only as a negative experience but also as a positive experience:

- This investigation explored how sociocultural factors not only influence the experiences and representations of sexual problems and the role of individuals in the construction of sexual problems, challenging the concepts of illness and sexual dysfunctions diagnoses and their treatments, but also produce empirical evidence, with clinical implications with regard to changes in everyday life.
- The results seem to indicate the existence of alternative models to the biomedical model, facilitating the diagnosis, treatment, and comprehension of sexual problems experiences. In line with Wentzell's (2013b) findings concerning men's perceptions of

sexual problems, some of our men experienced erectile dysfunction as a failure of masculinity that required medical treatment, whereas others understood it as an embodied marker of 'mature masculinity'.

- Furthermore, our scripting approach enabled a comprehension that this notion of "aging respectably" underlined a shift from a sexual to an emotional focus, without always challenging the traditional power dynamics of gender relationships (Wentzell, 2013a).

The main outcome of **Article 4** (Alarcão, Beato, Almeida, Machado, & Giami, 2015) is that the diversity of Portuguese sexologists' views on sexuality, in addition to the social movements, defines and defies the power of sexology to establish the normative parameters of sex and gender:

- The data indicated that Portuguese sexologists view sexology as unified in its definition but multiple in its clinical and therapeutic practices, which constitutes not only the challenge of its identity but also the richness of its potential vision of sexuality and social theory.
- As in the past when they emerged, in the present, the new views on sexuality, in addition to the social movements, remain disruptive with regard to scientific sexology's strategy for professionalization and the internal self-definition of sexology (Irvine, 2005, 2014a; Jackson & Scott, 2010b).
- Institutional (bio)medical, scientific, and mediatized discourses and practices seemed to influence lay cultural understandings of sexual dysfunctions and vice versa, with the view of "experts" being better understood if they are articulated with "lay" views (study 1 and 3). According to Marshall (2002: 146), this dynamic occurs in the broader social context of a "*shifting coalition of actors – including scientists, doctors, patients, industries, media and consumers – operating within a cultural horizon of rationalization, medicalization, commodification and gendered heteronormativity*".

Implications and future directions

From the main results of the studies described above, it is possible to offer some considerations and implications for the practice. In this context, the practical implications are focused primarily on three areas: **the definition, classification, and treatment of sexual problems; sexual rights and freedom in intimate relations; and sexual health promotion**.

1) *Alternative models to the biomedical definition, classification, and treatment of sexual problems*
    - Men's and women's sexual problems, needs, and satisfaction do not fit neatly into categories of desire, arousal, orgasm, or pain.
    - Plurality cannot be captured by an identical notion of "dysfunction".
    - This research provided conceptual definitions that reflect the construct and participant's understandings of it that may be helpful for the understanding and broadening of the classifications of sexual problems.

2) *The exercise of rights and freedoms in the context of everyday practices of intimacy*
    - Sexuality, intimacy, and sexual and relationship satisfaction are complex and multifaceted. This study contributes to the available information to facilitate a better understanding of the impact of sexual and non-sexual variables on these constructs, both in and out of the bedroom.
    - Shifting sexual roles may potentially contribute to decreased gender inequality.
    - Our results support the findings of previous studies suggesting that more flexible personal definitions of sexual function enable individuals to better cope with sexual problems.

3) *Sexual promotion of sexual health, focusing not only on its biomedical but also on it social dimensions*
    - The confluence of the new views on sexuality, in addition to the social movements, continues to challenge the power of sexology to define the normative parameters of sex and gender, offering alternative views on sex and gender that are grounded in people's own experiences and within a sociopolitical context that especially considers the power inequalities between men and women, the concepts of maleness and femaleness, and masculinity and femininity.
    - The interdisciplinary and overlapping fields of sexuality studies and LGBT and queer studies have been flourishing in Portugal, which are intimately bound up with feminist, queer, AIDS, and trans activism, indicating the dynamics of the field.

Finally, it is important to underline the need to further the development of studies on these issues, which, apart from their intrinsic interest, allow for an accumulation of knowledge beyond the area of sexual dysfunctions and sexology in the strict sense, covering sexuality, sex, gender, the rights of citizenship, and public policy.

It is important to note that, despite the centrality of the biomedical perspective and the promotion of individualized treatments focused on sexual dysfunctions (which show a tendency to be presented as heterosexual and focused on the improvement of sexual performance), sexology, notably in Portugal, does not end with sexual medicine. It also includes a social and political dimension focused on issues related to diversity and sexual and reproductive rights.

However, by deleting the individualizing perspective of individuals and their "dysfunctions", this universe of rights and public policy ignores the ability to perceive the consequences related to the economic and political interests that have transformed the lives of many people, in addition to understanding the impacts of these new technologies and standards in the imaginary, bodies, and behaviors registered in the generalization of an ideal sexuality that is open to constant improvement (Rohden, Russo, & Giami, 2014).

Indeed, there seems to exist a long way to go for the academic legitimacy and destigmatization of research in the area of sexuality, which is still regarded as "dirty work", affecting not only researchers in this area but also the production of scientific knowledge (Irvine, 2014a). In Irvine's own words:

> *"The problem is not simply that sexuality research remains stigmatized. It is that, in many circumstances, sex itself remains stubbornly discrediting. Sexuality's cultural meanings are paradoxical—it is simultaneously repulsive and attractive, taboo yet vital to our happiness. It is difficult to write sexual stories without reproducing what Michael Warner calls 'the ordinary power of sexual shame.*'" (Irvine, 2014b: 37)

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> *The construction of disease categories entails a complex set of negotiations among professionals, the general public and afflicted individuals, which is always mediated by broader cultural ideologies.*
>
> Irvine J. (2005: 165) *Disorders of Desire: Sexuality and Gender in Modern American Sexology.*

I – THEORETICAL-METHODOLOGICAL PREPARATION STUDY OF SEXUAL DYSFUNCTIONS

Research script n. º1

This first article emerges from the awareness of disagreements between the evaluation of sexual problems through a self-diagnosis and the results of the widely used international indexes to estimate sexual dysfunctions prevalence. These contradictions have led us to question whether the classification processes are identical for men and women and have a particular expression in the Portuguese society, markedly gendered.

Reference:

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Traditions and contradictions of sexual function definitions for heterosexual Portuguese men and women: introducing social construction and gender bias through a sociology of diagnosis frame

Abstract

Research on how sexual changes are understood as dysfunctions versus normal change remains scarce, namely in societies where traditional gender roles persist among the growing diversity of sexual relationships and practices. This article discusses controversies on sexual function definitions through sociology of diagnosis and sexual scripting theoretical frameworks, drawing on 313 structured interviews with primary healthcare users of the Greater Lisbon area, followed by in-depth interviews with a subsample of 25 heterosexual men and women. The low level of agreement found between the scores of the most widely used instruments for sexual function evaluation in epidemiology studies and self-diagnosis may be understood as a challenge for the predominant biomedical model and a need to re-conceptualize sexual dysfunctions other than as organic dysfunctions, with implications for both research and practice. Results show that individuals not only challenge illness concepts and sexual dysfunction diagnoses and their treatments, as they also construct sexual problems based on their impacts in daily life. Demonstrating the permanence of traditional social scripts that operate in the definitions of sexual function is one way to understand gender as an embodied social structure and get adequate practice to the problem, particularly in Portuguese society where sexuality remains highly gendered.

Keywords: sexual dysfunctions, self-diagnosis, diagnostic tools, gender differences, Portugal

Introduction

In the nineteenth-century, sexology was concerned with classifying sexual practices and with distinguishing the pathological from the normal, while since the twentieth-century heterosexual non-reproductive performance is at the centre of the rationalization of sexuality. As Jackson and Scott (2010: 62) said: *It is as if once the parameters of normality had been set in terms of normative monogamous heterosexuality, attention could then be given to what the 'normal' couple did (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) and how they could do it better (Masters and Johnson 1966).*

Nonetheless, traditional gender roles such as the assumption of an "innate spontaneous male sexuality" and a "quiescent female sexuality" seem to persist in the late modern western societies among the growing diversity of sexual relationships and the increasing attention on men's and, especially, women's sexual pleasure (Jackson & Scott, 2010; Tiefer, 2002). This is why institutional, biographical and interactional contexts of sexual lives and the cultural understanding of sexuality need to be investigated.

Foucault's *History of* Sexuality (1978) is one of the most famous, influential, widely used and critically discussed social constructionist texts in the study of human sexuality (Giami, 2005; Morrow, 1995; Rahman & Jackson, 2010). Since this work, sexuality started to be understood as being produced and reinvented by institutions with the power of classification, regulation and separation between the normal and the deviant. In sociology, both sexuality and gender are now understood as socially constructed and regulated through a range of contexts and institutions, namely with important contributions from the two sociological frameworks that have mostly influenced the study of human sexuality, symbolic interactionism and scripting theory (Irvine, 2003a; Simon & Gagnon, 2003), within the broad paradigm of social constructionism (Berger & Luckmann, 1966). Having rejected the notion of an essential, biologically determined sexuality, Simon and Gagnon's scripting theory has indeed long proven to provide a useful framework to understand sexual roles and negotiating sexual life in the context of social change and concurrent levels of individuation (Masters, Casey, Wells, & Morrison, 2013). Sexual scripts are important determinants of individuals' sexual beliefs and behaviors that operate on cultural, intrapsychic and interpersonal levels, in the sense that each level dynamically influences the others; and because sexual scripts operate on different levels there can be areas of discontinuity between the mainstream norms of the cultural scenarios and the relational or intra-psychic scripts for gendered behavior (Simon & Gagnon, 2003). However, the conceptualization of a script guiding sexual behavior applied to sexual function

from a patient-centered approach is scarce, despite its potential for the understanding of sexual experience (Gagnon, Rosen, & Leiblum, 1982; Mitchell & Wellings, 2013). Indeed, not only the sociological legacy has been neglected in the broader interdisciplinary science of sexuality, but also the study of sexuality has been marginal within sociology itself, (Irvine, 2003b).

This article discusses disagreements on sexual function definitions through sexual scripting theory and the sociology of diagnosis theoretical framework, whose developments are briefly presented at first. Next, the specificities of the changes in the system of classification of sexual disorders are discussed in line with socio-cultural implications. Then, we report on contradictions on sexual function definitions for both men and women based on the results of an observational study by comparing two methods of sexual function evaluation: self-report assessment and sexual function indexes. Finally, based on a qualitative approach, men and women's sexual narratives are looked into in an attempt to scrutinize the binary sexuality categorizations of functional/dysfunctional, normal/pathological, male/female. We will raise critical issues concerning medical understandings of a "universal body" and "perfect sexual performance" and the diversity within gender and sexual categories, along with changes in the nature of intimacy and self-identity and in gender and sexual rights. How large are the contradictions between the self-report assessment of sexual problems and sexual function indexes? Will the contradictions between the self-report assessment of sexual problems and sexual function indexes vary among men and women? And will the contradictions be country-specific; being Portugal a Southern European country with a specific cultural profile and changing gender relations?

Sociological approaches to sexual dysfunction diagnosis

The contribution of social scientists to the development of a systematically comprehensive approach to diagnosis is very recent (Anspach, 2011). In the 1990s, Brown (1990) presented a preliminary outline of the issues which sociology of diagnosis should integrate. The author referred to an existing body of work in medical sociology touching on diagnostic issues, although not considered specifically as such, concerned with lay-professional differences in disease and illness conception and experience, and with the social construction of disease (Freidson, 1970; Schneider & Conrad, 1983). Indeed, at first, medical sociologists gave important insights, namely on the cultural meanings of diagnosing illness and illness experience (Conrad & Barker, 2010). Two decades later, in Jutel's (2009) recovery attempt to establish the

first steps of a specific sociology of diagnosis, diagnoses are entangled in medicalization and described as being "the classification tools of medicine" and enabling its role in society. More recently, diagnoses have been investigated from diverse perspectives (Jutel & Nettleton, 2011; McGann & Hutson, 2011), and of particular interest for this investigation is the focus on how medical classification interacts with social and cultural interests and the link of the diagnostic process to sexuality and gender (Jutel, 2010).

Within the theoretical framework of the sociology of diagnosis, diagnosis is seen both as a process and a category which carries significant social, economic, psychological, ethical and political consequences. Medical professionals draw upon a range of taxonomies and other authoritative classification systems (e.g. 'International Statistical Classification of Disease, Injuries and Causes of Death' (ICD) and the 'Diagnostic and Statistical Manual of Mental Disorders' (DSM)) for diagnostic guidance. However, each classification system has its own history and serves its own purposes (Anspach, 2011). Diagnosis plays an important role in how disease is understood and how medicine proves its status in contemporary society. However, diagnoses are more fluid than their taxonomies suggest (Jutel, 2013), which raises the question: What constitutes a diagnosis and what are the socio-economic, cultural and political forces that contribute to the fabrication of a sexual dysfunction diagnostic category?

Since the first edition of the DSM-I was published in 1952 by the American Psychiatric Association, until the current DSM-5 released in 2013 and with ongoing discussion of the changes in diagnostic criteria (Sungur & Gündüz, 2014), sexual function problems have been classified under the rubric of mental health. Critics, at both research and clinical levels, to the DSM, including the system for classifying sexual disorders, suggested that it has reduced research into the etiology, pathophysiology, and treatment of the disorders (Mitchell & Graham, 2008; Tiefer, 2002).

The growth in the number of categories of mental illness as explained in the various versions of the DSM is a primary area of the so-called medicalization. In 1992, Payer introduced the term "disease mongering" to designate the practice of widening the diagnostic boundaries of illnesses as a mechanism for advancing political, social and commercial interests (Payer, 1994), which was applied to sexuality research, and to the female sexual dysfunction case, by the voice of Tiefer (2006) and the activist response that came to be called the "New View of women's sexual problems" (Tiefer, 2002). However, the re-conceptualization of erectile dysfunction as an organic dysfunction and the abandonment of the psychogenic model did not spur the same scientific discussion generated at the time of the application of the same

organic/biological model of sexual function to female sexual dysfunctions, reinforcing the stereotypical common sense picture about male sexuality organically driven, in opposition to female sexual function, determined by the social, psychological and interpersonal context of female sexual activity and relations (Fishman & Mamo, 2001; Giami, 2007; Rohden, 2009; Rohden & Russo, 2011). Indeed it seems important to acknowledge the processes that reproduce the assumptions that male and female sexual models are fundamentally different in nature. Since 2000, considerable interest has been generated by Basson's (2000) description of men's desire as linear, that is, arousal leads to desire and initiation of sex, while women's desire is portrayed as circular, where interpersonal intimacy can lead to willingness to respond to the partner's initiation; sexual activity can then generate arousal and eventually desire. This unique biomedical model throughout the lifespan continues to be popular among clinicians (Brotto, 2010; Kleinplatz, 2010; Ménard et al., 2015).

A new generation of feminist researchers have been critical about the different framing and treatment of sexual dysfunction for men and women, including the representation of "female passivity" which reflected in the new female sexual dysfunction categorizations of Basson and DSM-5. In their views, diagnostic and therapeutic changes influence how women relate to their sexual bodies and those of their partners and have biopolitical, experiential, and psychorelational consequences (Angel 2012; Duschinsky, & Chachamu, 2013; Spurgas, 2013). While medical definitions of sexual difficulties, and their interventions, are based in an understanding of a “universal body”, that is an essentially biological body, that transcends culture and history, empirical studies show that, in some cases, the experiences and perspectives of men (Loe, 2004b; Potts, Grace, Gavey, & Vares, 2004; Wentzell, 2013; Wentzell & Salmerón, 2009) and women (Cacchioni, 2007; Hinchliff, Gott, & Wylie, 2012; Loe, 2004a; Potts, Gavey, Grace, & Vares, 2003) challenge the biomedical model of sexuality. The study of individuals’ representations of sexual dysfunctions and the identification and the understanding of their distance to scientific or professional definitions is crucial (Bancroft, Loftus, & Long, 2003; Brotto, Heiman, & Tolman, 2009; Mitchell, Wellings, & Graham, 2012).

Focus and methodology

The main aim of this article is to discuss disagreements on sexual function definitions by focusing on medicalization and socially constructed gender effects through the framework of sociology of diagnosis as well as the sexual scripting theory. We investigate the definitions of

sexual function/dysfunction through Portuguese men and women's sexual narratives, recognizing them as active agents in doing gender and sexuality in their daily lives and contributing to the knowledge of patients' diagnostic repertoires. The rationale for this investigation was that sexual problems are context-related and ongoing socially constructed processes, which means that their definitions and classification processes are variable, since they are influenced by gender, aging and other social and cultural factors, which should be taken into consideration to explore differences and to avoid pathologizing normal variation.

Research on male and female sexual dysfunctional beliefs developed in Portugal has shown that conservative attitudes towards sexuality and unrealistic expectations regarding sexual performance are commonly related to sexual difficulties in heterosexual men and women (Nobre, Gouveia, & Gomes, 2003; Nobre & Pinto-Gouveia, 2006). Although in Portugal, as in many other countries, the position of women in society has changed tremendously and is still changing, and the fact that Portuguese society of the 21st century distances itself from the rigid and conservative reality that reigned in 1950's and 60's (Aboim, 2013), gendered sexual scripts of both types with traditional sexual scripts and change in these scripts (Masters et al., 2013) are expected to be found and coexist among our participants' sexual stories.

We draw on data collected through empirical research using a mixed methods approach, which integrated both quantitative and qualitative strategies (Pearce, 2012). First, the use of multi-method is expected to produce a richer set of evidence to the understanding of sexual problems' classification. Secondly, a quantitative data collection preceded a qualitative component as a strategy to optimize the sample for diversity and to overcome the topic's sensitivity challenge of face-to-face interviews in the area of sexuality and intimacy.

Even though our sample is not representative of the Portuguese adult population, a good level of diversity in terms of socio-demographic characteristics and sexual function experiences was reached. Of the 323 interviewees (180 women), around 30% of men and 19% of women were or have been in treatment for sexual problems.

This article draws on data from the Sexual Observational Study in Portugal, designed to characterize the management of sexual dysfunctions in primary care (Alarcão et al., 2012), and conducted between January and September 2011 in Lisbon primary health care centers (PHCC). After obtaining the ethical and legal permissions, men and women, aged 18-80 years, users of the collaborating PHCC were systematically invited to enter the study. The participants gave their informed written consent to participate in semi-structured interviews and the majority

(n=245, 76%) gave permission at the outset to be identified and sampled for a second qualitative component. Interviews were conducted in a private room of the participating PHCC, providing an environment where participants felt comfortable discussing their sexual lives. The interviewers were psychologists with specific training on the topics under study, following good practices guidelines for sexuality surveys (Kinsey, Pomeroy, & Martin, 1948).

At a first stage, individuals were interviewed using a standardized survey interview divided in two parts, one with questions posed by the interviewer concerning socio-demographic variables, health and lifestyle, and a sexual health inquiry, including the self-report of sexual problems; and the other to be completed by the interviewee with self-administered questionnaires for assessing sexual activity, knowledge, practices and beliefs about sexual problems and their treatment. The International Index of Erectile Function (IIEF) and the Female Sexual Function Index (FSFI), the most widely used, including in Portugal (Peixoto & Nobre, 2015; Quinta Gomes & Nobre, 2014), and validated international scales for accessing sexual dysfunction (Lewis et al., 2010), were also distributed.

Whereas FSFI provides a global score for overall sexual function in women, normative scores only exist for the IIEF erectile function domain (Rosen, Revicki, & Sand, 2014). A cut-off score of 25 was used for erectile dysfunction domain of the 15-item IIEF (Rosen et al., 1997); and a cut-off score of 5 for the hypoactive sexual desire domain of the FSFI (Gerstenberger et al., 2010) and of 29 for overall female sexual dysfunction based on a prevalence study (Veronelli et al., 2009) and the FSFI mean score in the current sample. We found the internal reliability for the total IIEF/FSFI scores and erectile function domain to range from good to excellent, with Cronbach alpha's >0.9, and =0.8 for the female sexual desire domain.

Quantitative data was coded onto SPSS's database and checked for accuracy. Prevalence of sexual problems in men and women, and 95% confidence intervals, were estimated, although our main goal was to explore sexual function changes understandings grounded on participants' views. Kappa statistic was used to measure agreement between IIEF/FSFI-related diagnosis and a self-diagnosis of sexual problems (SPSS 20.0).

Interviewees were categorized, based on Mitchell et al. sampling strategy (2011), according to the presence or absence of sexual difficulties, in order to maximize the variation in sexual function experience. Then, in a second phase, the participants who consented to remain in the study and provided a telephone number were randomly selected to perform in-depth interviews. The interview guide was structured by a body of open-ended questions that intended to access

participants' views about their sexual lives and sexual problems. Background information of previous questionnaires helped plot connections between experiences and representations of sexuality and various facets of identity. Discussions were audio taped and transcribed systematically, and completed by appropriate labeling and content-related information. Transcripts were checked against the original recordings in a continual process of revision (Davidson, 2009).

The 15 feminine and 10 masculine sexual stories, i.e. personal narratives of the intimate (Plummer, 1995), were narrated predominantly by residents of the Greater Lisbon area, with a range of ages between 21 and 71 years. A brief study of the sociocultural context of sexuality in relation to participant's experiences was initially designed and extended on the basis of the narrative (Hydén, 1997). Then, we unraveled the meanings attributed to sexual dysfunctions and the scenarios of sexual problems experience (Simon & Gagnon, 2003), the storyline and the outcome engineered by narrators.

Results

Extensive analysis of disagreements on sexual problems evaluation

To identify the disagreements on sexual problems prevalence, we compared the answers given by the participants on both scale and single self-reported questions (103 men and 116 women). The estimated prevalence of IIEF-defined erectile dysfunction was 35.9% [95% CI (27.3, 45.5)] and for FSFI-defined sexual desire problems the prevalence was 66.4% [95% CI (57.4, 74.3)]. Participants' self-reported prevalence was lower: self-reported erectile dysfunction was 15.5% [95% CI (9.8, 23.8)] and self-reported sexual desire problems were 24.1% [95% CI (17.3, 32.7)]. These findings represent a fair agreement (kappa = 0.349; $p < 0.001$) between erectile dysfunction based on the IIEF score and self-evaluation and a poor agreement (kappa = 0.160; $p = 0.013$) between sexual desire problems based on the FSFI score and self-evaluation.

Results indicated a very high specificity of IIEF/FSFI instruments (95.5% and 89.7%), which means a good diagnosis in sexual problem absence. On the other hand, sensitivity was very low (35.1% and 31.2%), which means that only 35% of men with erectile dysfunction and 31% of women with a sexual desire disorder acknowledge or recognize their problem. The majority of the participants that contribute to the disagreement between sexual function evaluation methods were individuals who fail to recognize their problems or for whom their

problem is not a dysfunction. Therefore, levels of distress of the self-reported difficulties were analyzed (**Tables 1** and **2**). Men's level of distress was higher than women's. Orgasmic and erectile problems presented the highest levels of distress among men (61% and 63% of very high or extreme distress), and dyspareunia among women (52% of very high or extreme distress). Lack of desire among women, although being the most prevalent sexual problem, was the least distressing one: 57% of the women indicated no distress.

Table 3 illustrates the categorization of the interviewees according to their experience of sexual difficulties enabling the exploration of the disagreements on instruments and self-diagnosis of sexual problems. Men and women with IIEF/FSFI and self-reported sexual difficulties were categorized as *problematic*; those without were categorized as *functional*; those who stated problems regardless of the IIEF/FSFI classification, were considered *dissatisfied*; finally, those who self-reported absence of sexual difficulties and had a diagnosis based on IIEF/FSFI, were categorized as c*ontradictory*. No statistically significant gender differences were found in the groups' distribution, although there were more *problematic* women (18% vs. 11%) and *dissatisfied* men (20% vs. 16%) or *contradictory* (16% vs. 10%). Given the gender effect on the disagreements, more women were expected in the *contradictory* type. The meanings attributed to sexual problems and their context will be explored in the qualitative analysis for enabling a deeper understanding of these contradictions. Moreover, higher percentages of treatment for sexual problems were found among the *dissatisfied*, while among the *contradictory* type there was no report of treatment.

Traditions and contradictions of sexual problems lay representations

Information obtained through the in-depth interviews was then used to better understand "lay" or "everyday" representations of sexual problems and their treatments, exploring inter- and intra-gender differences. Results are presented accordingly to our categorization of participants' perceptions of sexual difficulties. Besides the types that indicated disagreement (*dissatisfied* and *contradictory*), the ones that indicated agreement (*problematic* and *functional*) will also be presented for their inputs to understand the social and gender construction of sexual difficulties.

Table 1. Self-reported prevalence of women's sexual difficulties and level of distress

	Self-reported	**Level of distress** (1 *without distress* to 5 *extreme distress*)				
Women's	**prevalence**	**1**	**2**	**3**	**4**	**5**
sexual difficulties, n (%)[a]	**n=180**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
Lack sexual desire	35 (19.4) [14.3, 25.8][b]	20 (57.1)	2 (5.7)	5 (14.3)	4 (11.4)	4 (11.4)
Sexual arousal/lubrification	23 (12.8) [8.7, 18.4][b]	6 (28.6)	2 (9.5)	6 (28.6)	7 (33.3)	0 (0)
Orgasmic difficulties	18 (10.9) [6.4, 15.3][b]	6 (40.0)	2 (13.3)	2 (13.3)	5 (33.3)	0 (0)
Dyspareunia	23 (12.8) [8.7, 18.4][b]	5 (21.7)	4 (17.4)	2 (8.7)	10 (43.5)	2 (8.7)

[a] % calculated for the number of valid cases in each variable
[b] 95% Confidence Interval

Table 2. Self-reported prevalence of men's sexual difficulties and level of distress

	Self-reported	**Level of distress** (1 *without distress* to 5 *extreme distress*)				
Men's sexual	**prevalence**	**1**	**2**	**3**	**4**	**5**
difficulties, n (%)[a]	**n=143**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
Erectile dysfunction	32 (22.4) [16.3, 29.9][b]	5 (16.1)	1 (3.2)	6 (19.4)	4 (12.9)	15 (48.4)
Sexual desire	16 (11.2) [7.0, 17.4][b]	3 (18.8)	1 (6.3)	3 (18.8)	3 (18.8)	6 (37.5)
Orgasmic difficulties	16 (11.2) [7.0, 17.4][b]	1(6.3)	1 (6.3)	4 (25.0)	3 (18.8)	7 (43.8)

[a] % calculated for the number of valid cases in each variable
[b] 95% Confidence Interval

Table 3. Characterization of participants by sexual function experience

Characteristics	Type 1 "Problematic"		Type 2 "Functional"		Type 3 "Dissatisfied"		Type 4 "Contradictory"	
	Men	**Women**	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
Total (n, %)	16 (11.3)	32 (18.0)	75 (52.8)	99 (55.6)	28 (19.7)	29 (16.3)	23 (16.2)	18 (10.1)
Mean age (SD), Range	59.9 (7.7) 43-72	44.1 (16.7) 20-75	48.4 (16.1) 21-79	40.6 (15.5) 18-76	63.3 (13.0) 37-80	46.3 (18.0) 22-75	57.1 (15.4) 20-78	45.7 (13.1) 21-75
Married/Living together	12 (75.0)	25 (78.1)	46 (61.3)	51 (51.5)	18 (64.3)	18 (64.3)	17 (73.9)	15 (83.3)
Mean years of education (SD)	6.8 (3.7)	8.0 (4.4)	9.8 (4.3)	11.2 (13.5)	7.6 (3.4)	8.1 (4.6)	7.8 (4.0)	8.2 (4.8)
Catholic	12 (75.0)	20 (62.5)	61 (81.3)	71 (71.7)	23 (82.1)	23 (79.3)	18 (78.3)	13 (72.2)
Religion commitment mean (SD)	2.1 (1.3)	1.8 (1.5)	2.1 (1.3)	2.2 (1.7)	2.1 (1.4)	2.2 (1.8)	2.0 (1.5)	2.7 (1.8)
GP asked about SP	2 (13.3)	2 (6.3)	8 (11.1)	20 (21.3)	2 (7.1)	5 (17.2)	3 (15.0)	1 (5.9)
SP discussed with the GP	9 (56.3)	7 (21.9)	9 (12.2)	32 (33.7)	14 (50.0)	6 (20.7)	3 (14.3)	2 (12.5)
Are in sexual treatment or have undergone	4 (25.0)	6 (20.7)	1 (16.7)	3 (21.4)	11 (39.2)	4 (16.6)	0 (0.0)	0 (0.0)
Subsample (N=25)	**4**	**8**	**1**	**2**	**1**	**3**	**4**	**2**

SD = Standard deviation; GP = General practitioner; SP = Sexual problems.

Problematic experience of sexual problems

Different levels of distress and coping approaches were identified among the *problematic*. Indeed, several accounts for sexual difficulties with different degrees of distress between men and women were recognized. In the case of men, changes related to age are frequently referred to in association with the idea of loss. The onset of sexual problems, particularly in terms of erection, is associated with a 'decline narrative' (Potts, Grace, Vares, & Gavey, 2006). Instead of adjusting their expectations, some men only seem to accept that sexual life has a different dynamic, leading to the persistence of negative feelings towards sexuality (Mitchell, King, Nazareth, Wellings, 2011). *Francisco* is a married man who is 64 years old who suffers from severe erectile problems, which cause negative feelings in him. He has searched for sexual treatment, but his and his wife's depression, economic difficulties, and his wife's desire problems, constitute major barriers to his search for a fulfilling sexual life, as he explains:

> *We're a couple; it would be totally useful to continue having sex. I lack the reaction (...) but it's been so long (...) we were talking about going to a sexologist, but I must get better first [depression]. But it's too expensive*.

Otherwise, examples of how high expectations concerning sexual performance are linked to the illness representation process were found, as in *Jorge*'s case:

> *But for me, sexual dysfunction is not having an erection. If one has no erection, there must be some problem in the organs, in the blood. Because if the head thinks, and the brain does not transmit. I think it's a physical problem.*

Jorge, 68 years old, associates the sexual difficulties to his hypertension medication and, more generally, to a physical cause. His family doctor prescribed him Viagra and *Jorge* was somehow pleased with the results, despite saying he would not take it forever and has not told his wife he was taking Viagra.

In women's *problematic* sexual narratives, it seems that there is an easier adaptation to the diminishing of sexual performance, which is seen as a normal process of ageing. Like *Dolores*, 60 years old, says:

> *The degree of excitement is not as high as when I was 30 years old, but from 1 to 10 it would be 6 or 7 (...) I went to the doctor and said it was painful, and that I felt a little frustrated when my husband wanted to have sex and I was afraid of sexual intercourse. I felt a bit uncomfortable, but not now. I'm much more comfortable, much more confident, and not afraid to get hurt.*

Moreover, among women, negative experiences associated to gender violence were found. *Mariana*, 31 years old with a degree, had two events worth noting: an interruption of pregnancy and a relationship marked by forced sexual intercourse. Currently she's single, but her previous relationship was punctuated by the emergence of several sexual difficulties: lack of sexual desire, arousal, and orgasm, and pain during physical contact. At that time, a psychologist followed her, for her anxiety problems. As she confesses:

> *I didn't feel good with my body because (...) I know I'm not like that. Because I know I can have desire for sexual activity. And then I felt bad because I thought somehow there was something that failed. (...) And then one feels a little frustrated ... It also consumed me a little.*

Furthermore women's sexual scripts are predominantly relational and turned to marital guidance (Mitchell, Wellings et al., 2011). For *Dolores*, a normal sexuality means having only one partner and "*having a good relationship and love-making two, three, four times a week if you feel like it*".

Functional experience of sexual problems

Among the group of participants who did not describe any significant frustration experience of sexual problems themselves, sexual problems can appear in the narratives related to the partner or referring to the past.

Pedro is 61 and has been married for 36 years. He seems to enjoy his sexual life, despite the diminishing of the frequency of intercourse, which he considers to be normal. His wife had breast cancer and was submitted to breast and ovary surgery. Consequently she suffers from sexual difficulties but *Pedro* mentioned that the couple has adapted and that they maintain a satisfactory sexual life. As he said: *"The woman, earlier than man, begins to lose that sort of desire, enters menopause early, the man starts a bit later. The woman tries to avoid intercourse often; then the man has to be understanding."*

More than physiological factors, women linked sexual difficulties to psychological causes. *Marlene* is a 21-year-old college student, living with her parents, who in the past felt sexual desire and arousal difficulties, which she associated to emotional problems and stress. At that time, she said she felt uncomfortable and avoided having intercourse. *Marlene* highlights the support and encouragement she received from her boyfriend, who helped her to overcome inhibitions related with physical involvement and the exposure of the body. *Marlene* considers that sexual dysfunctions are obstacles to the communication with the partner, which may be exceeded precisely through dialogue and the search for help from a specialist. In her opinion: "*If one knows what each other likes it's easier [...] it [communication] helps to know the other and also to make us understand* ".

The case of *Graça* is illustrative of how family constraints can affect intimate sexual life. Both her ex-husband and her new partner had died recently, and the fact she has the responsibility of taking care of her aging parents confines her to celibacy. *Graça*, 59 years old, has always been an independent woman, who felt the desire to be a man to live her independence without constrains, as society did not accept it well. She divorced when she found a new fulfilling sexual partner:

> *Before it was a chore. (...) I didn't have desire. (...) It was different with this other person, or because he had more experience (...) he was the one who made me a woman,*

because I didn't know what that was. (...) After that I realized that there was something else that was good for both parties.

Dissatisfied experience of sexual problems

Minor sexual difficulties were described among the *dissatisfied,* although sometimes linked with other major problems in life that enhance sexual problem experiences of both men and women.

Indeed, sexual narratives illustrated more complex patterns of problems, at the individual level or interpersonal relationship, as illustrated in *Manuel*'s case, 66 years old, divorced, and in a long-distance relationship. *Manuel* has erection difficulties, which he links to age and what he called "the circumstances of life", and which worries him, as also the possibility of having prostate problems as in the past. Health issues are major concerns, as he says:

Health is health, it's not being sick. Normal would be that everything worked normally, right? Sexuality or any other function of the body: food, walking, vision, any other component of life, sexuality is like any other (...) However the private life went a little out of sorts... I also didn't care for a long time.

Isabel is a 49-year-old woman living a complicated stage of marital life. Shackled by her husband's erectile dysfunction, they are still trying to figure out how to deal with this recently emerged problem; and she herself has experienced some sexual difficulties: "*I notice less desire, less appetite, less interest; I don't think much [about sex]. It's a little painful. I feel that, quite a few times. I have a [vaginal] cream, a lubricant. Sometimes I'm completely dry.*"

Susana is 40 years old and has been married for 6 years to a much younger man. She describes herself as an independent woman and sometimes feels uncomfortable with the need of excessive attention her husband requires. She has been feeling a loss of sexual desire, which especially troubles her husband, since she considers her diminishing desire normal, in the context of lifecycle stage of their marriage. Despite some less positive moments, *Susana* is satisfied with their intimate life, and despite the lower frequency of sexual activity, she feels

that they have "enough" sexual intercourse. In reality, women's views on sexual problems seem to be more challenging of the biomedical model.

Contradictory experience of sexual problems

Finally, the "contradictory" narratives seem to indicate an over classification of problems, namely with sexual indexes borderline scores. An idea noticeable in *Paulo's* speech, a 44-year-old architect:

> *Perhaps today I see sex in a different way and the intimate relation with the other person in a more comfortable way. (...) Perhaps what I pictured as a problem back then, I don't feel anymore now. (...) I play football. When I was 20 years old I had a way of being on the field that I don't have today. It's no worse or better, it is different.*

Paulo seems to live his married and sexual life with satisfaction. For him, sexuality represents more than the physical part, and there is a very relevant emotional component both in marital as in sexual life, indicating elements of a more relational script (Mitchell, Wellings et al., 2011).

The same 'progress narrative', (Potts et al., 2006) based on the understanding that sexuality evolves with ageing is noticed in *Álvaro* case, a 54-year-old widowed man who does not seem to evaluate erection problems as being serious: "*What was important to the age of 18, 20, is no longer the same (...) Nowadays it is no longer when one wants (...) but one keeps on going. No longer when you want, but when you remember."* He has an occasional partner, who understands him, and he feels that in a relationship one must understand the difficulties of the other. For him, sexuality is very important within a relationship, but in a broader context, not just the sexual act itself.

Women's narratives were focused on relational and emotional issues. *Carla* refers to the sexual problem of her partner:

He doesn't see it as a problem, but I think it's a problem (...) He gives me no reasons: 'there is a lot of work, a lot of stress'. I tell him that I also have it but still have some needs. Making love can greatly help the psychological level.

Carla is 39 years old and has been married for 17 years and has no children. The dating period and first two years of marriage were idyllic. With the passage of time, the matter settled and now the couple does not have an active sex life, and she feels very uncomfortable with the situation. Experiencing marital problems with distress, she had a severe depression and she was diagnosed with bipolar disorder, for which she has been treated.

In the same vein, *Cristina,* 49 years old, had some difficulties in dealing with her orgasm problems, associated to her low self-esteem caused by her excess weight, and has sought professional help for her self-confidence issues, but in relation to her sexual difficulties she did not consider them to be a problem needing specialized treatment.

Discussion

The discrepancies found between the IIEF/FSFI and self-diagnosis reinforce the idea that both indexes may not reflect an empirical "normality" from which deviation is measured (Jutel, 2010; Katz & Marshall, 2004; Yule, Davison, & Brotto, 2011). Implications of using only those instruments, based on preconceived concepts of sexual dysfunction rather than men and women's own description of their problems (Bancroft, Loftus, & Long, 2003), should be considered in future research.

The theoretical Dual Control Model, developed by Kinsey Institute researchers (Bancroft, & Janssen, 2000), conceptualizes inhibition of sexual response as an adaptive mechanism for the majority of individuals. This underlines the point that a reduction in sexual interest or an impaired response to sexual interaction can be an understandable reaction to adverse conditions in the relationship with the partner or in the individual's general life situation. A key characteristic of the Dual Control Model is its focus on the understanding of individual variability (Bancroft, Graham, Janssen, & Sanders, 2009). Socioeconomic and educational factors have also been demonstrated to be associated with different attitudes about sex and different patterns of male–female relationships, which may undermine sexual satisfaction, particularly in women. Within this view, a woman in a low-intimacy marriage, in which sex has

been regarded as a wifely duty, may have low self-esteem and be less likely to feel positive about her own sexuality or the experience of sexual interaction with her partner (Bancroft, Loftus, & Long, 2003).

Additionally, in a postmodernist line, academic feminists started to criticize the essentialism of earlier feminist work with a binary view of inequality that ignored the social relations and historical contexts within which categories take on meaning and establish important differences among women (Angel 2012; Duschinsky, & Chachamu, 2013; Spurgas, 2013). As so, the persuasion of pharmaceutical companies on researchers to develop a "male pill" or "female Viagra" analyzed and understood as gender forces on the diffusion of some medical technologies, highlights diagnosis and treatment decisions linked to social as well as medical influences (Anspach, 2010).

Our narratives illustrated a wide variety of problems, needs and sexual dissatisfactions, that sometimes do not fit into the categories of desire, arousal, orgasm, or genital pain, while at other times they reinforce these same categories. Variations found in the sexual stories also showed differences in terms of values and cultural references, sexuality representations, and of past and present situations. These differences cannot be reduced to a fixed and closed definition of dysfunction. Indeed, sexual dysfunctions are not self-evident disorders discovered through the value-neutral methods of scientific sexology but are socially constructed as problems with reference to "hegemonic masculine" standards and patterns of normal sexual functioning and interaction (Fishman & Mamo, 2001; Giami, 2007; Morrow, 1994; Rohden, 2009; Rohden & Russo, 2011).

The presented sexual stories indicate that sexual problems for both genders go beyond disorders of physiological function; cultural, social and economical conditions, as well as the relational context, playing important roles. Inter- and intra-gender differences in terms of values, approaches to sexuality, social and cultural background, past and current situations were found. For that reason, men's and women's sexual problems, needs, and satisfaction do not fit neatly into categories of desire, arousal, orgasm or pain. Plurality cannot be captured by an identical notion of "dysfunction". Based on the "new view" classification of sexual problems (Tiefer, 2002), our participants' dissatisfaction were related to inadequate sex education (*Jorge*), anxiety or shame about own body (*Cristina*), family and work obligations (*Graça*), partner's abuse or couples unequal power (*Mariana*), partner's health status or sexual problems (*Pedro, Isabel*), relationship (*Susana*), depression or anxiety (*Francisco, Marlene*), fear of sexual acts, e.g. pain during intercourse (*Dolores*), medical factors (*Jorge, Manuel*).

Our main findings illustrated that sexual problems can be a relevant constrain in intimates' lives and that women and men who feel sexual difficulties play an important part in the definition of sexual function. Nonetheless, some of our stories were challenging of the "forever functional" convention (Marshall & Katz, 2002), again reinforcing sexual problems, ageing bodies, sexuality and intimacy, as complex and multifaceted social constructed phenomena (Marshall, 2009; Marshall, 2012). Results seem to indicate the existence of alternative models to the biomedical definition, classification, and treatment of sexual problems. Data also appears to point out gender differences; women's views on sexual problems being a bit more challenging of the biomedical model. Nevertheless, both genders sexual stories complicated the medical model of sexuality, in line with previous findings (Potts et al., 2004).

Our results should be replicated to reach well-founded conclusions and to reconceptualize the sexual problems and "dysfunctions" of men and women in a way to enable more therapeutic and predictive significance.

Conclusion

This study aimed to contribute to the current debate on how best to conceptualize men and women's sexual problems, while exploring the role of Portuguese heterosexual men and women in the construction of sexual dysfunctions, highlighting the complexity of the subjective meanings associated to the experience of sexual problems. Illness and disease are not closed systems but mutually constitutive and continuously interacting worlds. Disease pictures are formally objective narratives that provide meaning as well as underline social hierarchies (Ebeling, 2011). Indeed, diagnosis remains a ritual of disclosure, and uncertainty is replaced by a structured narrative (Rosenberg, 2002).

Our results have given strength to the idea that sexual double standards are influenced by situational and interpersonal factors, and that they are local constructions (Crawford & Popp, 2003; Sanchez, Fetterolf, & Rudman, 2012). This Portuguese case, similar to others (Petersen & Hyde, 2011), helped to illustrate the fact that conforming to strict gender roles may limit one's sexual expression as culturally imposed gender roles could increase sexual problems in both men and women. Notwithstanding the increasing individualization of sexual biographies in Portugal, men and women sexual patterns continue to show two distinct sides of sexuality, reinforcing a patriarchal form of machismo.

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> *I wondered, is Viagra simply about erecting the penis, or does it lend itself to a broader sociological analysis of the way patriarchy is supported in cultural, economic and political realms? (...) In this case, "patriarchy" has a new public and private face-that of the ashamed, vulnerable, dysfunctional, white, middle- or upper-class, middle-aged, heterosexual American male.*
>
> Loe M. (2004: 192) *The rise of Viagra: how the little blue pill changed sex in America.*

> *Mas apenas uma minoria de mulheres (parte delas profissionais liberais e muitas delas solteiras), conseguia fugir ao cerco do «bom funcionamento feminino», defendido pela Igreja e pelo Estado. Aventuraram-se em gestos proibidos, pejados de desconfiança e preconceitos, mas também em decisões escandalosas, como pedir um divórcio, ter relações fora do casamento, criar os filhos sozinhas, levar uma carreira por diante, e no meio de tanta afronta, ainda ter a leviandade de parecer gozar a vida.*
>
> Freire I. (2010]: 271-2) *Amor e Sexo no Tempo de Salazar.*

II – REPRESENTATIONS OF MALE AND FEMALE SEXUALITY

Research script n. º2

This second article aims to map and explore the diversity of sexual scripts in Portugal. In a context of growing complexity promoted by individualization processes, on the one hand, and the recent medicalization of male and female sexuality, on the other, we have tried to figure out how issues of sexual experiences and sexual and marital satisfaction are played in the empirical arena. We have tried to understand to what extent and with what specificities the "confluent love" as epitomized in Giddens' "pure relationship" exists, namely in men and women of different generations and social groups.

Reference:

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EXPLORING GENDER IN PORTUGUESE BEDROOMS: Men's and Women's Narratives of their Sexuality through a Mixed Methods Approach

Abstract

The nature of intimacy and self-identity changed profoundly over the past century. The disruption between sex and procreation enabled the emergence of new forms of relationships and contributed towards the legitimacy of a sexuality focused on pleasure, as a mean of self-realization and an expression of intimacy. Despite the evidence that most individuals now approach close relations with expectations of mutual emotional support and romantic love, intimate relationships remain highly gendered, particularly in societies where traditional roles of men and women persist in the growing diversity of sexual relationships.

To address this topic, an empirical research was conducted in the Greater Lisbon area using a mixed methods approach. First, a quantitative study, with 323 primary healthcare users, intended to explain how gender influences self-constructions of sexuality and intimacy. Then, a qualitative study, with a subsample of 10 heterosexual men and 15 heterosexual women, employed in-depth interviews to explore how individuals construct their etiquette of sexual behavior. Building upon Gagnon and Simon's scripting theory and Giddens' transformations of intimacy, along with feminist criticisms concerning male dominance in hetero-relationships, we have reached an explanatory typology that focuses on Portuguese specificity in terms of the subjective experience of sexuality and intimate relationships.

Sexuality and intimacy are complex and multifaceted phenomena that are affected by sexual and non-sexual factors, both in and out of the bedroom. Key findings reveal a coexistence of highly gendered sexual scripts with increasingly more egalitarian sexual roles, namely among the youngest and the most educated generations in Portuguese society.

Keywords: intimacy, (double standard of) sexual behavior, scripting theory, sexual experiences, gender, Portugal

Introduction

Aligned with the perspectives of Jackson (2008), Jackson and Scott (2010), and Beasley (2011), it is important to understand sexuality in the context of a wider reality and within other spheres of social life. In fact, heterosexuality is socially constructed, and sexual norms, perceptions, behaviors, and everyday practice of (hetero)-sexuality are culturally-bounded.

Having rejected the notion of an essential, biologically determined sexuality, the pioneering scripting theory, developed by Gagnon and Simon in the 1970s, suggests that the majority of sexual behaviors in heterosexual relationships tend to follow a prescribed social scenario that reflects the cultural norm (Gagnon & Simon 1973). However, sexual scripts are not socially determined as fixed lines of conduct. Instead, they are fluid improvisations involving ongoing processes of interpretation and negotiation (Jackson & Scott 2010). Sexual scripts are important determinants of individuals' sexual beliefs and behaviors that operate on cultural, intrapsychic, and interpersonal levels, in the sense that each level dynamically influences the others (Gagnon 1990; Simon & Gagnon 1986). The existence of three different but interrelated dimensions of scripting enables the understanding of individual agency and variation, with sexual script theory being a useful framework in understanding sexual roles in the context of social change (Simon & Gagnon 2003).

As Masters et al. (2013) recently demonstrated, gender structures shape individuals' beliefs, desires, and behaviors through culture-level sexual scripts which, in turn, can be reinforced or changed through inter or intrapersonal scripts. Their study, which sought to characterize the way sexual gender scripts may be contested, suggests that, although for most young people interviewed culture-level gender scripts for behaviors in sexual relationships fit the traditional descriptions of masculine and feminine sexuality, there is heterogeneity in the way and extent that these scripts were incorporated into individual relationships (Masters et al. 2013).

This fluid nature of sexuality, relationships, and intimacy in contemporary Western societies was captured in Giddens' (1992) concept of "plastic sexuality", which refers to the malleability of erotic expression, in terms of both individual choice and frameworks of social norms. In fact, in the late twentieth century, new connections between sexuality and intimacy were formed, and sexuality became doubly constituted as a way of self-realization, as well as an expression of intimacy. Giddens set out for women a key role in this changing process leading to the ascendancy of "confluent love" and "the pure relationship". These two notions

rely on the fact that the distribution of resources and tasks is negotiated in a spirit of justice and mutual respect, both in the public and private spheres (Giddens 1992). However, little explanation was given on the way pure relationship takes place. Giddens' optimistic theory of the global transformation of intimacy ignores the evidence of continuing inequality in heterosexual intimate relationships at economic and emotional levels (Duncombe & Marsden 1993), which has generated considerable discussion (Jackson & Scott 2010).

Jamieson (1999), for example, has articulated a critical look regarding Giddens' concept of pure relationship from an empirical perspective. In her words: "Empirically, intimacy and inequality continue to coexist in many personal lives. Personal relationships remain highly gendered. Men and women routinely both invoke gender stereotypes or turn a convenient blind eye to gendering processes when making sense of themselves as lovers, partners, mothers, fathers and friends." (Jamieson 1999: 491) Attention to practices of intimacy can assist the need to explain continuity and change, as practices of intimacy can sustain or subvert inequalities such as those of age, class and gender (Jamieson 2011).

However, Gabb (2011) has a different approach on the study of personal relationships and families and on the central idea of reciprocity for understanding the everyday practices of intimacy (Jamieson 1999). She explained that: "(…) rather than seeing differences as contra-evidence and/or a qualification to the democratic relational paradigm we should pay more attention to the ways that practices create embedded multidimensional emotional-social worlds in ways that embrace otherness in relationships" (Gabb 2011: 1). Therefore, according to the author, the focus should be on how differences between self and the other are played on everyday life.

The comprehension of this dynamic is relevant within the context of the sexuality of Portuguese people, where in the past decades, major changes have taken place. In line with the transformations occurring in sexual life in western societies, recent studies have demonstrated a similar emergence of a plurality of affections in contemporary heterosexual conjugalities in Portugal and a democratization of the ideals of conjugal relationships based on affection and orientations towards love and intimacy (Aboim 2009). In the 50's and 60's, the society was conservative and strict in matters of sexual morality, and sexuality was a domain whose knowledge and rules were supposed to follow the restrictive moral teachings of the Catholic Church. Men's sexual freedom contrasted with the purity and containment requirements placed on women. Indeed, as Aboim (2013) discussed, in the Catholic countries of southern Europe, the cult of the figure of the Virgin Mary has been seen as a castrating force for women's

sexuality and one of the main pillars of *machismo*, which reinforces male domination over women. And despite the increasing individualization of sexual biographies, sexual patterns of men and women continue to differ.

Results of the Sexuality Portuguese Survey (Ferreira et al. 2010), which were also found in other European surveys (Bajos et al. 2010; Mercer et al. 2013; Teva et. al 2013), indicated that the number of sexual partners men and women claim to have had and the age at first intercourse were still contrasting, although less markedly in younger generations, and with major changes among women. Despite the increase in women's expectations for a fulfilling sexual life during the past 40 years in Portugal, this 'transformation' should not be overstated, and evidence proving that women's romantic ambitions have declined is still lacking (Costa et al. 2009).

In this article, we will first try to map the variety of responses to dominant sexual scripts in Portugal by identifying different frequencies or intensities for heterosexual relations, different forms of relationship between genders, and different representations of sexual satisfaction. Then, in a comprehensive look, we will explore this diversity. If *pure relationships* were emerging, equalization in sexual behaviors of men and women and in their meanings and significance should be expected in Portuguese results. Will relations remain strict and bound to traditional gender stereotypes? Will we find in the Portuguese couples of today the *confluent love* as typified in Giddens' concept, and if so, with which new configurations, specificities, and differences? And what other forms of intimate relationships and sexuality exist? Will other models of love with multiple possibilities of combination between sexuality, marriage, and procreation be uncovered? As Jackson and Scott stated (2010: 98): "If Giddens were correct, the transformations he identifies could be seen as signaling the demise of compulsory heterosexuality – the heterosexual contract becomes voluntary and fragile."

We will, therefore, stand in the middle ground between the two main challenges posed by Jackson (2008): the need to chart variation and change within normative, everyday sexuality, on one side, and the necessity of thinking beyond the parochial 'western' highlighted by most of the existing work in the field, on the other. This position will be adopted to explore the consequences of having differing cultural and historical traditions, attending to both continuity and change and investigating ordinary as well as extraordinary sex and intimacy.

Through this work, we will focus on identifying practices among Portuguese men and women that might challenge heteronormativity (Beasley 2011), with an aim of contributing to the theoretical and empirical knowledge of heterosexual experience as something beyond a standard (Jackson 2008).

Methods

Sexuality and gender relations are complex phenomena. For that reason, methodological approaches combining multiple methods are indicated as ideal in a research (Crawford & Popp 2003). Therefore, multi-method data were used is this study, as they were expected to produce a richer set of evidence on the understanding of sexuality and intimacy in everyday life, through the dialectic between inductive and deductive theoretical developments (Pearce 2012). Like Moore (2007), we considered both qualitative and quantitative data as 'situated knowledge' that can only be understood as and through 'partial perspectives'. Reflexivity reveals all research as situated, and attention was paid to the conditions of production of the research. The data collection strategy consisted of a quantitative component preceding a qualitative one, in order to optimize the sample for diversity. Moreover, this strategy helped to overcome the topic's sensitivity challenge of face-to-face interviews in the area of sexuality and intimacy.

This article draws on data from the *Sexual Observational Study in Portugal* conducted between January and September 2011 in primary healthcare centers in Lisbon (Alarcão et al. 2012). Male and female users of the collaborating centers were systematically invited to answer face-to-face surveys, giving at the outset their informed consent to be interviewed and their permission to be identified and sampled for a second qualitative component. To preserve anonymity, participants were attributed a code number in the survey, and only pseudonyms were used in the writing of the research. These measures are aimed at honoring confidentiality agreements between the participant and the researchers (Gabb 2010).

Several studies have found that the reliability of self-reported sexual behavior varies with a range of factors, such as sex-related bias in the direction of over-reporting of the mean number of partners over a defined period by men and/or underreporting by women (Fenton et al. 2001). In the present study, data collection of both quantitative and qualitative components took place in a private room of the participating units and was conducted by male and female interviewers for male and female users, respectively. The setting made it socially acceptable to discuss these issues, and, in general, participants felt comfortable discussing their sexual lives.

The interviewers were psychologists with specific training on the topics under study, following good practices and guidelines for sexuality surveys (Kinsey et al. 1948; Brewer 1985).

Data collection and analysis procedures will be detailed at first for the quantitative component and secondly for the qualitative one. In the quantitative study, each participant was interviewed using a standardized survey interview combining questions posed by the interviewer concerning socio-demographic characteristics of both the participants and their partners (e.g., sex, age, educational attainment, and occupational characteristics) and questionnaires for assessment of sexual activity to be completed by the interviewees (e.g., number of sexual partners in the past 12 months, and frequencies and intensities of sexual intercourse, sexual function, and marital and sexual satisfaction). Sexual function was assessed using the International Index of Erectile Function (IIEF) and the Female Sexual Function Index (FSFI), the most widely used worldwide and validated self-completion questionnaires (Lewis et al. 2010), including in Portugal (Peixoto & Nobre, 2013; Quinta Gomes & Nobre, 2014). The quality of the relationship was assessed using the Golombok-Rust Inventory of Marital State (GRIMS) (Rust et al. 1990), which covers topics on satisfaction, communication, shared interest, trust, and respect among heterosexual-partnered participants. Finally, the quality of sexual functioning was assessed by the Golombok-Rust Inventory of Sexual Satisfaction (GRISS), which covers the most frequent sexual complaints of heterosexual people with a steady partner (Rust & Golombok 1986).

This mixed mode of administration was implemented in the survey due to its intimate and sensitive nature, and the procedure was pre-tested. Combinations of the benefits of a face-to-face interview and the privacy of self-completion for more sensitive questions have been used in many of the large surveys, with self-completion modules producing higher rates of sensitive behaviors than face-to-face interviews (Fenton et al. 2001).

Quantitative data were coded onto IBM SPSS Statistics 20.0 database and checked for accuracy. To study how gender influences self-constructions of sexuality and intimacy, associations between socio-demographic variables and sexual activity were tested using Chi-square or Fisher's exact tests. Nonparametric Mann-Whitney or Kruskal-Wallis tests were used to compare age, GRIMS and GRISS scores and other continuous variables between two independent groups (gender) or three or more independent groups (partnership status), respectively, as data normality assumption was not satisfied. Pearson's or Spearman's correlation coefficients were used to compare GRIMS, GRISS, and FSFI/IIEF scores. Linear

regression was performed to identify factors associated to sexual satisfaction in univariate- and multivariate-adjusted models. For all tests the level of statistical significance was set at 0.05.

In the qualitative phase, those initial participants who gave their consent to remain in the study and provided a telephone number (n=245, 76%), were randomly selected and invited for in-depth interviews (n=25), lasting about an hour, to explore how individuals construct their etiquette of sexual behavior. Open-ended questions probed participants' perceptions of their sexual experiences and their views of a satisfactory sex life, as well as the function of sex in their lives (**Box 1**). Background information of previous questionnaires facilitated connections between experiences and representations of sexuality and various facets of identity.

Interviews were audio–taped, transcribed systematically, and completed by indicating appropriate labeling and content-related information. Transcripts were checked against the original recordings in a continual process of revision (Davidson 2009).

For the process of typology construction, Kluge's (2000) model of empirically grounded type construction was used in its different analysis stages of the qualitative data: 1) development of relevant analyzing dimensions; 2) grouping the cases and analysis of empirical regularities; 3) analysis of meaningful relationships and type construction; and 4) characterization of the constructed types. Our purpose was not to establish an absolute typology nor obscure its intratypes' singularities. The ideal types should be considered as theoretical and methodological constructions aiming to capture the diversity of the responses to dominant sexual scripts and highlighting certain characteristic traits.

It must be pointed out, however, that the assignment of informants to the constructed typology was not a linear procedure, as the process of making sense of and shifting sexual practices and desires is shaped by cultural and personal experiences. Nonetheless, and despite the individuals sharing characteristics of more than one ideal type, the allocation on a single type remained heuristically useful. Variables, such as number of or changes in marital relations and early life events, influence sexual and intimate experiences, where a greater fluidity originates between the established types and imposing, in some cases, a kind of contamination or, in others, sites of disjuncture. One good example is the case of older widows or divorced women's narratives concerning the process of recovering their self-achievement, self-esteem, and femininity, which enabled them to live independent lives.

Box 1 – Excerpt from the interview topic guide

- *What is the meaning of "sexual health" for you? What represents "normal sexuality" for you?*
- *How would you describe "sexual activity"? What sexual practices do you consider sexual activity?*
- *What is satisfactory sexual activity for you?*
- *Do you consider sexual dysfunction a disease? According to you, what are the main causes of sexual problems?*
- *What represents for you being a man/woman? Did the way you see yourself as a man/woman change since you started having sexual problems?*

Results

Sexual activity and satisfaction based on questionnaire data

Although our sample of primary care users is not representative of the Portuguese adult population, a good level of diversity in terms of socio-demographic characteristics was reached with the quantitative study (**Table 1**). Of the 323 participants, 180 (55.7%) were women, and mean age was 47.7 years. Few had a college degree (14.0% men, 16.6% women). The majority of participants were catholic (81.0% men, 71.1% women). All women and most men (95.3%) were exclusively heterosexual; 63.4% of participants described their marital status as ''married/partnered''. Most (84.7% men, 93.1% women) referred that they had been sexually active in the past 4 weeks.

Table 1. Sociodemographic characterization of the participants of the quantitative study

	Men (n=143)	Women (n=180)	Total (n=323)	p-value
Age in years, mean±SD	54.1±15.8	42.6±15.9	47.7±16.8	**<0.001**[1]
Age-wise group, n (%)				
18-39	30 (21.0)	84 (46.7)	114 (35.3)	
40-59	50 (35.0)	60 (33.3)	110 (34.0)	**<0.001**[2]
60-80	63 (44.0)	36 (20.0)	99 (30.7)	
Marital status, n (%)				
Single	22 (15.4)	40 (22.3)	62 (19.3)	
Married/living together	94 (65.7)	110 (61.5)	204 (63.4)	0.278[2]
Divorced/separated or widowed	27 (18.9)	29 (16.2)	56 (17.4)	
Educational level, n (%)				
Until the 7th grade	59 (41.3)	67 (38.3)	126 (39.6)	
Until high school	64 (44.8)	79 (45.1)	143 (45.0)	0.771[2]
Some college graduate	20 (14.0)	29 (16.6)	49 (15.4)	
Employment status, n (%)				
Employed	61 (42.7)	106 (58.9)	167 (51.7)	
Unemployed	13 (9.1)	36 (20.0)	49 (15.2)	**<0.001**[2]
Retired	65 (45.5)	31(17.2)	96 (29.7)	
Other	4 (2.8)	7 (3.9)	11(3.4)	
Religion, n (%)				
No religion	20 (14.1)	25 (13.9)	45 (14.0)	
Catholic	115 (81.0)	128 (71.1)	243 (75.5)	**0.030**[2]
Other	7 (4.9)	27 (15.0)	34 (10.5)	

SD: standard deviation; [1] Mann-Whitney Test; [2] Chi-Square Test
Bold numbers indicate statistically significant correlation ($p < 0.05$).

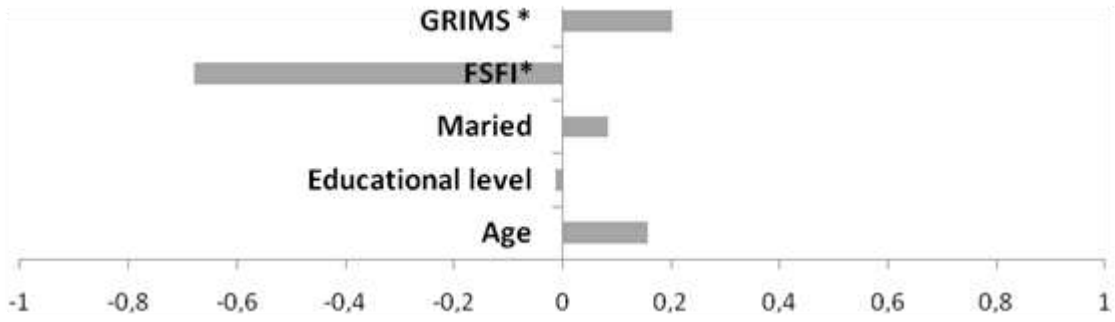
When asked about the number of sexual partners in the past 12 months, the majority of the respondents (76% of women and 71% of men) reported having just one partner for over a year (**Table 2**). Yet, there were statistically significant gender differences: more women (16% vs. 10% of men) indicated not to have had any partner in the past 12 months, and more men (7% vs. 1% of women) indicated having three or more. In terms of the situation that best describes the relationship with the partner, the majority responded on cohabitation (66% of women and 76% of men), but there were more women indicating being in a relationship for more than three months without cohabitation (17% vs. 13% of men), and more men indicating casual relationship (8% vs. 4% of women). In general, most of the respondents considered sexual life as important or very important, while men attach more importance than women.

Women reported to be less satisfied with their intimate relationships than men, and other gender differences related to relationship satisfaction were found in the results of GRIMS questionnaire. Relationship functioning was related to age among men, and religion commitment among women; it was found to be related to sexual satisfaction in both men and women. The two major determinants of sexual satisfaction assessed through GRISS questionnaires in both genders were sexual performance evaluation and relationship satisfaction. Sexual satisfaction was found to be related to sexual performance evaluation, independent of relationship satisfaction, adjusted for age, educational level, marital status, and religion, for both genders (**Figures 1** and **2**). Educational level seemed to play an important role in men's sexual satisfaction.

Table 2. Sex and number of sexual partners in the last 12 months, relationship status, and importance of sexual life among men and women

	Men			Women		
	N	**%**	**95% CI**	**n**	**%**	**95% CI**
Sex of the sexual partners						
Only different-sex partners	121	95.3	90.1; 97.8	150	100	97.5; 100
Both-sex partners	1	0.8	0.1; 4.3	0	0.0	0.0; 2.5
Only same-sex partners	5	3.9	1.7; 8.9	0	0.0	0.0; 2.5
Number of sexual partners in the last 12 months*						
No partner	14	9.9	6.0; 16.0	29	16.1	11.5; 22.2
1 partner for more than 1year	100	70.9	63.0; 77.8	137	76.1	69.4; 81.8
1 partner for less than 1year	8	5.7	2.9; 10.8	3	1.7	0.6; 4.8
2 partners	9	6.4	3.4; 11.7	10	5.6	3.1; 9.9
3 or more partner	10	7.1	3.9; 12.6	1	0.6	0.1; 3.1
Relationship status+						
Cohabitation	97	75.8	60.7; 75.9	111	65.7	54.4; 68.5
Relationship >3 months without cohabitation	16	12.5	7.1; 17.6	28	16.6	11.1; 21.6
Relationship <3 months without cohabitation	1	0.8	0.1; 3.9	3	1.8	0.6; 4.8
Casual relationship	10	7.8	3.9; 12.6	7	4.1	1.9; 7.8
Importance of sexual life*						
Very important	54	38.3	30.7; 46.5	45	25.0	19.2; 31.8
Important	74	52.5	44.3; 60.6	84	46.7	39.5; 53.9
Not very important	8	5.7	2.9; 10.8	37	20.6	15.3; 27.0
Not important at all	5	3.5	1.5; 8.0	14	7.8	4.7; 12.6

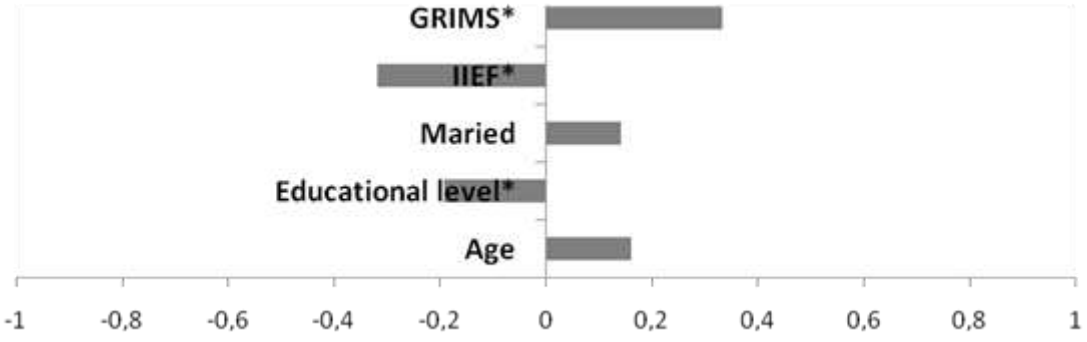
*$p<0.01$; +$p<0.01$; CI = Confidence interval



FSFI: Female Sexual Function Index (higher scores indicate higher sexual function); GRIMS: Golombok-Rust Inventories of Marital State (higher scores indicate more severe marital problem); GRISS: Golombok-Rust Inventories of Sexual Satisfaction (higher scores indicate more severe sexual satisfaction problem).

Values are Beta; *p<0.05; Number of participants included in the final model (adjusted for socio-demographic variables): 71; R^2=0.793.

Figure 1. Multivariate analysis of factors associated to sexual satisfaction (GRISS) in women



IIEF: International Index of Erectile Function (higher scores indicate higher sexual function); GRIMS: Golombok-Rust Inventories of Marital State (higher scores indicate more severe marital problem); GRISS: Golombok-Rust Inventories of Sexual Satisfaction (higher scores indicate more severe sexual satisfaction problem).

Values are Beta; *p<0.05; Number of participants included in the final model (adjusted for socio-demographic variables): 72; R^2=0.589.

Figure 2. Multivariate analysis of factors associated to sexual satisfaction in men

A typology of sexual experiences and representations based on in-depth interviews

The sample of the qualitative study achieved a good representation in key socioeconomic variables and on sexual experiences. The actors of the collected sexual narratives were predominantly resident in the Greater Lisbon area, had a range of ages between 21 and 71 years old, and followed, for the most part, a Christian religion. The majority were involved in a couple relationship, with some maintaining a single status, within or without a relationship, and different levels of marital and sexual satisfaction (**Table 3**).

An explanatory typology was developed to capture the diversity of sexual experiences and representations and to understand the meanings of sexual and relationship satisfaction from a layperson's perspective. The typology, which aimed to focus the Portuguese specificity in terms of the subjective experience of sexuality and intimate relationships, was constructed semi-inductively from the in-depth interviews. It was anchored in the theory of sexual scripts (Simon & Gagnon 1986, 2003) in articulation with Giddens' theory of intimacy (Giddens 1992), along with the feminist critics concerning male dominance in hetero-relations (Beasley 2011, Jackson & Scott 2010, Jamieson 1999).

Four ideal types were identified, referring to the date on which sexual narratives were collected but incorporating the sexual trajectories of the participants. The first ideal type, the *strict conservative,* represents the combination of a model of unequal close relations with a sexuality essentially characterized by the classic double standard. Men and women in this type prominently tend to deal with traditional, mainstream, highly gendered cultural sexual norms in a conforming way, reflecting a match between inter/intrapersonal and cultural scripts. Social scenarios are not diversified, and sexual practices are centered in the 'coitus imperative' (Jackson 1984: 44). The second ideal type, the *traditional attenuated,* represents the combination of a model of intimate relationships typified by a masked inequality and an attenuated sexual double standard, in which different kinds of male and female sexual experiences still co-exist. The idea that some of the conventional strict norms are not a suitable framework to be followed at the intimate level is sustained. Hence, there is a window for alternative sexual scripts, even though they must be upheld by the general picture of heteronormativity, which is not questioned but is just put into perspective. The third ideal type, the *progressive adaptive,* combines a model of intimate relationships based on a democratic root and a sexuality characterized by a single sexual standard. It is characterized by an ability to overcome gender inequality. Interviewees of this type indicated intra- and interpersonal gender scripts that differ from traditional cultural scripts for sex and relationships, but without

a reflexive remaking of gender rules. The last type, the *confluent transformative,* is a result of a combination of a democratic style of intimate relationships with a "plastic sexuality" (Giddens 1992). "Confluent lovers" emerge along with the process of self-individualization and attempt to remake traditional cultural-level scripts, thus increasing opportunities for sexual satisfaction for both men and women.

Sociodemographic characteristics and relationship factors differ from people who engage in the confluent transformative type of script (younger and more educated), as compared to those who engage in the more conservative scripts (older, less educated, and more religious). Sexual and relationship satisfactions (GRISS and GRIMS) also seem to be related to distribution of types (**Table 3**).

Table 3. Characterization of the interviewees of the qualitative study by the ideal types of the sexual experiences' typology

	Type 1 ***Strict conservative***	***Type 2 Traditional attenuated***	***Type 3 Progressive adaptive***	***Type 4 Confluent transformative***
Total nº in group (n=25)	4 (100%)	8 (100%)	6 (100%)	7 (100%)
Women (n=15)	3 (75%)	3 (38%)	5 (83%)	4 (57%)
Average age (range)	57.5 (54-67)	62.5 (49-71)	56.0 (31-68)	43.0 (21-59)
Average years of education	4.0	4.0	6.5	14.0
Religion commitment - from 0 (no religion) to 5, median	3.0	3.0	1.0	2.0
Partnership status				
Living in couple	4 (100%)	7 (88%)	4 (67%)	4 (50%)
Solo-living, within relationship	0 (0%)	1 (12%)	0 (0%)	2 (33%)
Solo-living, without relationship	0 (0%)	0 (0%)	2 (33%)	1 (17%)
GRIMS, median (N=18)	82.0	58.5	57.0	52.5
GRISS, median (N=16)	68.0	34.5	23.0	28.5

GRIMS: Golombok-Rust Inventories of Marital State (higher scores indicate more severe marital problem);
GRISS: Golombok-Rust Inventories of Sexual Satisfaction (higher scores indicate more severe sexual satisfaction problem).

Strict conservative

In this first essentialist type, 'sex' is equated with heterosexuality, and coitus is assumed to be a biological imperative; male violence against women is legitimated; and sexual practices, associated with dominance and submission, are 'normalized' on the basis of biological determinism (Jackson 1984). There is a submission to stereotypical social norms, permeated with taboos. Therefore, couple relationships are depicted by long lasting marriages where there is a clear wedge between man and woman, by means of an attachment to the traditional asymmetrical roles of husband and wife. Within the duo dynamics, men tend to assume a controlling position, and their main concern is their personal and sexual satisfaction at any cost, while women, repressed by a moral obligation, just function to obey and please the partner, as subservient devoted spouses. *Maria do Carmo*, a 67-year-old retired woman, verbalizes this way of being in a longstanding relation, obscured by the ghost of cheating, a treason only tolerable for men: *"More often than not I don't have desire, but… Why did we get married?! (…) Or else what makes a man unhappy? He will seek other women! (…) Because he has done it once, and he can do it again."*

Nevertheless, women assigned to this category might express some dissatisfaction with those established differences, which shattered the romantic ideal nourished for years, and the rude and uncaring way their partners treat them, showing a somehow conflicted conformity, albeit not paralleled by a genuine willingness to change the situation. *Maria José*, a 54-year-old Christian woman, married for 37 years, conveys this ambiguity: *"For me, it's part of the marriage (…). I lay down to rest, not to have affection (…). I have to endure. I don't think about anything stronger; I don't miss it."* The same submissive, and yet unhappy, position is revealed in *Maria Rosa's* words, after 38 years of marriage: *"I felt like a woman-object. (…) The mentality that we had was: 'You get married and you have to have* [sexual intercourse], *whether you want it or not'. I still feel this way."*

Sexuality, necessarily heterosexual and an obligation in marriage, is largely seen as a means to procreation and as *"a way of woman to provide a service to her husband and vice versa, and the whole body to function"*, as mentioned by *Maria José*. Sexual scripts are limited regarding partners' and practices' diversity. Following the exposed biological stance, *Maria do Carmo*, *Maria Rosa*, and *Maria José*, all women assigned to this type, stated they never had an orgasm. And because of never having experienced that pleasure, the topic is conceptualized in an abstract way: *"They said that it was a chill right up through your spine, that it was good… The doctor said to me that if I have three kids, I had to have felt that."*

Men separate the biological need of sexual satisfaction and the experiment of different forms of sexual practices from the holiness attached to their marriage, as expressed in *Joaquim*'s narrative, a 57-year-old man married for 40 years:

> *"My wife is sacred, [is] at home, is the mother of my child, takes care of the house, [and] takes care of me. And if I want fantasies, I look for them outside. (...) As long as we don't bring that infidelity to our home (...) and the family unit remains the same, there is absolutely no problem."*

The fulfillment of a biological need can be conceived as a way to legitimatize infidelity, as indicated by *Joaquim*: *"(...) sometimes the partner may not contribute to certain stimuli as she should. We may require that from a stranger; not from a partner who lives with us everyday..."*

Family of origin's *education* plays a crucial role in the plot of intimate relations, especially for women. Their background is usually strict and oppressive, and in line with the conventional values. As a result, couple interactions tend to be remarkably repressed and strongly fixed. The compliment to the inherited conservative values has repercussions on the sexual practices as well, by and large restricted to penetration, with *religion* representing a noteworthy influence at this level, comparable to the one imposed by education, which is not always accompanied by the same outlook on men's part as it is sustained by women. In fact, women are devoted to a catholic morale laudatory of feminine chastity and virtue. Both influences are reflected in *Maria José's* narrative, a strongly devoted Christian. Firstly, on *education*: *"I play my role (...), serving my people at home (...) I didn't have another kind of instruction".* And secondly, on *religion*: *"When he returned* [from Israel, in the 80's], *he came back with different ideas... And I said stop (...) given my evangelic conduct; I said to him: '(...) you have your wife* [only admitting to have sexual intercourse in the traditional way], *not in a different way'."*

Traditional attenuated

In this second ideal type, marriage is a precious achievement for both men and women, which needs to be preserved. Women, in particular, strive to make their husbands satisfied, even when the relation is not going in the ideal direction, demonstrating an acceptance of cultural scripts subordinated to male dominance. Like *Dolores*, who has been married for almost 40 years, she said: *"I think marriage is something that we have to take seriously. It has to be a lot of love,*

plenty of respect, so things can work out." Rosário, in the same vein, reveals, about her husband for 11 years: *"He's a little bit old-fashioned (...) He doesn't keep up [on] life's evolution. (...) I'm his mother, his wife, but I'm his friend, too. (...) Everything I do, I do it for him. (...) I don't feel bad* [in this position]*; I am 71 years old, [so] what else do I need?"*

In general, it is the men's preferences and demands that prevail in case of disagreement, although in a less dictatorial way, unlike the ones that characterize couple relationships in the first described type. That means that, even though they comprise a traditional way of thinking and behavior, there is, on men's part, a concern about their partner's needs and wishes, which represents, at the interpersonal level, an endeavor of dissociation from cultural norms. Pedro, whose wife's sexual desire was affected after breast cancer, shows some concern about what she is comfortable with: *"She never denied herself"*, but *"as far as possible, I try to assure that she has pleasure."*

Sexuality is seen as an essential part of marriage, despite the substantial consideration given to love, caring, and mutual support in the dyadic relationship. *Cristina*, a 49-year-old woman, currently engaged in a non-marital partnership, stated: *"*[If there is no sexuality between the couple, the relationship] *will deteriorate. (...) It's part of the marriage, (...) part of a life together.* [Otherwise] *it will be a friendship."* Likewise, we have the case of *Rosário*, who held the same line of thought: *"If she likes her husband and he wants her, I think they must have…it… that! (...) Sex is very important in a couple's life. (...) If they* [the husbands] *don't have it* [sex] *at home, they need to look for it outside. (...) And then, what problems can appear?"* Lastly, *Dolores*, 60 years old, stated: *"There has to be a lot of love, love above all… Only love can tear down barriers. It's* [sexuality] *part of our marriage, it's part of being human (...), we like each other very much (...). At some point, if I'm not into it, he respects me."* Men, in a similar vein, show deference in respect to sex, a complement of marriage and love. Sexuality is part of a couple's relationship and "*is part of life*" in *Pedro*'s words. For this 61-year-old man who is devoted to his family, marriage without this element is not acceptable. Sexuality is, however, seen as a biological component of all human beings, as confirmed by *Serafim*, married for 25 years: *"I think sexuality is part of the human being. We were made with this purpose (...) It is part of life, having sexual intercourse with our wife or with anyone else."*

Sexual practices tend to be conservative, but are shaped by each partner's wishes and desires. *Education* has an important role at this point, both for men and women. For instance, on the women's side, *Dolores*, who has preserved her marriage for almost a lifetime, declared: *"More of this, more of that, but usually within the same standards (...) I think it has to do with*

education… (…) more or less, we have the same guides and we follow them. (…) In bed there is no program". Rosário, similarly, as a consequence of being raised in a military school, sustains a strong reluctance towards the experience of alternative forms of sexuality, besides *"that part of sexuality* [penetration]*". Serafim* revealed how his conventional education constrained the way he sees and lives sexuality, confined to the most traditional practices and with no openness to any variation whatsoever: *"I'm a 60-year-old person… It's traditional. (…) Perhaps the education that we had; I've never talked… My mother never… Those were things that we acquired along the way."*

Progressive adaptive

Individuals that fit this type dissociate themselves from the traditional models, but without truly creating alternative ones. There is a site of disjuncture between inter/intrapersonal and cultural scripts, which is not accompanied by a true critical position or a desire to modify imposed gender roles. However, an effort to change the way of being in a sexual and intimate relationship is visible. Divorce or couple trial separation is an option for a non-satisfying relationship, as exemplified in *Carla*'s case:

> *"I told him to give me a break so I could think about my life and what I wanted to do, and he would do the same… Because this was not working, every time we talked, we raised our voices and attacked each other. (…) Right now, after I left and we talked (…) we're better."*

Some women hold a romantic vision of marriage that contrasts with the strict perspective upheld by their husbands, usually associated solely with a procreation end. Others express the struggle over the years towards the attainment of a union rooted in support, mutual understanding, and companionship. In either case, in the thin balance between love and sex, the first one is glorified and escorted by an attempt to use it as a flag in the couple's relationship development. This revolution in process is a reflection of women's endeavors towards their independence, or at least the reaching of an equal relation, to be personally fulfilled. Women's submission, representative of the previous ideal types, is attenuated and replaced by an attitude of profound respect for their husbands. *Clotilde*, an already-retired 63-year-old woman, revealed this example: *"My husband gives me a lot of love, comprehension, [and] stability". Isabel*, a middle-aged woman, referred to an identical interaction: *"We dated 3 years, got married by 26 (…) He's a wonderful person. (…) To be fulfilled, it's not necessary to have sex. It only takes tenderness, love, a kiss, (…) a good talk, communicate well (…)."*

Getting out of the ordinary circumstances can contribute to a change from one type to another type, similar to what happened to *Florbela*. Now 65 years old, her life can be divided into two distinct periods: before and after her widowhood. As a young woman, she passed from an extremely oppressive family context, typically rural and subordinated to the Church's rules, to an equally repressive one when she got married, shortly after 18, with a person who was 9 years older than her. *"It was complicated because his mind was that of a 'macho Lusitano' [Latino male]. I was younger and that made him very jealous".* At that time, although strong-minded, Florbela did not manage to cut off that relation and moved on. Only later, when her husband died, that she achieved her independence. Now, still struggling for a true transformation, she has a big family that is always there for her and learned to occupy her daily life with numerous activities, in a satisfactory way: *"I didn't feel that I needed to fill my life with more love. (...) Sex wasn't a necessity either. (...) The only thing for what I needed a man in my life was for sex, but for that I didn't have that urge. (...)"*

In this type, individuals detach themselves from the traditional values and practices, especially regarding intimate and sexual relationships, and show an individualization process in sexual life. Apart from that, some containment regarding sex life is still noticeable, particularly in older women sustaining a more traditionalist view on those matters. *Clotilde* personifies the conservative part of this type, given that her husband was the first and only man she got involved with sexually, and questions considering sexuality were, for many years, feared and not openly discussed. *Jorge's* statement, a married man for 48 years, revealed the same conservatism about sexual practices: *"Sexual activity is normal. (...) It's to have normal sex, not oral, anal, or anything like that". Isabel*, slightly younger, on the other hand, represents the least traditional subgroup on that matter. For her, *"it's acceptable* [other forms of sexual practices]*, as long as the couple has a good relationship, (...), everything is acceptable, there's no problem. (...) If you want to do it this way, we'll do it. If you don't, I don't push it".* Mariana, too, a single young woman with a degree, who experienced a troubled relationship that ended up because of the lack of caring on her boyfriend's part that led to a deadlock, considers herself to be now a *"more mature woman"* who is reconstructing herself. She thinks that her previous relationships were oppressive, and for that reason she *"lowered herself, in terms of sexuality and intimate relation."*

Education seems to have a particular role in the process of transformation in progress that is taking place. *Clotilde* received a typically provincial, conservative education that prevented her from taking the leap and detaching herself completely from the reverence towards

traditional gender roles, despite the support of her husband and children. *Isabel*, conversely, had a different experience. While her mother was *"reserved, even old-fashioned"*, her father had *"an open mind"*, which influenced the light way she embraces sexuality.

Confluent transformative

Informants included in this type of sexual experiences step over traditional gender roles, by adopting new forms of intimate relationship or opting for celibacy. Alternative discursive spaces that challenge normative heterosexual practice were found (Potts 2000; McPhillips et al. 2001). In Artur's case, a 49-year-old divorced man that does not maintain a regular sexual activity, this progressive devaluation of sexual intercourse started when he was married: *"I'm much more demanding now; I don't accept everybody. (...) For me, sex [is] not everything. (...) For me and my* [ex-] *wife, sex was not essential."*

Gender equality is now clearly established, at times after a past of trial and error in previous relationships, as experienced by *Sandra*, a 34-year-old modern woman, single and with a university degree: *"I think that, considering all my [previous] relationships, this is the one that fulfills me most (...) We talk about love and the care we have for each other (...), not exactly the sexual part, but everything that [is] around it."*

A transformed form of intimacy, which characterizes this type, can also be revealed in a reversed age difference between the couple, like what is happening to *Susana*, a 40-year-old woman, married to a man 15 years younger than her for 6 years. She explained that this hiatus accounts for their dissimilar way of being: *"I'm in a different phase. But he is a very mature person, considering his age. We're different. He wants a lot of attention, and I need more my space, my things."*

Men and women can build up new life styles, often possible due to strong professional and/or educational investments. Sexuality is related primarily to personal pleasure and not to the relational one. *Graça*, 59 years old, divorced, went through a transformation process that exemplifies the above-described change. She found a new fulfilling partner and ended a dead marriage from which she didn't draw any satisfaction and where sex was perceived as a marital requirement and a natural consequence of sleeping in the same bed as her husband:

> *"Before it was a chore. (...) I didn't have desire. (...) It's different with this person, or because he had more experience (...) he was the one who made me a woman,*

because I didn't know what that was. (…) After that I realized that there was something else that was good for both parties."

Sexuality is, within the broad framework of a couple's relationship, an important element but not the ultimate requirement for a shared happiness. Nonetheless, it is related primarily to personal pleasure and not to a relational gratification, with orgasm becoming something tangible and emphasized. We found in *Álvaro's* statement, a 54-year-old widow, a clear illustration of this:

"At least 50% of a relationship [is] the sexual part. (…) Sexuality is not just sex; it's everything around it, harmony, well-being, common interests, that's it. It's more than the sexual act. Intimacy [is] part of that. The wriggles and not wriggles, everything, it includes a mise-en-scéne… That's what makes sexuality."

Confluent transformative interviewees have the belief that today's relationships have a different tone as compared to those of former generations, which reflects a detachment from the highly gendered culture-level scripts, subjugated to male hegemony, as mentioned by Sandra: *"Today, sexuality is experienced in a different way, with a greater openness and with changed experiences. Nowadays, teenagers have more partners than they used to. Now, if there is more or less quality, I can't tell."*

In the same vein, *Marlene*, a college student, the youngest interviewee, only 21 years old, expressed that nowadays there are no differences between men and women*:*

"A woman can do anything a man does. I do not see big differences. We have more freedom and rights than before... And that presents advantages. I think that women and men no longer have, in the relationship, the same roles that they had previously."

Men in this type also believe that society is becoming more open and more gender-equal in sexuality matters; nevertheless, they feel that the idea of men with an active role and always ready to have sexual intercourse still persists.

Besides *education*, *communication* assumes a privileged status. For instance, *Marlene's* interview was predominantly focused on this topic; the pillar of any relationship, from her viewpoint: *"I don't know if it always helps* [to solve conflicts]*, but I think it's a good start. (…) It's useful to understand the partner and to make ourselves understood."*

Discussion

This research focused on understanding the gendered diversity of responses to dominant (hetero)sexual scripts through empirical research conducted in the Greater Lisbon area using a mixed methods approach. Our findings seem to reinforce the fact that the Portuguese society of the 21st century distances itself from the strict and conservative reality that reigned in the 1950's and 1960's (Aboim 2013), although heterosexual experience seems to remain mostly unchallenged as a standard in everyday life.

The findings obtained through both quantitative and qualitative approaches support the claim that gender and other socio-demographic differences related to sexual activity, and to sexual and intimate relationship satisfaction, still persist in Portugal (Ferreira et al. 2010), as verified in other countries (Bajos et al. 2010; Mercer et al. 2013). Results of the quantitative study indicated that sexual performance evaluation and intimate relationship satisfaction are the two major predictors of sexual satisfaction in both genders. Yet, men attach more importance to sexual life than women, and are also more satisfied with their relationship. Socioeconomic factors have an impact in sexual satisfaction as previously demonstrated, with disadvantaged socioeconomic status being markedly associated with lower levels of satisfaction among women, whose sexual satisfaction is also influenced by tasks related to social reproduction and the gender-based division of work (Castellanos-Torres et al. 2013). While socioeconomically disadvantaged people tend to report less sexual satisfaction, more socioeconomically advantaged people have a greater awareness of their own needs and a greater ability to develop their sexuality (Ruiz-Muñoz et al. 2013).

In Portugal, as in many other latitudes, the position of women in society is evolving. Examination of the sexual lifestyles of men and women, at different stages of the life course and with diverse forms of partnerships, needs to be understood in light of changing social norms, demographic trends, and changing legislations and policies. The demographic and social changes provide new opportunities for women and their sexual lifestyles as shown by the variety of representations regarding sexual and gender roles and a diverse range of sexual experiences that emerged from the participants' discourses. Results of the qualitative study indicate that conceptions of desire, arousal, and satisfaction are complex constructions affected by different sources of social control (Castellanos-Torres et al. 2013; DeLamater 1981; Ruiz-Muñoz et al. 2013). Some people are still too much or a little conservative (Types 1 and 2) while others try to modify the traditional frame and the gender rules for relationships and sex (Type 3) and some seem to represent the ideals of "confluent lovers" and "pure relationship"

(Type 4). There are different ways of perceiving sexuality, depending on gender, age, education, religion, and relationship and sexual satisfaction, as posed by Jackson (2008) who argued that ordinary sexuality is neither monolithic nor the same for everyone. Overall, men and women give importance to sexual intercourse, as a condition to have pleasure and to the sexual and emotional involvement of both partners. However, sexual function depends heavily on daily routines, personal cognitive variables, and emotional states. In most cases, women's sexuality was less genitally focused than men's. Nonetheless, more and more men and some women pursue relationships and mutually satisfying sex, and increasingly chase sexual agency and self-love, such as individuals of Type 3 and especially Type 4, striving to enact inter/intrapersonal scripts detached from the cultural traditionally sustained ones. These results extend evidence on gendered sexual scripts through participants' sexual stories of both continuity with traditional sexual scripts and change in these scripts, corroborating Masters et al.'s (2013) findings. Both distinctive beliefs and experiences among men and women and across gender were found, indicating potentially emerging transgressive heterosexual practices (Beasley, 2011). In these terms, heterosexuality, far from being a static and unchanging standard, reflects broader changes in articulation with other spheres of social life (Jackson, 2008; Jackson and Scott, 2010; Beasley, 2011).

In general, participants mentioned consensual sex as an ultimate requirement for sexual health and liberation. Still, women, regardless of the type they were assigned to, were more likely to comply with a sexually interested partner's desire for sex, as has been demonstrated by a systematic review on sexual compliance in heterosexual relationships (Impett & Peplau 2003).

This study is likely to be burdened with social desirability bias, as in all surveys based on self-reporting, namely those concerning sexual behavior (Wellings et al. 2006). Reporting bias undoubtedly accounted for some of the differences between genders, with women, and specially 'strict conservative' women (Type 1), probably underreporting same-sex partners, number of sexual partners, sexual satisfaction, and importance of sexual life in the survey. However, we believe that reliable reporting was facilitated with the participants' trust in the legitimacy and confidentiality of the survey (Mitchell et al. 2007). Data were drawn from Portuguese urban men and women living in the Lisbon Greater area. It is difficult to infer whether men and women outside the capital city would have the same type of sexual experiences and understanding, so findings must be considered tentative and exploratory. Nonetheless, the sample included men and women other than the typical middle-class, college

educated individuals that comprise many studies of sexuality, which is an important merit of this study. Results can be of particular interest for other predominantly Catholic countries where religion and educational factors play an important role in sexual scripts. More research is needed to explore the tension between sexual restraint and sexual expression that is still present in the Western culture today (Cowden & Bradshaw 2007).

Our typology that emerged from a broad range of perspectives along the qualitative study should be validated through a more diverse, gender-balanced, and larger sample, which could include, for instance, different social and ethnic backgrounds, and enable the analysis of group-specific scripts and a more systematic investigation of the diversity of social condition (Crawford & Popp 2003; Fasula et al. 2012).

This research combined qualitative and quantitative methods to develop a comprehensive understanding of men's and women's experiences of sexuality and intimacy (Crawford & Popp 2003). The use of a mixed methods design demonstrated two benefits: it increased comprehensiveness of the results and enhanced the understanding of sexual satisfaction in the intimate relationship and related to the individualization process. As shown in this Portuguese case, and as previously demonstrated in other studies (Petersen & Hyde 2011), conforming to strict gender roles may limit one's sexual expression, and culturally imposed gender roles could increase sexual problems in both men and women.

The use of sexual script theory to the interpretation of data showed that our findings are consistent with those of previous studies, which indicated that women's submissive sexual behavior predicts lower sexual autonomy and satisfaction (Kiefer & Sanchez 2007). Moreover, relationships that reject the traditional sexual script tend to have greater sexual satisfaction and relationship outcomes (Sanchez et al. 2012). Finally, even if this study combines both genders' sexual narratives, as an attempt to identify differences and resemblances, they were not related, and so it did not include points of view of sexual partners who play a role in the sexual stories.

Final considerations

Our results reinforce evidence of increasingly egalitarian sexual scripts among men and women and highlight age and educational differences (Crawford & Popp 2003). That might have to do with the fact that in sexual life, as elsewhere, the more privileged have more choices and more opportunities to explore different sexual lifestyles, with age and life-course variations also

becoming part of the sexual landscape (Jackson 2008). Although women's level of sexual satisfaction was similar to men's, they did not reach men's level in relationship satisfaction (Pedersen & Blekesaune 2003; Sanchez et al. 2012).

Sexuality, intimacy, and sexual and relationship satisfaction are complex and multifaceted. This study adds to the information available to help towards a better understanding of the impact of sexual and non-sexual variables on these constructs, both in and out the bedroom. Shifting sexual roles could potentially contribute to decreased gender inequality in the sexual and social arena, for both men and women.

This recognition of gender similarities in sexuality where they exist is essential for challenging the double standard and gaining equality for sexual expression. If societies become more sexually liberal and gender differences continue to narrow, equal opportunities for sexual expression become more realistic. Trends in various cultures toward or away from societal gender equality, in turn, are likely to have implications for gender differences in sexuality (Petersen & Hyde 2011).

From this perspective, it is through everyday practices of intimacy that social transformations take place to ensure the full exercise of rights and freedoms. At the same time, the embrace of otherness in relationships can only occur if the exercise of economic, social, and cultural rights is made possible. In this context, intimacy is the room for human life to be democratized and, in the absence of democracy, the stage where inequalities would be brought into light.

Ethical standards

This study has been approved by the appropriate ethics committees (Lisbon Faculty of Medicine and Lisbon Regional Health Administration) and has therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. Also, permission from the Portuguese Protection Data Authority was obtained. All persons gave their informed consent prior to their inclusion in the study.

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Conflict-of-Interest Statement

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> *Erectile difficulties are real. But so are the fears that men have about such difficulties, as well as cultural ideals conflating potency, manhood, and individualism.*
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III – SEXUAL PROBLEMS EXPERIENCE IN EVERYDAY LIFE

Research script n. º3

In this third article we describe and discuss the representations about sexual problems. We have tried to understand how men who experience sexual problems, and specifically erectile dysfunction, understand, explain and interpret them, on the one hand, and how they introduce them in their daily lives, on the other, highlighting tensions between the past, lived as the "normal" time, and the present, where the new subjective "self" and the current identity are rebuild.

Reference:

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The intimate world of men's sexual problems: Portuguese men's and women's narratives explicated through a mixed methods approach

Abstract

This study used a mixed methods approach to investigate the intimate world of men's sexual problems in Portugal, and particularly erectile dysfunction, focusing on the interplay between individual, societal and relational factors. First, a community-based survey was designed, with 323 primary health care users, to investigate how sociocultural factors influence experiences and representations of sexual problems. Second, a qualitative study, involving in-depth interviews with a subsample of 10 heterosexual men, complemented by 5 heterosexual women's narratives, concerning men's sexual problems, was carried out to understand the meaning of sexual problems from a lay perspective. Statistical analysis of quantitative data was carried out through logistic regressions to evaluate the sociodemographic predictors of lay representations of sexual problems. Qualitative data was analyzed using an empirically grounded typology. The role of individuals in the construction of sexual dysfunctions, particularly erectile dysfunction, was explored using sexual script theory. Key findings revealed the impact of sexual problems on daily life. Gender analysis results contributed to the understanding of how men and women challenge the definition of sexual problems as normal changes versus dysfunctional changes. Specific patterns of change in sexual experiences and sexual problems were identified in the Portuguese gendered society, which can possibly be applied to other nations and cultures.

Keywords: sexual problems; erectile dysfunction; sexual narratives; sexual scripts; gender relations; Portugal

Introduction

As the other aspects of health in contemporary societies are characterized by 'healthism' (Crawford, 1980), sex is characterized by biomedicine (Clarke et al., 2003). Changing sexual capabilities, once associated with 'normal' aging, are now pathologized as 'sexual dysfunctions' (SD) that require treatment (Katz & Marshall, 2004; Marshall, 2010; Potts et al., 2006). The development of Viagra and other erectile dysfunction (ED) drugs and the impact they had on men's (Grace et al., 2006; Loe, 2001, 2004b; Potts et al., 2004; Tiefer, 2006; Wentzell, 2013b) and women's (Loe, 2004a; Potts et al., 2003) lives have been critically analyzed. Meika Loe (2004b) demonstrated in her pioneering work how the advent of Viagra, in 1998, changed the meaning of sex in the American society, particularly the medicalization of impotence preceding the advent of Viagra. But, the biotechnology and the medical hegemony, the aging population, the changes in gender roles and the recent political movements all contributed to this cultural phenomenon. While this dominant biomedical model of sexuality seeks to reduce men's bodily and sexual experiences to a universal model of male (hetero) sexuality, empirical research lays emphasis on exploring the changes that occur in sexual practices and pleasures with time and experience (Potts et al., 2006), individually and in the context of relationships (Mitchell et al., 2011a; Wentzell & Salmeron, 2009). In fact, the findings suggest that, on the contrary, some men tend to use changes in sexual function, which can be diagnosed as "dysfunction", to enact gender norms they consider socially positive and incorporate decreased erectile function in "mature" masculinities (Wentzell, 2013a). Empirical research on culturally-specific patterns of change in sexual pleasures, experiences and difficulties over the lifetime is still needed to reveal how these changes occur in response to relationships, to understand individual and societal feelings about sex and intimacy, to access the shared stories of men with the same background or generation, and to search for gender distinctions as well as to recognize similarities in more liberal and equal societies (Aboim, 2010).

Lay peoples' conceptualization of functional sex

The conceptualization of a script, guiding sexual behavior applied to sexual function from a patient-centered approach, has been seldom attempted, despite its potential for understanding sexual experience (Gagnon, Rosen, & Leiblum, 1982; Mitchell et al., 2011b). Indeed, Simon and Gagnon's scripting theory, which is based on a broader theoretical work of the scripted

nature of social interactions in general (Goffman, 1959), has long been proven to provide a useful framework to understanding sexual roles and to negotiating sexual life in the context of social change and concurrent levels of individuation (Masters et al., 2013). Sexual scripts are important determinants of individuals' sexual beliefs and behaviors that operate on cultural, intrapsychic and interpersonal levels, in the sense that each level dynamically influences the others. Notwithstanding, there can be areas of discontinuity between the mainstream norms of the cultural scenarios and the relational or intra-psychic scripts for gendered behavior because sexual scripts operate on different levels (Simon & Gagnon, 2003).

Mitchell and collaborators (2011b) attempted to reconceptualize sexual function, based on lay conceptualizations, and identified three different scripts: the relational, the erotic and the biomedical. While the relational script focuses on relational aspects of encounters and values emotional intimacy and security, the erotic script focuses on pleasure and values novelty and excitement. The biomedical script focuses on genital function and physical release. The findings of this qualitative investigation challenge the current domination of the biomedical script in measuring, diagnosing and treating SD, since the construct does not adequately reflect the main concerns of those who prioritize alternative scripts. For that reason, further research is required to systematically explore these scripts at the cultural level.

Sexual dysfunction as biographical disruption

In contemporary reflexive societies, cultural scripts are growingly complex, fluid and ambivalent, and the event of 'critical situations', such as ED, can be transformative. Bury's (1991) classic concept of 'biographical disruption' provides an understanding about the changes a person might experience with the onset of an illness and offers a discussion of the problems of legitimation, the impact of treatment, and the development of adaptive response and mobilization of resources in the face of changed situations. Within the scripting framework, cultural scripts can be seen as resources used to make sense of the sexual life. As such, biographically-related health research has the potential to highlight the timing, context and circumstances in which illnesses are 'normalized' or 'problematized', as well as how identities are threatened or affirmed (Williams, 2000).

Conceptual framework and key hypotheses

The study of the representations of sexual problems (SPs), namely ED, among individuals with and without the experience of SPs, allows exploring the variations in lay peoples' conceptualization of functional sex. The inclusion of women's perspectives enables a better discussion of gender issues, which are interwoven with the study of sexuality. Systematic exploration of shifting dynamics of sexual scripts in Portugal, focusing on their cultural specificity, for a generational and gender-based analysis, is needed. These interactions will be analyzed through the plural and profound changes that the Portuguese society has undergone over the last four decades, following almost 50 years of a right-wing dictatorship which has affected sexuality and intimate relationships. In the 50's and 60's, Portuguese society was mainly conservative and strict in matters of sexual morality, and sexuality was a domain whose knowledge and rules were supposed to follow the restrictive moral teachings of the Catholic Church. Men's sexual freedom contrasted with the purity and containment requirements placed on women (Aboim, 2013; Freire 2010; Policarpo, 2011). Findings will be interpreted within this specific cultural context.

Our central hypothesis is that not only sexual experiences are influenced by the emergence of sexual function changes, but also the definitions of healthy and normal sexualities are shaped by their continued existence. It is then hypothesized that men, and women, will differ in their experiences of SPs, and that their experiences will influence their representations of SPs.

This article investigates how men and women's experiences and representations of SPs are shaped by sociocultural factors and how SPs are socially constructed by individuals and their intimate relationships. We tried to understand more specifically how men who experience SPs, particularly ED, recognize, explain, and interpret this reality, and how they introduce it in their daily lives. We also intend to explore how the growing plurality of sexual scripts impacts the gender order. In addressing these questions, we draw on the data collected through an empirical research using the mixed methods approach, which integrates both quantitative and qualitative strategies.

Methods

Sexuality, intimacy, and sexual problems are complex and multifaceted phenomena, impacted by sexual and non-sexual variables. A plurality of methods is required to develop a comprehensive understanding of men's and women's sexual experiences and representations. The use of a multi-method approach is expected to produce richer evidence to the understanding of sexual problems, namely erectile difficulties, in everyday life, through the dialectic process between inductive and deductive theoretical development (Pearce, 2012). Data collection strategy was formulated so as to include a quantitative component preceding a qualitative one, in order to optimize the sample for diversity and to overcome the sensitivity challenge of conducting face-to-face interviews on the topics of sexuality and intimacy.

This article draws on the data from the *Sexual Observational Study in Portugal* conducted between January and September 2011 in Lisbon primary health care centers (Alarcão et al. 2012). After obtaining the participants' written informed consent to be interviewed and their permission to be identified and sampled for a second qualitative component, male and female users of the collaborating centers were systematically invited to participate in semi-structured interviews.

The interviews of both quantitative and qualitative components were conducted in a private room of the participating units by male interviewers for male users and female interviewers for female users. The setting was made socially acceptable and comfortable to the participants for discussing their sexual lives. The interviewers were psychologists with special training on the topics under study and were known to follow good practices guidelines for sexuality surveys (Kinsey, Pomeroy, & Martin, 1948).

Data collection and analysis procedures will be detailed at first for the quantitative component and secondly for the qualitative one. In the quantitative study, each participant was interviewed using a standardized survey questionnaire, divided into two parts, one dealing with questions concerning socio-demographic variables (e.g., sex, age, marital status, religion, educational attainment and occupational characteristics) and sexual health questions (e.g., self-report of sexual problems), and the other dealing with self-administered questions of the interviewee for assessment of sexual activity (e.g., number of sexual partners in the last 12 months, frequencies and intensities of sexual intercourse), sexual knowledge, and practices and beliefs about sexual problems (e.g., causes of sexual problems, sexual problems of the partner). Sexual function was assessed using the International Index of Erectile Function (IIEF) and the

Female Sexual Function Index (FSFI), the most widely used worldwide and validated self-completion questionnaires (Lewis et al., 2010), including Portugal (Peixoto & Nobre, 2015; Quinta Gomes & Nobre, 2014).

Whereas FSFI provides a global score for overall sexual function in women, it provides only normative scores for the IIEF erectile function domain (Rosen, Revicki, & Sand, 2014). Based on a prevalence study (Veronelli et al., 2009) and the FSFI mean score in the current sample, a cut-off score of 25 was used for erectile dysfunction domain of the 15-item IIEF (Rosen et al., 1997), 5 for the hypoactive sexual desire domain of the FSFI (Gerstenberger et al., 2010), and 29 for overall female sexual dysfunction. We found that the internal reliability of the total IIEF/FSFI scores and erectile function domain ranges from good to excellent, with Cronbach alpha's >0.9, and =0.8 for the female sexual desire domain.

Quantitative data was coded onto SPSS 20.0 database and checked for accuracy. Descriptive and inferential statistics were performed to investigate how sociodemographic characteristics influence self-constructions of SP, and thereby help to identify possible associations between age and education, and lay representations of SP causes, among men and women with and without SP.

Although not representative of the Portuguese adult population, our sample (323 men and women) reflects a good level of diversity, in terms of socio-demographic characteristics (**Table 1**).

Following the sampling strategy of Mitchell et al. (2011b) and to maximize the variation in sexual function experience, the interviewees were categorized, based on the presence or absence of sexual difficulties. Those participants who gave their consent to remain in the study and provided a telephone number (n=245, 76%) were then randomly selected and invited for in-depth interviews, lasting about an hour.

The open-ended questions of the interview probed the participants' perceptions of their sexual experiences and their views on satisfactory sex life (see **Box 1**). Background information of previous questionnaires facilitated connections between experiences and representations of sexuality and various facets of identity. The discussions were audio taped, transcribed, and labeled according to the type of information. The transcripts were checked against the original recordings as a continual process of revision (Davidson, 2009).

To explore the conceptions and representations about SP, namely ED, participants' narratives were analyzed through Bury's (1991) concept of illness as biographical disruption. The analysis highlighted, particularly, the tensions between the past, lived as the 'normal time', and the present, wherein the subjective experimentation of the new 'self' happens and the current identity is 'rebuilt' or the 'old' one is reinforced.

The participants included 10 heterosexual men and 15 heterosexual women. Of these women, 5 reported to be having partners with ED, and therefore this analysis focused on the views of those women concerning their partners' SPs. This approach was adopted to contribute to the research of the partner's perspectives and desires and to the specific dynamics of a relationship, information on which is still lacking (Potts et al., 2003).

For typology construction, Kluge's (2000) model of empirically grounded type construction was used in different stages of the analysis: 1. Development of dimensions, relevant to the analysis; 2. Grouping the cases and analysis of empirical regularities; 3. Analysis of meaningful relationships and type construction; and 4. Characterization of the constructed types. Our purpose was neither to establish an absolute typology nor to obscure its intra-types' singularities. The ideal-types should be considered as theoretical and methodological constructions aiming at capturing the diversity of the responses to dominant sexual scripts, and highlighting certain characteristic traits. It must be pointed out, however, that the assignment of informants to the constructed typology was not linear, because the process of making sense of and shifting sexual practices and desires is shaped by cultural and personal experiences, as explained. Nonetheless, and despite the fact that individuals shared some characteristics of more than one ideal-type, the allocation to a single type remained heuristic in nature.

Table 1. Sociodemographic characterization of the participants

	Men (n=143)	Women (n=180)	Total (n=323)	p-value
Age in years, mean±SD	54.1±15.8	42.6±15.9	47.7±16.8	**<0.001**[1]
Age-wise group, n (%)				
18-39	30 (21.0)	84 (46.7)	114 (35.3)	
40-59	50 (35.0)	60 (33.3)	110 (34.0)	**<0.001**[2]
60-80	63 (44.0)	36 (20.0)	99 (30.7)	
Marital status, n (%)				
Single	22 (15.4)	40 (22.3)	62 (19.3)	
Married/living together	94 (65.7)	110 (61.5)	204 (63.4)	0.278[2]
Divorced/separated or widowed	27 (18.9)	29 (16.2)	56 (17.4)	
Educational level, n (%)				
Until the 7th grade	59 (41.3)	67 (38.3)	126 (39.6)	
Until high school	64 (44.8)	79 (45.1)	143 (45.0)	0.771[2]
Some college graduate	20 (14.0)	29 (16.6)	49 (15.4)	
Employment status, n (%)				
Employed	61 (42.7)	106 (58.9)	167 (51.7)	
Unemployed	13 (9.1)	36 (20.0)	49 (15.2)	**<0.001**[2]
Retired	65 (45.5)	31(17.2)	96 (29.7)	
Other	4 (2.8)	7 (3.9)	11(3.4)	
Religion, n (%)				
No religion	20 (14.1)	25 (13.9)	45 (14.0)	
Catholic	115 (81.0)	128 (71.1)	243 (75.5)	**0.030**[2]
Other	7 (4.9)	27 (15.0)	34 (10.5)	

SD: standard deviation; [1] Mann-Whitney Test; [2] Chi-Square Test.

Bold numbers indicate statistically significant correlation ($p < 0.05$).

Box 1 – Excerpt from the interview topic guide

- *What is the meaning of "sexual health" for you? What represents "normal sexuality" for you?*
- *How would you describe "sexual activity"? What sexual practices do you consider sexual activity?*
- *What is satisfactory sexual activity for you?*
- *Do you consider sexual dysfunction a disease? According to you, what are the main causes of sexual problems?*
- *What represents for you being a man/woman? Did the way you see yourself as a man/woman change since you started having sexual problems?*

Results

Sexual functioning based on survey data

Overall, 31% of the 323 participants reported at least one sexual problem (SP): Among men, 22% reported of erectile difficulties, and 11% of decreased sexual desire and also of ejaculation problems; among women, 19% reported of decreased sexual desire, 13% of sexual arousal disorder and of painful intercourse, and 10% of orgasm disorder. The prevalence rates of men's ED and female's decreased sexual desire, measured by the IIEF and the FSFI, are higher than the self-reported rates, indicating that changes in sexual function may not always represent a sexual problem of the individuals.

Considering SPs as important personal turning points, comparisons were made to explore lay representations about SP causes among participants with and without SP (**Table 2**). The major lay representations reported by the participants without SP are *stress* (65%), *relationship difficulties* (59%) and *psychological issues* (54%); the ones reported by the participants with SP are *stress* (58%), *physical causes* (57%) and *lifestyle factors* (53%). The main causes attributed to the self-reported SPs of both genders are more related to medical factors than to psychological factors. However, there are differences between men and women. Compared to women, more men reported both medical and psychological causes.

Table 2. Lay representations of the causes of sexual problems among men and women, with and without sexual problems

	Without SPs n (%)			With SPs n (%)		
	Men	**Women**	**OR**	**Men**	**Women**	**OR**
Medical Factors[1]	**83 (90.6)**	**86 (71.1)**	**1.37***	**43 (97.7)**	**45 (81.8)**	**2.26***
Physical causes	60 (62.5)	31 (25.6)	1.56*	31 (70.5)	25 (45.5)	1.05*
Medical conditions	62 (64.6)	32 (26.4)	1.62*	31 (70.5)	11 (20.0)	2.26*
Related to medications	56 (58.3)	9 (7.4)	-0.85*	33 (75.0)	6 (10.9)	3.20*
Age	57 (59.4)	14 (11.6)	2.41*	31 (70.5)	9 (16.4)	2.50*
Lifestyle	59 (61.5)	45 (37.2)	0.99*	35 (79.5)	17 (30.9)	2.16*
Psychological factors[2]	**85 (88.5)**	**102 (84.3)**	**0.36**	**41 (93.2)**	**39 (70.9)**	**1.72***
Psychological issues	72 (75.0)	45 (37.2)	1.62*	36 (81.8)	15 (27.3)	2.49*
Relationship difficulties	69 (71.9)	60 (49.6)	0.96*	33 (75.0)	18 (32.7)	1.82*
Stress	78 (81.3)	64 (52.9)	1.35*	38 (86.4)	19 (34.5)	2.49*
Sexual inexperience	30 (31.3)	8 (6.6)	1.86*	20 (45.5)	2 (3.6)	3.10*

SP = Sexual Problems; With SPs = At least one SP reported (*erectile difficulties, decreased sexual desire* and *ejaculation problems* among men; *decreased sexual desire, sexual arousal disorder, painful intercourse*, and *orgasm disorder* among women); Without SPs = No self-reported SPs.

OR = odds-ratio; *$p \leq 0.01$.

Note: Participants were given a list to indicate *the factors they consider as sexual problems' causes, in general*?

[1] At least one of the medical factors reported.

[2] At least one of the psychological factors reported.

To identify other sociodemographic predictors of lay representations of SP causes, besides gender, several logistic regressions were carried out for individuals with and without SP, and the overall population (**Table 3**). Age and religion are found to be sociodemographic predictors of lay representations of SPs related to medical causes, while age and education are found to be inversely related to psychological causes. In this sense, the older and catholic participants reported more causes for medical factors, and the younger and higher educated people for psychological factors. Gender, however, is the only variable, which remained with statistical significance in the adjusted model for psychological causes. These models should be considered merely exploratory, because no variables other than the sociodemographic ones were included in the analysis.

Table 3. Lay representations of the causes of sexual problems and sociodemographic predictors (Odds ratio)

	Medical factors[1]				Psychological factors[2]			
	With SPs	**Without SPs**	**Total unadjusted**	**Total adjusted**	**With SPs**	**Without SPs**	**Total unadjusted**	**Total adjusted**
SPs	-	-	-0.71**	-	-	-	-0.39	-
Male	1.22	1.30*	1.39*	1.18*	2.38*	0.59	0.83*	1.23*
Age	0.06	0.01	0.03*	0.03**	-0.02	-0.30	-0.02**	-0.02
Married	0.25	-0.07	0.22	0.08	0.04	-0.03	-0.25	-0.17
Education	0.58	0.13	0.42	0.35	0.01	-0.60	-0.77**	-0.35
Employment	0.57	0.62	-0.09	0.35	0.90	-0.20	0.55	0.24
Religion	1.31	0.28	0.67**	0.41	-0.60	-0.13	-0.62	-0.37
Nagelkerke R^2	0.33	0.12	-	0.14	0.23	0.09	-	0.11

Note: Participants were given a list to indicate *the factors they consider as sexual problems' causes, in general*?

[1] At least one of the medical factors reported (*physical causes, medical conditions, related to medications, age, lifestyle*).

[2] At least one of the psychological factors reported (*psychological issues, relationship difficulties, stress, sexual inexperience*).

SPs = Sexual Problems; With SPs = At least one SP reported (*erectile difficulties, decreased sexual desire* and *ejaculation problems* among men; *decreased sexual desire, sexual arousal disorder, painful intercourse*, and *orgasm disorder* among women); Without SPs = No self-reported SP.

*$p \leq 0.01$; ** $p \leq 0.05$.

A typology of sexual problems' experiences and representations based on in-depth interviews

An explanatory typology was developed to capture the diversity of SP's experiences and representations and to understand the meaning of SP from a lay perspective. The typology, which aimed to focus the Portuguese specificity in terms of subjective experience of sexuality, intimate relationships and SPs, was constructed semi-inductively from the interviews. It was anchored in the theory of sexual scripts (Simon & Gagnon, 1986, 2003) in articulation with the theory of reflexive modernity (Giddens, 1991, 1992) and the concept of biographical disruption (Bury, 1991, 2001), for understanding the processes associated with the narratives of subjective experience of SPs.

A typology with four ideal-types of sexual experiences emerged from back and forth movement between data and theory. In the first *strict conservative* ideal-type, the gender scripts related to sexual moral and behavior tend to be strict, and individuals tend to naturalize sex and medicalize SP. The degree of reflexivity and critical distance regarding hegemonic models of sexuality is very low or non-existent and the narratives are focused on sexual function loss. In the *traditional attenuated* ideal-type, compared to the first one, gender inequality is attenuated and individualization of sexual biographies increased. However, as in the previous type, sexual narratives are predominantly medicalized and the understanding of the causes and background of SP remain imbedded in the biomedical domain. In the *progressive adaptive* ideal-type, heteronormativity is still present, but the experiences become fluid, and the focus and adaptive practices keep changing. There is room for change at the individual level, and sexual narratives are introduced in a positive way; the narratives demonstrate the ability to overcome gender inequality. Participants of the fourth *confluent transformative* ideal-type represent Giddens' concept of 'confluent love' or 'opening oneself out to the other', based on individual choice and individual fulfillment (Giddens, 1992). Some of our 'confluent lovers' defy normative sexuality and prioritize non-sexual relations or dimensions of their lives. The reduction of the sexual act to penetration is contested, and there is fluidity of their experience and resistance to heteronormativity.

Strict conservative type

In this first ideal-type, sex is seen as a biological act, although elements of a more relational script might also be present (Mitchell et al., 2011b). Sexuality, necessarily heterosexual and perceived as an obligation in marriage, is largely seen as a means to procreation. Social

scenarios within marital relationship are not diversified and sexual practices are centered on the coitus imperative. The fulfillment of a biological need can be conceived as a way to legitimate infidelity, as conveyed in *Joaquim*'s narrative about a 57-year-old man married for 40 years: *"my wife is sacred, she's at home, she's the mother of my children, takes care of the house, takes care of me. And if I have daydreams, I search for it in another place."* Men separate the biological need of sexual satisfaction and the experiment of different forms of sexual practices from the holiness attached to their marriage.

SP etiology is linked to physiological causes, such as diabetes and hypertension, or the intake medications. Also, the way of coping with SP, namely ED, is strictly biomedical, considering sexuality merely as any other aspect of health. Men usually seek treatment through general practice, addressed specifically to treat physiological changes, such as Viagra. Nonetheless, these treatments are widely equated to other medications, as stressed by *Joaquim*: *"Usually, medications are like that… to do some good to one thing they cause harm to another. (…) Medicine is evolving; they will come up with something that (…) has minor side effects".*

Sexual performance is evaluated based on erection, orgasm and ejaculation. It is presumed that penetration and orgasm are necessary to sexual and relational satisfaction, and when there is no penetration, satisfaction is not complete. Once sexual performance does not fulfill the expectations, it leads to frustration. For instance, *Maria Rosa*, 58, married for 38 years, tells how her relationship has deteriorated because of her husband's ED: *"He prefers not to have intercourse. (…) I don't say anything either, so he won't feel bad (…) We used to fight a lot."* In the same way, *Maria do Carmo*, a 67-year-old retired woman explains how her relationship with her husband changed drastically: *"When we got married, he just lean against me and had it* [erection]. *Now he feels angry."*

Changes related to age are considered in association with the idea of loss. The onset of SP, particularly in terms of erection, is associated with a 'decline narrative' (Potts et al., 2006). Men focus only on the loss of their capabilities in comparison with their youth faculties, as pointed out by *Joaquim*: *"A man with sexual ability feels more accomplished. When we see it declining, we are getting older."* For him, the idea of loss and deterioration is also visible when he talks about how his marriage of 40 years deteriorated: *"Normally, sexual act, for people in this age, follows a routine (…) is almost an obligation. There are exceptions, but… after many years of marriage the woman offers always the same thing."* In some cases, instead of adjusting their expectations, men only seem to accept that sexual life has a different dynamic, leading to the persistence of negative feelings towards sexuality (Mitchell et al., 2011a).

From women's sexual narratives, a moral obligation to engage in sexual intercourse with their husbands emerged (Potts et al., 2003):*"(...) a way of woman to provide a service to her husband and vice-versa, and the whole body to function"*, as narrated by *Maria José*, a 54-year-old Christian woman, married for 37 years.

Traditional attenuated type

In this ideal-type, sexual scripts are predominantly relational and turn to marital guidance (Mitchell et al., 2011b), wherein sex serves to establish and maintain the relationship, besides serving as a source of gratification, especially in men's case, and as a form of satisfying the partner, in the case of women. *Francisco*, a 64-year-old married man, explains thus: *"Sexuality is part of the couple, part of everyday life (...) If sexuality didn't exist, the world would come to an end."*

The importance of sexuality for the couple is clearly expressed in the narrative of *Pedro* (61 years old): *"*[A normal sexuality is] *to have a real relationship with the partner one has chosen, it's the most normal thing. One has his house, his partner, is no exception to the rules. When there is marriage, there is love, and sex is a complement of all that activity. Then we have children… (...). Essential."*

In these men's narratives, mutuality emerges as a necessary issue in sexual function. Although erection and orgasm are valued, and sexual satisfaction remains dependent on sexual performance, affective issues assume greater importance in their sexual life, as expressed by *Manuel*, a 66-year-old divorced man: *"Sexual activity is to have sexuality, not just intimate relations, but with affection, during and when both agree, when both are willing."*

Unlike the previous type, in this type, instincts are overtaken, because men have the capability to guide them in a responsible way, as explained by *Manuel*, who criticizes excessive pursuit of instincts in sexuality: *"Obviously there is a lot more besides the instinct. That would take us to a quick copulation with someone we want at the time, and that happens by chance. It was limited to that."*

Women assume an important role in the process of coping with problems and often advise men to seek help (Potts et al., 2003), as narrated by *Carlos*, a 65 year old woman: *"…those things need a doctor, you have to talk to a doctor, there is no reason for embarrassment'."*

The end of sexual life is normal and inevitable, as observed by *Pedro*: *"The life of a couple is not only about that sexual part. It completes the couple. If one thinks that's natural that it will end little by little, when it ends, it ends."* Seeking treatment is highly valued as a way to cope with SPs. Men generally try to change the circumstances for gaining sexual satisfaction by seeking a solution to their problems, but they do not alter the goals of sexual function (Mitchell et al., 2011a). Sexual practices remain unchanged, despite the value men give to affective issues, such as intimacy.

Physiological causes continue to be indicated as SP causes, but there is a wider view. For instance, *Pedro* says thus: *"Everything depends on the state of the person, whether physically or psychologically. (…) Sometimes, it's psychological situations that have nothing to do with the sexual part (…). If a person has a (…) quiet life, without troubles, it will fade away, but it continues until a certain age."* Men also hold a critical view about treatments, albeit they don't enact diversified strategies. While struggling with SP, the general practitioner is perceived as a relevant figure throughout the process of seeking treatment.

Progressive adaptive type

In this ideal-type, sexual performance is less valued and men emphasize mainly relational aspects, associated with mutuality and intimacy. *Jorge*, a 68 year old married man with erectile difficulties, values marital intimacy and considers that orgasm is not the center of his sexual practice, as is evident form his narration: *"For me, it is better before the orgasm, rather than after, it has always been."* Praising emotional issues, *Jorge* tries to satisfy his wife, as can be made out from his line of thinking, which goes thus: *"I try to please her too (…). If it's just me, it's not worth it either. She's not there only to cook and iron."* He also mentions that he compromises whenever his wife is not capable of having intercourse, as she suffers from pain during sexual act.

Although *Jorge* did not talk to his wife when he began to take Viagra, she understands that his capabilities are no longer the same as they were. In return, he understands his wife's problems of pain and lack of lubrication. He developed strategies to adjust his life and live with a gap between goals and circumstances (Mitchell et al., 2011a), namely by engaging in avoidance of sex work, in order to hide his SP, and thus does not have to deal with frustration: *"There were times she couldn't but I wanted to, but then, as she couldn't I didn't try either. She found it odd."*

Isabel, 49 years old, complains that her husband is somewhat reluctant to consult a health care professional for his problem; instead, he often asks her to do it for him. Thus, in a joint movement, they always try to enrich their sex life with different practices and routines. *Clotilde*, a 63 year old woman, with severe sexual difficulties, also refers to the adjustments she and her husband made to suit the circumstances.

Indeed, emotional highlight is necessary to dealing with sexual difficulties, when they are put in perspective (Mitchell et al., 2011a). We can find this approach in *Jorge's* discourse, when he says the problem does not affect his day-to-day life: *"If I can't today, I can tomorrow, but it doesn't affect me at all… I live my life normally."* As only one side of his existence, he adds that he will eventually be able to accept the end of his sexual life: *"Why should I think I will be sexually active until 90 years old? Maybe at 70 or 80 I won't be able to do it. It wouldn't be bad. (…) There's life* [beyond that]*."*

In this type, men tend to adopt 'progress narratives', finding ways to overcome SP (Potts et al., 2006). Even though there is no adaptation in terms of sexual practices, and biomedical strategies may still be searched for, these men are able to resume a positive experience of their sexuality, as exemplified by *Jorge*. He sought for help, adjusted his medication, took Viagra, and readjusted his sexual performance. To achieve this, *Jorge* had to overcome shame, namely when he was consulting his doctor, and when he got Viagra at the pharmacy: *"I felt a little bit embarrassed… I had to walk around looking for pharmacies, because the pharmacy where I usually go with my prescriptions has ladies there."* He was able to overcome constraints and build a positive experience, to the extent that he no longer needs Viagra.

Confluent transformative type

In this last ideal-type, sexual scripts are detached from traditionally imposed norms, and individuals may develop new ways to live their sexuality. *Artur*, a 49-year-old man, adopted celibacy after his divorce, denying all sexual involvements. He suffered from premature ejaculation, but confessed that it never conditioned his sexual life. Rather, he adjusted his daily existence to loneliness and refused to get involved in meaningless adventures: *"I'm much pickier now, I don't accept any person. Adventures: zero! They create problems and hassles, mostly when there are feelings involved."* Premature ejaculation worked as a regulator preventing him from engaging in problematic relationships: *"If I didn't have that problem, I would have been involved in excesses. This problem controls it."*

When they have an active sexual life, men move away from a biological perspective regarding sexuality and set up a dynamic view that values mutuality, intimacy and evolution. Sexuality is by far regarded in a dual perspective, where the partners' needs and desires are respected and valued. Men's sexuality is centered on giving and receiving pleasure, an idea noticeable in *Paulo's* speech, a 44-year-old architect: *"Sexuality is part of the intimate relation I have with my wife. It's a way of getting close, staying together."* For him, sexuality goes beyond sexual performance and individual needs: *"It's not just the physical part, it also associates the emotional part, the way people engage, get involved… affection too. (…) it's every way they connect with each other."*

Men in this type contest the reduction of sex to penetration and consider this definition 'phallocentric'. Their narratives reflect their fluidity of experience and resistance to heteronormativity, as quoted by *Álvaro*, a 54-year-old widower*: "In a sexual relation, it's important, although we can just be playing, in terms of sexuality. It can be satisfying, without penetration."*

This view of sexuality is of great importance on the way these men face and cope with sexual difficulties, and the changes that come with age. These difficulties are relativized and framed in a personal and marital context of change and adaptation. Experiencing changes in the sexual lives of these men does not define their sexuality. *Paulo*, for instance, says thus: *"When two people live together, that happens (...) People adapt to one another and to the changes that happen concurrently. When that takes place, it's not negative at all. I think it's just positive."*

This type, like the previous one, is characterized by the use of 'progress narratives'; it is even 'heroic', as in this case, wherein individuals accept and overcome the various changes that happen in their lives, particularly those relating to naturalization of SP and menopause/andropause, regarded as signs of female/male aging. This 'heroic self' carries the idea of non-passivity in the face of problems and valorization of individuality, in a way that the changes are regarded as normal and having been framed in a process of personal growth (Bury, 2001), like the case of *Paulo: "Perhaps today I see sex in a different form and the intimate relation with the other person in a more comfortable way (…) So, perhaps what I pictured as a problem back then, I don't feel anymore. (…) I usually play football. When I was twenty I had a way of being on the field that I don't have today. It's no worse or better, is different."*

As age affects sexual function and experiences, new sexual goals and meanings also evolve. Consequently, men do not feel frustrated with the decrease in sexual activities'

frequency; they even say that sexual satisfaction improved with age, or what they say goes thus in *Paulo*'s words: *"We change. I may draw more pleasure from a relation today, even if didn't have any yesterday (...)."*

Communication with the partner is emphasized and has great meaning in the way men cope with SP. The presence of difficulties does not define the relation between the couple, and as *Álvaro* opines he and his partner are able to change their sexual practice in order to achieve pleasure: *"And nowadays there are several ways to provide pleasure. (...) If people are in a relationship, they have to understand each other and know each other's problems."*

Discussion

The present study enhances our knowledge of how representations of SP are shaped by sociocultural factors and how they contribute to the understanding of the subjective meanings associated with the experiences of SP, namely ED, highlighting their social construction. In this sense, this work is innovative, complementing some of the previous Portuguese sociological findings concerning sexuality, intimacy and SP dimensions (Ferreira et al., 2010), and triggering debate in areas still understudied, such as gendered sexualities over the life course (Carpenter, 2010), and health needs linked with 'practices of masculinity'. The use of the theory of sexual scripts (Simon & Gagnon, 1986) helped to understand the construction of subjective experience in its cultural, interpersonal and intra-psychic dimensions. Our findings are consistent with those of previous studies, in that they strengthen the idea that definitions of sexuality vary greatly, from more traditional gender relations-based scripts, wherein sexuality is limited to intercourse alone, to more confluent scripts, wherein sexuality is defined in a much broader context and sexual experiences are linked to sexual pleasure and viewed as an important element in the marital relationship (Masters et al., 2013). Moreover, this study adds to our understanding of gender differences and similarities concerning lay representations of sexual functioning (Mitchell et al., 2011b). We conclude that older men with SP tend to relate more to the biomedical script, while younger women, with higher education and without SP relate more to a more relational script.

Reading scripts as a dynamic process also revealed the emergence of new constructions in men's narratives by adapting or incorporating alternative scenarios, including rejection of the generally accepted social representations of sexuality and SP and their age-related limits. Our results support the findings of previous research suggesting that more flexible personal

definitions of sexual function enable individuals to cope better with SP. Indeed, the biomedical script does not fit well for older individuals to whom vaginal dryness or erection difficulties make penile or vaginal intercourse difficult or impossible, and the lack of sexual fulfillment stems from their inability to shift to a script that is more feasible in a specific life stage (Mitchell et al., 2011a).

The analysis of sexual function changes through the biographical disruption concept (Bury, 2001) reveals the singularities of men's stories, whose different styles highlight different forms of introducing the new 'self'. It also allows the identification of similarities and tendencies. Furthermore, the physical, relational, affective, and moral problems men suffer with the aging process are seen not only as a negative experience but also as a positive one.

In line with Wentzell's (2013b) findings concerning men's perceptions about SP, some of our men experienced ED as a failure of masculinity that required medical treatment, while others understood it as an embodied marker of 'mature masculinity'. Also our scripting approach enabled a comprehension that this 'aging respectably' underlined a shift from a sexual to an emotional focus without always challenging the traditional power dynamics of gender relationships.

Following others (Tolman & Szalacha, 1999), this study provides an example of how sociological research of sexuality can bridge qualitative and quantitative methods, while keeping life experience at the center of an inquiry. We described two separate and synergistically related analyses of interviews with Portuguese adults. We began with a quantitative analysis of men and women's perceptions of SP and their treatments, followed by a qualitative analysis of their voiced experiences of SP, namely ED, and concluded with a scripting theory analysis exploring the interaction between social location and reported sexual experiences. These analyses enabled us to quantify interrelated dimensions of sexuality and to understand sexual narratives qualitatively.

The complementary use of non-problematized sexual narratives in our sampling approach enabled finding a counterpoint to the medical models that pathologized sexuality changes, which some individuals may see as appropriate revisions and adaptations of sexual practice, like the decrease in sexual activity and the rejection of anti-aging sexuopharmaceuticals.

This investigation explored how sociocultural factors influence experiences and representations of SP and also the role of individuals in the construction of SPs, challenging

illness concepts and SD diagnoses and their treatments, but also putting on empirical evidence with clinical implications of changes in daily life. Results seem to indicate the existence of alternative models to the biomedical one, helping diagnosis, treatment and comprehension of SP experiences. By focusing on biographical disruption as a cause of illness (Williams, 2000), a new link between the sociology of health and illness, and the sociology of sexuality and aging, could be underlined.

The study of women's narratives showed a wide range of experiences both in relation to their partner's changes in sexual function and experiences with treatments and in relation to the changes in the nature of their sexual relationship, as illustrated in previous studies (Potts et al., 2003). There were also brought out similarities between men and women in terms of sexuality and intimacy dimensions, while revealing differences in terms of age, education and social life. As hypothesized, our data show that men, and women, differ in their experiences of SPs, and that their experiences influence their representations of SPs. Evidence from several studies shows that differences between men and women are smaller than between men, and between women (Connell & Connell, 2002; Kimmel, 2000). Indeed, findings are consistent with Connell & Connell (2002) and Kimmel (2000) that perceptions are more variable amongst men instead of between men and women.

Final considerations

Our findings seem to reinforce the fact that the Portuguese society of the 21st century distances itself from the strict and conservative reality that reigned in the 1950's and 1960's (Aboim 2013). The study of the sexual lifestyles of men and women, at different stages of the life course and with diverse forms of partnerships, needs to be understood in light of changing social norms, demographic trends, and changing legislations and policies. If societies become more sexually liberal and gender differences continue to narrow, equal opportunities for sexual expression become more realistic. Research suggests that gender differences in sexual behaviors and attitudes are a product of gender differences in biological factors, societal power differentials, and social pressures to respond according to assigned gender roles. Trends in various cultures toward or away from societal gender equality, in turn, are likely to have implications for gender differences in sexuality (Petersen & Hyde 2011).

Data from the present study were drawn from men and women living in the Greater Lisbon area and our typology would have benefited from a more diverse and slightly larger

sample, enabling the analysis of group-specific scripts (Crawford & Popp, 2003; Fasula, Carry, & Miller, 2012). Nonetheless, the sample included men and women, other than the typical middle-class, college educated individuals who constituted the samples of many studies of sexuality. The results of this study can be particularly interesting to other predominantly Catholic countries where religion and educational factors play an important role in sexual scripts.

Ethical standards

This study has been approved by the appropriate ethics committees (Lisbon Faculty of Medicine and Lisbon Regional Health Administration) and has therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki and its later amendments. Also, permission from the Portuguese Protection Data Authority was obtained. All persons gave their informed consent prior to their inclusion in the study. To preserve anonymity, participants were attributed a code number in the survey and only pseudo names were used in the writing of the research.

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Conflict-of-Interest Statement

The authors declare that they have no conflict of interest.

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> *Discourse about sexuality does not take place in a vacuum but is a reflection of the concerns of the time and society in which it exists. Research itself has tended to reflect this, which priorities on what is important depending on what issues seem of most concern at any one time to significant segments of the population.*
>
> Bullough V. (1994: 241) *Science in the Bedroom: a history of sex research*.

IV – MAPPING SEXOLOGY IN PORTUGAL

Research script n. º4

The fourth article is part of a research into sexology as a science and profession in Portugal and aimed at understanding and interpreting the self-identifications of sexologists with the sexology and the meanings assigned to them. Additionally the emergency context of sexology in Portugal is described and its development compared with international trends.

Reference:

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Sexology in Portugal: Narratives by Portuguese sexologists

Abstract

This study aims to present the emergence and development of modern sexology in Portugal through the analysis of Portuguese sexologists' narratives, to explore how they commit to a professional identity as sexologists, and to discuss how they integrate their professional role into the vast multidisciplinary field of sexology. In-depth interviews were conducted with 44 key professionals purposefully recruited to guarantee heterogeneity concerning generation, gender, training, and practice. Content analysis focused on highlighting differences and articulations between the main professionals in the making up of the field. The findings indicate that sexology is not seen as a fully-fledged profession but rather as a specialization or a secondary field of action. Sexual medicine perspective is prevalent and more visible among physicians, thus, reflecting the gap between psychosocial and biomedical approaches. A close link between clinical work and research and a gap between clinical work and health promotion were found. Despite the multidisciplinary nature of sexology being acknowledged, it is not fully implemented by the experts in the field. However, it is this characteristic that permitted sexology to institutionalize and to legitimate itself as a discourse of truth about sex, in Portugal as in other countries.

Keywords: sexology; sexological training; clinical sexology; sexual education; sexual medicine; medicalization; Portugal

INTRODUCTION

Although sexology as a specific field of knowledge, practice, and the profession appeared in the second half of the nineteenth century (Ariès & Béjin, 1985; Bland & Doan, 1999), the field remains controversial and more challenged as the multidisciplinary nature of sexology strongly contributes for its "outlaw" (Zucker, 2002) and "dirty" characters (Irvine, 2014). Sexuality field produces paradoxical cultural reactions. This lead Irvine (2014) to study sexuality research as a form of "dirty work", an occupation that is simultaneously socially necessary and stigmatized, using Everett Hughes' (1958, 1962) dirty work paradox, in which society disavows a type of work, while at the same time recognizing it as a crucial form of labor. The constitution of sexuality research as dirty work has implications not only for the researchers which face barriers establishing academic legitimacy but it also affects the broad production of sexual knowledge and also sexological practice (Irvine, 2014).

Sexology is an "umbrella" term used to represent the multidisciplinary activities of groups of researchers, clinicians, and educators related to sexuality (Irvine, 2005). However, sexology and sex therapy, and more recently, sexual medicine, are not practiced in the same way in different cultures or even in the Western culture. The variations in professional practices of sexology relate to national and cultural contexts, training, organization of health services, and professional motivation (Fruhstuck, 2003; Giami, 2012; Kontula, 2011). In this study, the term sexologist was used to describe people with different degrees and levels of training who work as physicians, psychologists, nurses, midwives, therapists, educators, and researchers, in settings that can range from universities to nongovernmental organizations (NGOs), health care, hospital, government entities, and private practice, and who contribute directly or indirectly to the sexology perspective.

Many professionals do not recognize themselves as sexologists and the profession of sexology is still not completely recognized as an autonomous profession by public health authorities in most European countries (Giami, 2012).

Sexual science was first developed in Western Europe, and was centered in Germany until the Nazi persecution (Haeberle, 1981). In the United States, it was developed by mid of the twentieth century, and it has historically been a domain of stigma and immorality in Western societies (Bancroft, 2004). This factor explains why sexology, as a profession, remains "relatively obscure", and why the "sex expert" is still often the object of parody and sometimes rejection (Irvine, 2005). Nevertheless, sexology has increasingly grown from the twentieth-

century social transformations and sexuality modernization, meanwhile contributing to the progressive achievement of sexual rights (Giami, 2015; Parker et al., 2004) and towards the legitimacy of a sexuality focused on pleasure as a mean of individual self-realization (Giddens, 1992).

Focus and research questions

This article focuses on describing and analyzing the characteristics of the scientific and professional organization of Portuguese sexology through Portuguese sexologists' self-descriptions and reflections on this ongoing process. How did the Portuguese sexologists build a professional identity and how did they integrate their professional role into the vast multidisciplinary field of sexual health? The interpretation of the diversity of meanings attributed to the identity of sexologist was linked with the different positions held by the participants in the field, and related to gender and professional category (physicians and non-physicians). A discussion of some of the challenges for the evolution of the field was made using sexologists' own words, which is possible, as most of the Portuguese sexology founders are still working in the field along with other new recognized figures.

In this paper, firstly the diversity of sexologies among European countries is outlined. Secondly the factors of social, cultural and political nature, linked to the emergence of sexology in Portugal are briefly contextualized, followed by the identification of the institutional factors that have boosted its professionalization. Then the methodological procedures that have guided the analysis of different modes of identification of sexologist are detailed. In a third part, the empirical information resulting from 44 in-depth interviews with key professionals is described. Finally, the social and symbolic relevance of the emerging profession of sexologist in Portugal is discussed and some implications arising from this professional development to the role of sexology as a science and profession in general are briefly outlined.

The diversity of professional sexologists in Europe

Since 1998 the Euro-Sexo study group has been characterizing sexologists in particular European countries and comparing data (Giami & de Colomby, 2003; Wylie, de Colomby, & Giami, 2004). Thus, seven national western European contexts were described using the same questionnaire (Denmark, Finland, France, Italy, Norway, Sweden and United Kingdom) during

the last decade; however Portugal, as well as Spain, was not yet included (Giami & de Colomby, 2006).

The diversity of professional profiles in the general sexology practice across countries is interesting to observe (Giami & de Colomby, 2006). For example, in Finland (Kontula & Valkama, 2006) and in the United Kingdom (Wylie, de Colomby, & Giami, 2004), the nursing professions are prevailing, which is different from Portugal, Italy (Simonelli et al., 2006), or Norway (Almaas & Giami, 2006), where midwives and nurses are much less frequently represented. Midwives are a large and important group participating in sexology in Sweden (Fugl-Meyer & Giami, 2006), but they are almost inexistent in Portugal. General practitioners are prominent in France (Giami & de Colomby, 2003) and Denmark (Kristensen & Giami, 2006) but they are less represented elsewhere, just like in Portugal, where other professions are also very short in number of professionals, such as teachers, social workers, occupational therapists, or physiotherapists, contrasting with other countries. The diversity of professions involved in the practice of sexology may explain the internal tensions of the field and justify why the institutional contexts and cultural understanding of sexuality need to be investigated (Hall, & Graham, 2012).

The field of sexology, the definition of a sexologist and the pathway leading to the professional practice of sexology and sex-therapy are still unexplored in Portugal. Sexuality studies is inherently interdisciplinary and the multidisciplinarity of the professionals of the field represent a real challenge to this investigation. The members of the different professions differ in their characteristics and specificities, which are historically and geographically shaped. They occupy diverse hierarchical positions, and obtain different levels of prestige, power, jurisdiction and authority (Freidson, 1988). This heterogeneity has been present since the origin of Portuguese sexology. There is no clear and set path to become a sexologist in Portugal. There is no consensus on the definition either of a sexologist, or an enunciation of its competencies and an accurate description of their tasks.

Sexology in Portugal: Social, cultural, and political challenges

The Portuguese experience of sexuality was shaped in part by a 48-year dictatorship (1926-1974), which kept Portugal at the margins of European social and legal transformations that contributed to deep changes in gender relations, family life-styles and the acceptance of different sexual orientation or gender identity. Political and legal concerns about lesbian, gay,

bisexual, and transgender (LGBT) rights only took place in the 1990s as a corollary of HIV/AIDS activism (in the Portuguese case especially among physicians and patients) and were linked to the economic and social development of the country, and consequently, to mentality change (Almeida, 2010).

Concerning the legal landmarks for the understanding of the context of the emerging field of sexology and sexuality in Portugal, the first major moment in contemporary history is the democratic revolution on the 25th of April 1974 and the Constitution of 1976, which legitimized a number of important rights and guarantees and allowed for a progressive transformation of practices. The second event, which occurred in 1982, is the decriminalization of homosexuality, and it is also linked to the emergence of other claims. In the 21st century, the law of cohabitation in 2001 was in fact a landmark for being an inclusive law, which extended to the same-sex couples the same rights as opposite-sex couples living in a de facto union for more than two years. The revision of the Constitution in 2004 was especially important as it made Portugal the first European country and the fourth worldwide to prohibit discrimination based on sexual orientation in its Constitution. The decriminalization of abortion in 2007 represents a recent legal mark with a social and political debate that is still ongoing in Portugal. In 2010, Portugal became the sixth country in Europe and the eighth country in the world to allow same-sex marriage nationwide, but it became as the only country in the world where same-sex marriage is allowed without parenting rights. In 2011, the Law of Gender Identity was ratified, which simplified the process of sex and name change for transsexual people. Finally, the most recent ongoing discussion in Portugal is the "co-adoption" of the biological or adopted child of the same-sex spouse or partner, wherein that spouse or partner is the only legally recognized parent of the child.

Indeed, some of the most significant changes in the Portuguese sexuality field that highlight a tremendous contrast between the past and present took place among the dissociation of reproductive and erotic sexual activities, the possibilities of non-marital sexual activity, and the reconstruction of non-binary standards for gender identity (Aboim, 2013). As in many countries, sexologists played a relevant role in managing sexual diversity in Portugal.

Emergence and institutionalization of sexology in Portugal

The first phase of Portuguese contemporary sexology is characterized by having two groups of actors and two separate paths, wherein the one is of gynecology and the other one is of

psychiatry. The initial connection of gynecology to family planning and sexual and reproductive health was particularly important in the Portuguese society in the sixties. The populations lived in a situation of extreme poverty with high rates of maternal and infant mortalities, a high prevalence of clandestine abortion, and the absence of contraceptive methods and family planning services. With the legitimation of sexual rights and sexuality for pleasure, there are presently a few gynecologists dedicated to the study of the sexual function and satisfaction. The Family Planning Association (APF – Associação para o Planeamento da Família) marks the emerging phase of sexual and reproductive health in Portugal and currently remains a reference association in this area, having an active role in the development and implementation of sexual and reproductive health policies and sexual health education, namely through the sex education in schools and the creation of services for young people (Vilar, 2009).

Clinical sexology started in public hospitals in Coimbra, Oporto, and Lisbon in the late sixties, and especially after the restoration of democracy in 1974, by some psychiatrists interested in implementing Masters and Johnson's work and training for other professionals and research development (Albuquerque, 2010). Most of the pioneering psychiatrists are still prominent figures in the field of sexology and are particularly linked to its postgraduate education.

In the second phase of Portuguese sexology, two groups of key actors, urologists and psychologists, with a common path, focused on the physiological and psychological research of sexual functioning, and this can be characterized as the second generation of Portuguese sexologists. This period is also marked by the affirmation of sexology as a science of sexuality, which is the first step towards its academic legitimacy. SPSC (Sociedade Portuguesa de Sexologia Clínica – Portuguese Clinical Sexology Association) delivers a sexual therapist title since 1995, for those who have a medical degree or a clinical psychology background and have undertaken the two-year training program offered in that association. Other institutions offer academic but not professional certification such as masters' degree (Kontula, 2011). Nevertheless, the sexologists practice is little institutionalized in terms of control and protection of the title and professional status of sexology, and the professionals are willing to forego the same, given that the title of psychologist, and even more so, the medical doctor title, transfers legitimacy enough, in Portugal as elsewhere (Giami, 2012).

In brief, the first period of the emergence and institutionalization of sexology in Portugal was guided above all by the national specificities that are associated with the cultural context of the country such as the presence of family planning, the influence of the Catholic religion,

and the interest of some professions such as gynecology, psychiatry, or psychology. In contrast, the most recent phase of sexology is marked by the medicalization and pharmaceuticalisation of sexuality (Williams, Martin, & Gabe, 2011), with a movement of homogenization of sexual medicine centered in the pharmacological treatment of sexual dysfunctions. Despite the dominance of sexual medicine, there is also the presence of the perspective of sexual health in the field of sexology in Portugal that is based on psychosocial and educational approaches and focuses on sexual rights, with the support of human rights organizations. This recent phase of Portuguese sexology is contemporary of the third wave of the international sexology represented by sexual medicine, which came to light in the last decade of the 20th century (Russo, 2013).

METHOD

To understand and interpret the different modes of commitment to a larger professional identity as sexologists in Portugal and produce knowledge about the meanings attributed to sexology, a qualitative study was carried out based on in-depth individual interviews with key players from the field. Selection criteria included: (a) being founding members, former presidents, or active participants of an institution dealing with sexology; (b) being leading social science experts on sexuality with a role on the field of sexology; (c) being regarded by key participants as relevant actors in the field of sexology; and (d) being available and willing to be interviewed. Social scientists were included to broaden our view on the professional role of sexuality specialists and selected from those who addressed sexuality issues and often interacted with well-known sexologists, even if they did not acknowledge themselves as such nor considered themselves part of the field of sexology. No restrictions of professional category or specific training in sexology were applied. Informants underwent an initial selection process whereby representatives of two generations of sexologists, considering their starting role in Portuguese sexology field (role in establishing the field of sexology), were identified. One main criterion for this division was the training. The first generation did not receive any initial training in sexology in Portugal, and because they sowed the seeds of the training institutions, the second did receive training in sexology.

Participants

Our sample selection followed a purposive strategy to cover different profiles of sexologists and to guarantee generation, gender, disciplinary, and practice diversity among actors in the field of sexology, and also to capture the tensions across the network of professionals. First, using the Google search engine, we carried out an overall mapping of sexology in Portugal, which included creating a directory of a heterogeneous group of associations, societies, institutes, clinics, NGOs, research groups, and professionals linked to sexology, through which we could identify the key players in the field. Then the interviewees indicated other key professionals, which were also included. Fifty-five sexology and/or sexual medicine key professionals/experts in clinical practice, research and teaching, sex education, health promotion, and public media fields were identified. Among those, five were not reached, five accepted collaborating but we could not schedule the interview, and one explicitly refused to participate. The purposeful sample was made up of twenty-six men and eighteen women: half of them were physicians, and among the other twenty-two non-medical professionals, thirteen were psychologists, and nine were social scientists.

Table 1 shows the interviewed key professional's characteristics of the first generation, considering their starting role in the Portuguese sexology field. Therein, the first generation was made up of 13 men and no women (although two of the unscheduled interviews were women of the first generation), and among those, seven were pioneers in the field. The pioneers are a group of founders of the field of sexology that had the role of creating sexual health clinical services, professional associations, journals and handbooks of the specialty, and informal training of the following generations. This group of founders played a key role in the construction of the professional identity, being consensually referred by all other experts as central figures in the field. The second generation of 13 men and 18 women is presented in **Table 2**. As opposed to the first generation, the non-medical professionals represent the majority of the second generation, being the thirteen participating psychologists part of this larger group.

Table 1. First generation of key professionals interviewed

	Gender	Age	Area of activity	Original Profession	Specialization in Sexuality
1	M	60-70*	Oporto	Urologist	Clinical work
2	M	70-80*	Lisbon	Psychiatrist	Clinical work
3	M	70-80*	Lisbon	Endocrinologist	Clinical work, teaching and research
4	M	70-80*	Oporto	Psychiatrist	Clinical work
5	M	60-70	Lisbon	Endocrinologist	Clinical work and teaching
6	M	50-60	Lisbon	Social Scientist	Teaching, research and health promotion
7	M	50-60	Lisbon	Social Scientist	Teaching and research
8	M	70-80*	Coimbra	Psychiatrist	Clinical work and teaching
9	M	70-80*	Lisbon	Urologist	Clinical work
10	M	60-70	Lisbon	Social Scientist	Teaching and research
11	M	60-70*	Oporto	Psychiatrist	Clinical work and teaching
12	M	50-60	Lisbon	Gynecologist	Clinical work, teaching and research
13	M	50-60	Lisbon	Medical doctor	Health promotion

* Pioneers in the field.

Table 2. Second generation of key professionals interviewed

	Gender	Age	Area of activity	Original Profession	Specialization in Sexuality
1	F	30-40	Lisbon	Psychologist	Clinical work, teaching and research
2	F	30-40	Coimbra	Social Scientist	Teaching, research and health promotion
3	M	40-50	Lisbon	Endocrinologist	Clinical work and teaching
4	F	40-50	Oporto	Psychologist	Clinical work and teaching
5	F	50-60	Coimbra	Psychiatrist	Clinical work
6	F	30-40	Lisbon	Psychologist	Clinical work and teaching
7	F	30-40	Lisbon	Social Scientist	Research and media
8	M	50-60	Lisbon	Endocrinologist	Clinical work and teaching
9	M	40-50	Lisbon	Psychologist	Clinical work and teaching
10	M	40-50	Lisbon	Endocrinologist	Clinical work and teaching
11	F	40-50	Lisbon	Gynecologist	Clinical work and health promotion
12	F	50-60	Lisbon	Gynecologist	Clinical work and media
13	F	30-40	Lisbon	Psychologist	Clinical work, health promotion and research
14	F	40-50	Lisbon	Psychologist	Clinical work and teaching
15	F	40-50	Lisbon	Gynecologist	Clinical work and health promotion
16	F	30-40	Lisbon	Social Scientist	Research and health promotion
16	F	40-50	Lisbon	Psychologist	Clinical work and media
18	M	50-60	Lisbon	Social Scientist	Teaching, research and health promotion
19	M	50-60	Lisbon	Urologist	Clinical work, teaching and research
20	M	30-40	Lisbon	Psychologist	Clinical work, teaching and research
21	F	30-40	Lisbon	Psychologist	Clinical work, teaching and research
22	M	50-60	Lisbon	Medical doctor	Teaching and research
23	M	40-50	Lisbon	Social Scientist	Teaching and research
24	M	40-50	Aveiro	Psychologist	Clinical work, teaching and research
25	M	40-50	Oporto	Urologist	Clinical work, teaching and research
26	M	40-50	Lisbon	Psychologist	Clinical work and media
27	M	60-70	Lisbon	Psychiatrist	Clinical work, teaching and research
28	F	30-40	Aveiro	Psychologist	Clinical work, teaching and research
29	F	30-40	Lisbon	Endocrinologist	Clinical work and teaching
30	F	30-40	Lisbon	Social scientist	Teaching and research
31	F	30-40	Algarve	Psychologist	Clinical work and media

Procedures

This study has been approved by the appropriate ethic committee (Lisbon Faculty of Medicine), and permission from the Portuguese Protection Data Authority was obtained. To preserve anonymity, participants were attributed a code number in the survey, and information that could be used for the identification of participants (e.g., work/organization affiliation) was omitted. These measures were aimed at honoring confidentiality agreements between the participant and the researchers.

The experts' invitations were made by email and by phone, and interviews were booked on dates and places chosen by the interviewees. Most interviews were performed in private offices and only a few were performed in public places that provided privacy, and those were held by a sociologist and three psychologists knowledgeable in the field and have training in qualitative research. The interviews took place between November 2011 and April 2012 and lasted between 45 minutes and 2 hours. The semi-structured interview script was divided into three major areas to be completed: personal and professional trajectory; sexology as a profession; and the sexology field in Portugal.

Open questions were made to identify how the interviewees define themselves in a professional perspective and in the context of sexology and what motivated their involvement in the sexology field and their professional path in the area, considering clinical work, research, education, and teaching. We also asked how each expert was related to other experts and sexology areas. Additionally, we explored experts' perspectives about concepts such as sexology, human sexuality, sexual medicine, sex education, and sex therapy, and their integration, similarities, and distinctions. Finally, we asked about the future directions in sexology clinical work, research, and education.

Data analysis

Interviews were audio-taped and transcribed with the participants' informed consent. The systematic examination of the whole set of data of interviews was carried out throughout the application of an objective coding scheme technique, which is the content analysis.

At the first step, exploratory data analysis focused on identifying and describing the broad themes (such as professional trajectory, professional identity, profession frontiers, and collaboration with other fields), which were inserted in an Excel spreadsheet. Then, a more detailed interpretative analysis was intended to capture the process of professional identification to sexology and participants' perceptions and experiences and the way they make sense of their

activity in the field of sexology. At this stage, we followed a grounded theory approach with Charmaz's (2003) open-coding strategy. This method of conducting the analysis of data results in the identification of new categories and dimensions that goes beyond the dimensions elicited by the initial script.

The analysis was conducted in three sequential steps independently by the four researchers who performed the interviews. First, each researcher attached labels to segments of data that depicted units of significance while bearing in mind the structuring dimensions that have been developed in the preparation of scripts for the interviews. The extraction of the gradually emergent main themes enabled the filtering and the sorting of the collected data, giving a handle for making posterior comparisons with other segments of the discourses. The purpose was to ensure that the essential contents were preserved, but a manageable short text was produced. Subsequently, inter-researcher agreement was achieved so any differences found could be reconciled for each code and both formed together the categories and dimensions that emerged from the material. Then, the final set of dimensions and categories were once again confronted with the ones that supported the scripts for the interviews to assure that the main questions, which guided the data collection, were answered by the analysis (Mayring, 2004).

The theoretically generated themes, which are grounded in empirical data, to be presented in this article are: *professional trajectory, professional self-identification to sexology, sex education, sexual medicine and sex therapy, pharmaceuticalisation of sexology, sexological perspectives on gender,* and *the journey of sexology*.

RESULTS

A profession?

The first major consensus among the interviewees is that they consider that sexology, as a scientific knowledge, has a multidisciplinary main characteristic; and the second is that sexology is not a profession in itself, but it is mainly seen as a secondary main professional specialization. The fact that there is no academic recognition of sexology is also associated to an absence of the pursuit of an academic career: *I identify myself as a psychiatrist, who later got a subspecialty in sexology, which did not exist in the Medical Association nor was officially recognized in Portugal. This was an option that did not correspond to any university career* (Male psychiatrist, first generation).

As can be inferred by the following quote of a male social scientist of the first generation of sexologists, the multidisciplinarity and the multiprofessionality are the two sides of the same coin:

> *I don't designate myself as a sexologist, and I don't like being called a sexologist. There are people who call themselves sexologists. Because I consider that sexology is an interdisciplinary area, there may be physician-sexologists, sociologist-sexologists, lawyer-sexologists, anthropologist-sexologists, and psychologist-sexologists. I do not think that sexology is a profession. I consider that a sex therapist can approach a profession, although I consider that one should be considered [as] a psychotherapist and not specifically [as]a sex therapist* (Male social scientist, first generation).

A distinction between sexology and sex therapy emerged in almost all the participant's discourses, being the latter the professionalized area of practice in the field of sexology, as illustrated by a male psychologist of the second generation: *It is difficult to define a sexologist: 'one should not close it in a box'. In relation to a sex therapist, it is already possible to establish rules: training in sexology and in the area of sexual difficulties must have a clinical practice. Ideally, a sex therapist must have training in psychotherapy, even physicians.*

Training is in fact another aspect that influences social and self-representation of sexology as a professional activity. Authority and recognition depend on academic and practical training:

> *I'm a clinical psychologist, researcher, and sexologist. A sexologist is someone who has clinical training, did a specialization in the area of human sexuality, and has done theoretical and practical training with supervision. A sexologist ideally would have training in areas of knowledge [such] as medicine, psychology, anthropology, and sociology. This is a life[time] journey – acquired throughout the academic and clinical path* (Female psychologist, second generation).

Even though both physicians and non-physicians attribute value and pursue a specialization in sexology, the self-recognition of sexology as a professional identity varies among them, and is specially used by non-medical professionals, as illustrated by the following quote of a female gynecologist:

> *I'm also a sexologist, we, doctors, have some reluctance to accept the title. Because sexuality has taboos and so do we. Sexual medicine for doctors is a well-accepted thing,*

> *and another tentacle of gynecology, sexology comes from sex, it is yet another word. But it's true, I am also a sexologist, in fact it's what I do too. Even without wanting to and trying to defend myself and move towards sexual medicine*.

Tensions in the field: sex education, sexual medicine, and sex therapy

There is one major division emerging from sexologists' discourses, clinical versus sex education narratives, as expressed by the following quote of a male urologist:

> *Sex education is a completely different area to this [the clinical practice]. It is another world. It's something that I am not interested in. Firstly, I am skeptical about sex education* (Male urologist, second generation).

This division existed since the beginning of Portuguese sexology in the seventies, and it is still prevalent, corresponding to a separation of professionals and also of scientific societies in the field of sexology:

> *In Portugal there is an historical link of sexologists with sex education, especially via the Family Planning Association* (*APF) and not via SPSC. Because APF appeared earlier and many were militants of APF before the founding of SPSC (...), there was a division of labor between the SPSC, which was founded in 1984, and was devoted to clinical issues, as the name indicates (...) Nowadays, it remains the same* (Male social scientist, first generation).

In fact, this distinction is linked to a separation of areas of expertise: sex education, sexual medicine, and sex therapy. The Sexology Transdisciplinary Master degree of *Lusófona* University is separated into three major specializations: *Sexual medicine* for physicians; *Sexual psychology* for psychologists; and *Human sexuality* for social scientists, nurses, educators, and others. Both physicians and psychologists can do research, training, and clinical practice, while social scientists can do research and training mostly focused on sex education.

The physicians prefer the term sexual medicine, and social scientists state that sexology is a broader area of knowledge, which has always been connected to social sciences: *Sexual medicine cannot be confused with sexology. The life of the study of human sexuality is deeply tangled with the social sciences, particularly sociology and anthropology* (Male social scientist,

first generation). But, in fact, sexual medicine represents a broader area for physicians' practice, compared to andrology, as expressed by a male urologist:

> *I specialized in urology, and early on I dedicated a lot to andrology. Now, I don't like this term so much. I prefer sexual medicine, because andrology limited what I always really liked – it restricted me just to sex.*

For psychologists who practice both in the sexual medicine and sex education areas, but also mostly in sex therapy, sexology is the hat that fits: *I believe that sexual medicine has grown with the pharmaceutical industry, which contributed to further research but has been an opening for other perspectives* (Male psychologist, second generation).

Even though sexology in Portugal had psychiatrists as its fundamental pioneers, psychologists were soon called to help them in the first created consultations:

> *Sexology at its start had a very strong psychiatric component that is more than psychological. Psychologists were, I say, the helpers of psychiatrists. Who were the founders? Psychiatrists – all of them. Because psychologists also worked in these consultations, since its beginning the Sexology Society [SPSC] also involved psychologists* (Male social scientist, first generation).

Those professionals still work together nowadays in sexology consultations in hospitals, which also include other medical specialties in the clinical team, such as endocrinologists, such as the following male interviewee: *We work in partnership (...) I have had a lot of support and collaboration. I have learned a lot from these professionals (...) A multidisciplinary approach is fundamental in sexology.*

The psychologists working in hospitals corroborate this positive evaluation of a multidisciplinary collaboration in sexology:

> *Even when the doctor considers that it is necessary to take a drug for erectile dysfunction or premature ejaculation, it is always preceded by a psychological consultation. That's where a therapeutic plan is established with the patient, and the beginning of what will be the 'journey' that they will take together, the perception of what the symptom means and the reasons that led to the appointment (...) The consultation is an integrated team, the relationship couldn't be better, it is a true collaboration* (Female psychologist, second generation).

However, these collaborative teams are less frequent outside the hospitals services:

> *There are two types of clinical practice, which are in hospitals and the private practice. In the hospitals, it is easier to work with multidisciplinary teams because the patient does not pay for each consultation or [he/she] pays marginally, so it's easier to work as a team. I've always had psychologists and psychiatrists who were interested in me and whom I am interested in this field. In private practice, obviously, the first approach is we try to solve the problem by ourselves, and then if needed, [we] ask for help* (Male endocrinologist, first generation).

In reality, outside sexology consultations, referrals to other specialists seem to be less frequent: *There are few physicians referring to psychologists, because they don't understand that there are psychological and double bases to explain the problems* (Female psychologist, second generation). In addition, the growing idea that sexual dysfunctions are predominantly organic limits the referral to psychologists or even psychiatrics, as in the following male gynecologist's statement: *A lot of my colleagues, if they had a woman without desire, would send her to a psychiatrist. I think that is complete nonsense, because 80 percent of the complaints, frigidity, anorgasmia, postpartum frigidity, [and] dyspareunia, none of these are psychiatric.*

Pharmaceuticalisation and naturalization of sexuality in Portuguese sexology

Medicalization and pharmaceuticalisation (Abraham, 2010; Conrad, 1992; Williams, Martin, & Gabe, 2011) introduced a new dynamic in the field of sexology, and different positions coexist concerning the impact of the pharmacologic management of erectile dysfunction such as oral sildenafil citrate on the field.

First, there was an accentuation of the redistribution of powers among the different professionals in the field. If endocrinology had a strong influence at the beginning through the SPA (*Sociedade Portuguesa de Andrologia* – Portuguese Andrology Society), urology will become as the strongest working force, as it can be understood by the following quote of a first generation endocrinologist:

> *Currently, the SPA could be named Portuguese Society of Sexual impotence (...) Initially, the treatment of sexual dysfunction was very psychological with the psychiatrists. Then when drugs came, medicalization began (...). This was caught by*

urology, both here and worldwide. People who do research are mostly urologists. And they forgot that andrology is all of this.

In fact, not only urologists take a leading position in the field, but there was also a narrowing into the biological and medical, often felt by a sense of the lost essence of sexology.

I'm old school ... before there were pharmacological therapies ... Viagra, whether we like it or not, is a milestone in the history of sexology. I continue to appreciate the breadth of knowledge in sexology. Otherwise, it is reductionist (...) I don't give up on the other side, which at the beginning, when I started doing sexology, was valued by my Masters, and continues to be valued by me. I think now the training is more reduced to biological and medical sciences. And sometimes, we lose because they do not look at the individual at the social context [and at], the cultural context (Female psychiatrist, second generation).

Second, generally the expression "Sexual Revolution" is somehow felt as exaggerated for Viagra compared to the birth-control pill: *Viagra was a media topic. There was no sexual revolution. Viagra is an instrument of erectile dysfunction, a medicine. But it brought important changes at the level of sexual behaviors of the elderly* (Male social scientist, first generation).

Nevertheless, the term "sexual revolution" (Hekma & Giami, 2014) is somehow used, and the idea that it generalized as the seeking for help seems to be more or less consensual:

It's not a social humiliation to see a doctor to confess a particular problem of erectile dysfunction or other. And if you go back a few decades, it was unthinkable. And that's why I was comparing to mental illness. Nowadays, to say that one has a depression is almost a commonplace. And a few years ago, it wouldn't be, it would be almost a taboo. The same applies to the field of sexology [and] of sexual therapy (Female social scientist, second generation).

Associated to this "normalization" of sexual dysfunction in men, is the perspective that men increased their ability to expose their sexual difficulties and reveal information about their sexual lives.

Viagra, in Portugal, was launched in November 1998. It was a fantastic landmark. Not [only] because it was a pharmacological landmark, which it was. It was a pharmacological revolution. A very effective medicine appeared, but a physiological one. But [being] more than a pharmacological revolution it was a cultural

> *revolution. From that moment, it became a disease with a treatment, and patients began to come to the doctor spontaneously. This revolution hasn't existed in women (...). In order for female Viagra to provoke a pharmacological and cultural revolution, I don't believe it. The woman is too complicated, female sexuality is too complicated* (Male urologist, second generation).

This last statement also seems to indicate a pharmaceuticalisation effect of raising expectations for physicians and male patients, however, without the same "cultural revolution" on women's sexuality.

Less expressive, seems to be the link to the social and cultural context and the challenging of "normal" standard of sexual life, with the understanding that there are different sexualities that the Viagra phenomenon covered in a "McDonaldization of sex" process (Tiefer, 2004b):

> *The therapeutic arsenal brings great benefits for many people, particularly for those who want to use it, but not always the same benefits to the other person [of the couple] or to his own... There are people who have a poor sex life but they're OK with it, it's not a problem for them. By what right do we have to impose a standard that is a social pattern, a cultural pattern?* (Male physician, second generation).

Sexology, as a scientific knowledge, somehow risks to be consumed by the influence of medicalization and pharmaceuticalisation of sexuality:

> *In the SPSC, there were great discussions about who could be a member. Because when it is named Clinical Sexology Society, we must surrender to the evidence that only those who can practice clinic can be members. (...) But if we compare with sexual medicine societies, we are an extraordinary breadth. The name itself is curious. What does sexual medicine mean? (...) We speak of anthropology of sexuality, sociology of sexuality; it doesn't cross your mind to say sexual anthropology or sexual sociology. But medicine is imperialistic* (Male psychiatrist, first generation).

The journey of sexology in the sexologists' perspectives: A discipline or a multidiscipline?

The limits of sexology are the society evolution, the sexologists' skills and practice, and the social organization of the profession (Giami, 2012). Both limits are perceived as less tied and constraining by the Portuguese sexologists:

> *[Sexology] technically can be much more empowered than it was a few decades ago, when it comes to prescribing certain conduct or to intervene directly on the reproductive system, either surgically or with auxiliary sexual relationship, but increasingly, there is the understanding that what has always been learned by us as the bio-psychosocial aspects of sexuality, that was just a buzzword, a bottomless thing, and that people hardly understand without knowing the cultural location in which we grew up* (Male physician, second generation).

Sexology as a transdisciplinary field is a promised land, as said by a female psychologist of the second generation:

> *In theory, in academia, there is a desire of transdisciplinarity and multidisciplinarity. I speak to some colleagues, saying that I've been told that I was going to work in multidisciplinary teams and such cooperation on the basis of the objectives that we want to achieve would exist (...) In practice, I think that there are many obstacles for that to happen.*

Among the several obstacles pointed out are indeed organizational and economic-related factors but there are also social- and cultural-rooted issues, in particular the conservative fascist government that was in office until the democratic revolution of 1974 and was anchored in the Catholic religion, where the cult of the figure of the Virgin Mary has been seen as a castrating force for women's sexuality and one of the main pillars of *machismo*.

The main challenges identified by the key professionals interviewed concerned the different areas of practice: research, clinical practice, and training. In terms of research, despite Portuguese social scientists having always been involved in some of the major sexuality investigations, there also seems to be a long way to go, not only in terms of the themes investigated as well as its acceptance in the social science field. The growing recognition of tangled fields can also be a way of developing the field of sexology:

> *There's a long way to go. It also includes legitimizing the field of gender studies, feminist studies, [and] LGBT studies. In the first two examples, there are masters and PhD programs, there is an offer, albeit reduced, in Lisbon and Coimbra. In the LGBT area,*

> *it does not exist, it is still an empty space. (…) Things are moving; there are more and more people working in this area. A closer collaboration between feminist studies and LGBT area is crucial* (Female social scientist, second generation).

There is also the recognition that research would help the other areas of practice to develop, namely, the improvement of the clinical practice:

> *I would study the sexuality of sexual minorities (...) More easily there is a campaign to prevent HIV-Aids, in a medical preventive perspective, than how to practice anal sex with greater security, greater pleasure (…) This is the side that also interests me in sexology and that can also help people who I get in clinic* (Female psychologist, second generation).

And clinical practice also struggles with the recognition of its importance in the medical or therapeutic field:

> *Sexology continues to be the poor relation, if psychiatry is poor, then, sexology is extremely poor. Poverty is greater in the institutions. It has nothing to do with poverty neither of the patients nor of the theme. It has [something] to do with the institutions, which continue to depreciate sexology a lot, which is an extremely important area for patients. And we feel that in our skin, since I have a huge backlog of appointments for consultations* (Male psychiatrist, second generation).

DISCUSSION

Professional self-identification to sexology

The professional legitimacy of sex therapists, as well as sexologists, is an important and controversial topic, as shown by the peer commentaries (Bancroft, 2009; Kleinplatz, 2009; Tiefer, 2009; Štulhofer & Arbanas, 2009) on Binik and Meana's (2009) essay on the current state and possible future of sex therapy. "Sex therapy" is an ambiguous term, and even from a patient or client perspective, it is not clear who a sex therapist is or what they offer. Is a sex therapist a trained psychologist, a physician, or even a non-professional? In Europe, this term is replaced by ''sexologist'' to represent clinicians, from various specialties, with further training in the treatment of sexual disorders (Giami & de Colomby, 2006). Some of the ambiguity is because of the nature of sexual concerns, as they cannot simply be seen as

psychogenic (addressed by psychologists and psychotherapists) or organic (addressed by physicians and physical therapists) and the whole person/couple needs to be taken into account when dealing with a sexual problem (Nasserzadeh, 2009). Unlike physicians, psychologists and other professions that have been defined through profession laws and government approvals, there is no official registration and regulation of who is entitled to present him/herself as a sexologist. Training programs and international rule of the practice of sexology are in process (Kontula, 2011; Porto, 2006; Pryor, 2006).

After a century of development in the field of sexology and decades of attempts to establish the field of sexual medicine, in 2011, the Multidisciplinary Joint Committee of Sexual Medicine established the curriculum for training, recommendations of care, and assessment of physicians in the field of sexual medicine (Reisman, Eardley, Porst, & Multidisciplinary Joint Committee on Sexual Medicine, 2013). Although this qualification is not a license to practice sexual medicine, it offers professional recognition for those practicing or wishing to practice in the field of sexual medicine (Arbanas, Reisman, & Andrews, 2015). The professional characteristics and motivational factors of these sexual medicine specialists reveal a wide diversity regarding their country of origin, religious background, years spend in the field of sexual medicine, time frame of their work, and sexual problems they are working with. Therefore, the sociocultural context and diversity of the professionals and patients should be taken into consideration (Arbanas et al., 2015).

As explained by Giami & Russo (2013), investigations concerning the field of sexology have a double relevance. On the one hand, they provide a comprehensive view of how sexuality is being addressed by the diverse experts on the subject. As so, they have the potential of contributing to the formulation of public policy regarding the control and prevention of sexually transmitted diseases and for the promotion of sex education in schools and the development of sexual health as a specific field. On the other hand, they enable the understanding of dominant conceptions of sexuality and of the definitions of normal/functional and pathological/dysfunctional sexuality, and they may foster a consistent and critical discussion about the application of policies, theories, and practices (Brigeiro & Facundo, 2013).

Social and legal recognition of sexology as a profession is linked to the acquisition and validation of knowledge through academic training. Without a broader academic education, in particular the existence of post-graduate and doctoral degrees in sexology in Portugal, the institutionalization and academic legitimacy of sexology remains incomplete. Indeed, most specializations in sexology remain outside the universities or on the hands of the most

prestigious institutions and specialties in the academic and professional areas. Sexology has not yet become a specific academic territory in Portugal and is still being constructed as a form of "dirty work" by systematic practices of the university system imposing stigma effects that are not simply individual but constitute persistent patterns of institutional inequality (Irvine, 2014).

Sexologists and sexual health experts may choose, as many Portuguese sexologists do, social scientists and psychologists in particular, not to comply with "intellectual and political marginalization" (Tiefer, 2009) and get involved in the sexual promotion of sexual health focusing not only on its biomedical but also social dimensions. Interdisciplinary and overlapping fields of sexuality and LGBT and queer studies have been flourishing in Portugal, which are intimately bounded with feminist, queer, AIDS research and activism, and trans activism, indicating the field dynamics.

The gap between sex education, sexual medicine, and sex therapy

Portuguese sexologists view sexology as unified in its definition but multiple in its clinical and therapeutic practices, which constitutes the challenge of its identity, but also the richness of its potential vision of sexuality and social theory. Sexology in Portugal is, however, still fragmented between different disciplines; sometimes close in practice and collaborations, nevertheless, far away in cooperation and articulation in some cases, services, and professionals. Each and every perspective has sexuality as a scientific object, and sexology must embrace them all and also their interdisciplinary practice, to establish it as a transdiscipline, different from each of the bordering domains. A qualitative study with sexologists members of the Swedish Association for Sexology also pointed to different groups of sexologists in the sexology landscape (Löfgren-Mårtenson, 2015) and highlighted the need of an interdisciplinary approach among sexologists (Dupras, 2010). The principal similarity between sexology realities in the two countries lies between the Portuguese and the Swedish so-called pioneers, both in terms of its basic training (physicians) and the activities (creation of associations, training and clinical queries) and even in the strong dedication to sexology. Another common aspect relates to the recognition and valuation of the research's potential value in Sexology.

The gap found in Portugal between sex educators and clinical sexologists can be related to this distance from the activism and sexual health promotion, which requires public and

visible values on critical issues like abortion (legally permitted on the women's will in 2007), LGBT that had some rights conquered in a late yet fast way, among others.

Sexological practice in Mexico has searched for the production and installation of a normative order of sexuality based on scientific knowledge, especially through a biomedical vision. Sexological discourse has gained also an increasing position in the field of human rights, especially with regard to sexual diversity, suggesting the possibility of wider alliances with social movements (Alcántara & Szasz, 2012). This dual movement is also in place in Portuguese sexology. The new "broadly trained sexologist" will be able to produce better research, education, and clinical work (Cacchioni & Tiefer, 2012).

Also, the descriptions presented in the Colombia case support to identify the role that certain professionals played in transforming a whole system of sexuality and also to identify the obstacles they faced (Brigeiro & Facundo, 2013). Some of the Portuguese narratives in each of the areas of practice also illustrate this reflexive and activist aspect of sexology not exempt of difficulties and barriers against homophobia and heterosexism (Moita, 2006), framed within a heteronormative conception of gender that oversimplified male-female difference and ignores differences and exclusions within the gender categories.

Quoting Giami & Russo (2013: 10) work: "The presence of the sexual health and sexual rights perspectives in the field of sexuality will help to maintain the ideals developed in the 1930s in Western Europe, with the World League for Sexual Reform, which linked medical psychological approaches to sexuality and the idea that sexuality can contribute to human and social emancipation." This was a cherished thought for some of the Portuguese sexologists. Nevertheless, as Lottes (2013) said in her discussion of the principles of human rights and rights-based approaches to sexual health policies, rights principles should be integrated into sexuality fields. The Portuguese case also illustrates well the desire of a seed of change in the scenario of a more participatory, inclusive and queer academia (Santos, 2006). In fact, although there is a growing concern on health and human rights issues in sexuality research, more investment is necessary to scientifically strengthen the domain worldwide. As an example to this statement, Mpinga and colleagues (2011) literature review in three of the major sexuality journals (*Archives of Sexual Behavior*, *Journal of Sex and Marital Therapy*, and *Journal of Sex Research*), covering the period from 1999 to 2008, only found six articles about health and human rights.

As Tiefer (2002) urged sexology professionals to actively promote sexual rights as human rights to avoid sexual rights discourse to remain empty rhetoric, Lottes (2013) illustrated how educators, researchers, and therapists can integrate sexual rights principles into their

teaching, professional education, ethical codes, and theoretical frameworks. Furthermore, Parker and collaborators (2004: 362) demonstrated that the increased use of sexual rights frameworks, such as the HIV/AIDS epidemic, sexual exploitation and violence, stigma and discrimination of sexual and gender minorities, prostitution, pedophilia, and sex trafficking, has given support to "an explicit politicization of research and the engagement of researchers in social justice causes".

The influence of the medicalization and pharmaceuticalisation of sexuality

The approach and discussion of the so-called process of "medicalization of sexuality" is critical to contextualize the constitution of the field of sexology as well as the professional activity of the sexologist (Giami, 2007, 2009; Rohden, 2009, 2012; Russo, 2013; Tiefer, 1996; Weeks, 2002). The "medicalization of sexuality" includes, in a structural and dynamic approach, the organization of knowledge, social organizations, the organization of professions and of the actors involved, as well as the subjectivities. This set comprises what Foucault (1978) called "apparatus of sexuality", which enables the understanding of sexuality as being produced and reinvented by institutions with the power of classification, regulation and separation between the normal and the deviant, the sane and the sick, and so on.

Sexology strengthening is in fact associated with the increasing medicalization of the field of sexology, intensified by the finding and the commercialization in the 1990s of the newborn "pill of love", Viagra, and by the fact that some sexual behaviors and states are defined as "health problems" that need medical and/or pharmaceutical drugs intervention (Loe, 2004; Marshall, 2002; Wentzell, 2013). It also has to do with the organization and the institutionalization of sexologists as professionals, marked by the development of new scientific and professional societies and by the development of academic teaching which are progressively recognized by the academic and health system. This set of dimensions may explain the current development of sex therapies.

The re-conceptualization of erectile dysfunction as an organic dysfunction and the relative abandonment of the psychogenic model, with the advent of Viagra, did not spur the same scientific discussion generated at the time of the application of the same organic/biological model of sexual function to female sexual dysfunctions. This dominant model of sexuality seeks to reduce men's bodily and sexual experiences to a universal model of male (hetero) sexuality and exemplifies the reinforcing of the stereotypical common sense picture about male sexuality organically driven, in opposition to female sexual function,

determined by the social, psychological and interpersonal context of female sexual activity and relations (Fishman & Mamo, 2001; Giami, 2007; Rohden, 2009).

As well defined and illustrated by a special issue of the *Journal of Sex Research,* medicalization of sex is a current trend that illuminates the importance of a broader view of sexology: "The medicalization of sex is now a complex domain of personal and professional activity at the intersection of technology, culture, professional training, medicine, gender, sexuality, global capitalism, politics, and rapid social change" (Cacchioni & Tiefer, 2012: 307). Therefore, historical and contemporary developments must be seen in association with diverse dimensions of sexual medical diagnosis, treatment, and surveillance, analyzing their advantages and disadvantages for social life, subjectivity, embodiment, and experience.

Our results indicate that sexology, in Portugal as worldwide, as a scientific knowledge, somehow risks to be erased in its practice by the influence of medicalization and pharmaceuticalisation of sexuality. As pointed by Tiefer (2001), the medicalization of sex process also generally implies a body-mind compartmentalization, generalizations about human function and experience, and a focus on the individual, creating a universalized function-focused sexuality. Some of the key professionals of the field of sexology in Portugal struggle with the "Tyranny of the Natural" and to reveal and decode gender meanings and significances (Tiefer, 2004a).

Limitations

Our findings were based on a purposively sample of key professionals to guarantee generation, gender, disciplinary, and practice diversity among actors in the field of sexology. Contrary to the qualitative study of sexologists in Sweden (Löfgren-Mårtenson, 2015), not all our key informants were members of an association for sexology, which we believed have diversified their views of the profession. Nonetheless, it is conceivable that less well-known sexologists and less expressive or emergent professions in the field in Portugal, such as nurses and physiotherapists, which are visible in other countries such as in Finland (Kontula & Valkama, 2006), in the United Kingdom (Wylie, de Colomby, & Giami, 2004) and in Sweden (Fugl-Meyer & Giami, 2006), but seem inexistent in Portugal, would provide different views of their profession. Thus, continuing research is important in order to observe new possible trends of the ongoing professionalization process of the field of sexology. Also, sex education is accommodated by different professional and institutional groups, such as nongovernmental

organizations and research groups at universities, with less clearly defined boundaries. This means that it overlaps with activities undertaken by representatives of social movements and encompasses activities such as HIV prevention. The inclusion of sex educators and the analysis of this subfield would overrun the scope of this article, as in Portugal, sex educators and sex counsellors are not professional specialties, and those doing sex education are mostly recruited among secondary school teachers, who do not recognize themselves as sex educators and even less as sexologists, and they do not come from a sexology perspective or contribute directly to it. Therefore, further research is needed in order to deepen our understanding of the professionalization process of sexologists. Nevertheless, the study had a great acceptability and the sample captured the diversity of key informants' main characteristics considering the important elements of the sexology field in Portugal, including the narratives of the founding members.

CONCLUDING REMARKS

This article discussed how Portuguese sexologists have been defining and legitimizing their own expertise. The Portuguese case illustrates how sexology is a potential transdiscipline, although it can be deeply complex due to its uncertainties (Reiss, 1999). Sexology in Portugal is becoming more visible and earning more public recognition as a professional field. The Portuguese context provided an incentive to talk about sexuality and so Portuguese sexologists enjoyed what Foucault (1978) called ''the speaker's benefit'', advantages for those speaking about the prohibited, i.e., unacceptable sexuality, and representing themselves as liberating sex from repression through speaking about it (Irvine, 2014).

Although scientific associations and research have been developed since the seventies, most experts do not consider it to be a profession, and medical and psychological societies tend to consider sexuality a marginal area. Since sexology and sex therapy are not yet well established and recognized healthcare professional activities, the endorsement of a professional identity of sexologist in Portugal as in other European countries (Giami, 2012) is low and may also suggest that the term sexologist is becoming problematic and is no longer accorded the prestige that was given during the thirties in Europe (Bland & Doan, 1999). Portuguese sexuality researchers have also been struggling to establish academic legitimacy in the face of deep cultural anxieties about their subject of study (Irvine, 2014).

The findings indicate that sexology in Portugal, as in other European countries, is not seen as a fully-fledged profession but rather as a specialization or as a secondary field of action

within the framework of mainstream health professions and even among professionals that are publicly associated with sexology. The sexual medicine area is more prevalent and visible among physicians (urologists, gynecologists, endocrinologists, and psychiatrics), thus reflecting the gap between psychosocial and biomedical approaches. A close link between clinical practice and research and a gap between clinical practice and sex education and health promotion were found. Cooperation and communication between areas is a shared but unreached aim mainly because of lack in established networking, with some exceptions.

The confluence of the new views on sexuality, along with the social movements, is still challenging the power of sexology to define the normative parameters of sex and gender, offering alternative views about sex and gender grounded on people's own experiences and within a sociopolitical context, especially considering power inequalities between men and women, the concepts of maleness and femaleness, and masculinity and femininity. Like in the past when they emerged, in the present, they remained disruptive of scientific sexology's strategy for professionalization and of the internal self-definition of sexology (Irvine, 2005; Irvine, 2014; Jackson & Scott, 2010). This seems to be the main defy of sexology in general.

If and how sexologists will continue to react to the new ethical and methodological challenges and become more cross-disciplinary and interdisciplinary is what will define the future of sexology in Portugal.

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APPENDIXES

Appendix A. Articles submission proofs

SEXUAL AND RELATIONSHIP THERAPY, 2015
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Traditions and contradictions of sexual function definitions for Portuguese heterosexual men and women: medicalization and socially constructed gender effects

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ABSTRACT

Research on how sexual changes are understood as dysfunctions versus normal change remains scarce, namely in societies where traditional gender roles persist among the growing diversity of sexual relationships and practices. This article discusses controversies on sexual function definitions through sociology of diagnosis and sexual scripting theoretical frameworks, drawing on 313 structured interviews with primary healthcare users of the Greater Lisbon area, followed by in-depth interviews with a subsample of 25 heterosexual men and women. The low level of agreement found between the scores of the most widely used instruments for sexual function evaluation in epidemiology studies and self-diagnosis may be understood as a challenge for the predominant biomedical model and a need to re-conceptualize sexual dysfunctions other than as organic dysfunctions, with implications for both research and practice. Results show that individuals not only challenge illness concepts and sexual dysfunction diagnoses and their treatments, as they also construct sexual problems based on their impacts in daily life. Demonstrating the permanence of traditional social scripts that operate in the definitions of sexual function is one way to understand gender as an embodied social structure and get adequate practice to the problem, particularly in the Portuguese society where sexuality remains highly gendered.

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Introduction

In the nineteenth century, sexology was concerned with classifying sexual practices and with distinguishing the pathological from the normal, while since the twentieth century, heterosexual non-reproductive performance is at the center of the rationalization of sexuality. As Jackson and Scott (2010, p. 62) said: *It is as if once the parameters of normality had been set in terms of normative monogamous heterosexuality, attention could then*

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Exploring Gender in Portuguese Bedrooms: Men's and Women's Narratives of Their Sexuality Through a Mixed Methods Approach

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Abstract

The nature of intimacy and self-identity changed profoundly over the past century. The disruption between sex and procreation enabled the emergence of new forms of relationships and contributed towards the legitimacy of a sexuality focused on pleasure, as a mean of self-realization and an expression of intimacy. Despite the evidence that most individuals now approach close relations with expectations of mutual emotional support and romantic love, intimate relationships remain highly gendered, particularly in societies where traditional roles of men and women persist in the growing diversity of sexual relationships.

To address this topic, an empirical research was conducted in the Greater Lisbon area using a mixed methods approach. First, a quantitative study, with 323 primary healthcare users, intended to explain how gender influences self-constructions of sexuality and intimacy. Then, a qualitative study, with a subsample of 10 heterosexual men and 15 heterosexual women, employed in-depth interviews to explore how individuals construct their etiquette of sexual behavior. Building upon Gagnon and Simon's scripting theory and Giddens' transformations of intimacy, along with feminist criticisms concerning male dominance in hetero-relationships, we have reached an explanatory typology that focuses on Portuguese specificity in terms of the subjective experience of sexuality and intimate relationships.

Sexuality and intimacy are complex and multifaceted phenomena that are affected by sexual and non-sexual factors, both in and out of the bedroom. Key findings reveal a coexistence of highly gendered sexual scripts with increasingly more egalitarian sexual roles, namely among the youngest and the most educated generations in Portuguese society.

Keywords: *Intimacy, (Double Standard Of) Sexual Behavior, Scripting Theory, Sexual Experiences, Gender, Portugal*

Introduction

1.1 Aligned with the perspectives of Jackson (2008), Jackson and Scott (2010), and Beasley (2011), it is important to understand sexuality in the context of a wider reality and within other spheres of social life. In fact, heterosexuality is socially constructed, and sexual norms, perceptions, behaviors, and everyday practice of (hetero)-sexuality are culturally-bounded.

1.2 Having rejected the notion of an essential, biologically determined sexuality, the pioneering scripting theory, developed by Gagnon and Simon in the 1970s, suggests that the majority of sexual behaviors in heterosexual relationships tend to follow a prescribed social scenario that reflects the cultural norm (Gagnon & Simon 1973). However, sexual scripts are not socially determined as fixed lines of conduct. Instead, they are fluid improvisations involving ongoing processes of interpretation and negotiation (Jackson & Scott 2010). Sexual scripts are important determinants of individuals' sexual beliefs and behaviors that operate on cultural, intrapsychic, and interpersonal levels, in the sense that each level dynamically influences the others (Gagnon

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ORIGINAL PAPER

The Intimate World of Men's Sexual Problems: Portuguese Men's and Women's Narratives Explicated Through a Mixed Methods Approach

Violeta Alarcão · Luis Roxo · Ana Virgolino · Fernando Luís Machado

Published online: 5 March 2015

Abstract This study used a mixed methods approach to investigate the intimate world of men's sexual problems in Portugal, and particularly erectile dysfunction, focusing on the interplay between individual, societal and relational factors. First, a community-based survey was designed, with 323 primary health care users, to investigate how sociocultural factors influence experiences and representations of sexual problems. Second, a qualitative study, involving in-depth interviews with a subsample of ten heterosexual men, complemented by five heterosexual women's narratives, concerning men's sexual problems, was carried out to understand the meaning of sexual problems from a lay perspective. Statistical analysis of quantitative data was carried out through logistic regressions to evaluate the sociodemographic predictors of lay representations of sexual problems. Qualitative data were analyzed using an empirically grounded typology. The role of individuals in the construction of sexual dysfunctions, particularly erectile dysfunction, was explored using sexual script theory. Key findings revealed the impact of sexual problems on daily life. Gender analysis results contributed to the understanding of how men and women challenge the definition of sexual problems as normal changes versus dysfunctional changes. Specific patterns of change in sexual experiences and sexual problems were identified in the Portuguese gendered society, which can possibly be applied to other nations and cultures.

Keywords Sexual problems · Erectile dysfunction · Sexual narratives · Sexual scripts · Gender relations · Portugal

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Decision on JSR Manuscript ID 14-314.R3

Caixa de entrada x submissões revistas x

Osmo.Kontula@vaestoliitto.fi através de manuscriptcentral.com 8/09 (há 12 dias)
para mim

08-Sep-2015

Dear Miss Alarcão:

I thank you for the final revision of your manuscript entitled "Sexology in Portugal: Narratives by Portuguese sexologists". I am pleased to accept your manuscript for publication in The Journal of Sex Research.

Thank you for your fine contribution to The Journal of Sex Research. I hope you will consider the journal as an outlet for your work in the future.

Although the print version will be several months in appearance, JSR has initiated an electronic ahead of print version. That should allow you to cite the paper as published several months before appearance of the print journal. You should receive information about this as you go through the publication process. Some of this information is summarized below.

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On behalf of the Editors of The Journal of Sex Research, we look forward to your continued contributions to the Journal.

Sincerely,
Dr. Osmo Kontula
Associate Editor, The Journal of Sex Research
Osmo.Kontula@vaestoliitto.fi

Appendix B. Research authorizations

COMISSÃO NACIONAL
DE PROTECÇÃO DE DADOS

Processo n.º 707/2010

AUTORIZAÇÃO N.º 922/2010

A Associação para a Investigação e Desenvolvimento da Faculdade de Medicina de Lisboa notificou à CNPD um tratamento de dados pessoais com a finalidade de elaborar um estudo para avaliar o perfil e características dos utentes com disfunções sexuais e a eficácia do tratamento para essas disfunções no contexto dos cuidados de saúde primários.

Serão incluídos no estudo os utentes dos centros de saúde aleatoriamente seleccionados, contactados pelos entrevistadores formados para o efeito, que solicitarão o consentimento informado, quer para a consulta de uma parte do processo clínico, quer para a marcação de uma nova entrevista.

Os dados serão recolhidos num caderno de recolha de dados em formato papel.

Do caderno de recolha de dados consta o nome, nº de utente, morada, telefone, raça, sexo, estado civil, escolaridade, ocupação principal, médico, profissão, situação profissional, naturalidade, nº de filhos, composição do agregado familiar, conforto no alojamento, tipologia da zona residencial, rendimento mensal médio per capita (por escalões), hábitos tabágicos, hábitos alimentares e de consumo de álcool, dados sobre a vida sexual e sobre disfunção sexual.

Os destinatários deverão ser ainda informados sobre a natureza facultativa da sua participação e garantida confidencialidade no tratamento da informação.

A CNPD já se pronunciou na sua Deliberação n.º 227 /2007 sobre o enquadramento legal, os fundamentos de legitimidade, os princípios orientadores para o correcto cumprimento da Lei de Protecção de Dados, bem como as condições gerais aplicáveis ao tratamento de dados pessoais para esta finalidade.

A informação tratada é recolhida de forma lícita (art.º 5º, n.º1 al. a) da Lei 67/98), para finalidades determinadas, explícitas e legítimas (cf. al. b) do mesmo artigo) e não é excessiva.

No que concerne à recolha e tratamento do dado raça, o responsável pelo tratamento justifica a sua necessidade do seguinte modo: "*... a raça/etnia é um elemento fundamental na descrição*

COMISSÃO NACIONAL
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demográfica das populações estudadas sendo que, para estudos internacionais esta variável é muitas vezes considerada tão fundamental como a idade ou o sexo. A não inclusão desta variável no nosso estudo poderá condicionar, por um lado a possibilidade de comparação com estudos internacionais e por outro poderá colocar dificuldades acrescidas de aceitação dos nossos dados em publicações internacionais (...) existem actualmente cerca de 309 publicações de estudos sobre disfunções sexuais em que esta variável foi um dado relevante (...) exemplificamos a importância da variável raça/etnia para o estudo com as seguintes publicações em diversas revistas internacionais de reputação: The prevalence of erectile dysfunction in heart failure patients by race and etnicity, Herbert K, Lopez B, Castellano J, Palacio A, Tamari L, Arcemen LM, INt J Impost REs. 2008 Sept-Oct; 20(5):507-11".

A justificação para a recolha do nº do processo clínico apresentada pela investigadora prende-se com a necessidade do médico assistente facultar aos investigadores apenas o acesso dos campos do processo clínico relacionados com a patologia, não sendo o nome, de acordo com a experiência transacta em estudos análogos dos investigadores, garante suficiente de que o processo clínico seja efectivamente o da pessoa que presta o seu consentimento, dado existirem frequentes casos de pessoas com o mesmo nome.

O fundamento de legitimidade é o consentimento expresso do titular dos dados.

Assim, tendo em atenção o disposto nas disposições combinadas dos artigos 28º, n.º1, alínea a) e 30º da Lei n.º 67/98, de 26 de Outubro, e as condições e limites fixados na referida Deliberação, que se dão aqui por reproduzidos e que fundamentam esta decisão, autoriza-se o tratamento de dados pessoais nos seguintes termos:

Responsável pelo tratamento: Associação para a Investigação e Desenvolvimento da Faculdade de Medicina de Lisboa
Finalidade: estudo para avaliar o perfil e características dos utentes com disfunções sexuais e a eficácia do tratamento para essas disfunções no contexto dos cuidados de saúde primários.
Categoria de Dados pessoais tratados: nome, nº de utente, morada, telefone, raça, sexo, estado civil, escolaridade, ocupação principal, médico, profissão, situação profissional, naturalidade, nº de filhos, composição do agregado familiar, conforto no alojamento, tipologia da zona residencial, rendimento mensal médio per capita (por escalões), hábitos tabágicos, hábitos alimentares e de consumo de álcool, dados sobre a vida sexual e sobre disfunção sexual.
Entidades a quem podem ser comunicados: Não há.

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Formas de exercício do direito de acesso e rectificação: junto dos investigadores.
Interconexões de tratamentos: Não há.
Transferências de dados para países terceiros: Não há
Prazo de conservação: os dados pessoais devem ser destruídos um mês após o fim do estudo.

Dos termos e condições fixados na presente Autorização decorrem obrigações que o responsável deve cumprir. Deve, igualmente, dar conhecimento dessas condições a todos os intervenientes no circuito de informação.

Lisboa, 8 de Março de 2010

Ana Roque, Luís Paiva de Andrade, Vasco Almeida, Helena Delgado António, Carlos Campos Lobo, Luís Barroso (Relator)

Luís Lingnau da Silveira (Presidente)

Rua de São Bento, 148-3º • 1200-821 LISBOA
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duvidas@cnpd.pt

FACULDADE DE MEDICINA
DA UNIVERSIDADE DE LISBOA
Comissão de Ética

Exmo Senhor
Prof. Doutor Alberto Galvão Teles
Instituto de Medicina Preventiva
Faculdade de Medicina de Lisboa

Assunto: Parecer da Comissão de Ética da FMUL
Data: 7 de Julho de 2010

Na sequência dos esclarecimentos enviados por Vª Ex.ª, em resposta às questões colocadas anteriormente por esta Comissão, vimos informar que foi dado parecer favorável à realização do estudo "Sexual dysfunction observational study (SEXOS) in Portugal: Treatment-seeking behavior of sexual dyfunctions ".

Com os nossos melhores cumprimentos,

Prof. Doutor João Lobo Antunes
Presidente da Comissão de Ética
da Faculdade de Medicina da Universidade de Lisboa

ARSLVT

Administração Regional de Saúde
de Lisboa e Vale do Tejo, I. P.

Ministério da Saúde

Exmº Senhor
Professor Doutor Alberto Galvão Teles
Unidade de Epidemiologia – Edifício Egas Moniz
a/c Dra. Violeta Alarcão
Instituto de Medicina Preventiva
Faculdade de Medicina de Lisboa
Avª Prof. Egas Moniz
1649-028 Lisboa

Sua Referência	Sua Comunicação	Nossa Referência	Data
		19907 Sec- CD	01-09-2010

Assunto: **"Sexos – Sexual dysfunction observational study in Portugal Treatment – Seeking behaviour of sexual dysfunctions.**

Relativamente ao projecto de investigação mencionado em epígrafe, e, após análise de toda a documentação constante do processo, cumpre-me informar que, por despacho de 30.08.2010, do Senhor Presidente do Conselho Directivo desta Administração Regional de Saúde, foi autorizada a realização do Estudo submetido por V.Exªs à apreciação desta ARS.

Com os melhores cumprimentos,

P' O Presidente do Conselho Directivo

Rui Portugal

Patrocínio Financeiro

Patrocínio Científico

ESTUDO SOBRE A SAÚDE SEXUAL DOS ADULTOS EM PORTUGAL

CONSENTIMENTO INFORMADO E ESCLARECIDO

CARO PARTICIPANTE,

Este documento descreve o estudo em que o/a convidamos a participar.

Por favor leia-o atentamente. No final, o investigador irá perguntar-lhe se concorda em participar. Se não se sentir totalmente esclarecido/a, sinta-se à vontade para colocar todas as questões que tenha ao investigador presente. Não fique com dúvidas. E se lhe surgirem novas questões após a entrevista, poderá contactar o investigador através dos contactos disponibilizados no final deste documento para esclarecê-las.

QUAL O OBJECTIVO DO ESTUDO?

Conhecer aspectos relacionados com a saúde sexual da população adulta através da realização de entrevistas e da recolha de dados clínicos.

PORQUE FUI SELECCIONADO PARA ESTE ESTUDO?

A Unidade Funcional de Odivelas e a Unidade Funcional da Pontinha estão a colaborar na fase piloto deste estudo. E, em cada uma destas Unidades de Saúde, foram seleccionados aleatoriamente, ou seja, perfeitamente ao acaso, homens e mulheres, com idades entre 18-80 anos, inscritos e com processo clínico no Centro de Saúde a que pertencem.

Salientamos que ninguém deu qualquer indicação para que o Sr./Sra. especificamente participasse neste estudo.

O QUE SE IRÁ PASSAR NESTE ESTUDO E O QUE ME SERÁ PEDIDO?

Trata-se de um estudo muito importante na área da saúde sexual, uma vez que será o primeiro a ser realizado em Portugal nestas condições. Esta fase piloto terá a duração de 3 meses e durante esse período iremos realizar 2 entrevistas individuais, esta e, para um número muito reduzido de participantes, mais uma daqui a 3 meses, a marcar em data e local do acordo do participante.

A par das entrevistas, iremos consultar o seu processo clínico do Centro de Saúde/USF, de forma a conhecermos melhor o seu historial de saúde, problemas de saúde que já tenha tido e tratamentos realizados.

Só o/a voltaremos a contactar no período previsto (caso faça a segunda entrevista), ou se existir alguma dúvida com os dados recolhidos. No fim do estudo, todos os dados que o possam identificar serão destruídos (ex: nome, morada, etc.).

OUTRAS INFORMAÇÕES RELEVANTES:

- A 1ª entrevista terá a duração de cerca de uma hora e a última, caso seja seleccionado/a, cerca de 20 a 30 minutos;
- As opiniões recolhidas serão utilizadas única e exclusivamente para fins científicos;
- A informação recolhida será mantida confidencial;
- Será mantido o anonimato dos participantes.

O QUE É QUE EU GANHO EM PARTICIPAR?

Pessoas participem em estudos como este ajudam a conhecer e compreender melhor a saúde sexual dos homens e mulheres em Portugal. Não serão dadas gratificações ou remunerações, nem situações especiais de atendimento de saúde.

O QUE ACONTECE SE EU DECIDIR NÃO PARTICIPAR?

Caso decida não participar, não será prejudicado/a em nenhum aspecto. Em qualquer altura, agora ou no futuro, pode decidir não participar neste estudo, pelo que bastará comunicar-nos a sua decisão através de número telefónico indicado na caixa de texto abaixo e todos os seus dados pessoais (o seu nome, telefone, ou outros) e outros que tenham sido recolhidos com a sua autorização serão apagados de forma definitiva.

Declaro que me sinto esclarecido/a com a informação que me foi prestada e que foram respondidas todas as questões que desejei colocar. Declaro, com a minha assinatura, que consinto participar e colaborar neste estudo.

Data: ___ de _____ de 2011

_____ _____

O Participante O Investigador

Qualquer dúvida, por favor não hesite em contactar-nos:

Dr.ª Violeta Alarcão – Telemóvel: 917908009

Instituto de Medicina Preventiva

Faculdade de Medicina de Lisboa

Telefone: 21 799 94 22, extensão: 47091

COMISSÃO NACIONAL
DE PROTECÇÃO DE DADOS

REGISTO N.º 13 /2013

A **AIDFM (Associação para a Investigação e Desenvolvimento da Faculdade de Medicina de Lisboa)** notificou à CNPD um tratamento de dados pessoais com a finalidade de elaborar um estudo observacional sobre a prática da sexologia em Portugal (Estudo Euro-Sexo).

Trata-se de um estudo internacional sobre a profissão de sexólogo na Europa.

Serão incluídos no estudo todos os profissionais inscritos como sexólogos, identificados a partir das listas públicas e de listas privadas fornecidas pelas principais associações profissionais, para os quais serão enviados por correio uma carta explicativa do estudo, um questionário em papel e um envelope pré-pago.

Aos participantes no estudo requer-se que respondam ao questionário anónimo e que o devolvam no envelope remetido para o efeito.

Os dados identificativos dos participantes serão apenas conhecidos da equipa de investigação, para gestão do envio dos questionários.

Os dados tratados são: ano de nascimento, sexo, concelho e freguesia de residência, conselho e freguesia de trabalho, formação de origem, formação complementar em sexologia, modalidades da sua prática profissional, perceção dos utentes das suas consultas, principais motivos de consulta, tipos de diagnóstico e de intervenção praticados.

Será também enviado um questionário de resposta nominal, em separado, solicitando o consentimento para a participação numa entrevista qualitativa, a realizar posteriormente, e independente do questionário anónimo. Juntamente com este questionário será enviado um outro envelope.

COMISSÃO NACIONAL
DE PROTECÇÃO DE DADOS

Os destinatários serão ainda informados sobre a natureza facultativa da sua participação e garantida confidencialidade no tratamento.

O fundamento de legitimidade para este tratamento de dados pessoais é o consentimento expresso do titular dos dados.

Assim, de acordo com as disposições conjugadas do n.º 1 do artigo 27.º e do n.º 1 do artigo 30.º da Lei n.º 67/98, de 26 de outubro, regista-se o tratamento nos seguintes termos:

Responsável pelo tratamento: AIDFM (Associação para a Investigação e Desenvolvimento da Faculdade de Medicina de Lisboa)

Finalidade: Estudo observacional sobre a prática da sexologia em Portugal (Estudo Euro-Sexo).

Categoria de Dados pessoais tratados: ano de nascimento, sexo, concelho e freguesia de residência, conselho e freguesia de trabalho, formação de origem, formação complementar em sexologia, modalidades da sua prática profissional, perceção dos utentes das suas consultas, principais motivos de consulta, tipos de diagnóstico e de intervenção praticados e resposta dadas na entrevista presencial.

Entidades a quem podem ser comunicados: Não há.

Formas de exercício do direito de acesso e retificação: Junto dos investigadores.

Interconexões de tratamentos: Não há.

Transferências de dados para países terceiros: Não há.

Prazo de conservação: Os dados pessoais devem ser destruídos um mês após o fim do estudo.

Dos termos e condições fixados no presente Registo decorrem obrigações que o responsável deve cumprir.

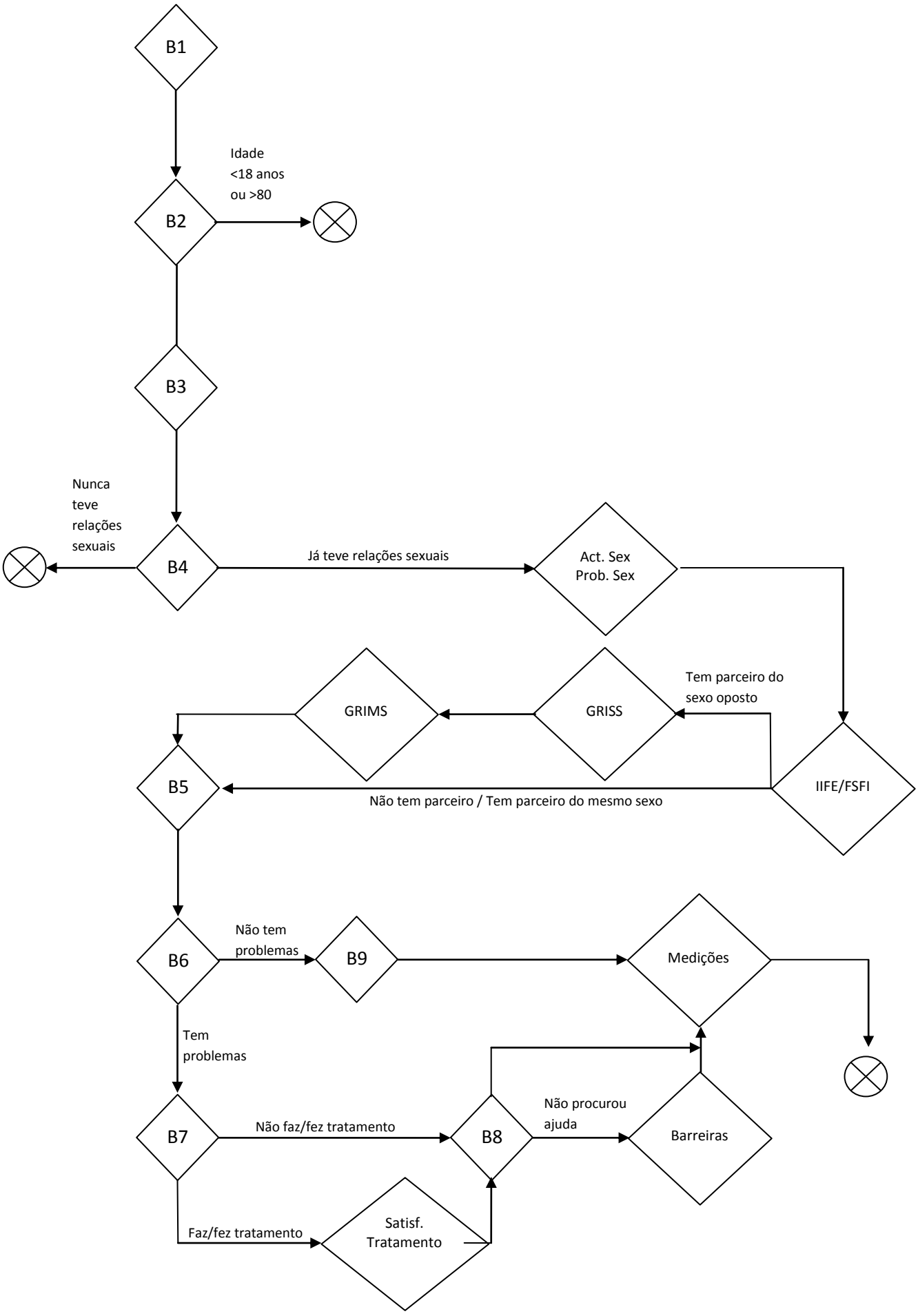
Lisboa, 25 de janeiro de 2013

A Secretária da CNPD

(Isabel Cristina Cruz)

Appendix C. Data collection instruments

Fluxograma de Aplicação de Questionários Projecto SEXOS



Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

Instituto de Medicina Preventiva
Faculdade de Medicina de Lisboa

Núcleo de Endocrinologia
Diabetes e Obesidade

Estudo sobre a Saúde Sexual da População Adulta Portuguesa

Questionário Principal

O Instituto de Medicina Preventiva da Faculdade de Medicina de Lisboa e o seu Centro de Saúde/ Unidade de Saúde Familiar estão a realizar um estudo sobre a Saúde Sexual da População Adulta Portuguesa.

Pedimos a sua colaboração na resposta a algumas perguntas de caracterização sócio-demográfica e de saúde, e sobre comportamentos e atitudes relacionados com a sexualidade, a fim de podermos alcançar um melhor conhecimento sobre esta realidade.

Todas as informações registadas neste questionário são ESTRITAMENTE CONFIDENCIAIS e todos os dados serão tratados de forma anónima e apenas serão utilizados de acordo com as finalidades deste estudo.

Agradecemos, desde já, a sua colaboração!

Patrocínio Financeiro:

FUNDAÇÃO MERCK SHARP & DOHME

Patrocínio Científico:

SOCIEDADE PORTUGUESA DE ANDROLOGIA

8231

A preencher pelo investigador (Conferir critérios de elegibilidade):

Nome da participante			
1-Nº Cartão Utente		**2**-Data de Hoje	(dia) (mês) (ano)
3-C.Saúde/ USF		**4**-Médico	

QUESTIONÁRIOS ANEXOS DE AUTO-PREENCHIMENTO:

Designação	Primeira entrevista	Última entrevista	Data do preenchimento
Inventário de Satisfação Sexual Golombok Rust **(GRISS)**	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Inventário de Satisfação Conjugal Golombok Rust **(GRIMS)**	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Questionário sobre actividade sexual e problemas sexuais	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Índice da Função Sexual Feminina **(FSFI)**	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Barreiras à procura de tratamento para problemas sexuais	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Utilização e Nível de Satisfação com o Tratamento Feminino	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)

B1 - Consultas Médicas

1. Quando foi a última vez que foi a uma consulta no Centro de Saúde/Unidade de Saúde Familiar com o(a) seu(sua) médico(a) de família?

☐ Nunca foi a uma consulta
☐ Há menos de 3 meses
☐ Entre 3 e 6 meses
☐ Entre 7 e 12 meses
☐ Há mais de 1 ano
☐ Não sabe / Não responde

2. Tendo como referência o último ano, com que frequência teve consultas com o(a) seu(sua) médico(a) de família? (em média)

☐ Nenhuma vez
☐ 1 vez por ano
☐ 2 vezes por ano (6 em 6 meses)
☐ 4 vezes por ano (3 em 3 meses)
☐ 1 ou mais vezes por mês
☐ Não sabe / Não responde

3. Está a ser acompanhado(a) por algum médico fora do Centro de Saúde/Unidade de Saúde Familiar?

☐ Sim
☐ Não -> Passar ao Bloco 2
☐ Não sabe / Não responde -> Passar ao Bloco 2

4. Se sim, poderia dizer-me qual(quais) a(s) especialidade(s)?

☐☐

B2 - Dados Sócio-Demográficos

1. Assinalar o sexo:
(sem perguntar)

Masculino ☐ Feminino ☐

2. Em que ano nasceu? ☐☐☐☐

2.1. Qual a sua idade? ☐☐ Anos

Se menor que 18 anos ou maior que 80 agradecer e terminar o questionário.

3. Qual é o seu estado civil?

☐ Solteiro(a)
☐ Casado(a) ou em união de facto (vive maritalmente há pelo menos 2 anos)
☐ Divorciado(a) ou separado(a)
☐ Viúvo(a)
☐ Não sabe / Não responde

4. Em que país nasceu?

☐ Portugal
☐ Brasil
☐ País Africano de Língua Oficial Portuguesa (PALOP)
☐ Europa Ocidental
☐ Europa do Leste
☐ Outros países da América do Sul e Central
☐ América do Norte
☐ Outros países de África
☐ Ásia
☐ Não sabe / Não responde

4.1 Se nasceu em Portugal, por favor indique em que região:

☐ Norte
☐ Centro
☐ Lisboa e Vale do Tejo
☐ Alentejo
☐ Algarve
☐ Madeira
☐ Açores
☐ Não sabe / Não responde

5. Assinalar o grupo étnico/raça: (sem perguntar)

☐ Branco
☐ Negro ou Mulato
☐ Asiático
☐ Latino-americano
☐ Outro (Qual?) ☐☐
☐ Não sabe / Não responde

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6. Qual a sua religião?

☐ Católica

☐ Ortodoxa

☐ Protestante

☐ Outra cristã

☐ Judaica

☐ Muçulmana

☐ Outra não cristã

☐ Sem religião -> Passar à pergunta 7

☐ Não sabe / Não responde -> Passar à pergunta 7

6.1 Qual o grau em que se considera ser praticante?
(De 1 a 5 em que 1 é muito pouco e 5 muitíssimo)

☐ ☐ ☐ ☐ ☐

Muito pouco Muitíssimo

7. Qual o nível de ensino mais elevado que frequenta ou frequentou?

☐ Nenhum
(0 anos)

☐ 1º Ciclo do ensino básico
4ª classe (1-4 anos)

☐ 2º Ciclo do ensino básico
Preparatório (5-6 anos)

☐ 3º Ciclo do ensino básico
5º ano dos liceus (7-9 anos)

☐ Ensino secundário
7º ano dos liceus (10-12 anos)

☐ Ensino pós-secundário não superior
(ou não terciário)

☐ Ensino superior universitário
(bacharelato, licenciatura, mestrado)

☐ Doutoramento

☐ Não sabe / Não responde

8. E quantos anos de escolaridade completou com aproveitamento?

☐☐ Anos

Se não souber ou não responder colocar 99 anos como resposta

9. Das seguintes categorias, qual a que melhor descreve a sua ocupação principal actual?

☐ Exerce uma profissão
Qual? ☐☐

☐ Estudante -> Passar à pergunta 12

☐ Ocupa-se das tarefas domésticas -> Passar à pergunta 12

☐ À procura do primeiro emprego -> Passar à pergunta 12

☐ Desempregado(a)

☐ Reformado(a)

☐ Permanentemente incapacitado(a)

☐ Outra situação

☐ Não sabe / Não responde -> Passar à pergunta 12

10. E qual é (era) a situação nessa profissão?

☐ Trabalha por conta de outrem

☐ Trabalha por conta própria

☐ Trabalha por conta própria como empregador(a)

☐ Trabalha para uma pessoa de família sem receber

☐ Outra situação

☐ Não sabe / Não responde

11. Independentemente do trabalho que realiza actualmente (realizava), qual a sua profissão de formação?

☐☐

12. Contando consigo, quantas pessoas (incluindo crianças) vivem habitualmente em sua casa?

☐☐ Pessoas

Se não souber ou não responder colocar 99 anos como resposta

Se mora sozinha, avançar para o Bloco 3

12.1 Podia dizer-me com quem vive?

Quanto tempo?

☐ Marido (mulher) / Parceiro(a) ☐☐ meses ☐☐ anos

☐ Filhos(as) menores de 12 anos

☐ Filhos(as) maiores de 12 anos

☐ Outros familiares menores de 18 anos

☐ Outros familiares maiores de 18 anos

☐ Outros não-familiares menores de 18 anos

☐ Outros não-familiares maiores de 18 anos

12.2 Tem filhos que não vivam consigo?

☐ Sim

☐ Não

☐ Não sabe / Não responde

Deixe-me confirmar se vive ou não em casal

Para os que não vivem em casal e nunca trabalharam passar à pergunta 16

13. Qual a idade do(a) seu(sua) parceiro(a)?

☐☐ Anos

14. Qual o nível de ensino mais elevado que frequenta ou frequentou?

☐ Nenhum
(0 anos)

☐ 1º Ciclo do ensino básico
4ª classe (1-4 anos)

☐ 2º Ciclo do ensino básico
Preparatório (5-6 anos)

☐ 3º Ciclo do ensino básico
5º ano dos liceus (7-9 anos)

☐ Ensino secundário
7º ano dos liceus (10-12 anos)

☐ Ensino pós-secundário não superior
(ou não terciário)

☐ Ensino superior universitário
(bacharelato, licenciatura, mestrado)

☐ Doutoramento

☐ Não sabe / Não responde

14.1 Quantos anos de escolaridade completou com aproveitamento?

☐☐ Anos

Se não souber ou não responder colocar 99 anos como resposta

15. Qual a ocupação principal actual do(a) parceiro(a)?

☐ Exerce uma profissão
Qual? _____ ☐☐

☐ Estudante

☐ Ocupa-se das tarefas domésticas

☐ À procura do primeiro emprego

☐ Desempregado(a)

☐ Reformado(a)

☐ Permanentemente incapacitado(a)

☐ Outra situação

☐ Não sabe / Não responde

Apenas para os que não vivem em casal e nunca trabalharam.

16. Qual o nível de ensino mais elevado que os seus pais frequentam ou frequentaram?

☐ Nenhum
(0 anos)

☐ 1º Ciclo do ensino básico
4ª classe (1-4 anos)

☐ 2º Ciclo do ensino básico
Preparatório (5-6 anos)

☐ 3º Ciclo do ensino básico
5º ano dos liceus (7-9 anos)

☐ Ensino secundário
7º ano dos liceus (10-12 anos)

☐ Ensino pós-secundário não superior
(ou não terciário)

☐ Ensino superior universitário
(bacharelato, licenciatura, mestrado)

☐ Doutoramento

☐ Não sabe / Não responde

Responder às próximas questões tendo em conta o progenitor utilizado na questão anterior.

16.1 Quantos anos de escolaridade o pai (ou mãe) completou com aproveitamento?

☐☐ Anos

Se não souber ou não responder colocar 99 anos como resposta

17. Qual a ocupação principal do pai (ou mãe)?

☐ Exerce uma profissão
Qual? _____ ☐☐

☐ Estudante

☐ Ocupa-se das tarefas domésticas

☐ À procura do primeiro emprego

☐ Desempregado(a)

☐ Reformado(a)

☐ Permanentemente incapacitado(a)

☐ Outra situação

☐ Não sabe / Não responde

B3 - Estilos de Vida

1. Nos últimos 12 meses, ingeriu bebidas alcoólicas?

☐ Sim

☐ Não -> Passar à pergunta 2

☐ Não sabe / Não responde -> Passar à pergunta 2

1.1 Em relação à última semana:	Quantos dias na semana?	Quantos copos em média/dia?
☐ Vinho	☐	☐☐
☐ Cerveja	☐	☐☐
☐ Bagaço, Aguardente, Brandy	☐	☐☐
☐ Vinho Porto, Martini, Licores	☐	☐☐
☐ Wisky, Gin, Vodka	☐	☐☐

2. Quanto aos seus hábitos tabágicos...

	Cigarros por dia?	Data Início	Data Fim
☐ Fumador(a)	☐☐	☐☐ mês ☐☐☐☐ ano	
☐ Ex-Fumador(a)	☐☐	☐☐ mês ☐☐☐☐ ano	☐☐ mês ☐☐☐☐ ano
☐ Nunca Fumou			

☐ Não sabe / Não responde

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3. Poderia dizer-me se consome ou já consumiu substâncias (drogas) ilícitas?

	Data Início	Data Fim
☐ Consome	☐☐ mês ☐☐☐☐ ano	
☐ Já consumiu	☐☐ mês ☐☐☐☐ ano	☐☐ mês ☐☐☐☐ ano

☐ Nunca Consumiu - Passar à pergunta 4

☐ Não sabe / Não responde - Passar à pergunta 4

3.1 Qual é/era a frequência de consumo?

☐ Diariamente

☐ Semanalmente

☐ Mensalmente

☐ Raramente

☐ Não sabe / Não responde

3.2 Poderia dizer-me que substâncias consome ou consumia?

	Sim	Não	NS / NR
a. Cannabis (haxixe, erva, marijuana, chamon)	☐	☐	☐
b. Ecstasy (pastilhas)	☐	☐	☐
c. Anfetaminas (speeds)	☐	☐	☐
d. Cocaína (coca)	☐	☐	☐
e. Heroína (pó, cavalo)	☐	☐	☐
f. LSD (ácidos)	☐	☐	☐
g. Cogumelos mágicos/alucinogénos	☐	☐	☐

h. Outro (Qual?) _____ ☐☐

Agora vou fazer algumas perguntas sobre o tempo dispendido em actividades físicas nos últimos 7 dias. Mesmo que não se considere uma pessoa activa, gostaria que pensasse nas actividades feitas no trabalho, em casa, no jardim ou na horta, na deslocação de um lugar para outro e ainda nos tempos livres em exercício ou desporto.

Em relação à última semana:

4. Fez durante pelo menos 10 minutos?

	Quantos dias na semana?	Quanto tempo num dia?
☐ Actividades Físicas Vigorosas (Fazem respirar mais forte do que o normal. Ex: levantar cargas pesadas, cavar, ginástica aeróbica ou andar de bicicleta rapidamente. Incluir actividade profissional)	☐ dias	☐☐ horas ☐☐ minutos
☐ Actividades físicas moderadas (Fazem respirar um pouco mais forte que o normal. Ex: transportar cargas leves, andar de bicicleta devagar, tarefas domésticas, cuidar do jardim. Não inclui o andar. Incluir a actividade profissional)	☐ dias	☐☐ horas ☐☐ minutos
☐ Andar (Andar no trabalho e em casa, deslocar-se de um lugar para outro e ainda o acto de caminhar somente por recreação, desporto, exercício ou lazer)	☐ dias	☐☐ horas ☐☐ minutos
☐ Estar sentado(a) (Tempo gasto no trabalho, em casa, enquanto faz o trabalho corrente e durante o tempo de lazer. Ex: sentado(a) a uma secretária, visita em casa de amigos, ler ou estar sentado(a) ou em repouso vendo televisão ou ouvindo música Inclui o tempo gasto estando deitado(a), mas acordado(a)).	☐ dias	☐☐ horas ☐☐ minutos

B4 - Estado de Saúde

1. Glicémia

1.1 Tem diabetes?

☐ Sim Tipo I ☐ Tipo II ☐

☐ Não -> Passar à pergunta 2.1

☐ Não sabe / Não responde -> Pg. 2.1

1.2 Quem lhe disse ter diabetes?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

1.3 Há quantos anos tem diabetes?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

1.4 Toma medicamentos para a diabetes?

☐ Sim

☐ Não -> Passar à pergunta 2.1

☐ Não sabe / Não responde -> Pg. 2.1

1.5 Há quantos anos toma medicamentos para a diabetes?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

2. Colesterol

2.1 Tem gorduras elevadas no sangue (colesterol elevado)?

☐ Sim

☐ Não -> Passar à pergunta 3.1

☐ Não sabe / Não responde -> Pg. 3.1

2.2 Quem lhe disse ter gorduras elevadas no sangue (colesterol elevado)?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

2.3 Há quantos anos tem gorduras elevadas no sangue (colesterol elevado)?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

2.4 Toma medicamentos para as gorduras elevadas no sangue (colesterol elevado)?

☐ Sim

☐ Não -> Passar à pergunta 3.1

☐ Não sabe / Não responde -> Pg. 3.1

2.5 Há quantos anos toma medicamentos para as gorduras elevadas no sangue (colesterol elevado)?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

3. Tensão Arterial

3.1 Tem problemas de tensão arterial elevada (hipertensão)?

☐ Sim

☐ Não -> Passar à pergunta 4.1

☐ Não sabe / Não responde -> P. 4.1

3.2 Quem lhe disse ter tensão arterial elevadas?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

3.3 Há quantos anos tem a tensão arterial elevada?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

3.4 Toma medicamentos para a tensão arterial elevada?

☐ Sim

☐ Não -> Passar à pergunta 4.1

☐ Não sabe / Não responde -> P. 4.1

3.5 Há quantos anos toma medicamentos para a tensão arterial elevada?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

4. Angina de Peito

4.1 Sofre de angina de peito (cardiopatia isquémica)?

☐ Sim

☐ Não -> Passar à pergunta 5.1

☐ Não sabe / Não responde -> Pg. 5.1

4.2 Quem lhe disse que sofria de angina de peito?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

☐☐

4.3 Há quantos anos sofre de angina de peito?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

4.4 Toma medicamentos para a angina de peito?

☐ Sim

☐ Não -> Passar à pergunta 5.1

☐ Não sabe / Não responde -> Pg. 5.1

4.5 Há quantos anos toma medicamentos para a angina de peito?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

5. Enfarte Agudo do Miocárdio

5.1 Já teve algum enfarte agudo do miocárdio (ataque cardíaco)?

☐ Sim

☐ Não -> Passar à pergunta 6.1

☐ Não sabe / Não responde -> Pg. 6.1

5.2 Há quantos anos teve um enfarte do miocárdio?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

5.3 Foi sujeita a alguma cirurgia ao coração?

☐ Sim

☐ Não

☐ Não sabe / Não responde

6. Insufuciência Cardíaca

6.1 Sofre de insuficiência cardíaca?

☐ Sim

☐ Não -> Passar à pergunta 7.1

☐ Não sabe / Não responde -> Pg. 7.1

6.2 Quem lhe disse que sofria de insuficiência cardíaca?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

☐☐

6.3 Há quantos anos sofre de insuficiência cardíaca?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

6.4 Toma medicamentos para a insuficiência cardíaca?

☐ Sim

☐ Não -> Passar à pergunta 7.1

☐ Não sabe / Não responde -> Pg. 7.1

6.5 Há quantos anos toma medicamentos para a insuficiência cardíaca?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

7. AVC

7.1 Já teve algum AVC?

☐ Sim

☐ Não -> Passar à pergunta 8

☐ Não sabe / Não responde -> Pg. 8

7.2 Há quantos anos teve um AVC?
(se mais do que 1, o último)

☐☐

Se não souber ou não responder colocar 99 anos como resposta

8. Apenas para mulheres com mais de 35 anos: Poderia indicar-me em que fase do climatério se encontra?

☐ Pré-menopausa
(regularidade menstrual durante os últimos doze meses)

☐ Perimenopausa
(irregularidades menstruais que antecedem a menopausa)

☐ Pós-menopausa
(um ano após a amenorreia)

☐ Não sabe / Não responde

9. Para darmos continuidade ao nosso inquérito, deixe-me perguntar-lhe se já teve relações sexuais ou se isso ainda não lhe aconteceu?

☐ Sim, já teve

☐ Não, nunca teve (Agradecer e terminar o questionário).

Entregar os questionários de auto-preenchimento anexos pela ordem indicada:

- Questionário Adicional sobre Actividade Sexual e Problemas Sexuais

- FSFI

- GRISS (não aplicar se: não tem parceiro ou tem parceiro do mesmo sexo que o seu - Ver na pergunta 2 do Questionário Adicional sobre Actividade Sexual e Problemas Sexuais)

- GRIMS (não aplicar se: não tem parceiro ou tem parceiro do mesmo sexo que o seu - Ver na pergunta 2 do Questionário Adicional sobre Actividade Sexual e Problemas Sexuais)

B5 - Discussão dos problemas sexuais entre médico de família e utente

Algumas pessoas atravessam períodos em que não estão interessadas na actividade sexual ou têm dificuldades durante o acto sexual.

1. De uma maneira geral, acha que esses problemas sexuais deveriam ser abordados pelo médico de família?

☐ Sim -> Passar à pergunta 3

☐ Não

☐ Não sabe / Não responde -> Passar à pergunta 3

2. Porque não?

☐ Não é uma área importante

☐ O médico de família não tem competência para isso

☐ Não é da área de intervenção do médico de família

☐ Outro motivo (Qual?) ☐☐

☐ Não sabe / Não responde

3. O seu médico de família alguma vez lhe perguntou se tinha problemas ou dificuldades sexuais?

☐ Sim

☐ Não -> Passar à pergunta 5

☐ Não sabe / Não responde -> Passar à pergunta 5

4. Das seguintes hipóteses, qual(quais) foi(foram) a(s) sua(s) reacção(ões) face ao início da conversa? (pode indicar mais do que uma opção)

	Sim	Não	NS / NR
a. Interesse e vontade de falar	☐	☐	☐
b. Alívio por este tema ser abordado	☐	☐	☐
c. Interesse em discutir opções e tratamentos	☐	☐	☐
d. Esperança de poder ser ajudado	☐	☐	☐
e. Indiferença	☐	☐	☐
f. Constrangimento	☐	☐	☐
g. Não quis falar novamente do assunto	☐	☐	☐
h. Desvalorização do assunto	☐	☐	☐

i. Outra (Qual?) ☐☐

Se respondeu a esta pergunta, passar à pergunta 7

5. Das seguintes opções, qual acha ser o motivo principal para o seu médico não lhe perguntar?

☐ Não é uma área importante

☐ Não tem competência para isso

☐ Não é da área de intervenção do médico de família

☐ Tem desconforto em falar do assunto

☐ Não quer invadir a sua privacidade

☐ Não tem tempo

☐ Outro motivo (Qual?) ☐☐

☐ Não sabe / Não responde

6. Acha que se sentiria confortável se o médico lhe perguntasse sobre eventuais problemas/dificuldades sexuais?

☐ Sim

☐ Não

☐ Não sabe / Não responde

7. Alguma vez falou com o seu médico de família sobre problemas/dificuldades sexuais, por iniciativa própria?

☐ Sim

☐ Não -> Passar à pergunta 9

☐ Não sabe / Não responde -> Passar à pergunta 9

8. Das seguintes hipóteses, qual(quais) foi(foram) a(s) reacção(ões) do seu médico face ao início da conversa? (pode indicar mais do que uma opção)

	Sim	Não	NS / NR
a. Interesse e vontade de falar	☐	☐	☐
b. Alívio por este tema ser abordado	☐	☐	☐
c. Interesse em discutir opções e tratamentos	☐	☐	☐
d. Indiferença	☐	☐	☐
e. Constrangimento	☐	☐	☐
f. Mudou de assunto	☐	☐	☐
g. Sugeriu falar com outro médico	☐	☐	☐
h. Encaminhou-o para um especialista	☐	☐	☐
i. Outra (Qual?)			☐☐

Se respondeu a esta pergunta, passar ao Bloco 6

9. Das seguintes hipóteses qual(quais) a(s) razão(ões) para nunca ter falado com o seu médico de família sobre problemas/dificuldades sexuais? (pode indicar mais do que uma opção)

	Sim	Não	NS / NR
a. Nunca precisei de falar com o meu médico	☐	☐	☐
b. Não é uma área importante	☐	☐	☐
c. É um assunto privado	☐	☐	☐
d. Tenho desconforto em falar do assunto	☐	☐	☐
e. O médico não tem competência para isso	☐	☐	☐
f. Não é da área de intervenção do médico de família	☐	☐	☐
g. O meu médico não é indicado para falar do assunto	☐	☐	☐
h. Não há tempo nas consultas	☐	☐	☐
i. Outra (Qual?)			☐☐

B6 - Auto-avaliação dos problemas sexuais

As perguntas que lhe vou fazer a seguir dizem respeito a eventuais dificuldades sexuais que possa ter.

1. Tem ou já teve algum problema de desejo sexual?

☐ Não tem e nunca teve -> Passar à pergunta 6
☐ Já teve
☐ Tem diminuição ligeira
☐ Tem diminuição moderada
☐ Tem diminuição severa/completa
☐ Não sabe / Não responde -> Passar à pergunta 6

2. Há quanto tempo tem? / Durante quanto tempo teve? (indicar os meses se inferior a 1 ano)

☐☐ meses ☐☐ anos

Se não souber ou não responder colocar 99 como resposta em ambas

3. Houve alguma mudança na sua vida que considere ter estado associada ao aparecimento destes problemas?
NÃO LER e assinalar opção principal

☐ Não
☐ Stress pessoal/problemas emocionais
☐ Doença
Qual? _____ ☐☐
☐ Problemas conjugais/relacionais
☐ Stress no parceiro/problemas emocionais
☐ Outros problemas sexuais
Quais? _____ ☐☐
☐ Medicação/doença física
☐ Gravidez/nascimento de um filho
☐ Outra
Qual? _____ ☐☐
☐ Não sabe / Não responde

4. Qual o grau de desconforto/mal-estar que sente/sentia com a situação? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

☐ ☐ ☐ ☐ ☐
Sem desconforto — Extremamente desconfortável

5. No último ano, alguma vez evitou ter relações sexuais por causa deste problema?

☐ Sim
☐ Não
☐ Não sabe / Não responde

6. Tem ou teve algum problema de excitação e/ou lubrificação?

☐ Não tem e nunca teve -> Passar à pergunta 11
☐ Já teve
☐ Tem diminuição ligeira
☐ Tem diminuição moderada
☐ Tem diminuição severa/completa
☐ Não sabe / Não responde -> Passar à pergunta 11

7. Há quanto tempo tem? / Durante quanto tempo teve? (indicar os meses se inferior a 1 ano)

☐☐ meses ☐☐ anos

Se não souber ou não responder colocar 99 como resposta em ambas

8. Houve alguma mudança na sua vida que considere ter estado associada ao aparecimento destes problemas?
NÃO LER e assinalar opção principal

☐ Não
☐ Stress pessoal/problemas emocionais
☐ Doença
Qual? _____ ☐☐
☐ Problemas conjugais/relacionais
☐ Stress no parceiro/problemas emocionais
☐ Outros problemas sexuais
Quais? _____ ☐☐
☐ Medicação/doença física
☐ Gravidez/nascimento de um filho
☐ Outra
Qual? _____ ☐☐
☐ Não sabe / Não responde

9. Qual o grau de desconforto/mal-estar que sente/sentia com a situação? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

☐ ☐ ☐ ☐ ☐
Sem desconforto — Extremamente desconfortável

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10. No último ano, alguma vez evitou ter relações sexuais por causa deste problema?

☐ Sim

☐ Não

☐ Não sabe / Não responde

11. Tem ou teve algum problema de orgasmo?

☐ Não tem e nunca teve -> Passar à pergunta 16

☐ Já teve

☐ Tem dificuldade/atraso ligeiro em alcançar

☐ Tem dificuldade/atraso moderado em alcançar

☐ Raramente consegue alcançar

☐ Não sabe / Não responde -> Passar à pergunta 16

12. Há quanto tempo tem? / Durante quanto tempo teve? (indicar os meses se inferior a 1 ano)

☐☐ meses ☐☐ anos

Se não souber ou não responder colocar 99 como resposta em ambas

13. Houve alguma mudança na sua vida que considere ter estado associada ao aparecimento destes problemas? NÃO LER e assinalar opção principal

☐ Não

☐ Stress pessoal/problemas emocionais

☐ Doença
Qual? _____ ☐☐

☐ Problemas conjugais/relacionais

☐ Stress no parceiro/problemas emocionais

☐ Outros problemas sexuais
Quais? _____ ☐☐

☐ Medicação/doença física

☐ Gravidez/nascimento de um filho

☐ Outra
Qual? _____ ☐☐

☐ Não sabe / Não responde

14. Qual o grau de desconforto/mal-estar que sente/sentia com a situação? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

☐ ☐ ☐ ☐ ☐

Sem desconforto — Extremamente desconfortável

15. No último ano, alguma vez evitou ter relações sexuais por causa deste problema?

☐ Sim

☐ Não

☐ Não sabe / Não responde

16. Tem ou teve algum problema de desconforto e/ou dor na relação sexual?

☐ Não tem e nunca teve -> Ver instrução no final do Bloco

☐ Já teve

☐ Tem, ocasionalmente

☐ Tem, frequentemente

☐ Tem, persistentemente

☐ Não sabe / Não responde -> Ver instrução no final do Bloco

17. Há quanto tempo tem? / Durante quanto tempo teve? (indicar os meses se inferior a 1 ano)

☐☐ meses ☐☐ anos

Se não souber ou não responder colocar 99 como resposta em ambas

18. Houve alguma mudança na sua vida que considere ter estado associada ao aparecimento destes problemas? NÃO LER e assinalar opção principal

☐ Não

☐ Stress pessoal/problemas emocionais

☐ Doença
Qual? _____ ☐☐

☐ Problemas conjugais/relacionais

☐ Stress no parceiro/problemas emocionais

☐ Outros problemas sexuais
Quais? _____ ☐☐

☐ Medicação/doença física

☐ Gravidez/nascimento de um filho

☐ Outra
Qual? _____ ☐☐

☐ Não sabe / Não responde

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19. Qual o grau de desconforto/mal-estar que sente/sentia com a situação? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

☐ ☐ ☐ ☐ ☐

Sem desconforto — Extremamente desconfortável

20. No último ano, alguma vez evitou ter relações sexuais por causa deste problema?

☐ Sim

☐ Não

☐ Não sabe / Não responde

Se respondeu "Não tem e nunca teve" nas perguntas 1, 6, 11, e 16, avançar para o Bloco 9 "Ausência de problemas sexuais"

B7 - Atitudes para com os problemas sexuais

1. Qual(quais) a(s) área(s) em que se sente afectada pelo(s) seu(s) problema(s) sexual(sexuais)?
NÃO LER as opções

	Sim	Não	NS / NR
a. Afecta a sua vida sexual	☐	☐	☐
b. Afecta a sua relação conjugal	☐	☐	☐
c. Afecta a sua vida familiar	☐	☐	☐
d. Afecta o seu trabalho	☐	☐	☐
e. Afecta as suas relações sociais	☐	☐	☐
f. Afecta a sua qualidade de vida	☐	☐	☐
g. Afecta o seu bem-estar	☐	☐	☐
h. Causa-lhe ansiedade	☐	☐	☐
i. Fá-la sentir-se deprimida	☐	☐	☐
j. Afecta o seu nível de confiança	☐	☐	☐
l. Afecta a sua auto-estima	☐	☐	☐

2. Qual das seguintes frases melhor descreve como os seus problemas sexuais afectam a relação com o(a) seu(sua) parceiro(a)? (apenas uma resposta)

☐ Um problema para si e para o(a) seu(sua) parceiro(a)

☐ Um problema para si mas não para o(a) seu(sua) parceiro (a)

☐ Não é problema para si mas é para o(a) seu(sua) parceiro(a)

☐ Nem é problema para si nem para o(a) seu(sua) parceiro(a)

☐ Não se aplica

☐ Não sabe / Não responde

3. Na sua opinião, qual é a causa principal do(s) seu(s) problema(s) sexual(sexuais)? (apenas uma resposta)

☐ Origem física/médica

☐ Relação com outras condições médicas

Quais? ☐☐

☐ Origem psicológica/emocional

☐ Dificuldades na relação conjugal

☐ Idade/envelhecimento

☐ Stress

☐ Estilo de vida

☐ Inexperiência sexual

☐ Não sabe / Não responde

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4. Quem lhe disse?

☐ Ninguém/foi a própria

☐ O(A) parceiro(a)

☐ Um amigo/familiar

☐ O médico de família

☐ Outro médico
Qual? ☐☐

☐ Outro profissional de saúde
Qual? ☐☐

☐ Outra pessoa
Qual? ☐☐

☐ Não sabe / Não responde

5. O que fez desde que se sentiu afectada?

NÃO LER as opções

Recorreu a outras formas de satisfação sexual (masturbação, sexo oral, etc.).
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Recorreu a material pornográfico, para uma maior estimulação.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Diminuiu o consumo de álcool.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Diminuiu o consumo de tabaco.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Passou a controlar o seu peso.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alterou os seus hábitos alimentares.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Começou a praticar mais exercício físico.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Ficou mais atenta à sua saúde.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alterou a sua medicação habitual.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversou com o seu parceiro(a).
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversou com amigos.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Falou com um membro religioso.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversou com pessoas na internet (através de chats ou fóruns).
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou outro(a) parceiro(a).
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionou a sua actual relação conjugal.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Pensou na causa dos problemas sexuais.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionou se tem andado com demasiadas preocupações.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou tratamentos alternativos (ervanárias, etc.).
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou informação nos meios de comunicação social.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Contactou uma linha telefónica de apoio
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Não fez nada.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

6. Faz ou já fez algum tratamento para o(s) seu(s) problema(s) sexual(ais)?

☐ Sim, faz (Aplicar Questionário Utilização e Nivel de Satisfação com o Tratamento Feminino) e depois Bloco 8

☐ Já fez (Aplicar Questionário Utilização e Nivel de Satisfação com o Tratamento Feminino) e depois Bloco 8

☐ Nunca fez -> Passe à pergunta 7

7. Porque é que não fez tratamento (razão principal)?

☐ O médico encaminhou para outro profissional

☐ O médico considerou não ser necessário fazer tratamento

☐ O médico não valorizou a situação

☐ O médico não prescreveu porque tem outras doenças

☐ Recusou fazer tratamento

☐ O(A) meu(minha) parceiro(a) recusou

☐ Não tem parceiro(a)

☐ Não sei / Não respondo

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B8 - Procura de ajuda junto de profissionais de saúde

1. Falou com algum profissional de saúde?

☐ Sim

☐ Não -> Passar ao Questionário Anexo "Ausência de procura de tratamento"

☐ Não sabe / Não responde -> Passar ao Questionário Anexo "Ausência de procura de tratamento"

2. Com qual ou quais?

a. Médico de Família	☐	f. Psicólogo	☐
b. Urolog/Ginecol	☐	g. Enfermeiro	☐
c. Endocrinologista	☐	h. Farmacêutico	☐
d. Psiquiatra	☐	i. Terapeuta Sexual	☐
e. Outro Clínica Geral	☐	j. NS/NR	☐

l. Outro (Quem?) _____ ☐☐

3. Quanto tempo após começarem os problemas procurou a ajuda de um profissional de saúde?

☐ Até 3 meses

☐ De 3 a 6 meses

☐ De 7 meses a 12 meses

☐ Mais de 1 ano

☐ Não sabe / Não responde

4. Qual o grau de desconforto/mal-estar com a situação quando procurou ajuda de um profissional? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

Sem desconforto ☐ ☐ ☐ ☐ ☐ Extremamente desconfortável

5. Das seguintes hipóteses, indique o motivo principal que a levou a procurar ajuda?

☐ Quer iniciar uma nova relação

☐ Sentiu que a sua relação se estava a deteriorar

☐ O(A) seu(sua) companheiro(a) pediu-lhe

☐ Quer aumentar a sua satisfação sexual

☐ Quer satisfazer melhor o(a) seu(sua) parceiro(a)

☐ Era fonte de sentimentos negativos

☐ O problema tornou-se mais severo e frequente

☐ Quer verificar se está tudo bem com a sua saúde

☐ Está preocupada com a sua fertilidade

☐ Outro motivo (Qual?) _____ ☐☐

☐ Não sabe / Não responde

Se não recorreu a nenhum médico passar às Medições.

6. Qual o sexo do primeiro médico a que recorreu?

☐ Masculino

☐ Feminino

☐ Não sabe / Não responde

7. Qual a faixa etária do primeiro médico a que recorreu?

☐ Até 40 anos

☐ 40-50 anos

☐ 51-60 anos

☐ Mais de 60 anos

☐ Não sabe / Não responde

8. Dos seguintes procedimentos, indique quais os que o médico adoptou nessa primeira vez?

Quis saber mais sobre os seus problemas sexuais.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou-lhe sobre a frequência das suas relações sexuais.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou por doenças e medicação
☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou sobre a qualidade da sua vida sexual.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Quis saber mais sobre o seu estado mental e emocional.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou por acontecimentos recentes na sua vida.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Observou os seus genitais.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Pediu análises e/ou exames.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Fez logo o diagnóstico.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Falou das opções do tratamento.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Prescreveu-lhe tratamentos.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Encaminhou-a para outro profissional.
☐ Sim ☐ Não ☐ Não sabe / Não responde

Se respondeu ao bloco 8 passar às Medições Antropométricas.

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B9 - Ausência de problemas sexuais

1. Se tivesse problemas sexuais, seria um motivo de preocupação?

☐ Não

☐ Sim, ocasionalmente

☐ Sim, frequentemente

☐ Sim, permanentemente

☐ Não sabe/ Não responde

2. Se tivesse algum problema sexual, procurava ajuda?

☐ Sim

☐ Não -> Passar à pergunta 6

☐ Não sabe/ Não responde -> Passar à pergunta 6

3. A que profissional de saúde recorreria em primeiro lugar?

☐ Médico de família

☐ Outro médico de clínica geral

☐ Psiquiatra

☐ Urologista/Ginecologista

☐ Endocrinologista

☐ Outra especialidade de medicina
Qual? ☐☐

☐ Terapeuta sexual

☐ Psicólogo

☐ Enfermeiro

☐ Farmacêutico

☐ Outro profissional de saúde
Qual? ☐☐

☐ Não sabe qual o profissional mais indicado

☐ Não sabe/ Não responde

4. Qual o sexo do profissional com o qual se sentiria mais confortável para falar sobre o assunto?

☐ Masculino

☐ Feminino

☐ Indiferente

☐ Não sabe/ Não responde

5. Qual a idade do profissional com o qual se sentiria mais confortável para falar sobre o assunto?

☐ Até 40 anos

☐ 51-60 anos

☐ Mais de 60 anos

☐ Indiferente

☐ Não sabe/ Não responde

6. O que faria se se sentisse afectada?

NÃO LER as opções

Recorria a outras formas de satisfação sexual (masturbação, sexo oral, etc.).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Recorria a material pornográfico, para uma maior estimulação.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Diminuía o consumo de álcool.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Moderava os seus hábitos tabágicos.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Começaria a controlar o peso.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alteraria os hábitos alimentares.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Faria mais exercício do que anteriormente.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Ficava mais atenta à sua saúde.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alterava a sua medicação habitual.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversava com o(a) seu(sua) parceiro(a).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversava com amigos.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Falava com um membro religioso.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversava com pessoas na internet (através de chats ou fóruns).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurava outro parceiro.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionava a sua actual relação conjugal.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Pensava na causa dos problemas sexuais.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionava se tem andado com demasiadas preocupações.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou tratamentos alternativos (ervanárias, etc.).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurava informação nos meios de comunicação social.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Contactava linha telefónica de apoio.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Tomava medicamentos sem prescrição médica.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Não faria nada.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

O nosso questionário chegou ao fim. Gostava de lhe agradecer toda a disponibilidade e aproveitar para lhe pedir para recolher dados sobre o seu peso e altura. Aceita ser pesada e medida?

Medições Antropométricas:

Qual o seu peso? ☐☐☐ kg

Qual a sua altura? ☐☐☐ cm

Perímetro da cintura ☐☐☐ cm

Se recusar colocar 000 como resposta em todas

Está a participar em algum estudo que envolva a realização de um tratamento?

☐ Sim ☐ Não

Qual?

Notas: Para dar continuidade ao nosso estudo sobre a saúde sexual da população adulta portuguesa, podemos ter de voltar a contactá-la. Estaria disponível para um novo contacto?

☐ Sim ☐ Não

Contacto:

Telefone ou Telemóvel

Hora preferencial de contacto

Agradecemos a sua colaboração!

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Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

Instituto de Medicina Preventiva
Faculdade de Medicina de Lisboa

Núcleo de Endocrinologia
Diabetes e Obesidade

Estudo sobre a Saúde Sexual da População Adulta Portuguesa

Questionário Principal

O Instituto de Medicina Preventiva da Faculdade de Medicina de Lisboa e o seu Centro de Saúde/ Unidade de Saúde Familiar estão a realizar um estudo sobre a Saúde Sexual da População Adulta Portuguesa.

Pedimos a sua colaboração na resposta a algumas perguntas de caracterização sócio-demográfica e de saúde, e sobre comportamentos e atitudes relacionados com a sexualidade, a fim de podermos alcançar um melhor conhecimento sobre esta realidade.

Todas as informações registadas neste questionário são ESTRITAMENTE CONFIDENCIAIS e todos os dados serão tratados de forma anónima e apenas serão utilizados de acordo com as finalidades deste estudo.

Agradecemos, desde já, a sua colaboração!

Patrocínio Financeiro:

Patrocínio Científico:

34753

A preencher pelo investigador:

Nome do participante			
1-Nº Cartão Utente		**2**-Data de Hoje	(dia) (mês) (ano)
3-C.Saúde/ USF		**4**-Médico	

QUESTIONÁRIOS ANEXOS:

Designação	Primeira entrevista	Última entrevista	Data do preenchimento
Índice Internacional de Função Eréctil **(IIFE)**	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Inventário de Satisfação Sexual Golombok Rust **(GRISS)**	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Inventário de Satisfação Conjugal Golombok Rust **(GRIMS)**	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Avaliação da andropausa (Androgen Deficiency in the Aging Male - **ADAM**)	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Barreiras à procura de tratamento para problemas sexuais	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)
Nível de satisfação com o tratamento para a disfunção eréctil (**EDITS**)	○	○	*1ª.:* (dia) (mês) (ano) *2ª.:* (dia) (mês) (ano)

B1 - Consultas Médicas

1. Quando foi a última vez que foi a uma consulta no Centro de Saúde/Unidade de Saúde Familiar com o(a) seu(sua) médico(a) de família?

☐ Nunca foi a uma consulta

☐ Há menos de 3 meses

☐ Entre 3 e 6 meses

☐ Entre 7 e 12 meses

☐ Há mais de 1 ano

☐ Não sabe / Não responde

2. Tendo como referência o último ano, com que frequência teve consultas com o(a) seu(sua) médico(a) de família? (em média)

☐ Nenhuma vez

☐ 1 vez por ano

☐ 2 vezes por ano (6 em 6 meses)

☐ 4 vezes por ano (3 em 3 meses)

☐ 1 ou mais vezes por mês

☐ Não sabe / Não responde

3. Está a ser acompanhado(a) por algum médico fora do Centro de Saúde/Unidade de Saúde Familiar?

☐ Sim

☐ Não -> Passar ao Bloco 2

☐ Não sabe / Não responde -> Passar ao Bloco 2

4. Se sim, poderia dizer-me qual(quais) a(s) especialidade(s)?

	☐☐

B2 - Dados Sócio-Demográficos

1. Assinalar o sexo:
(sem perguntar)

Masculino ☐ Feminino ☐

2. Em que ano nasceu? ☐☐☐☐

2.1. Qual a sua idade? ☐☐ Anos

Se menor que 18 anos ou maior que 80 agradecer e terminar o questionário.

3. Qual é o seu estado civil?

☐ Solteiro(a)

☐ Casado(a) ou em união de facto (vive maritalmente há pelo menos 2 anos)

☐ Divorciado(a) ou separado(a)

☐ Viúvo(a)

☐ Não sabe / Não responde

4. Em que país nasceu?

☐ Portugal

☐ Brasil

☐ País Africano de Língua Oficial Portuguesa (PALOP)

☐ Europa Ocidental

☐ Europa do Leste

☐ Outros países da América do Sul e Central

☐ América do Norte

☐ Outros países de África

☐ Ásia

☐ Não sabe / Não responde

4.1 Se nasceu em Portugal, por favor indique em que região:

☐ Norte

☐ Centro

☐ Lisboa e Vale do Tejo

☐ Alentejo

☐ Algarve

☐ Madeira

☐ Açores

☐ Não sabe / Não responde

5. Assinalar grupo étnico/raça: (sem perguntar)

☐ Branco

☐ Negro ou Mulato

☐ Asiático

☐ Latino-americano

☐ Outro (Qual?) ☐☐

☐ Não sabe / Não responde

34753

6. Qual a sua religião?

☐ Católica

☐ Ortodoxa

☐ Protestante

☐ Outra cristã

☐ Judaica

☐ Muçulmana

☐ Outra não cristã

☐ Sem religião -> Passar à pergunta 7

☐ Não sabe / Não responde -> Passar à pergunta 7

6.1 Qual o grau em que se considera ser praticante?
(De 1 a 5 em que 1 é muito pouco e 5 muitíssimo)

☐ ☐ ☐ ☐ ☐

Muito pouco Muitíssimo

7. Qual o nível de ensino mais elevado que frequenta ou frequentou?

☐ Nenhum
(0 anos)

☐ 1º Ciclo do ensino básico
4ª classe (1-4 anos)

☐ 2º Ciclo do ensino básico
Preparatório (5-6 anos)

☐ 3º Ciclo do ensino básico
5º ano dos liceus (7-9 anos)

☐ Ensino secundário
7º ano dos liceus (10-12 anos)

☐ Ensino pós-secundário não superior
(ou não terciário)

☐ Ensino superior universitário
(bacharelato, licenciatura, mestrado)

☐ Doutoramento

☐ Não sabe / Não responde

8. E quantos anos de escolaridade completou com aproveitamento?

☐☐ Anos

Se não souber ou não responder colocar 99 anos como resposta

9. Das seguintes categorias, qual a que melhor descreve a sua ocupação principal actual?

☐ Exerce uma profissão
Qual? ☐☐

☐ Estudante -> Passar à pergunta 12

☐ Ocupa-se das tarefas domésticas -> Passar à pergunta 12

☐ À procura do primeiro emprego -> Passar à pergunta 12

☐ Desempregado(a)

☐ Reformado(a)

☐ Permanentemente incapacitado(a)

☐ Outra situação

☐ Não sabe / Não responde -> Passar à pergunta 12

10. E qual é (era) a situação nessa profissão?

☐ Trabalha por conta de outrem

☐ Trabalha por conta própria

☐ Trabalha por conta própria como empregador(a)

☐ Trabalha para uma pessoa de família sem receber

☐ Outra situação

☐ Não sabe / Não responde

11. Independentemente do trabalho que realiza actualmente (realizava), qual a sua profissão de formação?

☐☐

12. Contando consigo, quantas pessoas (incluindo crianças) vivem habitualmente em sua casa?

☐☐ Pessoas

Se não souber ou não responder colocar 99 anos como resposta

Se mora sozinha, avançar para o Bloco 3

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12.1 Podia dizer-me com quem vive?

Quanto tempo?

☐ Marido (mulher) / Parceiro(a) ☐☐ meses ☐☐ anos

☐ Filhos(as) menores de 12 anos

☐ Filhos(as) maiores de 12 anos

☐ Outros familiares menores de 18 anos

☐ Outros familiares maiores de 18 anos

☐ Outros não-familiares menores de 18 anos

☐ Outros não-familiares maiores de 18 anos

12.2 Tem filhos que não vivam consigo?

☐ Sim

☐ Não

☐ Não sabe / Não responde

Deixe-me confirmar se vive ou não em casal

Para os que não vivem em casal e nunca trabalharam passar à pergunta 16

13. Qual a idade do(a) seu(sua) parceiro(a)?

☐☐ Anos

14. Qual o nível de ensino mais elevado que frequenta ou frequentou?

☐ Nenhum
(0 anos)

☐ 1º Ciclo do ensino básico
4ª classe (1-4 anos)

☐ 2º Ciclo do ensino básico
Preparatório (5-6 anos)

☐ 3º Ciclo do ensino básico
5º ano dos liceus (7-9 anos)

☐ Ensino secundário
7º ano dos liceus (10-12 anos)

☐ Ensino pós-secundário não superior
(ou não terciário)

☐ Ensino superior universitário
(bacharelato, licenciatura, mestrado)

☐ Doutoramento

☐ Não sabe / Não responde

14.1 Quantos anos de escolaridade completou com aproveitamento?

☐☐ Anos

Se não souber ou não responder colocar 99 anos como resposta

15. Qual a ocupação principal actual do(a) parceiro(a)?

☐ Exerce uma profissão
Qual? _____ ☐☐

☐ Estudante

☐ Ocupa-se das tarefas domésticas

☐ À procura do primeiro emprego

☐ Desempregado(a)

☐ Reformado(a)

☐ Permanentemente incapacitado(a)

☐ Outra situação

☐ Não sabe / Não responde

Apenas para os que não vivem em casal e nunca trabalharam.

16. Qual o nível de ensino mais elevado que os seus pais frequentam ou frequentaram?

☐ Nenhum
(0 anos)

☐ 1º Ciclo do ensino básico
4ª classe (1-4 anos)

☐ 2º Ciclo do ensino básico
Preparatório (5-6 anos)

☐ 3º Ciclo do ensino básico
5º ano dos liceus (7-9 anos)

☐ Ensino secundário
7º ano dos liceus (10-12 anos)

☐ Ensino pós-secundário não superior
(ou não terciário)

☐ Ensino superior universitário
(bacharelato, licenciatura, mestrado)

☐ Doutoramento

☐ Não sabe / Não responde

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Responder às próximas questões tendo em conta o progenitor utilizado na questão anterior.

16.1 Quantos anos de escolaridade o pai (ou mãe) completou com aproveitamento?

☐☐ Anos

Se não souber ou não responder colocar 99 anos como resposta

17. Qual a ocupação principal do pai (ou mãe)?

☐ Exerce uma profissão
Qual? _____ ☐☐

☐ Estudante

☐ Ocupa-se das tarefas domésticas

☐ À procura do primeiro emprego

☐ Desempregado(a)

☐ Reformado(a)

☐ Permanentemente incapacitado(a)

☐ Outra situação

☐ Não sabe / Não responde

B3 - Estilos de Vida

1. Nos últimos 12 meses, ingeriu bebidas alcoólicas?

☐ Sim

☐ Não -> Passar à pergunta 2

☐ Não sabe / Não responde -> Passar à pergunta 2

1.1 Em relação à última semana:	Quantos dias na semana?	Quantos copos em média/dia?
☐ Vinho	☐	☐☐
☐ Cerveja	☐	☐☐
☐ Bagaço, Aguardente, Brandy	☐	☐☐
☐ Vinho Porto, Martini, Licores	☐	☐☐
☐ Wisky, Gin, Vodka	☐	☐☐

2. Quanto aos seus hábitos tabágicos...

	Cigarros por dia?	Data Início	Data Fim
☐ Fumador(a)	☐☐	☐☐ mês ☐☐☐☐ ano	
☐ Ex-Fumador(a)	☐☐	☐☐ mês ☐☐☐☐ ano	☐☐ mês ☐☐☐☐ ano
☐ Nunca Fumou			

☐ Não sabe / Não responde

3. Poderia dizer-me se consome ou já consumiu substâncias (drogas) ilícitas?

	Data Início	Data Fim
☐ Consome	☐☐ mês ☐☐☐☐ ano	
☐ Já consumiu	☐☐ mês ☐☐☐☐ ano	☐☐ mês ☐☐☐☐ ano

☐ Nunca Consumiu - Passar à pergunta 4

☐ Não sabe / Não responde - Passar à pergunta 4

3.1 Qual é/era a frequência de consumo?

☐ Diariamente

☐ Semanalmente

☐ Mensalmente

☐ Raramente

☐ Não sabe / Não responde

3.2 Poderia dizer-me que substâncias consome ou consumia?

	Sim	Não	NS / NR
a. Cannabis (haxixe, erva, marijuana, chamon)	☐	☐	☐
b. Ecstasy (pastilhas)	☐	☐	☐
c. Anfetaminas (speeds)	☐	☐	☐
d. Cocaína (coca)	☐	☐	☐
e. Heroína (pó, cavalo)	☐	☐	☐
f. LSD (ácidos)	☐	☐	☐
g. Cogumelos mágicos/alucinogénos	☐	☐	☐
h. Outro (Qual?)			☐☐

Agora vou fazer algumas perguntas sobre o tempo dispendido em actividades físicas nos últimos 7 dias. Mesmo que não se considere uma pessoa activa, gostaria que pensasse nas actividades feitas no trabalho, em casa, no jardim ou na horta, na deslocação de um lugar para outro e ainda nos tempos livres em exercício ou desporto.

Em relação à última semana:

4. Fez durante pelo menos 10 minutos?

	Quantos dias na semana?	Quanto tempo num dia?
☐ Actividades Físicas Vigorosas (Fazem respirar mais forte do que o normal. Ex: levantar cargas pesadas, cavar, ginástica aeróbica ou andar de bicicleta rapidamente. Incluir actividade profissional)	☐ dias	☐☐ horas ☐☐ minutos
☐ Actividades físicas moderadas (Fazem respirar um pouco mais forte que o normal. Ex: transportar cargas leves, andar de bicicleta devagar, tarefas domésticas, cuidar do jardim. Não inclui o andar. Incluir a actividade profissional)	☐ dias	☐☐ horas ☐☐ minutos
☐ Andar (Andar no trabalho e em casa, deslocar-se de um lugar para outro e ainda o acto de caminhar somente por recreação, desporto, exercício ou lazer)	☐ dias	☐☐ horas ☐☐ minutos
☐ Estar sentado(a) (Tempo gasto no trabalho, em casa, enquanto faz o trabalho corrente e durante o tempo de lazer. Ex: sentado(a) a uma secretária, visita em casa de amigos, ler ou estar sentado(a) ou em repouso vendo televisão ou ouvindo música Inclui o tempo gasto estando deitado(a), mas acordado(a)).	☐ dias	☐☐ horas ☐☐ minutos

B4 - Estado de Saúde

1. Glicémia

1.1 Tem diabetes?

☐ Sim Tipo I ☐ Tipo II ☐

☐ Não -> Passar à pergunta 2.1

☐ Não sabe / Não responde -> Pg. 2.1

1.2 Quem lhe disse ter diabetes?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

1.3 Há quantos anos tem diabetes?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

1.4 Toma medicamentos para a diabetes?

☐ Sim

☐ Não -> Passar à pergunta 2.1

☐ Não sabe / Não responde -> Pg. 2.1

1.5 Há quantos anos toma medicamentos para a diabetes?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

2. Colesterol

2.1 Tem gorduras elevadas no sangue (colesterol elevado)?

☐ Sim

☐ Não -> Passar à pergunta 3.1

☐ Não sabe / Não responde -> Pg. 3.1

2.2 Quem lhe disse ter gorduras elevadas no sangue (colesterol elevado)?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

2.3 Há quantos anos tem gorduras elevadas no sangue (colesterol elevado)?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

2.4 Toma medicamentos para as gorduras elevadas no sangue (colesterol elevado)?

☐ Sim

☐ Não -> Passar à pergunta 3.1

☐ Não sabe / Não responde -> Pg. 3.1

2.5 Há quantos anos toma medicamentos para as gorduras elevadas no sangue (colesterol elevado)?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

3. Tensão Arterial

3.1 Tem problemas de tensão arterial elevada (hipertensão)?

☐ Sim

☐ Não -> Passar à pergunta 4.1

☐ Não sabe / Não responde -> P. 4.1

3.2 Quem lhe disse ter tensão arterial elevadas?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

3.3 Há quantos anos tem a tensão arterial elevada?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

3.4 Toma medicamentos para a tensão arterial elevada?

☐ Sim

☐ Não -> Passar à pergunta 4.1

☐ Não sabe / Não responde -> P. 4.1

3.5 Há quantos anos toma medicamentos para a tensão arterial elevada?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

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4. Angina de Peito

4.1 Sofre de angina de peito (cardiopatia isquémica)?

☐ Sim

☐ Não -> Passar à pergunta 5.1

☐ Não sabe / Não responde -> Pg. 5.1

4.2 Quem lhe disse que sofria de angina de peito?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

☐☐

4.3 Há quantos anos sofre de angina de peito?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

4.4 Toma medicamentos para a angina de peito?

☐ Sim

☐ Não -> Passar à pergunta 5.1

☐ Não sabe / Não responde -> Pg. 5.1

4.5 Há quantos anos toma medicamentos para a angina de peito?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

5. Enfarte Agudo do Miocárdio

5.1 Já teve algum enfarte agudo do miocárdio (ataque cardíaco)?

☐ Sim

☐ Não -> Passar à pergunta 6.1

☐ Não sabe / Não responde -> Pg. 6.1

5.2 Há quantos anos teve um enfarte do miocárdio?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

5.3 Foi sujeita a alguma cirurgia ao coração?

☐ Sim

☐ Não

☐ Não sabe / Não responde

6. Insufuciência Cardíaca

6.1 Sofre de insuficiência cardíaca?

☐ Sim

☐ Não -> Passar à pergunta 7.1

☐ Não sabe / Não responde -> Pg. 7.1

6.2 Quem lhe disse que sofria de insuficiência cardíaca?

☐ Médico

☐ Enfermeiro

☐ Farmacêutico

☐ Não sabe / Não responde

☐ Outro (Quem?)

☐☐

6.3 Há quantos anos sofre de insuficiência cardíaca?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

6.4 Toma medicamentos para a insuficiência cardíaca?

☐ Sim

☐ Não -> Passar à pergunta 7.1

☐ Não sabe / Não responde -> Pg. 7.1

6.5 Há quantos anos toma medicamentos para a insuficiência cardíaca?

☐☐

Se não souber ou não responder colocar 99 anos como resposta

7. AVC

7.1 Já teve algum AVC?

☐ Sim

☐ Não -> Passar à pergunta 8

☐ Não sabe / Não responde -> Pg. 8

7.2 Há quantos anos teve um AVC?
(se mais do que 1, o último)

☐☐

Se não souber ou não responder colocar 99 anos como resposta

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8. Para darmos continuidade ao nosso inquérito, deixe-me perguntar-lhe se já teve relações sexuais ou se isso ainda não lhe aconteceu?

☐ Sim, já teve

☐ Não, nunca teve (Agradecer e terminar a entrevista).

Entregar os questionários de auto-preenchimento anexos pela ordem indicada:

- Questionário Adicional sobre Actividade Sexual e Problemas Sexuais

- IIFE

- ADAM (não aplicar se: idade menor que 40 anos)

- GRISS (não aplicar se: não tem parceiro ou tem parceiro do mesmo sexo que o seu - Ver na pergunta 2 do Questionário Adicional sobre Actividade Sexual e Problemas Sexuais)

- GRIMS (não aplicar se: não tem parceiro ou tem parceiro do mesmo sexo que o seu - Ver na pergunta 2 do Questionário Adicional sobre Actividade Sexual e Problemas Sexuais)

B5 - Discussão dos problemas sexuais entre médico de família e utente

Algumas pessoas atravessam períodos em que não estão interessadas na actividade sexual ou têm dificuldades durante o acto sexual.

1. De uma maneira geral, acha que esses problemas sexuais deveriam ser abordados pelo médico de família?

☐ Sim -> Passar à pergunta 3

☐ Não

☐ Não sabe / Não responde -> Passar à pergunta 3

2. Porque não?

☐ Não é uma área importante

☐ O médico de família não tem competência para isso

☐ Não é da área de intervenção do médico de família

☐ Outro motivo (Qual?) ☐☐

☐ Não sabe / Não responde

3. O seu médico de família alguma vez lhe perguntou se tinha problemas ou dificuldades sexuais?

☐ Sim

☐ Não -> Passar à pergunta 5

☐ Não sabe / Não responde -> Passar à pergunta 5

4. Das seguintes hipóteses, qual(quais) foi(foram) a(s) sua(s) reacção(ões) face ao início da conversa? (pode indicar mais do que uma opção)

	Sim	Não	NS / NR
a. Interesse e vontade de falar	☐	☐	☐
b. Alívio por este tema ser abordado	☐	☐	☐
c. Interesse em discutir opções e tratamentos	☐	☐	☐
d. Esperança de poder ser ajudado	☐	☐	☐
e. Indiferença	☐	☐	☐
f. Constrangimento	☐	☐	☐
g. Não quis falar novamente do assunto	☐	☐	☐
h. Desvalorização do assunto	☐	☐	☐

i. Outra (Qual?) ☐☐

Se respondeu a esta pergunta, passar à pergunta 7

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5. Das seguintes opções, qual acha ser o motivo principal para o seu médico não lhe perguntar?

☐ Não é uma área importante

☐ Não tem competência para isso

☐ Não é da área de intervenção do médico de família

☐ Tem desconforto em falar do assunto

☐ Não quer invadir a sua privacidade

☐ Não tem tempo

☐ Outro motivo (Qual?) ☐☐

☐ Não sabe / Não responde

6. Acha que se sentiria confortável se o médico lhe perguntasse sobre eventuais problemas/dificuldades sexuais?

☐ Sim

☐ Não

☐ Não sabe / Não responde

7. Alguma vez falou com o seu médico de família sobre problemas/dificuldades sexuais, por iniciativa própria?

☐ Sim

☐ Não -> Passar à pergunta 9

☐ Não sabe / Não responde -> Passar à pergunta 9

8. Das seguintes hipóteses, qual(quais) foi(foram) a(s) reacção(ões) do seu médico face ao início da conversa? (pode indicar mais do que uma opção)

	Sim	Não	NS / NR
a. Interesse e vontade de falar	☐	☐	☐
b. Alívio por este tema ser abordado	☐	☐	☐
c. Interesse em discutir opções e tratamentos	☐	☐	☐
d. Indiferença	☐	☐	☐
e. Constrangimento	☐	☐	☐
f. Mudou de assunto	☐	☐	☐
g. Sugeriu falar com outro médico	☐	☐	☐
h. Encaminhou-o para um especialista	☐	☐	☐
i. Outra (Qual?)			☐☐

Se respondeu a esta pergunta, passar ao Bloco 6

9. Das seguintes hipóteses qual(quais) a(s) razão(ões) para nunca ter falado com o seu médico de família sobre problemas/dificuldades sexuais? (pode indicar mais do que uma opção)

	Sim	Não	NS / NR
a. Nunca precisei de falar com o meu médico	☐	☐	☐
b. Não é uma área importante	☐	☐	☐
c. É um assunto privado	☐	☐	☐
d. Tenho desconforto em falar do assunto	☐	☐	☐
e. O médico não tem competência para isso	☐	☐	☐
f. Não é da área de intervenção do médico de família	☐	☐	☐
g. O meu médico não é indicado para falar do assunto	☐	☐	☐
h. Não há tempo nas consultas	☐	☐	☐
i. Outra (Qual?)			☐☐

B6 - Auto-avaliação dos problemas sexuais

As perguntas que lhe vou fazer a seguir dizem respeito a eventuais dificuldades sexuais que possa ter.

1. Tem ou já teve algum problema de erecção?

☐ Não tem e nunca teve -> Passar à pergunta 6

☐ Já teve

☐ Incapacidade mínima

☐ Incapacidade moderada

☐ Incapacidade severa/completa

☐ Não sabe / Não responde -> Passar à pergunta 6

2. Há quanto tempo tem? / Durante quanto tempo teve? (indicar os meses se inferior a 1 ano)

☐☐ meses ☐☐ anos

Se não souber ou não responder colocar 99 como resposta em ambas

3. Houve alguma mudança na sua vida que considere ter estado associada ao aparecimento destes problemas?
NÃO LER e assinalar opção principal

☐ Não

☐ Stress pessoal/problemas emocionais

☐ Doença
Qual? _____ ☐☐

☐ Problemas conjugais/relacionais

☐ Stress no parceiro/problemas emocionais

☐ Outros problemas sexuais
Quais? _____ ☐☐

☐ Medicação/doença física

☐ Gravidez/nascimento de um filho

☐ Outra
Qual? _____ ☐☐

☐ Não sabe / Não responde

4. Qual o grau de desconforto/mal-estar que sente/sentia com a situação? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

☐ ☐ ☐ ☐ ☐

Sem desconforto — Extremamente desconfortável

5. No último ano, alguma vez evitou ter relações sexuais por causa deste problema?

☐ Sim

☐ Não

☐ Não sabe / Não responde

6. Tem ou teve algum problema de desejo sexual?

☐ Não tem e nunca teve -> Passar à pergunta 11

☐ Já teve

☐ Tem diminuição ligeira

☐ Tem diminuição moderada

☐ Tem diminuição severa/completa

☐ Não sabe / Não responde -> Passar à pergunta 11

7. Há quanto tempo tem? / Durante quanto tempo teve? (indicar os meses se inferior a 1 ano)

☐☐ meses ☐☐ anos

Se não souber ou não responder colocar 99 como resposta em ambas

8. Houve alguma mudança na sua vida que considere ter estado associada ao aparecimento destes problemas?
NÃO LER e assinalar opção principal

☐ Não

☐ Stress pessoal/problemas emocionais

☐ Doença
Qual? _____ ☐☐

☐ Problemas conjugais/relacionais

☐ Stress no parceiro/problemas emocionais

☐ Outros problemas sexuais
Quais? _____ ☐☐

☐ Medicação/doença física

☐ Gravidez/nascimento de um filho

☐ Outra
Qual? _____ ☐☐

☐ Não sabe / Não responde

9. Qual o grau de desconforto/mal-estar que sente/sentia com a situação? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

☐ ☐ ☐ ☐ ☐

Sem desconforto — Extremamente desconfortável

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10. No último ano, alguma vez evitou ter relações sexuais por causa deste problema?

☐ Sim

☐ Não

☐ Não sabe / Não responde

11. Tem ou teve algum problema de ejaculação?

☐ Não tem e nunca teve -> Ver instrução no final do Bloco

☐ Já teve

☐ Ejaculação precoce

☐ Ejaculação retardada

☐ Ejaculação diminuída

☐ Não sabe / Não responde -> Ver instrução no final do Bloco

12. Há quanto tempo tem? / Durante quanto tempo teve? (indicar os meses se inferior a 1 ano)

☐☐ meses ☐☐ anos

Se não souber ou não responder colocar 99 como resposta em ambas

13. Houve alguma mudança na sua vida que considere ter estado associada ao aparecimento destes problemas? NÃO LER e assinalar opção principal

☐ Não

☐ Stress pessoal/problemas emocionais

☐ Doença
Qual? ☐☐

☐ Problemas conjugais/relacionais

☐ Stress no parceiro/problemas emocionais

☐ Outros problemas sexuais
Quais? ☐☐

☐ Medicação/doença física

☐ Gravidez/nascimento de um filho

☐ Outra
Qual? ☐☐

☐ Não sabe / Não responde

14. Qual o grau de desconforto/mal-estar que sente/sentia com a situação? (De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

☐ ☐ ☐ ☐ ☐

Sem desconforto — Extremamente desconfortável

15. No último ano, alguma vez evitou ter relações sexuais por causa deste problema?

☐ Sim

☐ Não

☐ Não sabe / Não responde

Se respondeu "Não tem e nunca teve" nas perguntas 1, 6, e 11, avançar para o Bloco 9 "Ausência de problemas sexuais"

B7 - Atitudes para com os problemas sexuais

1. Qual(quais) a(s) área(s) em que se sente afectado pelo(s) seu(s) problema(s) sexual(sexuais)?
NÃO LER as opções

	Sim	Não	NS / NR
a. Afecta a sua vida sexual	☐	☐	☐
b. Afecta a sua relação conjugal	☐	☐	☐
c. Afecta a sua vida familiar	☐	☐	☐
d. Afecta o seu trabalho	☐	☐	☐
e. Afecta as suas relações sociais	☐	☐	☐
f. Afecta a sua qualidade de vida	☐	☐	☐
g. Afecta o seu bem-estar	☐	☐	☐
h. Causa-lhe ansiedade	☐	☐	☐
i. Fá-lo sentir-se deprimida	☐	☐	☐
j. Afecta o seu nível de confiança	☐	☐	☐
l. Afecta a sua auto-estima	☐	☐	☐

2. Qual das seguintes frases melhor descreve como os seus problemas sexuais afectam a relação com o(a) seu(sua) parceiro(a)? (apenas uma resposta)

☐ Um problema para si e para o(a) seu(sua) parceiro(a)
☐ Um problema para si mas não para o(a) seu(sua) parceiro (a)
☐ Não é problema para si mas é para o(a) seu(sua) parceiro(a)
☐ Nem é problema para si nem para o(a) seu(sua) parceiro(a)
☐ Não se aplica
☐ Não sabe / Não responde

3. Na sua opinião, qual é a causa principal do(s) seu(s) problema(s) sexual(sexuais)? (apenas uma resposta)

☐ Origem física/médica
☐ Relação com outras condições médicas
Quais? ☐☐
☐ Origem psicológica/emocional
☐ Dificuldades na relação conjugal
☐ Idade/envelhecimento
☐ Stress
☐ Estilo de vida
☐ Inexperiência sexual
☐ Não sabe / Não responde

4. Quem lhe disse?

☐ Ninguém/foi o próprio
☐ O(A) parceiro(a)
☐ Um amigo/familiar
☐ O médico de família
☐ Outro médico
Qual? ☐☐
☐ Outro profissional de saúde
Qual? ☐☐
☐ Outra pessoa
Qual? ☐☐
☐ Não sabe / Não responde

5. O que fez desde que se sentiu afectado?
NÃO LER as opções

Recorreu a outras formas de satisfação sexual (masturbação, sexo oral, etc.).
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Recorreu a material pornográfico, para uma maior estimulação.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Diminuiu o consumo de álcool.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Diminuiu o consumo de tabaco.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Passou a controlar o seu peso.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alterou os seus hábitos alimentares.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Começou a praticar mais exercício físico.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Ficou mais atento à sua saúde.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alterou a sua medicação habitual.
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversou com o seu parceiro(a).
☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversou com amigos.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Falou com um membro religioso.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversou com pessoas na internet (através de chats ou fóruns).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou outro(a) parceiro(a).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionou a sua actual relação conjugal.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Pensou na causa dos problemas sexuais.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionou se tem andado com demasiadas preocupações.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou tratamentos alternativos (ervanárias, etc.).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou informação nos meios de comunicação social.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Contactou uma linha telefónica de apoio

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Não fez nada.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

6. Faz ou já fez algum tratamento para o(s) seu(s) problema(s) sexual(ais)?

☐ Sim, faz (Aplicar Questionário Utilização e Nivel de Satisfação com o Tratamento Masculino) e depois Bloco 8

☐ Já fez (Aplicar Questionário Utilização e Nivel de Satisfação com o Tratamento Masculino) e depois Bloco 8

☐ Nunca fez -> Passe à pergunta 7

7. Porque é que não fez tratamento (razão principal)?

☐ O médico encaminhou para outro profissional

☐ O médico considerou não ser necessário fazer tratamento

☐ O médico não valorizou a situação

☐ O médico não prescreveu porque tem outras doenças

☐ Recusou fazer tratamento

☐ O(A) meu(minha) parceiro(a) recusou

☐ Não tem parceiro(a)

☐ Não sei / Não respondo

B8 - Procura de ajuda junto de profissionais de saúde

1. Falou com algum profissional de saúde?

☐ Sim

☐ Não -> Passar ao Questionário Anexo "Ausência de procura de tratamento"

☐ Não sabe / Não responde -> Passar ao Questionário Anexo "Ausência de procura de tratamento"

2. Com qual ou quais?

a. Médico de Família	☐	f. Psicólogo	☐
b. Urolog/Ginecol	☐	g. Enfermeiro	☐
c. Endocrinologista	☐	h. Farmacêutico	☐
d. Psiquiatra	☐	i. Terapeuta Sexual	☐
e. Outro Clínica Geral	☐	j. NS/NR	☐

l. Outro (Quem?) ☐☐

3. Quanto tempo após começarem os problemas procurou a ajuda de um profissional de saúde?

☐ Até 3 meses

☐ De 3 a 6 meses

☐ De 7 meses a 12 meses

☐ Mais de 1 ano

☐ Não sabe / Não responde

4. Qual o grau de desconforto/mal-estar que sentia com a situação quando procurou ajuda de um profissional?

(De 1 a 5 em que 1 é sem desconforto e 5 extremamente desconfortável)

Sem desconforto ☐ ☐ ☐ ☐ ☐ Extremamente desconfortável

5. Das seguintes hipóteses, indique o motivo principal que o levou a procurar ajuda?

☐ Quer iniciar uma nova relação

☐ Sentiu que a sua relação se estava a deteriorar

☐ O(A) seu(sua) companheiro(a) pediu-lhe

☐ Quer aumentar a sua satisfação sexual

☐ Quer satisfazer melhor o(a) seu(sua) parceiro(a)

☐ Era fonte de sentimentos negativos

☐ O problema tornou-se mais severo e frequente

☐ Quer verificar se está tudo bem com a sua saúde

☐ Está preocupado com a sua fertilidade

☐ Outro motivo (Qual?) ☐☐

☐ Não sabe / Não responde

Se não recorreu a nenhum médico passar às Medições.

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6. Qual o sexo do primeiro médico a que recorreu?

☐ Masculino

☐ Feminino

☐ Não sabe / Não responde

7. Qual a faixa etária do primeiro médico a que recorreu?

☐ Até 40 anos

☐ 40-50 anos

☐ 51-60 anos

☐ Mais de 60 anos

☐ Não sabe / Não responde

8. Dos seguintes procedimentos, indique quais os que o médico adoptou nessa primeira vez?

Quis saber mais sobre os seus problemas sexuais.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou-lhe sobre a frequência das suas relações sexuais.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou por doenças e medicação

☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou sobre a qualidade da sua vida sexual.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Quis saber mais sobre o seu estado mental e emocional.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Perguntou por acontecimentos recentes na sua vida.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Observou os seus genitais.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Pediu análises e/ou exames.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Fez logo o diagnóstico.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Falou das opções do tratamento.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Prescreveu-lhe tratamentos.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Encaminhou-o para outro profissional.

☐ Sim ☐ Não ☐ Não sabe / Não responde

Se respondeu ao bloco 8 passar às Medições Antropométricas.

B9 - Ausência de problemas sexuais

1. Se tivesse problemas sexuais, seria um motivo de preocupação?

☐ Não

☐ Sim, ocasionalmente

☐ Sim, frequentemente

☐ Sim, permanentemente

☐ Não sabe/ Não responde

2. Se tivesse algum problema sexual, procurava ajuda?

☐ Sim

☐ Não -> Passar à pergunta 6

☐ Não sabe/ Não responde -> Passar à pergunta 6

3. A que profissional de saúde recorreria em primeiro lugar?

☐ Médico de família

☐ Outro médico de clínica geral

☐ Psiquiatra

☐ Urologista/Ginecologista

☐ Endocrinologista

☐ Outra especialidade de medicina
Qual? ☐☐

☐ Terapeuta sexual

☐ Psicólogo

☐ Enfermeiro

☐ Farmacêutico

☐ Outro profissional de saúde
Qual? ☐☐

☐ Não sabe qual o profissional mais indicado

☐ Não sabe/ Não responde

4. Qual o sexo do profissional com o qual se sentiria mais confortável para falar sobre o assunto?

☐ Masculino

☐ Feminino

☐ Indiferente

☐ Não sabe/ Não responde

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5. Qual a idade do profissional com o qual se sentiria mais confortável para falar sobre o assunto?

☐ Até 40 anos

☐ 51-60 anos

☐ Mais de 60 anos

☐ Indiferente

☐ Não sabe/ Não responde

6. O que faria se se sentisse afectado?

NÃO LER as opções

Recorria a outras formas de satisfação sexual (masturbação, sexo oral, etc.).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Recorria a material pornográfico, para uma maior estimulação.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Diminuía o consumo de álcool.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Moderava os seus hábitos tabágicos.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Começaria a controlar o peso.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alteraria os hábitos alimentares.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Faria mais exercício do que anteriormente.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Ficava mais atento à sua saúde.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Alterava a sua medicação habitual.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversava com o(a) seu(sua) parceiro(a).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversava com amigos.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Falava com um membro religioso.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Conversava com pessoas na internet (através de chats ou fóruns).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurava outro parceiro.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionava a sua actual relação conjugal.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Pensava na causa dos problemas sexuais.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Questionava se tem andado com demasiadas preocupações.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurou tratamentos alternativos (ervanárias, etc.).

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Procurava informação nos meios de comunicação social.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Contactava linha telefónica de apoio.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Tomava medicamentos sem prescrição médica.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

Não faria nada.

☐ Sim ☐ Não ☐ Não se aplica ☐ NS / NR

O nosso questionário chegou ao fim. Gostava de lhe agradecer toda a disponibilidade e aproveitar para lhe pedir para recolher dados sobre o seu peso e altura. Aceita ser pesado e medido?

Medições Antropométricas:

Qual o seu peso? ☐☐☐ kg

Qual a sua altura? ☐☐☐ cm

Perímetro da cintura ☐☐☐ cm

Se recusar colocar 000 como resposta em todas

Está a participar em algum estudo que envolva a realização de um tratamento?

☐ Sim ☐ Não

Qual?

Notas: Para dar continuidade ao nosso estudo sobre a saúde sexual da população adulta portuguesa, podemos ter de voltar a contactá-lo. Estaria disponível para um novo contacto?

☐ Sim ☐ Não

Contacto:

Telefone ou Telemóvel

Hora preferencial de contacto

Agradecemos a sua colaboração!

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Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

Questionário Auto-preenchido sobre Actividade Sexual e Problemas Sexuais

As próximas perguntas são sobre a sua vida sexual. É muito importante que responda, pois só assim poderemos ter informação sobre a saúde sexual da população portuguesa. É natural que considere algumas perguntas bastante íntimas, mas lembre-se que as suas respostas serão tratadas com absoluta confidencialidade e anonimato. Coloque uma ☒ na reposta adequeda.

1. Qual o número de parceiros sexuais que teve nos últimos doze meses?

☐ Nenhum -> Passe à pergunta 5
☐ Um(a) só parceiro(a) há mais de um ano
☐ Um(a) só parceiro(a) há menos de um ano
☐ Dois(duas) parceiros(as)
☐ Três parceiros(as) ou mais
☐ Não sei / Não me lembro

2. Qual o sexo dos(as) seus(suas) parceiros(as), nos últimos doze meses?

☐ Sem parceiro(a) -> Passe à pergunta 5
☐ Unicamente parceiros do sexo oposto
☐ Parceiros dos dois sexos
☐ Unicamente parceiros do mesmo sexo
☐ Não sei / Não me lembro

3. Das seguintes hipóteses, qual é a situação que melhor descreve a sua relação com o(a) seu(sua) parceiro(a) sexual?

☐ Sem parceiro(a) -> Passe à pergunta 5
☐ Em coabitação
☐ Uma relação há mais de três meses, mas sem coabitação
☐ Uma relação há menos de 3 meses e sem coabitação
☐ Uma relação ocasional

4. Quando foi a última vez que teve relações sexuais?

☐ Há menos de uma semana -> Passe à pergunta 6
☐ Entre 1 semana e 1 mês -> Passe à pergunta 6
☐ Entre 1 e 3 meses -> Passe à pergunta 6
☐ Entre 3 e 6 meses -> Passe à pergunta
☐ Entre 6 meses e 1 ano -> Passe à pergunta 6
☐ Entre 1 ano e 5 anos
☐ Há mais de 5 anos
☐ Não sei / Não me lembro -> Passe à pergunta 6

Existem várias razões que levam as pessoas a não terem relações sexuais.

5. Caso não tenha tido actividade sexual nos últimos doze meses, qual o motivo principal? (apenas uma resposta)

☐ Sem relação amorosa no último ano
☐ O(a) meu(minha) parceiro(a) não quer
☐ Não queremos os dois
☐ Já não tenho idade para isso
☐ Falta de tempo
☐ É contra a minha religião ou moral
☐ Não dou importância à sexualidade
☐ Desconforto nas relações sexuais
☐ Motivo de doença do(a) próprio(a)
Qual? | | | |
☐ Motivo de doença do(a) parceiro(a)
Qual? | | | |
☐ Gravidez (da própria ou parceira)
☐ Falta de desejo
☐ Não quero engravidar / Não quero que a minha parceira engravide
☐ Não quero apanhar nenhuma infecção sexualmente transmissível
☐ Outro motivo
Qual? | | | |

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6. Qual é a importância que atribui à sua vida sexual?

☐ Muito importante

☐ Importante

☐ Pouco importante

☐ Nada importante

7. Como se sentiria se tivesse de passar o resto da vida com o actual desempenho sexual?

☐ Extremamente satisfeito(a)

☐ Ligeiramente satisfeito(a)

☐ Nem satisfeito nem insatisfeito(a)

☐ Ligeiramente insatisfeito(a)

☐ Extremamente insatisfeito(a)

8. Qual a frequência das suas relações sexuais no último ano?

☐ Todos ou quase todos os dias

☐ Algumas vezes por semana

☐ Algumas vezes por mês

☐ Algumas vezes por ano

☐ Não tive relações no último ano

9. Quanto à sua satisfação com a frequência das suas relações sexuais, qual das seguintes situações seria a sua preferida?

☐ Gostava de ter relações sexuais muito mais frequentemente

☐ Gostava de ter relações sexuais mais frequentemente

☐ Está bem assim

☐ Gostava de ter relações sexuais menos frequentemente

☐ Gostava de ter relações sexuais muito menos frequentemente

☐ Gostava de não ter relações sexuais

Algumas pessoas atravessam períodos em que não estão interessadas na actividade sexual ou têm dificuldades durante o acto sexual.

10. O seu(sua) parceiro(a) tem algum problema sexual?

☐ Sim

☐ Não

☐ Não tenho parceiro

☐ Não sei

10.1 Se sim, qual(quais) dos problemas a seguir identificados?

	Sim	Não	Não Sei
a. Problema de excitação e/ou lubrificação	☐	☐	☐
b. Problema de orgasmo	☐	☐	☐
c. Problema de desconforto e/ou dor na relação sexual	☐	☐	☐
d. Problema de desejo/interesse sexual	☐	☐	☐
e. Problema de erecção (obter e/ou manter erecção)	☐	☐	☐
f. Problema de ejaculação (prematura/retardada)	☐	☐	☐
g. Outro (Qual?)			☐☐

11. Concorda com as seguintes afirmações?

As alterações do desejo sexual afectam a qualidade de vida do casal.

☐ Sim ☐ Não ☐ Não sei

Alterações da excitação/lubrificação e diminuição do desejo são a mesma coisa.

☐ Sim ☐ Não ☐ Não sei

Alterações do orgasmo e diminuição do desejo são a mesma coisa.

☐ Sim ☐ Não ☐ Não sei

As alterações da excitação/lubrificação afectam a qualidade de vida do casal.

☐ Sim ☐ Não ☐ Não sei

As alterações do orgasmo afectam a qualidade de vida do casal.

☐ Sim ☐ Não ☐ Não sei

O desconforto/dor na relação sexual afecta a de vida do casal.

☐ Sim ☐ Não ☐ Não sei

12. De uma maneira geral, quais pensa poderem ser as causas dos problemas sexuais?

	Sim	Não	Não Sei
a. Origem física/médica	☐	☐	☐
b. Relação com outras doenças	☐	☐	☐
c. Efeitos secundários de medicação	☐	☐	☐
d. Origem psicológica/emocional	☐	☐	☐
e. Dificuldades na relação conjugal	☐	☐	☐
f. Idade/envelhecimento	☐	☐	☐
g. Stress	☐	☐	☐
h. Estilo de vida	☐	☐	☐
i. Inexperiência sexual	☐	☐	☐
j. Outro (Qual?)			☐☐

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13. Concorda com as seguintes afirmações?

É possível prevenir a diminuição do desejo.

☐ Sim ☐ Não ☐ Não sei

É possível tratar a diminuição do desejo.

☐ Sim ☐ Não ☐ Não sei

É possível prevenir as alterações da excitação/lubrificação.

☐ Sim ☐ Não ☐ Não sei

É possível tratar as alterações da excitação/lubrificação.

☐ Sim ☐ Não ☐ Não sei

É possível prevenir as alterações do orgasmo.

☐ Sim ☐ Não ☐ Não sei

É possível tratar as alterações do orgasmo.

☐ Sim ☐ Não ☐ Não sei

É possível prevenir o desconforto/dor na relação sexuais.

☐ Sim ☐ Não ☐ Não sei

É possível tratar o desconforto/dor na relação sexuais.

☐ Sim ☐ Não ☐ Não sei

14. Conhece tratamentos para os problemas sexuais?

☐ Sim

☐ Não -> Fim do questionário

15. Dos seguintes métodos de tratamento para os problemas sexuais femininos, qual ou quais considera eficazes:

	Sim	Não
a. Medicação hormonal	☐	☐
b. Medicação oral	☐	☐
c. Lubrificantes vaginais	☐	☐
d. Cremes e anestésicos	☐	☐
e. Psicoterapia	☐	☐
f. Terapia sexual	☐	☐
g. Terapia/aconselhamento de casal	☐	☐

h. Outro (Qual?) _____ ☐☐

16. Dos seguintes métodos de tratamento para os problemas sexuais masculinos, qual ou quais considera eficazes:

	Sim	Não
a. Implante peniano	☐	☐
b. Injecções vasodilatadoras	☐	☐
c. Medicação hormonal	☐	☐
d. Viagra	☐	☐
e. Medicação oral (além do Viagra)	☐	☐
f. Dispositivos de vácuo	☐	☐
g. Cremes e anestésicos	☐	☐
h. Psicoterapia	☐	☐
i. Terapia sexual	☐	☐
j. Terapia/aconselhamento de casal	☐	☐

l. Outro (Qual?) _____ ☐☐

17. No geral, o que pensa dos tratamentos para os problemas sexuais?

	Sim	Não	Não Sei
a. São fáceis de realizar	☐	☐	☐
b. Causam desconforto	☐	☐	☐
c. São pouco naturais	☐	☐	☐
d. Têm muitos efeitos secundários	☐	☐	☐
e. São caros	☐	☐	☐
f. Aumentam a satisfação	☐	☐	☐
g. Interferem com a actividade sexual	☐	☐	☐
h. São eficazes	☐	☐	☐

Agradecemos a sua colaboração!

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Auto-preenchimento ☐ Sim ☐ Não

FSFI

ID do Questionário: | | | | | |

Coloque uma cruz na resposta que mais se adequa à sua situação, tendo em conta as **últimas quatro semanas**.

Ao responder a estas perguntas, deverá ter em mente as seguintes definições:

- Actividade sexual inclui relações sexuais, carícias, cenas de sedução e masturbação.
- Relação sexual é definida como penetração do pénis na vagina.
- Estímulo sexual inclui situações como cenas de sedução com o parceiro, ver fotografias eróticas, etc.

1. Com que frequência sentiu desejo ou interesse sexual?

☐ Quase sempre/sempre
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ Poucas vezes (muito menos de metade das vezes)
☐ Quase nunca/nunca

2. Como classifica o seu nível de desejo ou interesse sexual?

☐ Muito Elevado
☐ Elevado
☐ Moderado
☐ Baixo
☐ Muito baixo/nenhum

3. Com que frequência se sentiu sexualmente excitada durante qualquer actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Quase sempre/sempre
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ Poucas vezes (muito menos de metade das vezes)
☐ Quase nunca/nunca

4. Como classifica o seu nível (grau) de excitação sexual durante qualquer actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Muito elevado
☐ Elevado
☐ Moderado
☐ Baixo
☐ Muito baixo/nenhum

5. Qual a sua confiança em conseguir excitar-se durante qualquer actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Confiança muito elevada
☐ Confiança elevada
☐ Confiança moderada
☐ Confiança baixa
☐ Confiança muito baixa/nenhuma

6. Com que frequência se sentiu satisfeita com a sua excitação sexual durante qualquer actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Quase sempre/sempre
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ Poucas vezes (muito menos de metade das vezes)
☐ Quase nunca/nunca

7. Com que frequência ficou lubrificada (molhada) durante qualquer actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Quase sempre/sempre
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ Poucas vezes (muito menos de metade das vezes)
☐ Quase nunca/nunca

8. Qual a dificuldade que teve em ficar lubrificada (molhada) durante qualquer actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Extremamente difícil ou impossível
☐ Muito difícil
☐ Difícil
☐ Ligeiramente difícil
☐ Nenhuma dificuldade

9. Com que frequência manteve a sua lubrificação até ao fim da actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Quase sempre/sempre
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ Poucas vezes (muito menos de metade das vezes)
☐ Quase nunca/nunca

10. Qual a dificuldade que teve em manter a sua lubrificação até ao fim de qualquer actividade ou relação sexual?

☐ Não tive actividade sexual
☐ Extremamente difícil ou impossível
☐ Muito difícil
☐ Difícil
☐ Ligeiramente difícil
☐ Nenhuma dificuldade

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11. Quando teve estimulação sexual ou relações sexuais, com que frequência atingiu o orgasmo (clímax)?

- ☐ Não tive actividade sexual
- ☐ Quase sempre/sempre
- ☐ A maioria das vezes (muito mais de metade das vezes)
- ☐ Algumas vezes (cerca de metade das vezes)
- ☐ Poucas vezes (muito menos de metade das vezes)
- ☐ Quase nunca/nunca

12. Quando teve estimulação ou relações sexuais qual a dificuldade que teve para atingir orgasmo (clímax)?

- ☐ Não tive actividade sexual
- ☐ Extremamente difícil ou impossível
- ☐ Muito difícil
- ☐ Difícil
- ☐ Ligeiramente difícil
- ☐ Nenhuma dificuldade

13. Qual foi o seu nível de satisfação com a sua capacidade para atingir o orgasmo (clímax) durante qualquer actividade sexual?

- ☐ Não tive actividade sexual
- ☐ Muito satisfeita
- ☐ Moderadamente satisfeita
- ☐ Igualmente satisfeita e insatisfeita
- ☐ Moderadamente insatisfeita
- ☐ Muito insatisfeita

14. Qual o seu nível de satisfação com o grau de proximidade emocional entre si e o seu parceiro durante a actividade sexual?

- ☐ Não tive actividade sexual
- ☐ Muito satisfeita
- ☐ Moderadamente satisfeita
- ☐ Igualmente satisfeita e insatisfeita
- ☐ Moderadamente insatisfeita
- ☐ Muito insatisfeita

15. Qual o seu grau de satisfação com o relacionamento sexual que mantém com o seu parceiro?

- ☐ Muito satisfeita
- ☐ Moderadamente satisfeita
- ☐ Igualmente satisfeita e insatisfeita
- ☐ Moderadamente insatisfeita
- ☐ Muito insatisfeita

16. Qual o seu nível de satisfação com a sua vida sexual em geral?

- ☐ Muito satisfeita
- ☐ Moderadamente satisfeita
- ☐ Igualmente satisfeita e insatisfeita
- ☐ Moderadamente insatisfeita
- ☐ Muito insatisfeita

17. Com que frequência sentiu dor ou desconforto durante a penetração vaginal?

- ☐ Não tentei ter relações sexuais
- ☐ Quase sempre/sempre
- ☐ A maioria das vezes (muito mais de metade das vezes)
- ☐ Algumas vezes (cerca de metade das vezes)
- ☐ Poucas vezes (muito menos de metade das vezes)
- ☐ Quase nunca/nunca

18. Com que frequência sentiu dor ou desconforto após a penetração vaginal?

- ☐ Não tentei ter relações sexuais
- ☐ Quase sempre/sempre
- ☐ A maioria das vezes (muito mais de metade das vezes)
- ☐ Algumas vezes (cerca de metade das vezes)
- ☐ Poucas vezes (muito menos de metade das vezes)
- ☐ Quase nunca/nunca

19. Como classifica o seu nível de dor ou desconforto durante ou após a penetração vaginal?

- ☐ Não tentei ter relações sexuais
- ☐ Muito Elevado
- ☐ Elevado
- ☐ Moderado
- ☐ Baixo
- ☐ Muito baixo/nenhum

20. Com que frequência a contracção dos músculos da sua vagina dificultou ou impediu a penetração do pénis durante qualquer relação sexual?

- ☐ Não tentei ter relações sexuais
- ☐ Quase sempre/sempre
- ☐ A maioria das vezes (muito mais de metade das vezes)
- ☐ Algumas vezes (cerca de metade das vezes)
- ☐ Poucas vezes (muito menos de metade das vezes)
- ☐ Quase nunca/nunca

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Auto-preenchimento ☐ Sim ☐ Não

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ID do Questionário: | | | | | |

Coloque uma cruz na resposta que mais se adequa à sua situação, tendo em conta as últimas quatro semanas.

Ao responder a estas perguntas, deverá ter em mente as seguintes definições:

- Actividade sexual inclui relações sexuais, carícias, cenas de sedução e masturbação.
- Relação sexual é definida como penetração do pénis na vagina.
- Estímulo sexual inclui situações como cenas de sedução com a parceira, ver fotografias eróticas, etc.
- Ejaculação: saída do sémen do pénis (ou a sua sensação).

1. Com que frequência foi capaz de conseguir uma erecção durante a sua actividade sexual?

☐ Não tive actividade sexual
☐ Quase nunca/nunca
☐ Poucas vezes (muito menos de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Quase sempre/sempre

2. Quando teve erecções com estimulação sexual, qual a frequência em que estas erecções foram suficientemente rígidas para permitir a penetração?

☐ Não tive relações sexuais
☐ Quase nunca/nunca
☐ Poucas vezes (muito menos de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Quase sempre/sempre

3. Quando tentou ter relações sexuais, quantas vezes foi capaz de penetrar a sua companheira?

☐ Não tentei ter relações sexuais
☐ Quase nunca/nunca
☐ Poucas vezes (muito menos de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Quase sempre/sempre

4. Durante as relações sexuais, quantas vezes é que é que foi capaz de manter a sua erecção depois de ter penetrado a sua companheira?

☐ Não tive actividade sexual
☐ Quase nunca/nunca
☐ Poucas vezes (muito menos de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Quase sempre/sempre

5. Durante as relações sexuais, qual a dificuldade que teve para manter a sua erecção até ao fim da relação sexual?

☐ Não tive relações sexuais
☐ Extrema dificuldade
☐ Muita dificuldade
☐ Dificuldade moderada
☐ Ligeira dificuldade
☐ Nenhuma dificuldade

6. Quantas vezes tentou ter relações sexuais?

☐ Não tentei
☐ Uma a duas tentativas
☐ Três a quatro tentativas
☐ Cinco a seis tentativas
☐ Sete a dez tentativas
☐ Onze ou mais tentativas

7. Quando tentou ter relações sexuais, qual a frequência com que se sentiu satisfeito?

☐ Não tentei ter relaçõese sexuais
☐ Quase nunca/nunca
☐ Poucas vezes (muito menos de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Quase sempre/sempre

8. Qual o grau de satisfação que teve com as suas relações sexuais?

☐ Não tive relações sexuais
☐ Nenhuma satisfação
☐ Pouca satisfação
☐ Satisfação moderada
☐ Grande satisfação
☐ Muito grande satisfação

9. Quando teve estimulação sexual ou relações sexuais, com que frequência ejaculou?

☐ Não tive estimulação/relações sexuais
☐ Quase nunca/nunca
☐ Poucas vezes (muito menos de metade das vezes)
☐ Algumas vezes (cerca de metade das vezes)
☐ A maioria das vezes (muito mais de metade das vezes)
☐ Quase sempre/sempre

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10. Quando teve estimulação sexual ou relações sexuais, com que frequência teve a sensação de orgasmo ou clímax?

- ☐ Não tive estimulação/relações sexuais
- ☐ Quase nunca/nunca
- ☐ Poucas vezes (muito menos de metade das vezes)
- ☐ Algumas vezes (cerca de metade das vezes)
- ☐ A maioria das vezes (muito mais de metade das vezes)
- ☐ Quase sempre/sempre

11. Com que frequência sentiu desejo sexual?

- ☐ Quase nunca/nunca
- ☐ Poucas vezes
- ☐ Algumas vezes
- ☐ A maioria das vezes
- ☐ Quase sempre/sempre

12. Como classifica o seu desejo sexual?

- ☐ Muito baixo/nenhum
- ☐ Baixo
- ☐ Moderado
- ☐ Elevado
- ☐ Muito elevado

13. Qual a sua satisfação com a sua vida sexual em geral?

- ☐ Grande insatisfação
- ☐ Insatisfação moderada
- ☐ Igualmente satisfeito e insatisfeito
- ☐ Satisfação moderada
- ☐ Grande satisfação

14. Qual a sua satisfação com o relacionamento sexual com a sua parceira?

- ☐ Grande insatisfação
- ☐ Insatisfação moderada
- ☐ Igualmente satisfeito e insatisfeito
- ☐ Satisfação moderada
- ☐ Grande satisfação

15. Qual a confiança que tem em conseguir atingir e manter uma erecção?

- ☐ Muito baixa
- ☐ Baixa
- ☐ Moderada
- ☐ Elevada
- ☐ Muito elevada

16. Quando teve erecções com estimulação sexual qual o grau de dificuldade que teve para atingir o orgasmo?

- ☐ Não tive actividade sexual
- ☐ Extrema dificuldade
- ☐ Muita dificuldade
- ☐ Dificuldade moderada
- ☐ Ligeira dificuldade
- ☐ Nenhuma dificuldade

17. Qual o seu nível de satisfação com a sua capacidade para atingir o orgasmo durante a actividade sexual?

- ☐ Não tive estimulação/relações sexuais
- ☐ Nenhuma satisfação
- ☐ Pouca satisfação
- ☐ Satisfação moderada
- ☐ Grande satisfação
- ☐ Muito grande satisfação

18. Durante as relações sexuais, com que frequência ejaculou sem o desejar, antes ou logo após a penetração?

- ☐ Não tive estimulação/relações sexuais
- ☐ Quase nunca/nunca
- ☐ Poucas vezes (muito menos de metade das vezes)
- ☐ Algumas vezes (cerca de metade das vezes)
- ☐ A maioria das vezes (muito mais de metade das vezes)
- ☐ Quase sempre/sempre

19. Durante as relações sexuais, qual a dificuldade que teve para controlar a sua ejaculação?

- ☐ Não tive actividade sexual
- ☐ Extrema dificuldade
- ☐ Muita dificuldade
- ☐ Dificuldade moderada
- ☐ Ligeira dificuldade
- ☐ Nenhuma dificuldade

20. Qual o seu nível de satisfação com a sua capacidade para controlar a ejaculação durante a actividade sexual?

- ☐ Não tive relações sexuais
- ☐ Nenhuma satisfação
- ☐ Pouca satisfação
- ☐ Satisfação moderada
- ☐ Grande satisfação
- ☐ Muito grande satisfação

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INVENTÁRIO DE SATISFAÇÃO MARITAL GOLOMBOK RUST

Cada uma das questões é seguida por uma série de respostas possíveis:

1=Discordo fortemente; 2=Discordo; 3=Concordo; 4=Concordo fortemente.

Leia cada questão cuidadosamente e decida qual das respostas melhor descreve o modo como se sente no relacionamento com o(a) seu(sua) parceiro(a). Seguidamente, assinale a sua resposta com uma cruz.

Por favor, responda a todas as questões e apenas dê uma resposta por pergunta. Se nenhuma das respostas lhe parecer completamente precisa, assinale a que considerar mais apropriada. Não demore muito tempo em cada questão. Para que possamos obter informação válida, é importante que responda de modo tão sincero e preciso quanto possível a cada uma das questões.

TODA A INFORMAÇÃO SERÁ TRATADA COM ESTRITA CONFIDENCIALIDADE.

	1	2	3	4
1. O(a) meu(minha) companheiro(a) é normalmente sensível e consciente das minhas necessidades.	☐	☐	☐	☐
2. Eu realmente aprecio o sentido de humor do(a) meu(minha) companheiro(a).	☐	☐	☐	☐
3. O(a) meu(minha) companheiro(a) parece já não me ouvir mais.	☐	☐	☐	☐
4.O(a) meu(minha) companheiro(a) nunca me foi desleal.	☐	☐	☐	☐
5. Eu estaria disposto(a) a desistir dos meus amigos se tal significasse salvar o nosso relacionamento.	☐	☐	☐	☐
6. Estou insatisfeito(a) com o nosso relacionamento.	☐	☐	☐	☐
7. Gostaria que o(a) meu(minha) companheiro(a) não fosse tão preguiçoso(a) e não andasse a pôr as coisas fora do lugar.	☐	☐	☐	☐
8. Algumas vezes sinto-me sozinho(a) mesmo quando estou com o(a) meu (minha) companheiro(a).	☐	☐	☐	☐
9. Se o(a) meu(minha) companheiro(a) me deixasse a vida não merecia a pena ser vivida.	☐	☐	☐	☐
10. Nós conseguimos "concordar em discordar" um com o outro.	☐	☐	☐	☐
11. É inútil manter um casamento para além de um certo limite.	☐	☐	☐	☐
12. Ambos parecemos gostar das mesmas coisas.	☐	☐	☐	☐
13. Considero difícil mostrar ao meu(minha) companheiro(a) que me sinto ligado(a).	☐	☐	☐	☐
14. Eu nunca tenho segundas intenções acerca do nosso relacionamento.	☐	☐	☐	☐
15. Tenho prazer em simplesmente em estar sentado e a falar com o(a) meu(minha) companheiro(a).	☐	☐	☐	☐
16. Considero bastante aborrecida a ideia de passar o resto da minha vida com o(a) meu (minha) companheiro(a).	☐	☐	☐	☐
17. Existe sempre bastante "dar e receber" no nosso relacionamento.	☐	☐	☐	☐
18. Tornamo-nos competitivos quando temos que tomar decisões.	☐	☐	☐	☐
19. Já não sinto que posso confiar verdadeiramente no(a) meu(minha) companheiro(a).	☐	☐	☐	☐
20. O nosso relacionamento ainda é pleno de alegria e excitação.	☐	☐	☐	☐
21. Um de nós fala continuamente e o outro normalmente está em silêncio.	☐	☐	☐	☐
22. O nosso relacionamento está constantemente em desenvolvimento.	☐	☐	☐	☐
23. O casamento tem muito mais a ver com segurança e dinheiro do que com amor.	☐	☐	☐	☐
24. Gostaria que houvesse mais entusiasmo e afecto no nosso relacionamento.	☐	☐	☐	☐
25. Estou completamente comprometido(a) no meu relacionamento com o(a) meu (minha) companheiro(a).	☐	☐	☐	☐
26. O nosso relacionamento é por vezes sufocante porque o(a) meu (minha) companheiro(a) está sempre a corrigir-me.	☐	☐	☐	☐
27. Eu suspeito que podemos estar à beira da separação.	☐	☐	☐	☐
28. Nós podemos sempre fazer as pazes depois de uma discussão.	☐	☐	☐	☐

Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

40837

INVENTÁRIO DE SATISFAÇÃO SEXUAL COLOMBOK RUST
Versão Feminina

Cada uma das questões é seguida por uma série de respostas possíveis:

1 = nunca; 2 = quase nunca; 3 = ocasionalmente; 4 = habitualmente; 5 = sempre

Leia cada questão cuidadosamente e decida qual das respostas melhor descreve o modo como as coisas têm acontecido consigo recentemente. Seguidamente, assinale a sua resposta com uma cruz.

Por favor, responda a todas as questões. Se não tiver a certeza em relação à resposta mais precisa, assinale a que considerar mais apropriada. Não demore muito tempo em cada questão. Por favor, responda a este questionário sem discutir qualquer das questões com o seu parceiro. Para que possamos obter informação válida, é importante que responda de modo tão honesto e preciso quanto possível a cada uma das questões.

TODA A INFORMAÇÃO SERÁ TRATADA COM ESTRITA CONFIDENCIALIDADE.

	1	2	3	4	5
1. Sente-se desinteressada em sexo?	☐	☐	☐	☐	☐
2. Pergunta ao seu parceiro o que é que ele gosta ou não gosta no vosso relacionamento sexual?	☐	☐	☐	☐	☐
3. Há semanas que não existe qualquer actividade sexual?	☐	☐	☐	☐	☐
4. Excita-se sexualmente com facilidade?	☐	☐	☐	☐	☐
5. Está satisfeita com o tempo que demora com o seu parceiro em preliminares?	☐	☐	☐	☐	☐
6. Considera a sua vagina tão apertada que o pénis do seu parceiro não consegue entrar?	☐	☐	☐	☐	☐
7. Tenta evitar praticar sexo com o seu parceiro?	☐	☐	☐	☐	☐
8. Consegue atingir um orgasmo com o seu parceiro?	☐	☐	☐	☐	☐
9. Tem prazer em abraçar e acariciar o corpo do seu parceiro?	☐	☐	☐	☐	☐
10. Considera satisfatório o relacionamento sexual com o seu parceiro?	☐	☐	☐	☐	☐
11. É-lhe possível inserir o seu dedo na sua vagina sem desconforto?	☐	☐	☐	☐	☐
12. Desagrada-lhe tocar e acariciar o pénis do seu parceiro?	☐	☐	☐	☐	☐
13. Fica tensa e ansiosa quando o seu parceiro quer praticar sexo?	☐	☐	☐	☐	☐
14. Considera impossível atingir um orgasmo?	☐	☐	☐	☐	☐
15. Tem relações sexuais mais do que duas vezes por semana?	☐	☐	☐	☐	☐
16. É-lhe difícil dizer ao seu parceiro o que gosta e não gosta no vosso relacionamento sexual?	☐	☐	☐	☐	☐
17. É possível o pénis do seu parceiro entrar na sua vagina sem desconforto?	☐	☐	☐	☐	☐
18. Sente que existe falta de amor e afecto no relacionamento sexual com o seu parceiro?	☐	☐	☐	☐	☐
19. Tem prazer em que os seus genitais sejam tocado e acariciados pelo seu parceiro?	☐	☐	☐	☐	☐
20. Recusa-se a praticar sexo com o seu parceiro?	☐	☐	☐	☐	☐
21. Consegue atingir o orgasmo quando o seu parceiro estimula o seu clitóris durante os preliminares?	☐	☐	☐	☐	☐
22. Sente-se insatisfeita com o tempo que o seu parceiro demora no acto sexual em si mesmo?	☐	☐	☐	☐	☐
23. Sente nojo em relação ao que faz enquanto faz amor?	☐	☐	☐	☐	☐
24. Considera a sua vagina de tal modo apertada que o pénis do seu parceiro não consegue penetrar com profundidade?	☐	☐	☐	☐	☐
25. Desagrada-lhe ser abraçada e acariciada pelo seu parceiro?	☐	☐	☐	☐	☐
26. A sua vagina fica húmida enquanto faz amor?	☐	☐	☐	☐	☐
27. Tem prazer em ter relações sexuais com o seu parceiro?	☐	☐	☐	☐	☐
28. Não consegue atingir o orgasmo durante o acto sexual?	☐	☐	☐	☐	☐

Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

35185

INVENTÁRIO DE SATISFAÇÃO SEXUAL GOLOMBOK RUST
Versão Masculina

Cada uma das questões é seguida por uma série de respostas possíveis:

1 = nunca; 2 = quase nunca; 3 = ocasionalmente; 4 = habitualmente; 5 = sempre

Leia cada questão cuidadosamente e decida qual das respostas melhor descreve o modo como as coisas têm acontecido consigo recentemente; seguidamente, assinale a sua resposta com uma cruz.

Por favor, responda a todas as questões. Se não tiver a certeza em relação à resposta mais precisa, assinale a que considerar mais apropriada. Não demore muito tempo em cada questão. Por favor, responda a este questionário sem discutir qualquer das questões com o seu parceiro. Para que possamos obter informação válida, é importante que responda de modo tão honesto e preciso quanto possível a cada uma das questões.

TODA A INFORMAÇÃO SERÁ TRATADA COM ESTRITA CONFIDENCIALIDADE.

	1	2	3	4	5
1. Tem relações sexuais mais do que duas vezes por semana?	☐	☐	☐	☐	☐
2. É-lhe difícil dizer à sua parceira o que gosta e não gosta no vosso relacionamento sexual?	☐	☐	☐	☐	☐
3. Excita-se sexualmente com facilidade?	☐	☐	☐	☐	☐
4. É capaz de atrasar a ejaculação durante o acto sexual se pensar que está a ser muito rápido?	☐	☐	☐	☐	☐
5. Está insatisfeito com a variedade da sua vida sexual com a sua parceira?	☐	☐	☐	☐	☐
6. Desagrada-lhe tocar e acariciar os genitais da sua parceira?	☐	☐	☐	☐	☐
7. Fica tenso e ansioso quando a sua parceira quer praticar sexo?	☐	☐	☐	☐	☐
8. Tem prazer em ter relações sexuais com a sua parceira?	☐	☐	☐	☐	☐
9. Pergunta à sua parceira o que é que ela gosta ou não gosta no vosso relacionamento sexual?	☐	☐	☐	☐	☐
10. Não consegue ter uma erecção?	☐	☐	☐	☐	☐
11. Sente que existe falta de amor e afecto no relacionamento sexual com a sua parceira?	☐	☐	☐	☐	☐
12. Tem prazer em que o seu pénis seja tocado e acariciado pela sua parceira?	☐	☐	☐	☐	☐
13. Consegue evitar uma ejaculação muito rápida durante o acto sexual?	☐	☐	☐	☐	☐
14. Tenta evitar praticar sexo com a sua parceira?	☐	☐	☐	☐	☐
15. Considera satisfatório o relacionamento sexual com a sua parceira?	☐	☐	☐	☐	☐
16. Consegue ter uma erecção durante os preliminares com a sua parceira?	☐	☐	☐	☐	☐
17. Há semanas que não pratica qualquer actividade sexual?	☐	☐	☐	☐	☐
18. Tem prazer na masturbação mútua com a sua parceira?	☐	☐	☐	☐	☐
19. Se quiser praticar sexo com a sua parceira toma a iniciativa?	☐	☐	☐	☐	☐
20. Desagrada-lhe ser abraçado e acariciado pela sua parceira?	☐	☐	☐	☐	☐
21. Tem relações sexuais com a frequência que gostaria?	☐	☐	☐	☐	☐
22. Recusa-se a praticar sexo com a sua parceira?	☐	☐	☐	☐	☐
23. Perde erecção durante o acto sexual?	☐	☐	☐	☐	☐
24. Tem uma ejaculação "sem querer", quase imediatamente após a entrada do seu pénis na vagina da sua parceira?	☐	☐	☐	☐	☐
25. Tem prazer em abraçar e acariciar o corpo da sua parceira?	☐	☐	☐	☐	☐
26. Sente-se desinteressado em sexo?	☐	☐	☐	☐	☐
27. Ejacula por acidente imediatamente antes da entrada do seu pénis na vagina da sua parceira?	☐	☐	☐	☐	☐
28. Sente nojo em relação àquilo que faz quando está a fazer amor?	☐	☐	☐	☐	☐

Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

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Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

QUESTIONÁRIO

AUSÊNCIA DE PROCURA DE TRATAMENTO PARA PROBLEMAS SEXUAIS

PARTE I - INTENÇÃO DE PROCURA DE TRATAMENTO

Por favor, preencha a resposta que considerar correcta para a sua situação.

A. Intenção de procura de ajuda	Sim	Não
1. Gostava de tratar os seus problemas sexuais?	☐	☐
2. Já ponderou procurar ajuda profissional?	☐	☐

B. Características dos profissionais

3. Se sim, a quem pensa recorrer?

- ☐ Médico de família
- ☐ Outro médico de clínica geral
- ☐ Psiquiatra
- ☐ Urologista/Ginecologista
- ☐ Endocrinologista
- ☐ Outro especialista de medicina (Qual?) _____ | |
- ☐ Terapeuta Sexual
- ☐ Psicólogo
- ☐ Enfermeiro
- ☐ Farmacêutico
- ☐ Outro profissional de saúde (Qual?) _____ | |
- ☐ Não sabe a quem recorrer

4. Qual o sexo do profissional com o qual se sentiria mais confortável para falar sobre o assunto? (seleccione apenas uma resposta)

☐ Masculino ☐ Feminino ☐ Indiferente

5. Qual a faixa etária do profissional com o qual se sentiria mais confortável para falar sobre o assunto? (seleccione apenas uma resposta)

☐ Até 40 anos ☐ 41-50 anos ☐ 51-60 anos ☐ Mais de 60 anos ☐ Indiferente

PARTE II - BARREIRAS À PROCURA DE TRATAMENTO JUNTO DE PROFISSIONAIS DE SAÚDE

Gostaríamos de conhecer melhor quais os motivos pelos quais não procurou tratamento para as suas dificuldades sexuais junto de um profissional de saúde.

As frases seguintes descrevem alguns dos motivos referidos por pessoas que não procuraram tratamento para as suas dificuldades sexuais. Para cada frase, pedimos-lhe então que preencha a resposta na coluna que considerar mais indicada:

Sim : Quando a frase tem um motivo pelo qual não foi procurar tratamento.
Não : Quando considerar que uma frase não reflecte um motivo pelo qual não foi procurar tratamento.
Não aplicável : Se achar que alguma das frases não se aplica à sua situação específica.

A. Intenção de procura de ajuda	Sim	Não	Não aplicável
1. Faz parte da idade	☐	☐	☐
2. Já não tenho idade para tratar isso	☐	☐	☐
3. Não é um problema médico	☐	☐	☐
4. Tenho outros problemas de saúde	☐	☐	☐
5. O problema vai resolver-se por si próprio	☐	☐	☐
6. Estes problemas não são importantes	☐	☐	☐
7. Continuo satisfeito(a) com a minha vida sexual	☐	☐	☐
8. Eu e o meu parceiro(a) demos a volta ao problema	☐	☐	☐
9. Já aprendi a viver assim	☐	☐	☐

B. Constrangimentos	Sim	Não	Não aplicável
1. Tenho vergonha de falar sobre estas dificuldades	☐	☐	☐
2. Não gosto de falar da minha vida sexual	☐	☐	☐
3. Tenho medo de parecer ignorante	☐	☐	☐
4. Assusta-me ter de fazer exames	☐	☐	☐

C. Relação com companheiro	Sim	Não	Não aplicável
1. O(A) meu(minha) parceiro(a) ainda não se queixou	☐	☐	☐
2. O(A) meu(minha) parceiro(a) não tem interesse sexual	☐	☐	☐
3. O(A) meu(minha) parceiro(a) não tem saúde	☐	☐	☐
4. Eu e o(a) meu(minha) parceiro(a) nunca falámos do assunto	☐	☐	☐
5. Se mudar de parceiro(a) o problema desaparece	☐	☐	☐

D. **Posicionamento face aos médicos**	Sim	Não	Não aplicável
1. Nunca me perguntaram sobre isso nas consultas	☐	☐	☐
2. Não achei que fosse assunto para falar com o meu médico	☐	☐	☐
3. O meu médico nunca se mostrou disponível	☐	☐	☐
4. Nenhum médico me pode ajudar	☐	☐	☐
5. O médico vai achar normal da idade e não vai compreender	☐	☐	☐
6. O meu médico não é indicado (idade e/ou sexo)	☐	☐	☐
7. Não tenho uma relação muito próxima com o meu médico	☐	☐	☐
8. Não achei o médico preparado para discutir este assunto	☐	☐	☐
9. Os médicos são sempre muito apressados	☐	☐	☐
10. O meu tempo com o médico é muito curto	☐	☐	☐

E. **Características dos tratamentos**	Sim	Não	Não aplicável
1. Não quero tomar drogas para este problema	☐	☐	☐
2. Não gosto de tomar medicação	☐	☐	☐
3. Os medicamentos para estes problemas são perigosos	☐	☐	☐
4. São tratamentos pouco naturais	☐	☐	☐
5. Esses tratamentos têm muitos efeitos secundários	☐	☐	☐
6. Os tratamentos são caros	☐	☐	☐
7. Os tratamentos actuais não são eficazes	☐	☐	☐
8. Tenho medo de ficar dependente da medicação/ dos tratamentos	☐	☐	☐

F. **Outros motivos**	Sim	Não	Não aplicável
1. Nunca tinha pensado em procurar ajuda	☐	☐	☐
2. Não sei onde procurar ajuda	☐	☐	☐
3. Não há serviços apropriados para tratar estes problemas	☐	☐	☐
4. Vou ter de esperar muito tempo pela consulta e pelos tratamentos	☐	☐	☐
5. Não tenho tempo	☐	☐	☐
6. Não tenho dinheiro para isso	☐	☐	☐
7. Tenho outras preocupações mais graves	☐	☐	☐
8. Tenho medo que isto seja sintoma de alguma doença grave	☐	☐	☐
9. O sexo não é muito importante para mim	☐	☐	☐
10. Não tenho desejo sexual	☐	☐	☐

Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

Questionário Auto-preenchido sobre Utilização e Nível de Satisfação com o Tratamento Feminino

As próximas perguntas são sobre os tratamentos para os problemas sexuais. É muito importante que responda, pois só assim poderemos ter informação sobre os tratamentos sexuais utilizados pela população portuguesa. É natural que considere algumas perguntas bastante íntimas, mas lembre-se que as suas respostas serão tratadas com absoluta confidencialidade e anonimato. Coloque uma ☒ na reposta adequada.

1. Que tratamentos fez da seguinte lista?

	Faço	Já fiz	Nunca Fiz
a. Medicação hormonal (adesivos)	☐	☐	☐
b. Medicação oral	☐	☐	☐
c. Lubrificantes vaginais	☐	☐	☐
d. Cremes e anestésicos	☐	☐	☐
e. Psicoterapia	☐	☐	☐
f. Terapia sexual	☐	☐	☐
g. Terapia/aconselhamento de casal	☐	☐	☐

h. Outro (Qual?) _____ ☐☐

2. Qual o papel do(a) seu(sua) parceiro(a) na escolha do tratamento?

☐ Escolhi sozinha o tratamento, sem discutir as opções com o(a) meu(minha) parceiro(a)
☐ Discuti as opções com o(a) meu(minha) parceiro(a), mas a decisão foi minha
☐ Decidimos juntos(as) o tratamento a efectuar
☐ Discutimos juntos(as) o tratamento, mas a decisão foi do(a) meu(minha) parceiro(a)
☐ O meu (minha) parceiro(a) escolheu sozinho o tratamento a efectuar
☐ Outro (Qual?) _____ ☐☐
☐ Não tenho parceiro(a)

3. Qual o papel do médico na escolha do tratamento?

☐ Prescreveu um tratamento, sem ter em conta a minha opinião
☐ Discutiu as opções de tratamento comigo, mas a decisão foi dele
☐ Discutiu as opções de tratamento comigo e tomámos uma decisão em conjunto
☐ Discutiu as opções de tratamento comigo e deixou que eu tomasse a decisão
☐ Limitou-se a prescrever o que lhe pedi
☐ Outro (Qual?) _____ ☐☐
☐ Não falei com o médico -> Passar à pergunta 5

4. Qual o grau de satisfação com o esclarecimento prestado pelo médico acerca do tratamento?

☐ Extremamente satisfeito
☐ Ligeiramente satisfeito
☐ Nem satisfeito nem insatisfeito
☐ Ligeiramente insatisfeito
☐ Extremamente insatisfeito
☐ Não falei com o médico

5. Qual a frequência com que realiza o tratamento?

☐ Quase nunca
☐ Poucas vezes (muito menos de metade das vezes) que tenho relações sexuais
☐ Algumas vezes (cerca de metade das vezes) que tenho relações sexuais
☐ A maioria das vezes (muito mais de metade das vezes) que tenho relações sexuais
☐ Quase sempre ou sempre
☐ Não se aplica / O tratamento não é realizado durante as relações sexuais
☐ Não sei / Não me lembro

6. Concorda ou discorda com as seguintes afirmações sobre o tratamento (se utiliza mais do que um tratamento, considere o que utiliza mais vezes):

	Sim	Não	Não Sei
a. É fácil de realizar?	☐	☐	☐
b. É desconfortável?	☐	☐	☐
c. Interfere com a minha vida sexual?	☐	☐	☐
d. Afecta o meu estilo de vida?	☐	☐	☐
e. Exige um grande esforço?	☐	☐	☐
f. É rápido a fazer efeito?	☐	☐	☐
g. Tem efeitos prolongados?	☐	☐	☐
h. Torna-me mais confiante?	☐	☐	☐
i. Aumenta a minha auto-estima?	☐	☐	☐
j. Aumenta a qualidade de vida?	☐	☐	☐

Certas pessoas sentem efeitos secundários/indesejáveis com o tratamento.

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7. Sentiu efeitos secundários do tratamento?

☐ Sim

☐ Não -> Passe à pergunta 9

☐ Não sei -> Passe à pergunta 9

8. Dos seguintes efeitos secundários indique se os sentiu ou não:

	Sim	Não	Não Sei
a. Dores de cabeça/tonturas	☐	☐	☐
b. Náuseas	☐	☐	☐
c. Congestão/corrimento nasal	☐	☐	☐
d. Alterações da pressão arterial	☐	☐	☐
e. Problemas respiratórios	☐	☐	☐
f. Problemas digestivos	☐	☐	☐
g. Dores musculares	☐	☐	☐
h. Problemas urinários	☐	☐	☐
i. Alterações de visão	☐	☐	☐
j. Nervosismo/agitação	☐	☐	☐
l. Alterações nos órgãos genitais	☐	☐	☐
m. Outro (Qual?)			☐☐

9. Após o início do tratamento, houve alguma alteração na frequência das suas relações sexuais?

☐ Aumentou consideravelmente

☐ Aumentou ligeiramente

☐ Nem aumentou nem diminuiu

☐ Diminuiu ligeiramente

☐ Diminuiu consideravelmente

☐ Não sei / Não me lembro

10. Após o início do tratamento, sentiu diferença no seu grau de actividade no seu dia-a-dia?

☐ Tornou-me muito mais activa

☐ Tornou-me ligeiramente mais activa

☐ Sem interferência no meu grau de actividade

☐ Tornou-me ligeiramente menos activa

☐ Tornou-me muito menos activa

☐ Não sei / Não me lembro

11. Comparando com o período anterior ao aparecimento dos problemas sexuais, considera ter havido alguma mudança quanto ao seu desempenho sexual?

☐ Está muito melhor

☐ Está um pouco melhor

☐ Está ao mesmo nível

☐ Um pouco pior

☐ Está muito pior

☐ Não sei / Não me lembro

12. Após o início do tratamento, houve alguma variação na sua satisfação sexual?

☐ Aumentou consideravelmente

☐ Aumentou ligeiramente

☐ Nem aumentou nem diminuiu

☐ Diminuiu ligeiramente

☐ Diminuiu consideravelmente

☐ Não sei / Não me lembro

13. Qual considera ter sido a eficácia do tratamento?

☐ Extremamente eficaz

☐ Ligeiramente eficaz

☐ Nem eficaz nem ineficaz

☐ Ligeiramente ineficaz

☐ Extremamente ineficaz

☐ Não sei / Não me lembro

14. No geral, qual a sua satisfação com o tratamento?

☐ Extremamente satisfeita

☐ Ligeiramente satisfeita

☐ Nem satisfeita nem insatisfeita

☐ Ligeiramente insatisfeita

☐ Extremamente insatisfeita

15. Qual o grau de satisfação do(a) seu(sua) parceiro(a) com o tratamento?

☐ Extremamente satisfeito(a)

☐ Ligeiramente satisfeito(a)

☐ Nem satisfeito(a) nem insatisfeito(a)

☐ Ligeiramente insatisfeito(a)

☐ Extremamente insatisfeito(a)

☐ Não sei / Não respondo

☐ Não tenho pareiro(a)

16. Quais as suas perspectivas em relação à continuação do tratamento?

☐ Desejo continuar -> Passe à pergunta 20

☐ Ainda não tenho opinião formada -> Passe à pergunta 20

☐ Não quero continuar

☐ Já abandonei o tratamento

17. Porquê?

☐ Tem/tinha muitos efeitos secundários

☐ Os resultados foram abaixo dos previstos

☐ Terminei a minha relação amorosa

☐ Alterei o meu estilo de vida

☐ Outro (Qual?) ☐☐

18. Fez mais tratamentos depois de ter abandonado?

☐ Sim

☐ Não -> Passe à pergunta 22

19. Quais?

	Sim	Não	Não Sei
a. Medicação hormonal	☐	☐	☐
b. Medicação oral	☐	☐	☐
c. Lubrificantes vaginais	☐	☐	☐
d. Cremes e anestésicos	☐	☐	☐
e. Psicoterapia	☐	☐	☐
f. Terapia sexual	☐	☐	☐
g. Terapia/aconselhamento de casal	☐	☐	☐

h. Outro (Qual?) ☐☐

20. Tem/teve consultas de acompanhamento acerca do tratamento?

☐ Sim

☐ Não -> Fim do questionário

☐ Não sei / Não me lembro -> Fim do questionário

21. Está satisfeita com o acompanhamento que tem tido relativamente ao tratamento?

☐ Sim

☐ Não

☐ Não sei / Não respondo -> Fim do questionário

22. Porque é que não fez outro tratamento (razão principal)?

☐ O médico encaminhou-me para outro profissional

☐ O médico considerou não ser necessário fazer tratamento

☐ O médico não valorizou a situação

☐ O médico não prescreveu porque tenho outras doenças

☐ Recusei fazer tratamento

☐ O meu(minha) parceiro(a) recusou

☐ Não tenho parceiro(a)

☐ Não sei / Não respondo

Agradecemos a sua colaboração!

Auto-preenchimento ☐ Sim ☐ Não

ID do Questionário: | | | | | |

Questionário Auto-preenchido sobre Utilização e Nível de Satisfação com o Tratamento Masculino

As próximas perguntas são sobre os tratamentos para os problemas sexuais. É muito importante que responda, pois só assim poderemos ter informação sobre os tratamentos sexuais utilizados pela população portuguesa. É natural que considere algumas perguntas bastante íntimas, mas lembre-se que as suas respostas serão tratadas com absoluta confidencialidade e anonimato. Coloque uma ☒ na reposta adequada.

1. Que tratamentos fez da seguinte lista?

	Faço	Já fiz	Nunca Fiz
a. Implante peniano	☐	☐	☐
b. Injecções vasodilatadoras	☐	☐	☐
c. Medicação hormonal	☐	☐	☐
d. Viagra	☐	☐	☐
e. Medicação oral (além do Viagra)	☐	☐	☐
f. Dispositivos de vácuo	☐	☐	☐
g. Cremes e anestésicos	☐	☐	☐
h. Psicoterapia	☐	☐	☐
i. Terapia Sexual	☐	☐	☐
j. Terapia/aconselhamento de casal	☐	☐	☐

l. Outro (Qual?) _____ ☐☐

2. Qual o papel do(a) seu(sua) parceiro(a) na escolha do tratamento?

☐ Escolhi sozinho o tratamento, sem discutir as opções com o(a) meu(minha) parceiro(a)
☐ Discuti as opções com o(a) meu(minha) parceiro(a), mas a decisão foi minha
☐ Decidimos juntos(as) o tratamento a efectuar
☐ Discutimos juntos(as) o tratamento, mas a decisão foi do(a) meu(minha) parceiro(a)
☐ O meu (minha) parceiro(a) escolheu sozinho o tratamento a efectuar
☐ Outro (Qual?) _____ ☐☐
☐ Não tenho parceiro(a)

3. Qual o papel do médico na escolha do tratamento?

☐ Prescreveu um tratamento, sem ter em conta a minha opinião
☐ Discutiu as opções de tratamento comigo, mas a decisão foi dele
☐ Discutiu as opções de tratamento comigo e tomámos uma decisão em conjunto
☐ Discutiu as opções de tratamento comigo e deixou que eu tomasse a decisão
☐ Limitou-se a prescrever o que lhe pedi
☐ Outro (Qual?) _____ ☐☐
☐ Não falei com o médico -> Passar à pergunta 5

4. Qual o grau de satisfação com o esclarecimento prestado pelo médico acerca do tratamento?

☐ Extremamente satisfeito
☐ Ligeiramente satisfeito
☐ Nem satisfeito nem insatisfeito
☐ Ligeiramente insatisfeito
☐ Extremamente insatisfeito
☐ Não falei com o médico

5. Qual a frequência com que realiza o tratamento?

☐ Nunca
☐ Poucas vezes (muito menos de metade das vezes) que tenho relações sexuais
☐ Algumas vezes (cerca de metade das vezes) que tenho relações sexuais
☐ A maioria das vezes (muito mais de metade das vezes) que tenho relações sexuais
☐ Quase sempre ou sempre
☐ Não se aplica / O tratamento não é realizado durante as relações sexuais
☐ Não sei / Não me lembro

Certas pessoas sentem efeitos secundários/indesejáveis com o tratamento.

6. Sentiu efeitos secundários do tratamento?

☐ Sim
☐ Não -> Passe à pergunta 8
☐ Não sei -> Passe à pergunta 8

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7. Dos seguintes efeitos secundários indique se os sentiu ou não:

	Sim	Não	Não Sei
a. Dores de cabeça/tonturas	☐	☐	☐
b. Náuseas	☐	☐	☐
c. Congestão/corrimento nasal	☐	☐	☐
d. Alterações da pressão arterial	☐	☐	☐
e. Problemas respiratórios	☐	☐	☐
f. Problemas digestivos	☐	☐	☐
g. Dores musculares	☐	☐	☐
h. Problemas urinários	☐	☐	☐
i. Alterações de visão	☐	☐	☐
j. Nervosismo/agitação	☐	☐	☐
l. Alterações nos órgãos genitais	☐	☐	☐

m. Outro (Qual?) _____ ☐☐

8. Após o início do tratamento, houve alguma alteração na frequência das suas relações sexuais?

☐ Aumentou consideravelmente

☐ Aumentou ligeiramente

☐ Nem aumentou nem diminuiu

☐ Diminuiu ligeiramente

☐ Diminuiu consideravelmente

☐ Não sei / Não me lembro

9. Após o início do tratamento houve uma alteração no seu nível de satisfação sexual, com a sua vida em geral?

☐ Está muito melhor

☐ Está um pouco melhor

☐ Está ao mesmo nível

☐ Um pouco pior

☐ Está muito pior

☐ Não sei / Não me lembro

10. Após o início do tratamento, sentiu diferença no seu grau de actividade no seu dia-a-dia?

☐ Tornou-me muito mais activo

☐ Tornou-me ligeiramente mais activo

☐ Sem interferência no meu grau de actividade

☐ Tornou-me ligeiramente menos activo

☐ Tornou-me muito menos activo

☐ Não sei / Não me lembro

11. Em termos gerais, até que ponto está satisfeito ou insatisfeito com este tratamento?

☐ Muito satisfeito

☐ Moderadamente satisfeito

☐ Nem satisfeito nem insatisfeito

☐ Moderadamente insatisfeito

☐ Muito insatisfeito

12. Durante as últimas quatro semanas, até que ponto é que o tratamento correspondeu às suas expectativas?

☐ Completamente

☐ Consideravelmente

☐ Parcialmente

☐ Um pouco

☐ Não satisfez de todo

13. Até que ponto é provável que continue a utilizar este tratamento?

☐ Muito provável -> Passar à pergunta 15

☐ Moderadamente provável -> Passar à pergunta 15

☐ Sem opinião -> Passar à pergunta 15

☐ Moderadamente improvável

☐ Muito improvável

14. Porquê?

☐ Tem/tinha muitos efeitos secundários

☐ Os resultados foram abaixo dos previstos

☐ Terminei a minha relação amorosa

☐ Alterei o meu estilo de vida

☐ Outro (Qual?) _____ ☐☐

15. Durante as últimas quatro semanas, até que ponto foi fácil para si utilizar este tratamento?

☐ Muito fácil

☐ Moderadamente fácil

☐ Nem fácil nem difícil

☐ Moderadamente difícil

☐ Muito difícil

16. Durante as últimas quatro semanas, até que ponto ficou satisfeito com a rapidez de actuação do tratamento?

☐ Muito satisfeito

☐ Moderadamente satisfeito

☐ Nem satisfeito nem insatisfeito

☐ Moderadamente insatisfeito

☐ Muito insatisfeito

20824

17. Durante as últimas quatro semanas, até que ponto ficou satisfeito com a duração dos efeitos do tratamento?

- ☐ Muito satisfeito
- ☐ Moderadamente satisfeito
- ☐ Nem satisfeito nem insatisfeito
- ☐ Moderadamente insatisfeito
- ☐ Muito insatisfeito

18. Até que ponto este tratamento o fez sentir confiante em relação à sua capacidade de praticar a actividade sexual?

- ☐ Muito mais confiante
- ☐ Moderadamente mais confiante
- ☐ Não teve qualquer impacto
- ☐ Moderadamente menos confiante
- ☐ Muito menos confiante

19. Em termos gerais, até que ponto acha que a seu(sua) parceiro(a), está satisfeito(a) com os efeitos deste tratamento?

- ☐ Muito satisfeito(a)
- ☐ Moderadamente satisfeito(a)
- ☐ Nem satisfeito nem insatisfeito(a)
- ☐ Moderadamente insatisfeito(a)
- ☐ Muito insatisfeito(a)

20. O que pensa a seu(sua) parceiro(a), do facto de você continuar a utilizar este tratamento?

- ☐ Quer absolutamente que eu continue o tratamento
- ☐ De um modo geral, prefere que eu continue o tratamento
- ☐ Não tem qualquer opinião sobre o tratamento
- ☐ De um modo geral, prefere que eu pare o tratamento
- ☐ Quer absolutamente que eu pare o tratamento

21. Até que ponto sentiu que foi natural para si a actividade sexual, quando usou este tratamento, durante as últimas quatro semanas?

- ☐ Muito natural
- ☐ Moderadamente natural
- ☐ Nem natural nem artificial
- ☐ Moderadamente artificial
- ☐ Muito artificial

22. Comparando com antes de ter o problema sexual, como avaliaria o seu desempenho quando usou este tratamento, durante as últimas quatro semanas?

- ☐ Muito melhor do que antes de ter o problema sexual
- ☐ Moderadamente melhor do que antes de ter o problema sexual
- ☐ O mesmo do que antes de ter o problema sexual
- ☐ Moderadamente pior do que antes de ter o problema sexual
- ☐ Muito pior do que antes de ter o problema sexual

23. Tem/teve consultas de acompanhamento acerca do tratamento?

- ☐ Sim
- ☐ Não -> Fim do questionário
- ☐ Não sei / Não me lembro -> Fim do questionário

24. Está satisfeito com o acompanhamento que tem tido relativamente ao tratamento?

- ☐ Sim
- ☐ Não
- ☐ Não sei / Não respondo -> Fim do questionário

Agradecemos a sua colaboração!

Guião de Entrevista (2ª Parte)

HOMENS

ANTES DO INÍCIO DA ENTREVISTA, REVER INFORMAÇÕES SOBRE DADOS DEMOGRÁFICOS E SEXUAIS:

a) Notas do status
b) Idade, Estado civil, Pessoas com quem vive
c) Actividade sexual (e.g. frequência de relações sexuais, satisfação sexual)
d) Questionários aplicados (Se algum não se aplicou, porque não)
e) Que problemas identificaram na auto-avaliação
f) Se fez tratamento, quem prescreveu, qual o tratamento, se ainda faz…

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1. REPRESENTAÇÕES FACE AO SEXO E À SEXUALIDADE

1.1. O que é para si "saúde sexual"? O que é para si ter uma "sexualidade normal"?
1.2. A sexualidade é algo importante para si? Porquê?
1.3. Qual a função da sexualidade? Para que serve?
1.4. O que entende por "actividade sexual"? Que tipo de práticas sexuais fazem parte da relação sexual (relações sexuais, carícias, cenas de sedução e masturbação)? Que actividades sexuais costuma ter?
1.5. O que significa para si ter uma actividade sexual satisfatória? O que necessita para si sentir-se satisfeito com a sua vida sexual?
1.6. Para si é fundamental sentir desejo para se envolver numa actividade sexual? E excitação? E orgasmo? É importante para si atingir e manter uma erecção? E qual a importância da penetração?
1.7. Considera que pessoas sem relação amorosa podem ter actividade sexual?
1.8. Considera que a resposta sexual se altera com a idade?
1.9. O que é para si uma disfunção sexual? Considera ser uma doença? Acha que dificuldades sexuais e disfunções sexuais são a mesma coisa? Quais as disfunções sexuais que conhece?
1.10. Quais as principais causas que estão na base dos problemas sexuais?

2. TRAJECTÓRIA DA DISFUNÇÃO SEXUAL

2.1. Recorda-se das queixas sexuais de que falou na última entrevista?
2.2. Houve alguma alteração nas mesmas desde há 3 meses atrás? Intensificaram-se? Melhoraram? Como explica essas alterações?
2.3. Conversou sobre este tema com algum profissional de saúde desde a última entrevista?
2.4. Considera que essas queixas correspondem a um problema sexual? Porquê? Se não, o que seria necessário suceder para considerar essa queixa como um problema? *Se sim, o que seria necessário suceder para deixar de considerar essa queixa como um problema?*
2.5. Que conhecimentos tem sobre o seu tipo de dificuldades sexuais? Considera-se suficientemente informado sobre o tema? Como obteve esse conhecimento?
2.6. Disse-me que procurou ajuda… Ao final de quanto tempo de ter o problema é que falou com um especialista sobre o tema? *O que o levou o procurar ajuda? O que o impediu de procurar ajuda mais cedo? Fale-me um pouco sobre isso.*
2.7. A sua companheira/esposa teve influência no processo de procurar ajuda? Qual o papel dela na tomada de decisão relativamente à realização de tratamentos?

2.8. Como escolheu o profissional de saúde com quem falou sobre o tema? Tomou iniciativa de abordar a temática com o profissional de saúde ou foi ele que o questionou sobre ela?
2.9. Qual a reacção do médico? Ficou satisfeito com a reacção? Falou sobre causas e/ou tratamentos?
2.10. Quais as causas apontadas pelo médico/terapeuta para explicar o início dos seus problemas (e.g. alcoolismo, toxicodependência, efeitos de medicação, acidentes, doença física, causas psicológicas/psiquiátricas, stress, insatisfação com a relação, etc.)?
2.11. Concorda com essa explicação? Considera haver outras causas que ajudam a explicar e manter as suas dificuldades? Qual a sua opinião sobre o assunto?
2.12. Considera que a qualidade de vida sexual se relaciona com estilos de vida saudáveis? *Acha que as queixas que me referiu estão relacionadas com o seu estilo de vida? Em que sentido?*

3. TRATAMENTO E CRENÇAS ASSOCIADAS

3.1. Quando teve início o seu tratamento para os problemas sexuais?
3.2. Que tipo de tratamentos faz ou já fez (e.g. …)?
3.3. Conhece outros tratamentos?
3.4. Ainda se encontra a fazer o tratamento que me referiu na última vez que falámos? Se não, porquê? Iniciou algum tratamento novo para estas dificuldades?
3.5. Sentiu-se bem informado sobre o mesmo? *Quem o informou sobre o assunto? Procurou mais informação?*
3.6. Teve dúvidas ou dificuldades na sua aplicação?
3.7. E o que achou do tratamento? Foi fácil de aplicar/ realizar? Causou transtorno à sua actividade sexual?
3.8. A sua parceira colaborou na realização do tratamento?
3.9. Que diferenças sentiu após começar o tratamento (A frequência de RS aumentou? Mais confiante? Menos desconforto?)
3.10. Receia ficar dependente destes tratamentos? Tem medos associados ao tratamento?
3.11. Está/Ficou satisfeito com o resultados dos tratamentos?
3.12. Qual a reacção da sua parceira ao tratamento? Ficou satisfeita?
3.13. Como avalia a situação actual do seu problema (resolvido, não resolvido, parcialmente resolvido)?
3.14. Quais as expectativas futuras em relação à continuação do tratamento?

4. VIVÊNCIA DA DISFUNÇÃO SEXUAL E INTIMIDADE SEXUAL

4.1. De que modo é que as suas queixas sexuais afectaram a sua vida? Interferiram na sua relação? Na sua vida diária? No seu bem-estar e auto-estima? Causaram-lhe sentimentos negativos?
4.2. Que estratégias ou tratamentos já experimentou para ultrapassar as suas dificuldades sexuais (e.g. produtos naturais, alteração de hábitos de vida, mudança de medicação)?
4.3. A quem partilhou estas queixas? Existem pessoas (familiares ou amigos) com quem partilhe as suas dificuldades íntimas? Se sim, com quem e porquê? Que tipo de apoio procura obter? Se não, porquê?
4.4. A frequência de relacionamentos sexuais diminuiu após o início dos problemas? E a qualidade da actividade sexual? Como explica estas alterações?
4.5. Falou com a sua parceira sobre os seus problemas sexuais? Qual a sua reacção?
4.6. De que modo as suas queixas afectam a sua parceira? Ela tem consciência do modo como estas dificuldades ocorrem e qual o seu impacto em si?
4.7. De que forma a sua parceira vive a sua própria sexualidade? Acha que é importante para ela?
4.8. A sua parceira tem algum problema sexual? Se sim, qual? De que forma a afecta? Há quanto tempo? Qual a repercussão deste problema na vossa vida íntima? Qual a sua postura perante o problema dela?

5. **INTERACÇÕES QUOTIDIANAS COM MULHERES** (APLICAR A HOMENS SEM RELAÇÃO AMOROSA)
   5.1. As suas queixas sexuais alteram ou comprometem de alguma forma as interacções estabelecidas com as mulheres em geral?
   5.2. Gostaria de voltar a relacionar-se novamente? Se não, porquê? Se sim, o que tem procurado fazer para o conseguir?

6. **PERCEPÇÕES DE MASCULINIDADE**
   6.1. O que significa para si ser homem?
   6.2. O que acha que a sociedade espera de si enquanto homem?
   6.3. E a sua companheira? Que expectativas tem em relação a si enquanto homem?
   6.4. A visão de si enquanto homem alterou-se desde que tem problemas sexuais? Sente que a imagem de si enquanto homem ficou perturbada com a procura de tratamentos para as disfunções sexuais?

7. **EXPECTATIVAS**
   7.1. Como imagina o seu futuro a nível sexual? O que espera que aconteça? O que gostaria que acontecesse?
   7.2. Acha que está no caminho certo para que isso aconteça? Que mais tenciona fazer?

Guião de Entrevista (2ª Parte)

MULHERES

ANTES DO INÍCIO DA ENTREVISTA, REVER INFORMAÇÕES SOBRE DADOS DEMOGRÁFICOS E SEXUAIS:

a) Notas do status
b) Idade, Estado civil, Pessoas com quem vive
c) Actividade sexual (e.g. frequência de relações sexuais, satisfação sexual)
d) Questionários aplicados (Se algum não se aplicou, porque não)
e) Que problemas identificaram na auto-avaliação
f) Se fez tratamento, quem prescreveu, qual o tratamento, se ainda faz…

Começar por falar da satisfação sexual

1. Trajectória da disfunção sexual (Para tipologia: Problemáticas e Insatisfeitas)

1.1. Recorda-se das queixas sexuais de que me falou na última entrevista?
1.2. Houve alguma alteração nas mesmas desde há 3 meses atrás? Intensificaram-se? Melhoram? Se sim, como explica essa alteração?
1.3. Considera que essas queixas correspondem a um problema sexual? Se sim/não, porquê? Se não, o que seria necessário suceder para considerar essa queixa como um problema?
1.4. Conversou sobre este tema com algum profissional de saúde desde a última entrevista?
1.5. Iniciou algum tratamento novo para estas dificuldades?
1.6. Ainda se encontra a fazer tratamento que me referiu na última vez que falámos? Se não, porquê?
1.7. Quando teve início o seu tratamento para os problemas sexuais?
1.8. Sentiu-se bem informada sobre o mesmo?
1.9. Teve dúvidas ou dificuldades na sua aplicação?
1.10. Que diferenças sentiu após começar o tratamento (A frequência de RS aumentou? Mais confiante? Menos desconforto?)
1.11. Qual o papel do seu parceiro na decisão de fazer o tratamento? E a satisfação dele com o tratamento?
1.12. Ao final de quanto tempo de ter o problema é que falou com um especialista sobre o tema?
1.13. Tomou iniciativa de abordar a temática com o profissional de saúde ou foi ele que a questionou sobre ela?
1.14. O seu companheiro/marido teve influência no processo de procurar ajuda? Qual o papel dele na tomada de decisão relativamente à realização de tratamentos?

1.15. Como avalia a situação actual do seu problema (resolvido, não resolvido, parcialmente resolvido)?
1.16. Quais as causas apontadas pelo médico/terapeuta para explicar o início dos seus problemas (e.g. alterações hormonais,efeitos de medicação, doença física, causas psicológicas/psiquiátricas, stress, gravidez/nascimento de um filho, problemas do parceiro, insatisfação com a relação, etc.)?
1.17. Concorda com essa explicação? Considera haverem outras causas que ajudam a explicar e manter as suas dificuldades?
1.18. Que conhecimentos tem sobre o seu tipo de dificuldades? Considera-se suficientemente informada sobre o tema? A informação que possui ajuda-a a lidar e ultrapassá-las?
1.19. Considera que a qualidade de vida sexual se relaciona com estilos de vida saudáveis?
1.20. Quais os cuidados que tem com a sua saúde (dieta, praticar desporto, não fumar, não consumir álcool, não beber café, levar uma vida calma)?
1.21. Tem objectivos e metas estalecidos para melhorar a sua saúde? (deixar de fumar, emagrecer, etc.)

2. TRATAMENTO E CRENÇAS ASSOCIADAS (PROBLEMÁTICO)

2.1. Mantém-se em tratamento para as dificuldades sexuais?
2.2. Que tipo de tratamentos faz ou já fez (e.g. medicação hormonal, medicação oral, lubrificantes vaginais, cremes e anestésicos, psicoterapia, terapia sexual, etc.)?
2.3. O que achas desse(s) tratamento(s)? Está/Ficou satisfeita?
2.4. Considera esses tratamentos necessários para conseguir manter uma vida sexual satisfatória?
2.5. Que outras estratégias ou tratamentos já experimentou para ultrapassar as suas dificuldades sexuais (e.g. produtos naturais, alteração de hábitos de vida, mudança de medicação)
2.6. Receia ficar dependente destes tratamentos?

3. REPRESENTAÇÕES FACE AO SEXO E À SEXUALIDADE

3.1. O que é para si ter uma “sexualidade normal”?
3.2. O que entende por “actividade sexual”? Que tipo de práticas sexuais fazem parte da relação sexual?
3.3. O que significa para si ter uma actividade sexual satisfatória? O que necessita para se sentir satisfeita com a sua vida sexual?
3.4. A sexualidade é algo importante para si? Se sim/não, porquê? E para o seu parceiro?
3.5. Qual a função da sexualidade? Para que serve?
3.6. Que práticas sexuais costuma adoptar?
3.7. Para si é fundamental sentir desejo para se envolver numa actividade sexual? E excitação? E orgasmo?

3.8. O que é para si uma disfunção sexual? Considera ser uma doença? Acha que dificuldades sexuais e disfunções sexuais são a mesma coisa? Quais as disfunções sexuais que conhece?
3.9. Quais as principais causas que estão na base dos problemas sexuais?
3.10. Considera que a resposta sexual se altera com a idade?
3.11. Considera que pessoas sem relação amorosa podem ter actividade sexual?

4. INTIMIDADE SEXUAL

4.1. De que modo é que as suas queixas sexuais afectaram a sua vida? Interferiram na sua relação? Na sua vida diária? No seu bem-estar e auto-estima? Causaram-lhe sentimentos negativos?

4.2. De que modo as suas queixas afectam o deu parceiro? Ele tem consciência do modo como estas dificuldades ocorrem e qual o seu impacto em si? Qual a posição dele em relação a elas?

4.3. A frequência de relacionamentos sexuais diminuiu após o início dos problemas? E a qualidade da actividade sexual?

4.4. O que já fez para resolver ou melhorar a situação actual? A quem partilhou estas queixas?

4.5. O seu parceiro tem algum problema sexual? Se sim, qual? De que forma a afecta? Há quanto tempo? Qual a repercussão deste problema na vossa vida íntima? Qual a sua postura perante o problema dele?

5. IMAGENS E FANTASIAS SEXUAIS

5.1. É habitual ter fantasias sexuais? Essas fantasias despertam-lhe desejo e excitação sexuais?

5.2. É habitual fantasiar durante a actividade sexual com o seu parceiro?

5.3. Houve alteração na frequência com que fantasia desde que surgiram problemas sexuais?

6. PERCEPÇÕES DA PRÓPRIA FEMINILIDADE E SATISFAÇÃO CORPORAL

6.1. O que significa para si ser mulher? O que distingue a mulher do homem?

6.2. Sente-se “feminina”? Recorre a alguns métodos para se sentir mais feminina (e.g. maquilhar-se, usar roupas específicas, arranjar o cabelo)

6.3. A visão de si enquanto “mulher” alterou-se desde que tem problemas sexuais?

6.4. O que acha que a sociedade espera de si enquanto mulher? E o seu companheiro?

6.4. Sente-se satisfeita com o seu corpo? Se pudesse o que mudaria?

6.5. Sente-se confortável quando vê o seu corpo ao espelho? E quando alguém a vê nua ou semi-nua?

6.6. É fácil para si tocar o seu corpo? E em zonas mais íntimas?

6.7. É fácil para si tocar o corpo do seu paceiro? E em zonas erogenas?

7. INTERACÇÕES QUOTIDIANAS COM HOMENS *(APLICAR A MULHERES SEM RELAÇÃO AMOROSA)*

7.1. As suas queixas sexuais alteram ou comprometem de alguma forma as interacções estabelecidas com os homens em geral?

7.2. Gostaria de voltar a relacionar-se novamente? Se não, porquê? Se sim, o que tem procurado fazer para o conseguir?

8. SUPORTE SOCIAL

8.1. O seu parceiro apoia na sua vida em geral? E em relação às suas queixas sexuais?

8.2. Existem pessoas com quem partilhe as suas dificuldades íntimas? Se sim, com quem e porquê? Que tipo de apoio procura obter? Se não, porquê?

9. EXPECTATIVAS

9.1. Como imagina o seu futuro a nível sexual? O que espera que aconteça? O que gostaria que acontecesse?

Unidade de Epidemiologia

Instituto de Medicina Preventiva

A Emergência do Campo Profissional da Sexologia em Portugal

Actores, Práticas, Identidades e Contexto Social

Guião de entrevista – Sexólogos

Perfil sócio-demográfico

Idade

Sexo

Profissão

A. Identidade profissional:

[terminologia usada: sexologia, sexualidade humana, medicina sexual, educação sexual, terapia sexual, etc. explorar a sua transformação no decorrer do tempo]

1. Se tivesse que se apresentar em termos profissionais, como o faria?

   [Sexólogo, especialista em sexualidade humana, urologista, ginecologista, psicólogo, educador, etc.]

2. Sexologia, sexualidade humana, medicina sexual, educação sexual, terapia sexual, o que significam para si estes termos? Representam todos a mesma coisa? Como hierarquizaria estes termos?
3. Acha que é possível falar de sexólogo como uma profissão?
4. O que é para si ser-se sexólogo?
5. Quais as áreas de saber associadas à profissão de sexólogo? E que competências específicas lhe estão associadas?
6. Que ideal de profissão sexólogo orienta sua prática?

B. O campo da sexologia em Portugal

1. História (Marcos / Pessoas / Associações / Instituições / Eventos / Cursos / Revistas / Impacto do Viagra e medicamentos semelhantes)
2. Avaliação da história da sexologia (Avaliação do papel da sexologia na emancipação social / Avaliação pessoal da imagem pública da sexologia)
3. Laboratórios farmacêuticos (Entrada dos laboratórios no campo / Papel dos laboratórios / Avaliação da participação dos laboratórios no campo / Principais laboratórios actuantes)
4. Meios de comunicação social (Avaliação do papel dos media no campo)
5. Avaliação da situação actual do campo da sexologia em Portugal

- Como classifica a saúde da sexologia em Portugal?
- Quais as áreas que considera prioritárias para o avanço do estudo da sexualidade em Portugal?
- Qual o papel de outras áreas do saber, como a antropologia, sociologia, direito, etc. para a sexologia?
- Qual a importância de ter sexólogos sem formação clínica?
- Considera haver separação entre profissionais focados na perspectiva psicossocial e os profissionais focados na perspectiva médica/orgânica da sexualidade?
- Acredita haver uma articulação fluida e eficaz entre os diferentes profissionais na área da sexologia (psicólogos, psiquiatras, urologistas, ginecologistas, etc.)?
- Considera haver uma boa articulação entre os centros de saúde e os profissionais na área da sexologia? (porquê?)
- Considera que os médicos de família e outros médicos de clínica geral estão capacitados para intervir eficazmente sobre as disfunções sexuais (e.g. disfunção eréctil)?

C. Trajectória profissional e Projecto pessoal (caracterização da prática e domínios de actividade):

[Peso relativo da clínica e da educação sexual / promoção da saúde sexual; no interior da clínica, peso da terapia psicológica e da terapia medicação; relação entre educação, prevenção e activismo; investigação e ensino]

1. Formação inicial
2. Formação secundária
3. Interesse pela sexologia
4. Formação específica em sexologia

- Qual a razão pela qual escolheu tirar formação em sexologia?
- Como avaliação a formação que obteve?

- Considera que as formações existentes em sexologia em Portugal capacitam os formandos a exercer a função com qualidade?

5. Actividade profissional

- Início da actuação, áreas de actuação no campo, área de actuação principal no campo
- Clínica: clientes; queixas; tratamento; técnicas/abordagens terapêuticas; local (consultório/clínica/hospital)
- Educação sexual: local (escola pública/privada); público-alvo; temas/actividades
- Ensino: Local (universidade pública/privada/instituição privada/hospital/clínica/ONG); disciplinas; público-alvo
- Investigação: temas/metodologia/local (universidade pública/privada/instituição privada/hospital/clínica/ONG); referenciais teóricos usados
- Relação com as outras categorias profissionais do campo
- Vínculos associativos
- Eventos da área da sexologia que mais frequenta

6. **Sugestão de nomes para entrevistar:**

- Para terminar, gostaria de lhe pedir para me indicar o nome de algumas pessoas que achasse que deveriam ser incluídas nesse estudo para uma entrevista semelhante à conversa que acabámos de ter.

Perguntas específicas para quem faz INVESTIGAÇÃO:

- Quais os principais resultados dos estudos em que tem participado?
- O que a surpreendeu ou não estava à espera?
- Considera que esses resultados trarão benefícios a uma melhor intervenção? Porquê? De que forma?
- Qual a relação entre a sua prática clínica e a investigação que faz? Baseia-se no que vê para o estudar? O que estuda influência o que aplica na prática? De que modo?
- Como são as mulheres portuguesas sexualmente? E os homens portugueses? Como imagina que sejam no futuro?
- O que é para si uma sexualidade saudável? É igual para homens e mulheres?
- Quais as vantagens e inconvenientes que vê no tratamento das disfunções sexuais?

Unidade de Epidemiologia

Instituto de Medicina Preventiva

A Emergência do Campo Profissional da Sexologia em Portugal

Actores, Práticas, Identidades e Contexto Social

Guião de entrevista – Peritos do Campo da Sexualidade

Perfil sócio-demográfico [rever no CV – não perguntar]

Idade

Sexo

Profissão

A. Trajectória profissional e Projecto pessoal (caracterização da prática e domínios de actividade):
[investigação e ensino]

1. Se tivesse que se apresentar em termos profissionais, indicando as suas principais actividades, seus domínios de especialização e interesses, como o faria?

2. ***Estamos, como sabe, a entrevistar peritos na área da sexualidade em Portugal e por isso pedimos a sua colaboração.*** Concorda com a nossa nomeação? Considera que é uma área de saber do seu domínio de especialização?

3. Poderia falar-me de como começou o seu interesse pela área da sexualidade?
4. Que actividades tem desenvolvido nesta área?

- Início da actuação, áreas de actuação no campo, área de actuação principal no campo
- Investigação: temas/metodologia/local (universidade pública/privada/instituição privada/hospital/clínica/ONG); referenciais teóricos usados
- Educação sexual: local (escola pública/privada); público-alvo; temas/actividades
- Ensino: Local (universidade pública/privada/instituição privada/hospital/clínica/ONG); disciplinas; público-alvo

- Relação com as outras categorias profissionais do campo
- Vínculos associativos
- Eventos da área da sexologia que mais frequenta

B. A profissão de sexólogo / sexologista:
[terminologia usada: sexologia, sexualidade humana, medicina sexual, educação sexual, terapia sexual, etc. explorar a sua transformação no decorrer do tempo]

1. Sexologia, sexualidade humana, medicina sexual, educação sexual, terapia sexual, o que significam para si estes termos? Representam todos a mesma coisa?
2. Acha que é possível falar de sexólogo como uma profissão?
3. E da sexologia como ciência? Considera existirem áreas específicas de saber associadas à profissão de sexólogo?

C. O campo da sexologia/sexualidade em Portugal

1. <u>História</u> (Marcos / Pessoas / Associações / Instituições / Eventos / Cursos / Revistas / Impacto do Viagra e medicamentos semelhantes)
2. <u>Avaliação da história da sexologia</u> (Avaliação do papel da sexologia na emancipação social / Avaliação pessoal da imagem pública da sexologia)
3. <u>Laboratórios farmacêuticos</u> (Entrada dos laboratórios no campo / Papel dos laboratórios / Avaliação da participação dos laboratórios no campo / Principais laboratórios actuantes)
4. <u>Meios de comunicação social</u> (Avaliação do papel dos media no campo)
5. <u>Avaliação da situação actual do campo da sexologia em Portugal</u>

- Quais as áreas que considera prioritárias para o avanço do estudo da sexualidade em Portugal?
- Considera existirem áreas de saber predominantes no campo da sexualidade? Qual o papel específico da antropologia e da sociologia, para o campo da sexologia / sexualidade? E o contrário? Ou seja, qual o contributo da sexualidade para a antropologia e a sociologia? Qual a relação com outras áreas de trabalho em concreto?

6. **<u>Sugestão de nomes para entrevistar</u>:**

Para terminar, gostaria de lhe pedir para me indicar o nome de algumas pessoas que achasse que deveriam ser incluídas nesse estudo para uma entrevista semelhante à conversa que acabámos de ter.

ESTUDO EURO-SEXO

O Instituto de Medicina Preventiva da Faculdade de Medicina de Lisboa (IMP-FML) e o Núcleo de Endocrinologia, Diabetes & Obesidade (NEDO) estão a implementar em Portugal o **estudo EURO-SEXO**, sobre a prática da sexologia.

O **EURO-SEXO** é um estudo colaborativo internacional sobre a Profissão de Sexólogo na Europa, já implementado em vários países (Dinamarca, Finlândia, França, Inglaterra, Itália, Noruega, Suécia), cujo protocolo e questionário foram desenvolvidos pelo Professor Alain Giami do **Institut National de la Santé et de la Recherche Médicale (INSERM-France).** A primeira tradução e adaptação do questionário original para português foram realizadas pelo **Centro Latino-Americano em Sexualidade e Direitos Humanos (CLAM-Brasil)**.

Independentemente de ter ou não formação específica em sexologia, vimos solicitar a sua colaboração nesta investigação que visa estudar a diversidade da prática da sexologia em Portugal, através da resposta a este **questionário anónimo**, de forma a conhecermos 1) a sua formação profissional inicial e em sexologia / sexualidade humana, 2) a sua prática profissional e prática em sexologia / sexualidade humana, 3) a sua opinião sobre sexologia / sexualidade humana; 4) dados sociodemográficos de caracterização.

Este questionário tem a duração de **cerca de 20 minutos a preencher**. Com o preenchimento e entrega, manifesta o seu consentimento em participar no **estudo EURO-SEXO**. **As respostas serão sempre tratadas de forma estritamente confidencial**, ou seja, não será possível identificar os respondentes.

Por favor, não hesite em colocar qualquer questão que possa surgir através dos contactos disponibilizados abaixo.

Agradecemos a sua colaboração nesta investigação que acreditamos ser de interesse comum e sem a qual este estudo não seria possível!

A equipa de investigação.

Endereço para correspondência:
Dra. Violeta Alarcão, Coordenadora do Projeto (Socióloga, Investigadora e Docente da Faculdade de Medicina de Lisboa)
Unidade de Epidemiologia – Instituto de Medicina Preventiva – Faculdade de Medicina de Lisboa
Av. Prof. Egas Moniz - 1649-028 Lisboa
Tel: 217999422 Ext: 47091 Fax: 217999421
Email: valarcao@fm.ul.pt

Patrocínio científico: APF ASSOCIAÇÃO PARA O PLANEAMENTO DA FAMÍLIA · SOCIEDADE PORTUGUESA DE ANDROLOGIA · Sociedade Portuguesa de Sexologia Clínica

INSTRUÇÕES GERAIS:

Pedimos que responda a cada uma das seguintes perguntas deste questionário assinalando as opções que correspondem às suas respostas e seguindo as instruções que são dadas em cada questão. Em algumas perguntas apenas lhe será pedida uma resposta, noutras poderá assinalar mais do que um item de resposta. É importante que responda a todas as perguntas colocadas.

Caso se engane e queira corrigir a sua resposta, dever®retirar a op´² o assinalada e posteriormente assinalar a correta. Por favor, n² o assinale 2 respostas numa pergunta de escolha ßnica.

Relembramos que este questionário é **confidencial** e que não será possível identificarmos nenhuma das suas respostas. Todos os seus dados serão tratados de forma **anónima** pela equipa de investigação, conforme procedimento referenciado à **Comissão Nacional de Proteção de Dados** (CNPD).

(Não preencher)

FORMAÇÃO PROFISSIONAL

1. Qual a sua formação fora do domínio da sexologia ou sexualidade humana? (o nível mais elevado)

Ano de conclusão:

- ☐ Licenciatura. Indique área de formação: _____ | | | | | | |
- ☐ Pós-graduação. Indique área de formação: _____ | | | | | | |
- ☐ Mestrado. Indique área de formação: _____ | | | | | | |
- ☐ Doutoramento. Indique área de formação: _____ | | | | | | |
- ☐ Outro. Qual? (indique tipo e área de formação) _____ | | | | | | |
- ☐ Nenhuma das anteriores

2. Ocupa algum cargo académico? *(Indique qual ou quais as opções que melhor descrevem a sua posição atual)*

- ☐ Docente ou supervisor numa instituição de ensino superior
- ☐ Investigador numa instituição de ensino superior
- ☐ Docente e investigador numa instituição de ensino superior
- ☐ Outro cargo académico. Qual? _____ | |
- ☐ Nenhum cargo académico

3. Se é médico, indique qual(ais) a(s) sua(s) especialidade(s) e ano de conclusão, caso contrário passe à *pergunta 4*

Ano de conclusão

- ☐ Não sou médico
- ☐ Sem especialidade | | | | |
- ☐ Cirurgia | | | | |
- ☐ Endocrinologia | | | | |
- ☐ Ginecologia/Obstreticia | | | | |
- ☐ Urologia | | | | |
- ☐ Psiquiatria | | | | |
- ☐ Clínica Geral | | | | |
- ☐ Outra especialidade. Qual? _____ | | | | |

4. Na atualidade, está: (indique a melhor opção)

- ☐ Empregado / Ativo | |
- ☐ Reformado | |
- ☐ Outra situação. Qual? _____

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FORMAÇÃO EM SEXOLOGIA

5. Obteve formação explicitamente na área da sexologia ou sexualidade humana? (formação cujo título refira explicitamente sexologia e/ou sexualidade)

☐ Sim

☐ Não (Passe para a pergunta 7) - pag.5

6. Se sim, que tipo de formação? *(pode assinalar abaixo mais que uma opção - pós-graduação, mestrado, doutoramento, outra formação)*

Ano de início | Duração (em meses)

☐ Pós-graduação em (indique o nome): _____ ☐☐☐☐ ☐☐ ☐☐

Instituição:

☐ Universidade pública (indique o nome): _____ ☐☐

☐ Universidade privada (indique o nome): _____ ☐☐

☐ Associação profissional (indique o nome): _____ ☐☐

☐ ONG (indique o nome): _____ ☐☐

☐ Clínica/Hospital (indique o nome): _____ ☐☐

☐ Outra (indique o nome): _____ ☐☐

Ano de início | Duração (em meses)

☐ Mestrado em (indique o nome): _____ ☐☐☐☐ ☐☐ ☐☐

Instituição:

☐ Universidade pública (indique o nome): _____ ☐☐

☐ Universidade privada (indique o nome): _____ ☐☐

☐ Associação profissional (indique o nome): _____ ☐☐

☐ ONG (indique o nome): _____ ☐☐

☐ Clínica/Hospital (indique o nome): _____ ☐☐

☐ Outra (indique o nome): _____ ☐☐

Ano de início | Duração (em meses)

☐ Doutoramento em (indique o nome): _____ ☐☐☐☐ ☐☐ ☐☐

Instituição:

☐ Universidade pública (indique o nome): _____ ☐☐

☐ Universidade privada (indique o nome): _____ ☐☐

☐ Associação profissional (indique o nome): _____ ☐☐

☐ ONG (indique o nome): _____ ☐☐

☐ Clínica/Hospital (indique o nome): _____ ☐☐

☐ Outra (indique o nome): _____ ☐☐

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☐ OUTRA FORMAÇÃO COM GRAU ACADÉMICO (indique o nome): _____

Ano de início ☐☐☐☐ Duração (em meses) ☐☐

Instituição:

☐ Universidade pública (indique o nome): _____
☐ Universidade privada (indique o nome): _____
☐ Associação profissional (indique o nome): _____
☐ ONG (indique o nome): _____
☐ Clínica/Hospital (indique o nome): _____
☐ Outra (indique o nome): _____

☐ OUTRA FORMAÇÃO SEM GRAU ACADÉMICO* 1 (indique o nome): _____

Ano de início ☐☐☐☐ Duração (em meses) ☐☐ (em semanas) ☐☐

Instituição:

☐ Universidade pública (indique o nome): _____
☐ Universidade privada (indique o nome): _____
☐ Associação profissional (indique o nome): _____
☐ ONG (indique o nome): _____
☐ Clínica/Hospital (indique o nome): _____
☐ Outra (indique o nome): _____

☐ OUTRA FORMAÇÃO SEM GRAU ACADÉMICO* 2 (indique o nome): _____

Ano de início ☐☐☐☐ Duração (em meses) ☐☐ (em semanas) ☐☐

Instituição:

☐ Universidade pública (indique o nome): _____
☐ Universidade privada (indique o nome): _____
☐ Associação profissional (indique o nome): _____
☐ ONG (indique o nome): _____
☐ Clínica/Hospital (indique o nome): _____
☐ Outra (indique o nome): _____

* Por exemplo, cursos de formação que conferem o grau de Terapeuta Sexual

☐ OUTRA FORMAÇÃO SEM GRAU ACADÉMICO 3 (indique o nome): _____

Ano de início ☐☐☐☐ Duração (em meses) ☐☐ (em semanas) ☐☐

Instituição:

☐ Universidade pública (indique o nome): _____
☐ Universidade privada (indique o nome): _____
☐ Associação profissional (indique o nome): _____
☐ ONG (indique o nome): _____
☐ Clínica/Hospital (indique o nome): _____
☐ Outra (indique o nome): _____

7. Qual ou quais as áreas em que considera que os seus conhecimentos em sexologia ou sexualidade humana beneficiariam em ser aprofundados? *(pode assinalar mais que uma opção)*

☐ Nenhuma área
☐ Anatomia e fisiologia
☐ Endocrinologia
☐ Epidemiologia
☐ Neurologia
☐ Farmacologia
☐ Psicologia e psicoterapia
☐ Terapia sexual
☐ Educação sexual
☐ Sociologia, antropologia, ciências sociais
☐ Métodos de investigação
☐ Desenvolvimento pessoal
☐ Outra área. Qual? _____

8. Para além da sua formação inicial em sexologia/sexualidade humana, frequenta ou frequentou alguma formação nalguma das seguintes abordagens? *(pode assinalar mais de uma opção)*

Abordagens psicoterapêuticas:

☐ Psicoterapia. Que vertente(s)? _____
☐ Terapia sistémica/familiar
☐ Terapias cognitivo-comportamentais
☐ Programação Neuro-linguística (PNL)
☐ Psicanálise
☐ Psicodrama
☐ Hipnose
☐ Terapia Gestáltica
☐ Aconselhamento/Terapia de apoio
☐ Outras (abordagens psicoterapêuticas). Qual? _____

Abordagens complementares:

☐ Relaxamento
☐ Massagem
☐ Psicossomática
☐ Homeopatia
☐ Acupuntura
☐ Outra(s), Qual(ais)? _____

Abordagens à sexualidade humana:

☐ Educação sexual
☐ Terapia sexual clássica (modelo de Masters and Johnson)
☐ Nova terapia sexual (modelo de Ellen Kaplan)
☐ Terapia de grupo
☐ Terapia de casal
☐ Outra(s). Qual(ais)? _____

9. Pessoalmente, a que tipo de terapia já se submeteu? *(apenas uma resposta possível)*

☐ Psicanálise ☐ Psicoterapia ☐ Ambas ☐ Nenhuma

10. Durante a sua carreira profissional em sexologia ou sexualidade humana... *(apenas uma resposta possível)*

☐ Teve supervisão individual ☐ Teve supervisão em grupo ☐ Ambas ☐ Nenhuma

11. Atualmente, considera-se... *(pode assinalar mais que uma opção)*

☐ Sexólogo(a)/Sexologista
☐ Terapeuta sexual/Sexólogo(a) clínico(a)
☐ Ambos
☐ Educador(a) sexual
☐ Outro. Qual? _____

PRÁTICA PROFISSIONAL

12. Qual a sua principal profissão de base (inicial)?

☐ Médico dos CSP
☐ Médico hospitalar
☐ Psicólogo
☐ Educador sexual
☐ Sexólogo/sexologista ou Terapeuta sexual
☐ Enfermeiro
☐ Assistente social
☐ Outra(s) ocupação(ões). Qual(ais)? _____

13. Em que ano começou a sua primeira profissão principal? ☐☐☐☐

13.1 Mudou entretanto de ocupação principal ou acrescentou alguma atividade profissional à sua formação de base?

☐ Sim ☐ Não -> Passe para a pergunta 14

13.2 Se mudou de ocupação principal, atualmente exerce como?

☐ Sexólogo ou terapeuta sexual ☐ Outra ocupação. Qual? _____

13.3 E em que ano começou a sua profissão principal atual? ☐☐☐☐

14. Atualmente qual a sua situação profissional? *(pode assinalar mais que uma opção)*

☐ Trabalha por conta própria ☐ Trabalha por conta de outrem
☐ Ambas as anteriores ☐ Outra situação. Qual? _____

15. Em qual ou quais áreas trabalha atualmente?

Prática clínica	☐ Sim	☐ Não
Ensino/Formação	☐ Sim	☐ Não
Investigação	☐ Sim	☐ Não
Atividades dirigidas à comunidade (e.g. educação/informação sexual)	☐ Sim	☐ Não

Outras. Especifique: _____

Se não exerce prática clínica na área da sexologia ou sexualidade humana, salte para a pergunta 44.

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PRÁTICA CLÍNICA EM SEXOLOGIA/SEXUALIDADE

16. Em que ano começou a exercer prática clínica com pessoas com dificuldades sexuais? ☐☐☐☐

17. Em média, quantos pacientes/doentes atende por semana especificamente com dificuldades sexuais?

☐ Menos de 5 ☐ Entre 5 e 10 ☐ Entre 10 e 20 ☐ Entre 20 e 50 ☐ Entre 50 e 70 ☐ Mais de 70

18. E no total da sua prática clínica quantos pacientes/doentes atende em média por semana?

☐ Menos de 5 ☐ Entre 5 e 10 ☐ Entre 10 e 20 ☐ Entre 20 e 50 ☐ Entre 50 e 70 ☐ Mais de 70

19. Em média, quanto tempo duram as suas consultas na área das disfunções sexuais?

☐ Menos de 15 minutos ☐ Entre 15 e 30 minutos ☐ Entre 30 e 45 minutos ☐ Entre 45 e 60 minutos ☐ Uma hora ou mais

20. Em média, para a maioria dos casos, qual a duração do tratamento ou aconselhamento dirigido aos problemas sexuais?

☐ Uma consulta
☐ Entre 2 a 4 consultas
☐ Entre 5 a 10 consultas
☐ Entre 11 a 20 consultas
☐ Mais de 20 consultas

21. Na sua prática privada, qual o preço médio das consultas que faz dirigidas ao tratamento de problemas sexuais? (apenas uma opção de resposta)

☐ Até 30€
☐ De 31€ a 50€
☐ De 51€ a 80€
☐ De 81€ a 100€
☐ De 101€ a 150€
☐ Mais de 150€
☐ Gratuitas
☐ Não exerço prática clínica privada

22. Considerando todos os pacientes/doentes que o consultam devido a dificuldades sexuais pela primeira vez, qual a proporção de... *(uma resposta para cada item)*

Casais ☐☐☐ % Homens ☐☐☐ % Mulheres ☐☐☐ %

23. Com que frequência intervém ao nível das dificuldades sexuais com... *(uma resposta para cada item)*

Crianças	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Adolescentes	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Adultos	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Idosos	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente

24. Com que frequência intervém ao nível das dificuldades sexuais com pacientes/doentes de nível socioeconómico... *(uma resposta para cada item)*

Baixo	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Médio	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Alto	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente

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25. Com que frequência atende este tipo de pacientes/doentes no âmbito da intervenção em dificuldades sexuais? *(uma resposta por item)*

	Nunca	Raramente	Algumas vezes	Frequente-mente	Muito frequentemente
Homens e mulheres heterossexuais	☐	☐	☐	☐	☐
Homens homossexuais	☐	☐	☐	☐	☐
Mulheres homossexuais	☐	☐	☐	☐	☐
Mulheres bissexuais	☐	☐	☐	☐	☐
Homens bissexuais	☐	☐	☐	☐	☐
Transexuais/Transgenders	☐	☐	☐	☐	☐
Pacientes com HIV ou seropositivos	☐	☐	☐	☐	☐
Pessoas com deficiência	☐	☐	☐	☐	☐
Pessoas com défice cognitivo	☐	☐	☐	☐	☐
Pessoas com doença crónica (diabetes, cancro, etc.)	☐	☐	☐	☐	☐

26.Recebe pessoas com ordem de tratamento obrigatório (e.g. agressores sexuais)?

☐ Sim ☐ Não

27. Para fazer o seu diagnóstico, com que frequência recorre a ou solicita a outro especialista que faça... *(uma resposta por item)*

	Nunca	Raramente	Algumas vezes	Frequente-mente	Muito frequentemente
Avaliação psicológica	☐	☐	☐	☐	☐
Avaliação da história sexual	☐	☐	☐	☐	☐
Exames clínicos gerais	☐	☐	☐	☐	☐
Exames clínicos específicos	☐	☐	☐	☐	☐
Análises de diagnóstico (doppler, ultrasom, hormonais,etc.)	☐	☐	☐	☐	☐
Teste com injeções intracavernosas	☐	☐	☐	☐	☐
Teste à medicação oral para a disfunção erétil	☐	☐	☐	☐	☐
Pletismografia peniana/RigiScan	☐	☐	☐	☐	☐
Testes psicométricos	☐	☐	☐	☐	☐
Outras avaliações.	☐	☐	☐	☐	☐

Especifique quais: _____ ☐☐

28. Pede para receber o/a parceiro/a dos seus pacientes/doentes do sexo masculino?

☐ Nunca ☐ Raramente ☐ Algumas vezes ☐ Frequentemente ☐ Muito frequentemente

29. Pede para receber o/a parceiro/a das suas pacientes/doentes do sexo feminino?

☐ Nunca ☐ Raramente ☐ Algumas vezes ☐ Frequentemente ☐ Muito frequentemente

30. Com que frequência trabalha em sistema de co-terapia?

☐ Nunca ☐ Raramente ☐ Algumas vezes ☐ Frequentemente ☐ Muito frequentemente

31. Quais as abordagens ou tratamentos a que recorre com os seus pacientes/doentes com dificuldades sexuais? *(pode assinalar mais do que uma opção)*

Abordagens psicoterapêuticas:

- ☐ Psicoterapia. Que vertente(s)? _____
- ☐ Terapia sistémica/familiar
- ☐ Terapias cognitivo-comportamentais
- ☐ Programação Neuro-linguística (PNL)
- ☐ Psicanálise
- ☐ Psicodrama
- ☐ Hipnose
- ☐ Terapia Gestáltica
- ☐ Aconselhamento/Terapia de apoio
- ☐ Outras (abordagens psicoterapêuticas). Qual? _____

Abordagens complementares:

- ☐ Relaxamento
- ☐ Massagem
- ☐ Psicossomática
- ☐ Homeopatia
- ☐ Acupuntura
- ☐ Outra(s). Qual(ais)? _____

Abordagens à sexualidade humana:

- ☐ Educação sexual
- ☐ Terapia sexual clássica (modelo de Masters and Johnson)
- ☐ Nova terapia sexual (modelo de Ellen Kaplan)
- ☐ Terapia de grupo
- ☐ Terapia de casal
- ☐ Outra(s). Qual(ais)? _____

Abordagens à sexualidade humana:

- ☐ Injeções intracavernosas
- ☐ Medicação oral para a DE
- ☐ Cirurgia
- ☐ Medicação intra-uretral
- ☐ Outra(s). Qual(ais)? _____

- ☐ Nenhuma

32. Na sua prática clínica, que tipo de terapia utiliza mais frequentemente? *(assinale apenas uma resposta)*

- ☐ Individual
- ☐ De casal
- ☐ De grupo
- ☐ Depende dos casos

33. Durante o diagnóstico ou tratamento, costuma encaminhar ou referenciar os seus pacientes/doentes a profissionais de outras especialidades?

- ☐ Sim
- ☐ Não -> Passar à pergunta 35

34. Se sim, a quem? *(Assinale as opções que melhor se aplicam)*

- ☐ Médicos de Clínica Geral e Familiar
- ☐ Urologista
- ☐ Ginecologista
- ☐ Psiquiatra
- ☐ Psicólogo
- ☐ Psicoterapeuta
- ☐ Terapeuta de casal
- ☐ Outra(s) especialidade(s). Qual(ais)? _____

Se não é médico, passe à pergunta 37

35. Se é médico, no tratamento dos problemas sexuais, com que frequência prescreve....
(Responda a cada item, por favor)

Tratamentos homeopáticos	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente
Psicotrópicos	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente
Tratamentos hormonais	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente
Tratamentos vasculares	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente
Tratamentos por injeção peniana para a DE	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente
Terapia intra-uretral para a DE	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente
Prescrição de fármacos orais para a DE	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente
Outras prescrições.	☐ Nunca	☐ Raramente	☐ Às vezes	☐ Frequentemente	☐ Muito frequentemente

Quais? _____

36. Com que frequência costuma prescrever um tratamento farmacológico para a disfunção eréctil em associação com uma abordagem psicológica?

☐ Nunca ☐ Raramente ☐ Algumas vezes ☐ Frequentemente ☐ Muito frequentemente

37. Os seus pacientes/doentes do **sexo masculino** procuram-no(a) porque motivos? *(Responda a cada item)*

Falta de informação sobre sexualidade	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dificuldades em obter ou ausência de orgasmo	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Perda ou ausência de desejo sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Esterilidade/Infertilidade	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dor durante o ato sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Ejaculação prematura	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Atraso ou ausência de ejaculação	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Adição/compulsão sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Disfunção erétil	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Infeções sexualmente transmissíveis	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Sensação de deformação genital	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Insatisfação sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Parafilias/desvios sexuais	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Problemas afetivos e relacionais	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Problemas associados ao envelhecimento	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Problemas associados à homossexualidade	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Transexualidade/Transgenderismo	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Vítimas de violência ou abuso sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Perpretadores de violência/abuso sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Procura de ajuda para o parceiro(a)	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dificuldade ou incapacidade em consumar o ato sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Outra(s) razão(ões) - Especifique: _____	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente

38. Os seus pacientes/doentes do **sexo feminino** procuram-no(a) porque motivos? *(Responda a cada item)*

Falta de informação sobre sexualidade	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dificuldades em obter ou ausência de orgasmo	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dificuldades em obter ou ausência de excitação	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dificuldades em obter ou ausência de lubrificação	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Perda ou ausência de desejo sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Esterilidade/Infertilidade	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dor não-coital	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dispareunia	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Vaginismo	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Adição/compulsão sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Infeções sexualmente transmissíveis	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Sensação de deformação genital	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Insatisfação sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Parafilias/desvios sexuais	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Problemas afetivos e relacionais	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Problemas associados ao envelhecimento	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Problemas associados à homossexualidade	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Transexualidade/Transgenderismo	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Vítimas de violência ou abuso sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Perpretadores de violência/abuso sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Procura de ajuda para o parceiro(a)	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Dificuldade ou incapacidade em consumar o ato sexual	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Outra(s) razão(ões) - Especifique: _____	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente

RELAÇÃO COM OS PACIENTES/DOENTES

39. Como costumam chegar os seus pacientes/doentes até si? *(Responda a cada item)*

Encontraram o seu nome nas páginas amarelas/internet	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Ouviram falar de si ("boca a boca")	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
São-lhe referenciados por outros pacientes	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
São-lhe referenciados por colegas seus	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Os pacientes/doentes que atendo são das instituições em que trabalho	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente

40. Com que frequência costuma receber pacientes/doentes encaminhados por... *(Responda a cada item)*

Médicos de clínica geral e familiar	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Urologistas	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Ginecologistas	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Psiquiatras	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Psicólogos/psicoterapeutas	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Assistentes sociais	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente
Outro(s).Qual(ais)? _____	☐ Nunca	☐ Raramente	☐ Algumas vezes	☐ Frequentemente	☐ Muito frequentemente

41. Na sua opinião, o sexo do profissional em sexologia influencia os pacientes/doentes na hora de escolherem o terapeuta?

☐ Sim ☐ Não

42.a) Desde o surgimento dos medicamentos orais para a disfunção eréctil assistiu a: *(assinale apenas uma opção de resposta)*

☐ Nenhuma alteração no número de pacientes/doentes
☐ Um aumento no número de pacientes/doentes
☐ Uma diminuição no número de pacientes/doentes
☐ Não se aplica

42.b) Na sua opinião, o surgimento dos medicamentos orais para a disfunção eréctil originou uma mudança nos pedidos dos pacientes que o/a procuram por causa de problemas sexuais?

☐ Sim ☐ Não -> Salte para a pergunta 44 ☐ Não se aplica -> Salte para a pergunta 44

43. Considera que esta mudança… *(pode assinalar mais do que uma opção)*

☐ Causou um aumento na procura de tratamento para a disfunção eréctil
☐ Causou um aumento na procura de tratamento para os problemas sexuais no geral
☐ Facilitou o processo de comunicação dos pacientes/doentes sobre os problemas sexuais
☐ Estimulou as pessoas a procurarem melhores "performances" sexuais
☐ Outra situação, qual? _____

OPINIÕES SOBRE SEXOLOGIA E SEXUALIDADE HUMANA

44. De uma maneira geral, para tratar problemas sexuais… *(Responda a cada item)*

	Concordo totalmente	Concordo parcialmente	Nem concordo nem discordo	Discordo parcialmente	Discordo totalmente
É melhor ser médico	☐	☐	☐	☐	☐
É possível não ser médico	☐	☐	☐	☐	☐
É indiferente ser médico ou não	☐	☐	☐	☐	☐
É melhor não ser médico	☐	☐	☐	☐	☐

45. Considera que a etiologia dos problemas da sexualidade masculina é na sua maioria... *(apenas uma resposta possível)*

- ☐ Somente orgânica
- ☐ Mais orgânica do que psicológica
- ☐ Tanto orgânica como psicológica
- ☐ Mais psicológica do que orgânica
- ☐ Somente psicológica

46. Considera que a etiologia dos problemas da sexualidade feminina é na sua maioria... *(apenas uma resposta possível)*

- ☐ Somente orgânica
- ☐ Mais orgânica do que psicológica
- ☐ Tanto orgânica como psicológica
- ☐ Mais psicológica do que orgânica
- ☐ Somente psicológica

OUTRAS ATIVIDADES NO CAMPO DA SEXOLOGIA E SEXUALIDADE

47. Atualmente desenvolve atividades de ensino ou formação na área da sexologia ou sexualidade humana?

☐ Sim ☐ Não -> Salte para a pergunta 49

48. Em que local ou locais… *(pode assinalar mais do que uma opção)*

- ☐ No ensino superior. Especifique as áreas lecionadas: _____
- ☐ Em cursos de formação pós-graduada. Especifique quais: _____
- ☐ Em cursos de formação contínua. Especifique quais: _____
- ☐ Outras formações. Especifique: _____

49. Atualmente desenvolve atividades de educação sexual / promoção da saúde sexual?

☐ Sim ☐ Não -> Salte para a pergunta 51

50. Essas atividades inserem-se… *(pode assinalar com X mais que 1 opção)*

- ☐ Em programas de educação sexual para crianças e/ou adolescentes em escolas
- ☐ Em programas de planeamento familiar
- ☐ Em ações de informação/prevenção do HIV/Sida e doenças sexualmente transmissíveis
- ☐ Em ações de informação/prevenção de violência sexual e abuso sexual
- ☐ Noutras ações e/ou instituições/contextos (Especifique) _____

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Para concluir e apenas para caraterização demográfica, pedimos que nos indique:

51. Alguma vez fez investigação na área da sexologia ou sexualidade humana?
(para além do trabalho de final de curso)

☐ Sim ☐ Não -> Salte para a 53

52. De que tipo? *(Pode responder mais de uma opção)*

☐ Investigação clínica baseada nos seus pacientes
☐ Investigação epidemiológica
☐ Investigação biomédica básica
☐ Investigação em ciências sociais e humanas
☐ Outro tipo. Qual? _____

53. Já assistiu a congressos ou seminários na área da sexologia ou sexualidade humana?

☐ Sim ☐ Não

54. Na área da sexologia ou sexualidade humana alguma vez já...

Apresentou um poster ou comunicação num congresso	☐ Sim	☐ Não
Publicou um ou mais artigos científicos	☐ Sim	☐ Não
Publicou um ou mais livros	☐ Sim	☐ Não

55. Alguma vez apareceu em meios de comunicação social (e.g. imprensa, rádio, televisão) no âmbito do seu trabalho em sexologia ou sexualidade?

☐ Sim ☐ Não

56. Dos seguintes itens, quais contribuem para os seus conhecimentos na área da sexologia ou sexualidade humana?
(pode assinalar com X mais que 1 opção)

☐ Congressos e/ou seminários científicos ou académicos
☐ Congressos e/ou seminários organizados pela indústria farmacêutica
☐ Contacto com os colegas
☐ Formação contínua
☐ Publicações especializadas ou científicas
☐ Jornais e revistas generalistas
☐ Participação em cursos pós-graduados
☐ Internet
☐ Formações complementares em sexologia
☐ Outras fontes de informação. Quais? _____

57. No total, que proporção da sua atividade profissional é dedicada à sexologia ou sexualidade *(incluindo prática clínica, atividades para o público em geral, ensino e investigação)?*

☐ Menos de 10%
☐ De 10% a 25%
☐ De 25% a 50%
☐ De 50% a 75%
☐ De 75% a 100%
☐ Todas as minhas atividades profissionais

DADOS SÓCIO-DEMOGRÁFICOS

Ano de nascimento: ☐☐☐☐

Sexo: ☐ Masculino ☐ Feminino

Concelho onde trabalha: _____

Sugestões/Comentários: _____

Obrigado pela sua colaboração!

Após preenchimento, por favor grave o seu documento numa pasta do computador ("Arquivo" -> "Salvar Como") e proceda ao seu envio por email para o endereço valarcao@fm.ul.pt

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