

WOMEN'S SEXUAL HEALTH

Communication About Sexual Matters With Women Attending a Danish Fertility Clinic: A Descriptive Study



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ABSTRACT

Introduction: Several studies have shown that sexuality is an important aspect of life. Nevertheless, sexual matters are only rarely discussed between patients and doctors. Other studies have suggested that women undergoing fertility treatment compose a group of patients with low satisfaction in their sexual life.

Aim: To investigate how women at a fertility clinic desire and experience communication about sexual matters with doctors and to investigate the sexual function of these women.

Methods: A cross-sectional self-administered questionnaire survey of women attending a Danish fertility clinic over 4 months was performed. Descriptive statistics were calculated and presented as frequencies.

Main Outcome Measure: Communication about sexual matters with doctors included the women's comfort, preferred and actual frequency of discussion, and initiation of the conversation. Sexual function included participants' sexuality during the past year including certain sexual difficulties.

Results: Of the 201 participating women in the survey, most felt comfortable discussing sexual matters with doctors and preferred gynecologists for such discussions. There was a greater desire for communication than what was actually experienced by the women, and most wanted to initiate the conversation themselves. The women were less satisfied with their sexual life compared with a national control group, and they experienced sexual difficulties more often.

Conclusion: There is an unmet desire of women in fertility treatment for discussing sexual matters, and greater communication on this subject needs to be clinically implemented. **Eldridge KE, Giraldi A. Communication About Sexual Matters With Women Attending a Danish Fertility Clinic. A Descriptive Study. Sex Med 2017;5:e196–e202.**

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Key Words: Sexuality; Sexual Dysfunctions; Psychological; Sexual Dysfunctions; Physiological; Communication; Health Knowledge; Attitudes; Practice; Counseling; Physician-Patient Relationships; Attitude of Health Personnel

INTRODUCTION

Sexuality is an important aspect of most people's lives, and a well-functioning sexuality has been shown to be an indicator of

good health. Several factors are known to influence sexuality in a negative way such as somatic diseases, depression, relationship issues, and fertility treatment. Conversely, a healthy lifestyle can affect sexual life in a positive way, and a well-functioning sexual life can improve the course of treatment for patients with a chronic disease. Nevertheless, sexual matters are rarely discussed in the meeting between patients and doctors.¹ Long consultations, discomfort, and ignorance are some common reasons given by patients and doctors.^{2,3} Therefore, sexuality can be described as a two-way taboo, which is necessary to break to achieve successful communication about sexual matters between doctor and patient. From a clinical point of view, it is important to help patients with their sexual difficulties.

During fertility treatment, sexual life becomes more a matter of reproduction and planning than a matter of desire and

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intimacy. Only a few studies have investigated the influence of fertility treatment on sexual life but they have drawn the same picture, namely that women undergoing fertility treatment are significantly less satisfied with their sexual life compared with before their wish of having a child⁴ and compared with women with spontaneous pregnancies.⁵ Moreover, the prevalence of sexual dysfunctions is higher in infertile women,^{6,7} but is this issue ever discussed between the women and their doctors?

In this study, sexual matters were defined as sexual activity, satisfaction, desire, specific sexual difficulties, and sexual distress. Sexually transmitted diseases, contraception, and infertility were not included.

AIMS

The aims of this study were (i) to investigate how women at a fertility clinic desire and experience communication about sexual matters with doctors and (ii) to investigate the sexual function of these women. Hypotheses were (i) that women in fertility treatment have a desire to discuss sexual matters that is not met in the meeting with doctors and (ii) that these women experience a range of sexual difficulties.

METHODS

The study was a cross-sectional self-administered questionnaire survey of women attending the Copenhagen Fertility Center (Copenhagen, Denmark) from October 2014 through January 2015.

Instrument

The questionnaire included questions on (i) basic demographic information; (ii) communication with doctors about sexuality; (iii) sexual function; and (iv) communication about sexuality with other health care professionals. The questionnaire was available in Danish and English. It took approximately 5 to 10 minutes to complete, and a pilot study was carried out before the survey was initiated. The definition of sexual matters was written in the questionnaire.

Data Collection

Most women attending the Copenhagen Fertility Center from October 2014 through January 2015 were approached for participation. Verbal information was given about the study and it was emphasized that participation was voluntary and that the information would remain anonymous. Inclusion criteria were that the woman could read and understand Danish or English and had interest in participating. If the woman wanted to participate, then the questionnaire was handed out at the reception, filled out in the waiting area, and returned to a sealed box at the reception desk with no identifying information on it. All women signed an informed consent before participating.

Statistical Method

Descriptive statistics were calculated and presented as frequencies with the use of Excel 2011 (Microsoft, Redmond, WA, USA). If participants did not answer all questions, then their responses were still included in the study and the results were reported.

Ethics

This type of project does not need approval by the ethics committee in Denmark. The project plan and questionnaire were approved by the head of the Copenhagen Fertility Center and the senior investigator at the Sexological Clinic in the Psychiatric Center of the Rigshospitalet in Copenhagen.

MAIN OUTCOME MEASURES

The questionnaire included 27 items for the participants to answer. Basic demographic information included sex, year of birth, relationship status, and sexual orientation.

To measure communication with doctors about sexuality, a range of questions was constructed. The first part investigated comfort in discussing the subject with doctors and was inspired by a range of similar studies.^{8–11} The second part investigated the preferred and actual frequency of discussion as presented in a survey by Metz and Seifert.¹² In addition, the women were asked about initiation of the conversation. These questions were modified from two US studies.^{9,13}

The questions about sexual function were based on questions from a large national Danish health study^{14–16} and dealt with participants' sexuality during the past year. These questions covered sexual activity, satisfaction, certain sexual difficulties, and whether these difficulties were experienced as a problem. Certain sexual difficulties included insufficient vaginal lubrication, great difficulties achieving orgasm, vaginal cramps hindering penetration, and genital pain during intercourse.

To include the influence of other health care professionals, two final questions were constructed. Furthermore, comments could be included at the end of the questionnaire. All questions and the related options are presented in [Appendix 1](#).

RESULTS

The response rate of women introduced to the survey was 93% (201 of 216). Demographic measurements ([Table 1](#)) showed that the average age was 35.1 ± 6.3 years, 79% were married or in an unmarried relationship, and 90% were sexually orientated toward the opposite sex.

Communication About Sexual Matters

Data on the comfort of participants in discussing sexual matters with doctors are presented in [Table 2A](#). The answers were pooled into groups. More than half the women felt comfortable or very comfortable discussing sexual matters with a

Table 1. Demographic characteristics of participating women (N = 201)

Age (y), mean ± SD	35.1 ± 6.3
Relationship status, n (%)	
Married	99 (49.3)
Unmarried couple	60 (29.9)
Single	38 (18.9)
Other or not indicated	4 (2.0)
Sexual orientation, n (%)	
Opposite sex	181 (90.0)
Same sex	12 (6.0)
Both sexes	5 (2.5)
Don't know or not indicated	3 (1.5)

doctor, but the distribution of answers varied with the specialty of the doctors. Most women felt comfortable with gynecologists (67%) and fewest felt comfortable with general practitioners (53%). Correspondingly, more than double the number of women felt uncomfortable with general practitioners (21%) compared with gynecologists (10%) and fertility doctors (9%). The number of women who were neither comfortable nor uncomfortable was approximately the same for all kinds of doctors (22–25%).

The women also were asked what kind of doctor they spoke with when they ever discussed sexual matters. The answers showed that 48% spoke with a general practitioner, 31% spoke with a gynecologist, 26% with a fertility doctor, 4% spoke with another kind of doctor, and 31% did not indicate an answer.

Table 2B presents how often communication was desired and how often it actually occurred. The answers were pooled into

groups. Thirty-four percent of women wished to talk about sexual matters once in a while but only 22% did so. Sixty-two percent rarely or never wished to discuss the matter, but 77% rarely or never did. Only 4% wished to discuss sexual matters often or at every consultation and 2% did so.

For the initiation of the discussion about sexual matters (Table 2C), more women preferred to initiate the discussion themselves (61%) rather than letting the doctor do so (30%). A smaller group (7%) answered themselves and the doctor. If the women ever discussed sexual matters with a doctor, then they were to indicate who initiated the conversation. Forty-eight percent of women initiated the conversation about sexual matters, 16% stated that the doctors started the conversation, and 5% answered that they and their doctors started the conversation.

Sexuality in Past Year

The sexuality of the women is presented in Table 3. All these questions related to the participants' sexual life in the past year. Some women (13%) had not had sexual activity with another person. Most women (68%) were satisfied or very satisfied with their sexual life, whereas 14% were dissatisfied or very dissatisfied. When asked about lack of or decreased desire for sex, almost half the women (45%) experienced this once in a while and 18% did so often or all the time. Thirty-seven percent rarely or never experienced lack of or decreased desire.

Table 3D lists women's answers to questions about some sexual difficulties. The most reported sexual complaint was difficulties achieving orgasm, which 15% experienced often or all the time and 10% reported as being a problem. The second-most reported complaint was insufficient vaginal lubrication, which

Table 2. Communication with doctors about sexuality*

A. Comfort of the participant in discussing sexual matters with doctors				
	Comfortable or very comfortable	Neither comfortable nor uncomfortable	Uncomfortable or very uncomfortable	Not indicated
General practitioner	107 (53.2)	51 (25.4)	42 (20.9)	2 (1.0)
Gynecologist	135 (67.2)	44 (21.9)	20 (10.0)	3 (1.5)
Fertility doctor	129 (64.2)	49 (24.4)	17 (8.5)	7 (3.5)
B. Frequency of discussing sexual matters with doctors				
	Every consultation or often	Once in a while	Rarely or never	Not indicated
Preferred frequency	7 (3.5)	68 (33.8)	125 (62.2)	3 (1.5)
Actual frequency	3 (1.5)	44 (21.9)	155 (77.1)	1 (0.5)
C. Initiation of discussion about sexual matters				
	Myself	Doctor	Both	Not indicated
Preferred initiation	123 (61.2)	60 (29.9)	14 (7.0)	4 (2.0)
Actual initiation	97 (48.3)	33 (16.4)	9 (4.5)	62 (30.8)

*The entire sample is composed of 201 women. Answers are presented as number (percentage).

Table 3. Sexuality of the women in the past year*

A. Sexual activity?							
Yes		No		Not indicated			
173 (86.1)		27 (13.4)		1 (0.5)			
B. Satisfaction with sexual life							
Satisfied or very satisfied		Neither satisfied nor dissatisfied		Dissatisfied or very dissatisfied		Don't know or not indicated	
136 (67.7)		35 (17.4)		28 (13.9)		4 (2.0)	
C. Lack of or decreased desire for sex							
Never or rarely		Once in a while		Often or all the time		Not indicated	
74 (36.8)		90 (44.8)		37 (18.4)		1 (0.5)	
D. Experienced sexual difficulties during sexual activity							
	Frequency of difficulty				If seen as a problem		
	Not at all or rarely	Sometimes	Often or all the time	Not indicated	Yes	No	Not indicated
Lubrication	111 (55.2)	37 (18.4)	24 (11.9)	30 (14.9)	19 (9.5)	72 (35.8)	110 (54.7)
Orgasm	97 (48.3)	45 (22.4)	31 (15.4)	28 (13.9)	20 (10.0)	81 (40.3)	102 (50.7)
Vaginal cramps	161 (80.1)	4 (2.0)	4 (2.0)	32 (15.9)	4 (2.0)	76 (37.8)	121 (60.2)
Genital pain	145 (72.1)	18 (9.0)	8 (4.0)	30 (14.9)	20 (10.0)	71 (35.3)	111 (55.2)

*The entire sample is composed of 201 women. Answers are presented as number (percentage). Questions were modified from a large Danish health study by the Statens Institut for Folkesundhed.¹⁶

12% experienced often or all the time and 10% experienced as a problem. Four percent experienced genital pain during intercourse often or all the time, another 9% experienced this problem sometimes, and 10% experienced it as a problem. Most rarely experienced was vaginal cramps hindering penetration, which only 4% experienced sometimes, often, or all the time and only 2% saw as a problem.

Compared with the rest of the questionnaire, there was a higher rate of non-indicated answers to these questions. Fourteen percent to 16% did not answer whether they experienced these difficulties and 51% to 60% did not answer whether they experienced it as a problem.

DISCUSSION

This study showed that our cohort of women in fertility treatment were interested in discussing sexual matters with their doctors more often than they actually did and that most preferred to initiate the conversation themselves. Our cohort preferred having the discussion with a gynecologist, but more often the discussion was with the general practitioner. It also showed that some of these women had sexual difficulties and experienced these as a problem.

In this study of female fertility patients, it was clear that the comfort of discussing sexual matters differed with the specialty of doctors. Women were most comfortable with a gynecologist and most uncomfortable with a general practitioner. One participant

stated that gynecologists and fertility doctors had a particular interest and better qualifications on the subject and that she therefore preferred them above general practitioners. The same reasons were given in an Australian study of patients visiting a general practitioner by Baker et al⁸ who reported that doctors with a special interest in sexual health enhanced the comfort level of the patient.

Although the women felt least comfortable discussing sexual matters with a general practitioner, most had actually discussed such matters (48%) with this type of doctor. Only 31% had the discussion with a gynecologist and 26% had the discussion with a fertility doctor. In the present study, it is not possible to explain the women's preferences, which could be influenced by the fact that it was a selected group, because they were recruited in a fertility clinic. However, these findings indicate that clinicians need to change their practices by improving the comfort of women for discussing sexual matters with general practitioners or increasing the opportunity of discussion with gynecologists and fertility doctors. A study of Swiss gynecologists by Kottmel et al¹⁷ looked at the same issue and found that 28% offered appointments specifically for sexual issues. It is not clear from the study whether the patients appreciated this option, but it would be interesting to investigate further, and this option could be applied more widely among practices.

For the frequency of discussing sexual matters, this study showed that the subject is not often brought up. Only 23% of women had discussed the subject more than rarely, although

37% wanted the discussion more than rarely. This demonstrates that the desire for discussing sexual matters was not strong among the women but was stronger than experienced. These questions were inspired by a US study by Metz and Seifert¹² and their results showed the same result for male patients.

The answers to questions on the preferred initiation of the discussion showed that most women wanted to start the conversation themselves (61%) and most had actually done so (48%). Although most preferred to initiate the conversation themselves, it is important to remember that 30% preferred the doctor to take the initiative. Somehow doctors have to handle the subject at their own initiative to please almost one third of female patients. The same pattern was described in a study by Clark and Williams.¹³ In their questionnaire of adult patients at a general practitioner's office, 58% preferred to start the conversation on sexual dysfunction rather than letting the doctor start. Nevertheless, they pointed out that patients did not object to inquiries on sexual dysfunctions by the doctor.

Although the women in this study preferred to initiate the conversation, they did not discuss sexual matters as much as they wanted to. Therefore, it is necessary to create better circumstances for bringing up the subject. Women need to know that it is acceptable to ask doctors about sexual matters. Moreover, doctors need to be able to handle these questions. Barriers for doctors to talk about sexual matters are mainly limited by lack of time and training, lack of treatment options, and gender differences between practitioner and patient.^{2,3,18,19} The PLISSIT (permission, limited information, specific suggestion, intensive therapy) model is a good instrument to address this subject in a structured way.²⁰ It covers permission, limited information, specific suggestions, and intensive therapy and can be used by nurses and any kind of doctor. Fertility doctors also should keep in mind that they can refer patients to specialists who feel more comfortable discussing sexuality.

When looking at the women's sexuality, some women had not had been sexually active with another person in the past year. This is an interesting finding because they were visiting a fertility clinic to become pregnant. As a part of applying the PLISSIT model and giving permission to talk about sexuality, it might be advisable to routinely ask women about sexual activity and function when they come to the clinic. In this way, the health care provider is signaling that a discussion about sexuality is appropriate. Furthermore, it should be an essential part of the fertility treatment because no sexual activity or sexual problems (eg, vaginismus) could be one of the reasons the women are infertile. Jindal and Jindal²¹ reported that 1.4% of women treated in their clinic for infertility were infertile from primary vaginismus, thus emphasizing the importance of routinely addressing sexuality in infertile couples.

In the present study, 68% were satisfied or very satisfied with their sexual life. This is a small number compared with a study by Giraldi et al²² who found that 76% of Danish women in a relationship were satisfied with their sexual life. In the present

study, 18% had experienced lack of or decreased desire for sex all the time or often in the past year, and 45% had experienced this once in a while. The same question was asked in a national Danish study in 2005¹⁶ of 11,238 participating men and women. In that study, 15% answered often or all the time and 24% answered once in a while. When comparing these numbers, it seems that the women in fertility treatment more often than other women have a decreased desire for sex. An important note to this is that men were included in the statistics and that men had a higher self-reported level of sexual desire than women.¹⁴ Nonetheless, this study showed a decrease in satisfaction and desire, which might be a cause for or a consequence of the fertility treatment. This correlation has been proved several times, for instance, in a case-control study by Millheiser et al,²³ in which a higher risk of sexual dysfunction was found in women undergoing fertility treatment. Likewise, Wischmann et al⁴ and Shoji et al⁵ reported significantly lower sexual satisfaction in fertility patients.

More than a third of the women in this survey had great difficulties in achieving orgasm sometimes or more often (38%), and a fewer (30%) experienced insufficient vaginal lubrication sometimes or more often. Only 13% answered correspondingly to the question about genital pain during intercourse. Despite the different distributions of these answers, almost the same percentage of women (10%) experienced these three sexual difficulties as a problem. This is an interesting finding and points out that not all sexual issues are problems. Genital pain seemed to be almost always be a problem, whereas orgasm difficulties and insufficient lubrication were seen as a problem in less than one third of cases. Vaginal cramps were a very rare experience in these women (4% answered sometimes or more often).

In the 2005 national study, the participating women were asked about the same four issues.^{15,16} When comparing the two groups, it is clear that the women from the fertility clinic experienced all four issues more often than the women participating in the national study. The women in fertility treatment also experienced these issues as a problem more often than the other group, except for lubrication issues.

STRENGTHS AND WEAKNESSES

Among the strengths of this study are the large number of participants and very high response rate. A limitation is that not all patients visiting the clinic were introduced to the questionnaire. The main reasons were busyness at the reception and no waiting time for consultation.

Another strength is that the questions were developed from previous questionnaires to ensure quality and to improve comparison of the results. However, it might be a weakness that not all questions were validated and that some questions referred to the past year and might be interpreted differently depending on the duration of infertility.

The low response rate to questions about problems with sexual difficulties presented in Table 3D is not desirable but can be explained in a logical way. The number of non-indicated answers about frequencies of experiences correlates to the number of women who did not have sexual activity with another person in the past year (13%). More than half the women did not answer if they felt these experiences were a problem. This correlates to the number that never or rarely experienced the four given sexual difficulties.

CONCLUSION

In summary, this study of women attending a Danish fertility clinic suggests that these women have an unmet desire of communication about sexual matters with doctors. They prefer to speak with gynecologists, but most often speak with their general practitioner. Furthermore, they tend to have sexual difficulties more often than women not undergoing fertility treatment. Therefore, it is important to have such discussions with these patients, and communication about sexual matters should be clinically implemented more widely according to these patients' experiences.

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SUPPLEMENTARY DATA

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.esxm.2017.06.005>.