



A Multidisciplinary Approach to Sexual Behavior Profiles: The SEX360 Model

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Abstract The diversity of sexual behaviors is driven by multiple determinants, including physiological, cultural, educational, and sociological factors. However, the definition of sexual behavior profiles has been barely addressed from a comprehensive point of view. We aimed to develop a multidisciplinary questionnaire for defining individual sexual behavior profiles. The questionnaire was developed by a panel of experts with research experience in the fields of urology, gynecology, psychology, anthropology, and sexology. The list of items was defined in a focus group session and was based on four categories—family-oriented, loving, recreational, and functional—resulting from the combination of two axes: traditional

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versus non-traditional and sexual benefit versus extra-sexual benefit. Real-time Delphi dynamics was used to assign a weight to each question and a bias to the corresponding responses. The final questionnaire included 50 items considered relevant for describing sexual profiles; the final questionnaire was named SEX360. Of the 50 items included in SEX360, 14 were considered essential for computing the final score; 9 of them were associated with 2 categories, 4 of them with 4 categories, and 1 of them with 3. Nine items referred to the category “family-oriented”, 10 to “loving”, 8 to “recreational”, and 9 to “functional”. The weights assigned to each question ranged from 3.00 to 4.33, and the centers of gravity ranged from 1 to 4. The questionnaire proposed shows the existence of a vast diversity of sexual behavior profiles and may serve as a tool for sexual behavior research.

Keywords Sexual behavior · Sexology · Anthropology · Psychosexual development

Introduction

The modern conception of sexology and sexual behavior began in the early 1970s with the scientific approach to sexual disorders proposed by Masters and Johnson (Masters and Masters 1980; Johnson et al. 1994; Masters et al. 1995). In their book *Human Sexual Inadequacy*, Masters and Johnson suggested various sexual profiles and behavior patterns based on studies recruiting prostitutes as the primary source of information for sexual behaviors. This early definition marked the onset of a period in which the approach to sexual behavior and sexual dysfunctions was mainly psychological. More than one decade after the work carried out by Masters and Johnson, the development of echo-Doppler flowmetry and neurophysiological procedures helped explain many sexual disorders physiologically, launching a new stage labeled by some authors as “medical reductionism” (Jannini et al. 2010). This new conception of sexuality and sexual disorders was enhanced by the emergence of pharmacological treatments for the management of major sexual dysfunctions such as erectile dysfunction, premature ejaculation and hypoactive sexual desire disorder (Hatzimouratidis et al. 2010; Waldinger 2015; Robinson et al. 2016). Still, clinical trials investigating the efficacy of treatments for sexual dysfunctions report remarkable contributions of the psychological domain in sexual disorders (McCabe 1997; Trudel et al. 1997; Leiblum et al. 2007; Hayes et al. 2008; Mathers et al. 2009; Andersson et al. 2011; Melnik et al. 2012; Akasheh et al. 2014; Boddi et al. 2015).

From a clinical point of view, there is currently a broad consensus on the fact that sexual disorders may be psychogenic, organic, or both (Montorsi et al. 2010). However, the study of sexual behavior requires the inclusion of other dimensions beyond the psychological and physiological domains. An example of this is the changes in sexual behavior and attitudes observed during the emergence of sexually transmitted diseases in the 1990s, which indicated that cultural, social, and educational domains have a strong influence on sexuality (Tuzin 1991; Ku et al.

1998). In fact, the AIDS outbreak motivated the incursion of anthropology in the scientific arena of sexual research and brought about an alternative approach based on the result of an interaction of cultural ideas and psychobiological impulses (Tuzin 1991). However, to date, there are few examples of comprehensive sexual research involving all areas of knowledge concerned with sexuality (e.g. medicine, anthropology, psychology, sociology, etc.), and it seems that each area is rather attached to its own paradigm. The little receptivity to other areas of knowledge is particularly noticeable in the clinical environment, where sexual health is very often seen as the mere absence of sexual disorders, rather than the fulfillment of autonomy and wellbeing in sexuality (Hawkes 2014). At this point, we believe that the study of sexuality should transcend the clinical framework based on the psychological-organic binomial and move forward to a comprehensive definition of sexual profiles which considers the multiple dimensions of sexuality. The aim of this work was to present a first attempt at the definition of sexual profiles based on a self-administered questionnaire conceived by a panel of experts in the fields of urology, gynecology, psychology, anthropology, and sexology.

Methods

Due to the limited literature on the definition of sexual profiles, we based our work entirely on the background experience of a panel of six experts with extensive research experience in the fields of urology, gynecology, psychology, anthropology, and sexology. The consensus process was structured into three meetings and approached through either focus group sessions or real-time Delphi dynamics combined with open discussions. In the real-time Delphi methodology, each expert provides a response to a given question anonymously. An external facilitator presents a summary of all responses—or a measure of central tendency and dispersion, for quantitative responses—and the result is openly discussed. Experts can modify their responses and discuss the new result again until a pre-set condition for consensus is reached. In our case, the Delphi methodology was used to agree on quantitative data; hence, consensus was deemed reached when the resulting median had an interquartile range (i.e. percentiles 25 and 75) of 1 or less in a 6-point scale.

The first meeting, which took place on June 2016, addressed the list of items to be included in the questionnaire. To this end, experts were asked to provide at least ten questions—along with the corresponding suggested answers—that they considered relevant to define a sexual profile. To facilitate the understanding of the model, categories were established according to two axes: traditional versus non-traditional and sexual benefit versus extra-sexual benefit. The following four categories resulted from these two axes: family-oriented (i.e. traditional and extra-sexual benefit), loving (i.e. traditional and sexual benefit), recreational (i.e. non-traditional and sexual benefit), and functional (i.e. non-traditional and extra-sexual benefit). For homogeneity, all incremental responses were tailored to a 6-point Likert scale. The list of items was openly discussed in a focus group moderated by the facilitator, who assisted experts in eliminating redundancy and ruling out questions with little influence on profile definition.

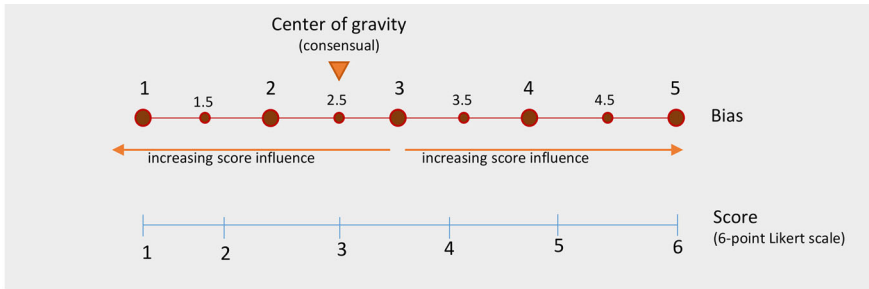
The purpose of the second meeting was to assign a weight to each question and to estimate a bias of the responses by using a real-time Delphi methodology for consensus (Monguet et al. 2016). First, experts were asked to assign a global weight to each question by anonymously suggesting a score from 1 (little influence on the model) to 6 (great influence on the model) to each question. The experts could then see the median score and who of them were out of the interquartile range. The reasons for each score were discussed openly and the experts had the opportunity to revise their choice in subsequent rounds. Figure 1 shows the interface used during the real-time Delphi process.

In addition to weighting each question in the general model, the experts assigned an estimated bias to the answers. The rationale for this bias was that the strength of each score on the 6-point Likert scale when approaching the respondent to a particular category was unlikely to be homogeneous (e.g. taking a given question, scoring 1 may make a great contribution to approaching the respondent to love and family categories, whereas scoring 6 may make a small contribution to approaching him/her to recreational and functional categories). Following a real-time Delphi methodology, the experts shifted the center of gravity of each 6-point scale by assigning a bias ranging from 1 (score 1 has maximum influence and score 6 has no influence) to 5 (score 1 has no influence and score 6 has maximum influence); bias 3 was assigned when responses were well-balanced and, therefore, all scores had the same influence on each profile. The resulting bias was translated to a factor to be applied to the score (Fig. 2).

The agreed questionnaire was introduced in Google form, and the weights and biases were used to create the algorithm for calculating the final model automatically from users' responses. The questionnaire link was sent to all experts, who tested the form during 3 weeks. During the last meeting, the overall performance of the questionnaire was discussed and a few adjustments were made. For the design of the final questionnaire, an introductory explanation was added, as well as a statement regarding the anonymous nature of responses and compliance with the local data protection law (LOPD 15/1999).



Fig. 1 Participants' graphical interface used in the real-time Delphi process for addressing question weight and response bias. *Green spots* and *lines* represent the median and the interquartile range, respectively



Center of gravity (agreed in the Delphi consensus)

	1	1.5	2	2.5	3	3.5	4	4.5	5
1	4	3.5	3	2.5	2	1.5	1	0.5	-
2	3.2	2.9	2.6	2.3	2	1.7	1.4	1.1	0.8
3	2.4	2.3	2.2	2.1	2	1.9	1.8	1.7	1.6
4	1.6	1.7	1.8	1.9	2	2.1	2.2	2.3	2.4
5	0.8	1.1	1.4	1.7	2	2.3	2.6	2.9	3.2
6	-	0.5	1	1.5	2	2.5	3	3.5	4

Fig. 2 Concept diagram and conversion table for assigning a bias to each response. The experts agreed on a center of gravity for each question (*orange triangle*), which was then used to estimate the bias of each response (table below). In the example shown in the figure, the experts assigned a center of gravity of 2.5; according to the table, the bias assigned to scores (responses) 1, 2, 3, 4, 5, and 6 were 2.5, 2.3, 2.1, 1.9, 1.7, and 1.5, respectively

Results

In the first focus session, the experts provided 118 questions they considered relevant for the definition of sexual profiles. After removing redundancy and ruling out questions with little influence on the final profile, a list of 50 questions was agreed on (supplementary Table 1). To facilitate administration of the questionnaire, items were grouped into four domains: childhood/education, sexuality, personality, and sexual behavior. The experts agreed that the minimum information needed to define sexual profiles could be summarized into 14 questions, which were selected in a way that the four categories were well-balanced. However, the remaining 36 items were kept in the final questionnaire despite being unnecessary for the final score as they were considered potentially useful for future research as well as for implementing further versions of the model. The resulting model was named SEX360. Table 1 shows the 14 questions used to define sexual profiles, along with the categories they are related to and the weight and bias assigned to questions and responses, respectively.

Twelve of 14 questions were well-balanced in terms of the number of categories favored by each extreme of the scale. Only questions 2 and 4 were non-symmetrical: question 2 had 1 and 2 categories favored by lower and higher scores, respectively, and question 4 had 0 and 2 categories favored by lower and higher scores, respectively. Regarding the total number of categories involved in each question,

Table 1 Questions used in profile definition

	Range of the 6-point Likert scale	Category favored	Question weight ^a	Response bias ^b
Childhood and education				
1. How would you describe the sexual education you got as a child/teenager?	1—very restrictive 6—very liberal	L/FA R/FU	3.67	2.5
2. How often were your parents physically affectionate in your presence?	1—never 6—all the time	FU L/FA	3.17	4
Sexuality				
3. You are a faithful person	1—disagree completely 6—agree completely	R/FU L/FA	3	4
4. Your level of sexual desire is:	1—low 6—high	— R/L	4	3.5
Sexual behavior				
5. You find it hard to have sex if you are not emotionally attached to a potential sexual partner	1—disagree completely 6—agree completely	FU L	3.83	4
6. You could have sex in order to obtain a benefit, such as get ahead at work or have influence on someone	1—disagree completely 6—agree completely	L FU	4.17	5
7. The main purpose of sex is to have children	1—disagree completely 6—agree completely	R FA	4	5
8. Having sex to get something in return (money, power, influence, etc.) is unacceptable	1—disagree completely 6—agree completely	FU L	4	2
9. Sex without pleasure is pointless	1—disagree completely 6—agree completely	FA R	4.17	4
10. The most important purpose of sex is to have a good time	1—disagree completely 6—agree completely	FA R	4.33	5
11. If I were unable to have children, I would stop having sex	1—disagree completely 6—agree completely	R FA	4	5
12. Loving or being emotionally attached to your sexual partner is important to you when it comes to having sex	1—disagree completely 6—agree completely	FU L	4.33	3
13. You consider yourself to have a traditional view of sexuality	1—disagree completely 6—agree completely	R/FU L/FA	4	4
14. You are driven by the bodily sensations caused by sex	1—disagree completely 6—agree completely	FA/FU R/L	4.17	1

FA family-oriented, L loving, R recreational, FU functional

^a Median agreed when interquartile range was 1 or less

^b Center of weight agreed when interquartile range was 1 or less

64% (9 questions) involved 2 categories, 29% (4 questions) involved 4 categories, and 7% (1 question) involved 3 categories. The various categories were also fairly balanced in the overall questionnaire: “family-oriented” was involved in 9 questions, “loving” was involved in 10 questions, “recreational” was involved in 8 questions, and “functional” was involved in 9 questions. The weights assigned to each question ranged from 3.00 to 4.33, and the centers of gravity ranged from 1 to 4.

The scores of each question, computed according to the weight and bias assigned, lead to a column chart which shows the level of influence of each category on the user’s sexual profile. The level of influence of each category ranges from 0–40. The result is presented along with a definition of each category (Fig. 3).

Considering this was a first attempt at the assessment of sexual profiles, experts agreed to add a sub-form to assess the perceived reliability of results. All questions in this sub-form are rated on a 6-point Likert scale and ask about three items: (1) to what extent the user understands the meaning of the four categories, (2) to what extent the user thinks this model might explain sexual behavior—albeit in a very succinct way, and (3) to what extent the user identifies with the result. Users are invited to participate in this sub-form upon completion of the main questionnaire and they are presented with the results, irrespective of their decision to respond to the sub-form or not.

A $Profile(i) = \sum_k (f(VQ_k, BQ_k) * WQ_k)$

K from 1 to 14

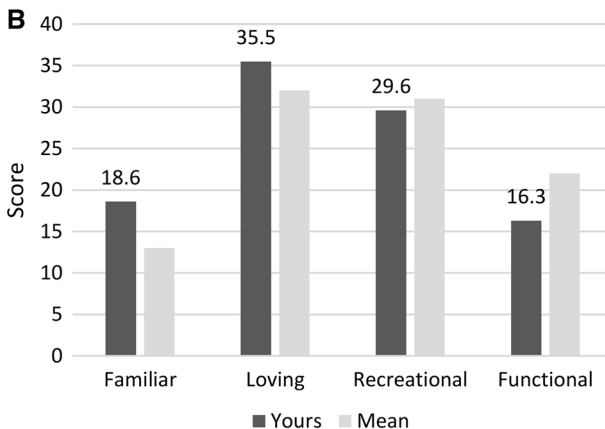


Fig. 3 **a** Equation used to estimate the final score in each profile (VQ value assigned by the user to each question, BQ bias assigned by experts to the question, f a function that establishes a value depending on VQ and BQ , WQ weight assigned by experts to the question). **b** Result as displayed to the user at the end of the questionnaire

Discussion

To the best of our knowledge, this is the first multidisciplinary conception of a questionnaire for describing and classifying the various sexual profiles underlying sexual behavior and attitudes. Since the works published by Masters and Johnson, various authors have addressed the classification and description of sexual profiles. In addition to a few studies on specific populations (Gwee et al. 2002; Williams and Weinberg 2003; Namiki et al. 2011), Gilbert and Gamache provided a questionnaire to assess sexual profiles in the overall population (Gilbert and Gamache 1984). Their “Sexual Opinion Survey” was based on the axis erotophobia-erotophilia and therefore contained questions regarding affinities towards different sexual practices. However, in line with the approach proposed by Popovic (2006), we understand psychosexual diversity as an evolving concept that may be influenced by many factors, including social context, upbringing or educational experience, historical-socio-cultural determinants, and the needs or concerns of the sexual partner. In this regard, a panel of experts including not only sexologists but also experts in the fields of urology, gynecology, psychology, anthropology, and sexology helped build a questionnaire encompassing most of the influencing factors described by Popovic et al.

The multidisciplinary nature of the panel of experts had the potential risk of hampering the consensus process as each area of expertise was likely to have a particular view of sexuality and even to use a slightly different language when referring to sexual terms. For this reason, we thought the participation of an external facilitator was a key condition for reaching a qualified consensus in a reasonable time. The facilitator conducted the process by following two different approaches: focus group sessions and a real-time Delphi method. The Delphi method is based on the principle that collective decision-making in medicine and scientific research is more accurate when the group of individuals is structured and coordinated (Rowe and Wright 2001; Green et al. 2007). Unlike other forecasting methods, in which the entire process is conducted openly, the Delphi method allows each expert to provide a response anonymously. Participants can review their own conclusions at any moment, which results in an evolving process continuously influenced by the opinions of the other experts. In our experience, this dynamics resulted in an agreed model which satisfied all experts, even after a few weeks testing the questionnaire and independently exploring its strengths and limitations.

The sexual model proposed is based on two axes: traditional versus non-traditional, and sexual benefit versus extra-sexual benefit. In addition to encompassing the various psycho-social and cultural determinants, these two axes were intended to fit with the various types of rewards that may motivate sexual attitude. Unlike other species, sexual activity in humans is not only driven by a reproductive or loving reward, but also by a recreational reward or even the willingness to obtain a benefit not related to sex, love or reproduction. In this regard, the sexual profiles resulting from these two axes (i.e. family-oriented, loving, recreational, and functional) encompass not only the cultural and educational perception of sex but also the various types of sexual reward observed in humans.

Our model is a preliminary attempt at the definition of sexual profiles. It is important not to lose sight of the fact that the internal validity of the proposed model lies entirely in the professional experience of the panel of experts. Moreover, although the SEX360 model aims to serve ultimately to describe sexual profiles worldwide, for this first approach, all experts were based in the same country as we considered this might lead to greater in-group consistency. Country-dependent cultural constraints shall be addressed in future versions of the questionnaire. Another issue to be considered in the future is the assessment of physical aspects of sexual health. Although the 50-item questionnaire addresses the presence of sex-related medical conditions such as erectile dysfunction or loss of sexual desire, we decided not to include this aspect in the list of items used to establish the sexual profile. The subjective perception of sex-related conditions may be of interest for future investigations. However, the assessment of these conditions was out of the scope of our questionnaire, and we deemed that the inclusion of an incomplete assessment of sexual health problems might introduce a biased input in the definition of the sexual profile. Taking advantage of the features of Internet-based questionnaires, future editions of the SEX360 questionnaire might include links to self-administered questionnaires to assess sex-related conditions at user's discretion. Of course, the advantages and disadvantages of this improvement must be carefully weighed.

In summary, despite the significant limitations of our work, we believe that a multidisciplinary approach to human sexual profiles was a necessary first step towards the definition and understanding of various sexual attitudes. The potential uses of this model involve both research and clinical practice. The environment of research in sexual behavior might find in this model a suitable way to stratify study samples by considering different profiles separately. Also, as the questionnaire was designed to be administered anonymously through any online resource, it may provide large datasets on population sexuality. From a clinical point of view, our model might provide healthcare professionals (including, but not limited to, urologists, sexologists, and psychologists) with an easy-to-use tool to target patients, which may help professionals tailor their advice to each profile. Ultimately, we hope that in the future, the widespread administration of this questionnaire may help both healthcare professionals and patients understand sexuality better and normalize the existence of a vast diversity of sexual behaviors. For this to be accomplished, however, the SEX360 model needs to be reviewed by the scientific community and validated by administration in a real-life setting.

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Compliance with Ethical Standards

Conflicts of interest E. García, J. M. Monguet, M. F. Peraza, M. González, D. Marre, C. Sánchez, C. Suso, A. Trejo, and A. Alcaraz declare that they have no conflicts of interest regarding the content of this manuscript.

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References

- Akasheh, G., Sirati, L., Noshad Kamran, A. R., & Sepehrmanesh, Z. (2014). Comparison of the effect of sertraline with behavioral therapy on semen parameters in men with primary premature ejaculation. *Urology*, *83*, 800–804. doi:[10.1016/j.urology.2013.12.004](https://doi.org/10.1016/j.urology.2013.12.004).
- Andersson, E., Walén, C., Hallberg, J., et al. (2011). A randomized controlled trial of guided internet-delivered cognitive behavioral therapy for erectile dysfunction. *The Journal of Sexual Medicine*, *8*, 2800–2809. doi:[10.1111/j.1743-6109.2011.02391.x](https://doi.org/10.1111/j.1743-6109.2011.02391.x).
- Boddi, V., Castellini, G., Casale, H., et al. (2015). An integrated approach with vardenafil orodispersible tablet and cognitive behavioral sex therapy for treatment of erectile dysfunction: A randomized controlled pilot study. *Andrology*, *3*, 909–918. doi:[10.1111/andr.12079](https://doi.org/10.1111/andr.12079).
- Gilbert, F. S., & Gamache, M. P. (1984). The sexual opinion survey: Structure and use. *Journal of Sex Research*, *20*, 293–309. doi:[10.1080/00224498409551227](https://doi.org/10.1080/00224498409551227).
- Green, K. C., Armstrong, J. S., & Graefe, A. (2007). Methods to elicit forecasts from groups: Delphi and prediction markets compared. *Foresight: The International Journal of Applied Forecasting (forthcoming)*, Munich Personal RePEc Archive. MPRA Paper, 4663.
- Gwee, K. P., Lim, L. E. C., & Woo, M. (2002). The sexual profile of rapists in Singapore. *Medicine, Science and the Law*, *42*, 51–57.
- Hatzimouratidis, K., Amar, E., Eardley, I., et al. (2010). Guidelines on male sexual dysfunction: Erectile dysfunction and premature ejaculation. *European Urology*, *57*, 804–814. doi:[10.1016/j.eururo.2010.02.020](https://doi.org/10.1016/j.eururo.2010.02.020).
- Hawkes, S. (2014). Sexual health: A post-2015 palimpsest in global health? *The Lancet Global Health*, *2*, e377–e378.
- Hayes, R. D., Dennerstein, L., Bennett, C. M., et al. (2008). Risk factors for female sexual dysfunction in the general population: Exploring factors associated with low sexual function and sexual distress. *The Journal of Sexual Medicine*, *5*, 1681–1693. doi:[10.1111/j.1743-6109.2008.00838.x](https://doi.org/10.1111/j.1743-6109.2008.00838.x).
- Jannini, E. A., McCabe, M. P., Salonia, A., et al. (2010). Organic vs. psychogenic? The manicbean diagnosis in sexual medicine. *The Journal of Sexual Medicine*, *7*, 1726–1733. doi:[10.1111/j.1743-6109.2010.01824.x](https://doi.org/10.1111/j.1743-6109.2010.01824.x).
- Johnson, A. M., Wadsworth, J., Wellings, K., & Field, J. (1994). *Sexual attitudes and lifestyles*. Oxford: Blackwell Scientific Publications.
- Ku, L., Sonenstein, F. L., Lindberg, L. D., et al. (1998). Understanding changes in sexual activity among young metropolitan men: 1979–1995. *Family Planning Perspectives*, *30*, 256–262. doi:[10.2307/2991500](https://doi.org/10.2307/2991500).
- Leiblum, S., Seehuus, M., & Brown, C. (2007). Persistent genital arousal: Disordered or normative aspect of female sexual response? *The Journal of Sexual Medicine*, *4*, 680–689. doi:[10.1111/j.1743-6109.2007.00495.x](https://doi.org/10.1111/j.1743-6109.2007.00495.x).
- Masters, W. H., Johnson, V. E., & Kolodny, R. C. (1995). *Human sexuality*. New York: Harper Collins College Publishers.
- Masters, W. H., & Masters, V. J. (1980). *Human sexual inadequacy*. New York: Bantam Books.
- Mathers, M. J., Klotz, T., Roth, S., et al. (2009). Safety and efficacy of vardenafil versus sertraline in the treatment of premature ejaculation: A randomised, prospective and crossover study. *Andrologia*, *41*, 169–175. doi:[10.1111/j.1439-0272.2008.00910.x](https://doi.org/10.1111/j.1439-0272.2008.00910.x).
- McCabe, M. P. (1997). Intimacy and quality of life among sexually dysfunctional men and women. *Journal of Sex and Marital Therapy*, *23*, 276–290.
- Melnik, T., Abdo, C. H. N., de Moraes, J. F., & Riera, R. (2012). Satisfaction with the treatment, confidence and “naturalness” in engaging in sexual activity in men with psychogenic erectile dysfunction: Preliminary results of a randomized controlled trial of three therapeutic approaches. *BJU International*, *109*, 1213–1219. doi:[10.1111/j.1464-410X.2011.10516.x](https://doi.org/10.1111/j.1464-410X.2011.10516.x).
- Monguet, J. M., Trejo, A., Martí, T., et al. (2016). Assessment of chronic health care through an internet consensus tool. In *Handbook of research on trends in the diagnosis and treatment of chronic conditions* (pp. 424–443). IGI Global Publisher.

- Montorsi, F., Adaikan, G., Becher, E., et al. (2010). Summary of the recommendations on sexual dysfunctions in men. *The Journal of Sexual Medicine*, 7, 3572–3588. doi:[10.1111/j.1743-6109.2010.02062.x](https://doi.org/10.1111/j.1743-6109.2010.02062.x).
- Namiki, S., Carlile, R. G., Namiki, T. S., et al. (2011). Racial differences in sexuality profiles among American, Japanese, and Japanese American Men with localized prostate cancer. *The Journal of Sexual Medicine*, 8, 2625–2631. doi:[10.1111/j.1743-6109.2011.02362.x](https://doi.org/10.1111/j.1743-6109.2011.02362.x).
- Popovic, M. (2006). Psychosexual diversity as the best representation of human normality across cultures. *Sexual and Relationship Therapy*, 21, 171–186. doi:[10.1080/14681990500358469](https://doi.org/10.1080/14681990500358469).
- Robinson, K., Cutler, J. B. R., & Carris, N. W. (2016). First pharmacological therapy for hypoactive sexual desire disorder in premenopausal women: Flibanserin. *Annals of Pharmacotherapy*, 50, 125–132. doi:[10.1177/1060028015622182](https://doi.org/10.1177/1060028015622182).
- Rowe, G., & Wright, G. (2001). Expert opinions in forecasting: The role of the Delphi technique. In *Principles of forecasting* (pp. 125–144). Springer US. <https://www.gwern.net/docs/predictions/2001-rowe.pdf>.
- Trudel, G., Landry, L., & Larose, Y. (1997). Low sexual desire: The role of anxiety, depression and marital adjustment. *Sexual and Marital Therapy*, 12, 95–99.
- Tuzin, D. (1991). Sex, culture and the anthropologist. *Social Science and Medicine*, 33, 867–874. doi:[10.1016/0277-9536\(91\)90258-E](https://doi.org/10.1016/0277-9536(91)90258-E).
- Waldinger, M. D. (2015). Pharmacotherapy for premature ejaculation. *Expert Opinion on Pharmacotherapy*, 16, 2615–2624. doi:[10.1517/14656566.2015.1096928](https://doi.org/10.1517/14656566.2015.1096928).
- Williams, C. J., & Weinberg, M. S. (2003). Zoophilia in men: A study of sexual interest in animals. *Archives of Sexual Behavior*, 32, 523–535. doi:[10.1023/A:1026085410617](https://doi.org/10.1023/A:1026085410617).