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PAIN WITH INTERCOURSE AND OTHER EMBARRASSING (SEXUAL) PROBLEMS: BARRIERS TO SEEKING OR PROVIDING PROFESSIONAL HELP

A quantitative cross-sectional survey study among patients, students, and GPs in Amsterdam (2016)

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Summary

According to the DSM-V, pain with intercourse, or dyspareunia, is when someone experiences repeated or intermittent pain in the genital area which is associated with sexual intercourse. The prevalence rates in men and women are 0.7% and 4.9% respectively. The percentage of people who need help for sexual dysfunctions and actually sought help is 46.7% of men, 37.2% of women. Using quantitative measures the following research question will be answered: "What are differences in reported barriers to seeking professional help in patients and students with pain with intercourse and other embarrassing problems?"

The study design concerned a cross-sectional survey study. The study population was tripartite;

- Patients of a general practice situated in the city centre of Amsterdam; the 'Huisartsen Oude Turfmarkt/Bureau Studentenartsen',
- Students that filled out the Studenthealthcheck,
- GPs of the Huisartsen Oude Turfmarkt/Bureau Studentenartsen.

Patients and students were asked if they had pain with intercourse. Patients and students who had pain with intercourse or had partners with pain with intercourse were asked if they had sought professional help for it. If the answer was no, then these patients and students were asked why they had not. If the answer was yes, then these patients and students were asked if they benefitted from the provided professional help. Patients and students who did not have pain with intercourse or did not have a partner with pain with intercourse were asked to imagine having an embarrassing problem. These patients and students were then asked what barriers they would experience to seeking professional help for this imagined embarrassing problem. GPs were asked what barriers they experience to providing professional help for pain with intercourse.

The prevalence rate of pain with intercourse is 27%. The odds of pain with intercourse is 3.8 times higher for females compared to males. The prevalence rate of help-seeking for pain with intercourse is 20%. Three out of 10 respondents agreed with benefitting from the professional help provided by the general practitioner for pain with intercourse. The median rating of the consultation with the general practitioner for pain with intercourse is 7.5. The only barrier to providing professional help for pain with intercourse that is scored on highly is lacking a reason to talk about it; 5 out of 7 GPs responded with "Agree".

If patients with pain with intercourse differ at all from patients with another embarrassing (sexual) problem regarding barriers to help seeking then they do so on the following barriers;

- Talking with others whom are not health professionals,
- Forgetting to ask about the problem during consultation,
- Lacking confidence in a medical solution for the problem,
- When consulting the general practitioner for the problem then they have to talk to their partner about it too,
- Wanting the general practitioner being of the same sex/gender as themselves when consulting the general practitioner for the problem,
- Not having a regular GP.

Contents

1. Introduction

Sexual health, as defined by the WHO, is a state of physical, emotional, mental and social wellbeing regarding sexuality. Sexual health is more than just the absence of disease, dysfunction or infirmity[1,2]. Everyone should have the opportunity to choose and experience sexual contacts and sexual relationships. These contacts and relationships should be free of constraint, discrimination or violence. Sexuality should contribute to your wellbeing[1,2]. Sexual health is deemed so important that anyone has the lawful right to pursue satisfactory, pleasurable and safe sex[3].

However, not everyone is able to have satisfactory and pleasurable sex. Often, people are faced with sexual dysfunctions. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), a sexual dysfunction refers to a self-reported disorder or dysfunction which disturbs the person in their sexual functioning[4]. Sexual dysfunctions, or sexual problems, are a biopsychosocial phenomenon and thus caused by biomedical, psychosexual, and contextual determinants[5]. For example, a medical drug, past trauma and/or stress can increase the risk of a sexual dysfunction. These determinants are also responsible for the maintenance of the dysfunction.

One of the many sexual dysfunctions is pain with intercourse. According to the DSM-V, pain with intercourse, or dyspareunia, is when someone experiences repeated or intermittent pain in the genital area which is associated with sexual intercourse[5,6]. The pain is not exclusively caused by vaginismus or reduced lubrication and not exclusively a result of medical drug use or a general medical condition. The pain can be superficial or deep. Furthermore, the pain can be distinguished between primary occurring; since first sexual contact, or secondary; arising after painless sexual contacts. The pain can also be situational; with intercourse but not with masturbation[6,7].

In the adjusted version of the 'Vragenlijst voor het signaleren van Seksuele Disfuncties (VSD)'[8], dyspareunia is questioned as followed: "Do you experience pain, itching or burning of your genitals, before, during or after sexual contact?[8,9]" The International Classification of Primary Care (ICPC) codes are often used in Dutch general practices. Dyspareunia in men is sometimes coded with ICPC as Y04; other symptoms/complaints penis and in women with X04; painful intercourse female[10].

During the period between 2003 and 2008, Kedde and colleagues did research on the incidence of sexual dysfunctions as reported in general practices (Dutch Sentinel General Practice Network) in the Netherlands. They found that the incidence of sexual dysfunction is 95.4 per 100,000 patients; 131.6 per 100,000 men and 59.8 per 100,000 women[11]. The most reported sexual dysfunction in women appears to be dyspareunia. The incidence of dyspareunia (from 2003-2008) in women is 28.5 per 100,000 and 1.3 per 100,000 in men[11]. In another article, Kedde reported prevalence rates of dyspareunia in members of a PanelClix panel. The prevalence rates in men and women are 0.7% and 4.9% respectively[9]. The prevalence of dyspareunia in other literature varies from 3-43% depending on culture (the lower estimates concern North-European countries, while higher estimates originate in the US), setting (3-18% in the general population, 3-46% in general practices, up to 30% in sexuological practices, and 10-20% in gynaecological policlinics), and health care worker (health care workers who ask about it report the complaint more frequently)[12].

Picavet and colleagues did research on the need for help and actual sought help for a sexual problem in the Netherlands in 2011. The need for help was assessed with one question; if one wanted help or advice from health care workers or general practitioners (GPs) regarding problems with sexuality and relationships[13]. The percentage of people with a sexual problem who need help is 14.3% (14.5% in women, 14.1% in men). The percentage of people who need help and actually sought help is 43.2% (46.7% in men, 37.2% in women)[13]. Recent and/or Dutch figures on people with, specifically, dyspareunia, who do or do not seek help, are not available.

As is said before, sexual dysfunctions can be viewed as a biopsychosocial phenomenon. The effects of untreated dyspareunia are then in three domains; biomedical, psychosexual, and contextual. For example, untreated dyspareunia can affect reproduction, the experience of pleasure and intimacy[14]. But more importantly, continuing sexual contact despite experiencing pain, contributes to the persistence of the problem[15]. Therefore, help-seeking, as the first step towards treatment of dyspareunia, is of great importance.

Yet, as is said before, over half of the people who experience sexual dysfunctions do not seek help. Furthermore, the prevalence rate as reported by Kedde[9] is not always found in general practice. This raises the following question: "Why is dyspareunia such a dark kept secret?" Barriers and settling factors to help-seeking for dyspareunia and other sexual dysfunctions have previously been described, both in patients and GPs. The data from these studies have mostly been gathered for female patients and with the help of qualitative measures (e.g. interviews). A review of the literature can be found in Table 1.

Since some of the environmental barriers concerned barriers that are thought to be found in physicians for providing help (e.g. physicians' ability to communicate about sexual functioning), there was done a scientific literature search on the barriers to providing professional help for dyspareunia and other sexual dysfunctions. The relation between barriers to providing help in physicians and help-seeking by patients has not been studied. A review of the literature regarding help-providing behaviour can be found in Table 2.

Barriers to help-seeking are bad enough as they are. However, they can be further reinforced by settling factors. Opposites of the settling factors are sometimes reported as stimulating factors. Shifren and colleagues found that the absence of a current partner in adult women in the US is of negative influence on help-seeking for self-reported sexual problems. This is contrary to having a current partner, which is of positive influence[16]. Shindel and colleagues showed that bisexual students enrolled in MD-degree-granting and osteopathic medical schools in the US and Canada are more likely to feel comfortable discussing sex with patients compared to heterosexual participants[17]. They also showed that participants without significant depressive symptoms and participants with six or more lifetime sexual partners were more comfortable discussing sexual health than their counterparts[17]. A review of the literature regarding settling factors can be found in Table 1 and 2.

1.1 Theoretical Framework

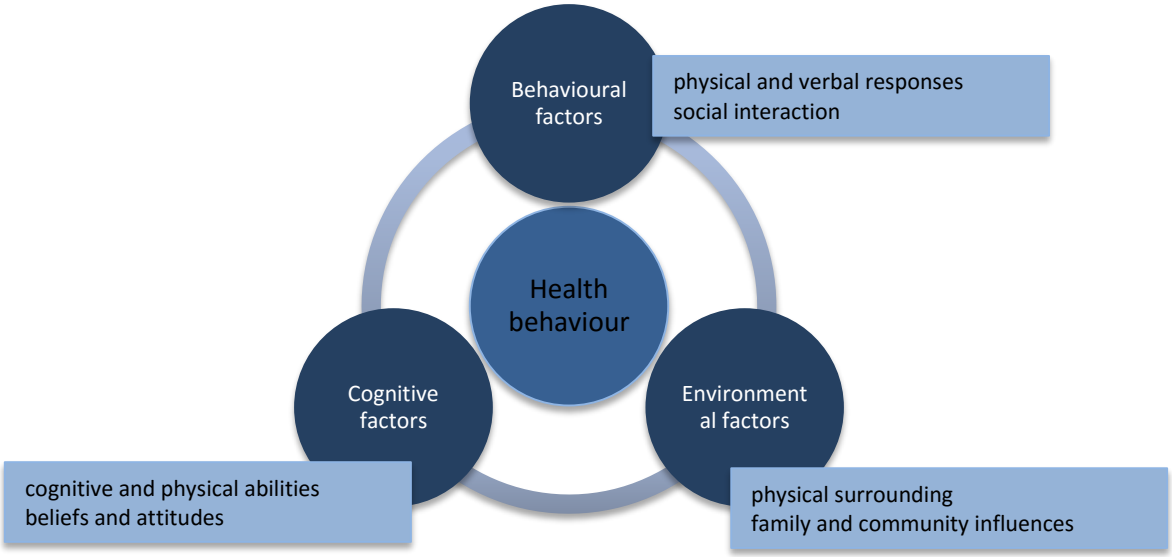
The fact that help-seeking is a health behaviour gave some direction to which model to choose for the theoretical framework. Help-seeking as a behaviour can be explained as a result of multiple determinants. An array of theories and models are developed to explain health behaviour. Some examples include the Theory of Planned Behaviour, the ASE model, the Health Belief Model, the Protection Motivation Theory, and the Social-Cognitive Theory.

The concept of self-efficacy can be measured using factors such as experience, modelling, social persuasion, and physiological factors. Since this study is going to make use of barriers and settling factors to help-seeking for dyspareunia and other sexual dysfunctions found in scientific literature, and experience, modelling, social persuasion, and physiological factors are not found, self-efficacy cannot be measured. Thus, the ASE Model[18] and the Theory of Planned Behaviour[19] will not be used for this study. Perceived susceptibility, perceived threat of disease, and (lack of) cues to action could be relevant barriers to help-seeking, but again, these factors have not been found in scientific literature. The Health Belief Model[20] is therefore, regrettably, disregarded. The Protection Motivation Theory[21] is interested in the assessment of the threat and coping-strategies. These processes which lead to a certain health-behaviour are very much individual, cognitive processes. The Protection

Motivation Theory therefore disregards other non-individual, cognitive processes which scientific literature has shown to affect seeking professional help for dyspareunia and other sexual dysfunctions.

The Social Cognitive Theory[22], developed by Bandura, explains behaviour as a result of the interplay of cognitive, behavioural, and environmental determinants (see Figure 1). Behavioural determinants are physical and verbal responses and social interactions. Cognitive determinants are cognitive and physical abilities and beliefs and attitudes. Environmental determinants are physical surroundings and family and community influences[23]. Most theories and/or models of health behaviour predict health habits, but they do not offer a lot of guidance on how to change these habits. The Social Cognitive Theory embeds determinants for health behaviour in a large body of knowledge that describes the way in which these determinants work and how to, in this case, delist them to enhance health[24]. Social cognitive approaches to health behaviour translate into, primarily, educative interventions. The end-goal of educative interventions is to increase health literacy[25].

Figure 1. Social Cognitive Theory; behaviour as a result of the interplay of cognitive, behavioural, and environmental determinants



The Social Cognitive Theory embeds barriers and settling factors for help-seeking behaviour (see Table 1 and 2). Not only does the theory explain help-seeking as a results of cognitive barriers, but also as a result of behavioural and environmental barriers. This fits the notion that help-seeking depends as much on peoples place in society which is mediated by ideologies and social-structures, as it does on cognitive processes[26]. However, help-seeking as a process structured by social networks and information seeking has its shortcomings[27]. For example, people are not always oriented toward medical instructions. Rather, help-seeking often serves a strategic purpose such as making sense of difficult social situations or negotiating priorities[27]. Fortunately, the Social Cognitive Theory leaves room for these aspect of help-seeking. Furthermore, the classification of barriers into three dimensions can help identify which dimensions might be most prominent in their effect on help-seeking. Sexual health help-seeking behaviour can be seen as a part of health literacy[28]. The information on the most prominent barrier-dimension to help-seeking can be used for the development of educative prevention material, with the end-goal of, as said before, increasing health literacy[25].

Table 1. Literature review regarding barriers to help-seeking for sexual problems including pain with intercourse

Help-seeking behaviour		
Cognitive barriers	**Behavioural barriers**	**Environmental barriers**
- Personal pain management: cognitive distraction/prolonging foreplay/changing intercourse positions/use of lubricants[29] - Finding it difficult to talk about the sexual problem[13] - Shame/embarrassment[16,29,30,31,32,33,34,35] - Waiting on the physician to ask about the sexual problem[29] - Perceiving that the sexual problem can be resolved by themselves[13] - Problem identifying/labelling: lack of knowledge/lack of reality testing[16,30,32] - Cognitive search for causal attributions: no solid theory/anatomy/infection/medical reason NOS/sexual history[30] - Faith in spontaneous remission[13,28,30,32,33,34] - Lack of confidence in a medical solution[30] - Perceived seriousness/severity of the sexual problem[13,30,31,33,34] - Perceiving that the sexual problem comes with ageing[13,31,33,34] - Sex is a very/extremely important part of life[33] - Comfortable with the way I am[33,34] - Perceiving that the sexual problem comes with child-delivery[32] - Bodily insecurity[32] - Perceiving that the sexual problem is not medical[33,34,35]	- Forget asking about the sexual problem during consultation[29] - Talking with initiates[32] - Then I have to talk to my partner about the sexual problem[13] - Fear of stigma associated with the sexual problem[28,30,32] - Professional relationship with physician: lack of trust/lack of comfort/very close[13,29,33,34]	- GPs workload; not wanting to bother[31] - Struggling finding professional help/health care facilities/services[13,28,31] - No time to spend on caring for my own health[32] - Don't think that the physician can help with the sexual problem[29,33,34,35] - Physician's attitude[31,36] - Physician's ability to communicate about sexual functioning[13,33,34,36] - Demographics of the physician: gender/age[31,33,34] - No regular physician[31,33,34] - Physician is expensive[33,34] - Not properly informed by health care workers[32]
	Settling factors	
	- Singlehood[16] - Older age[31,33] - Medium/high household income[33] - Religion[33]	

Table 2. Literature review regarding barriers to providing help for sexual problems including pain with intercourse

Help-providing behaviour		
Cognitive barriers	**Behavioural barriers**	**Environmental barriers**
- Shame/embarrassment[17,28] - Lack of confidence in speaking about the sexual problem[29,37] - Not knowing when/what/how to ask[36,38,39] - Inadequately trained to approach the subject[17,36,37,39,40]	- Language and terminology problems[36] - Afraid to offend the patient[36,37,38,39] - Fear of alienating the patient[28]	- Concern of sexual harassment[36,38] - Perceiving that the patient will bring it up anyway[36,38] - Lack of a reason to talk about sexual health[29,37,39] - Lack of time[37,39,40] - Older age of the patient[36,37,38]

- Uncertainty about therapeutic options[36,38] - Sexual problem is too (biopsychosocially) complex[39] - Not interested in the field[38,40] - Discomfort with the nature of a the patient's sexual proclivities[39]	- Professional relationship with the patient: lack of trust/lack of comfort/very close[29] - Prefer to refer the patient[40]	- Perceived patient denial[36,38] - Cultural, religious, and ethnic factors related to the patient's attitudes and beliefs[36] - Patient's unwillingness to discuss the topic[38]
Settling factors		
	- Virginity[17] - Asian ethnicity[17] - Significant depressive symptoms[17] - Heterosexuality[17] - Fewer than six lifetime partners[17] - (High risk of) sexual dysfunction[17]	

1.2 Research gap and -questions

This study will contribute to filling the research gap regarding barriers and settling factors to seeking professional help for pain with intercourse and other embarrassing problems in patients and students and to providing professional help for pain with intercourse in GPs. Using quantitative measures the following research question will be answered: "What are differences in reported barriers to seeking professional help in patients and students with pain with intercourse and other embarrassing problems?" In order to answer the main research questions and discover other relevant information regarding pain with intercourse and help-seeking, the following sub questions will be answered:

- "What is the prevalence of pain with intercourse?"
- "What is the difference in odds of pain with intercourse for females compared to males?"
- "What is the prevalence of seeking professional help?"
- "Did patients and students who did seek professional help for pain with intercourse benefit from the professional help that was provided?"
- "What are barriers and settling factors to seeking professional help for pain with intercourse in patients and students?"
- "What are barriers to seeking professional help for other (imagined) embarrassing (sexual) problems in patients and students?"
- "What are barriers and settling factors to providing professional help for pain with intercourse in GPs?"
- "What are the statistically significant highest scored on barrier-dimensions (Social-Cognitive Theory)?"

There are a few barriers that respondent with pain with intercourse are expected to report more often compared to respondents with an imagined other embarrassing (sexual) problem. The hypothesis is thus: "Barriers that respondents with pain with intercourse report more often compared to respondents with an imagined embarrassing problem are shame/embarrassment, cognitive search for causal attributions, fear of stigma associated with the problem, and demographics of the physician: gender/age. Barriers that respondents with pain with intercourse report more often compared to respondents with an imagined other embarrassing sexual problem are perceiving that the sexual problem can be resolved by themselves, problem identifying/labelling the problem, faith in spontaneous remission, struggling finding professional help, and thinking that the physician cannot help with the problem."

2. Methods

2.1 Literature review

The literature was collected using two main resources; NCBI and Google Scholar. The following MeSH terms were used to search for scientific literature in NCBI:

- "Dyspareunia"[Mesh]
- Pain with intercourse[tiab] OR dyspareunia[tiab]
- "Communication Barriers"[Mesh:NoExp]
- Barrier*[tiab]
- "Help-Seeking Behavior"[Mesh]
- Help-seeking[tiab]
- "General Practice"[Mesh:NoExp]
- "General Practitioners"[Mesh]

The following search term combinations were used to search for scientific literature in Google Scholar:

- "Dyspareunia OR pain with intercourse AND help-seeking AND barriers"
- "Dyspareunia AND providing help AND general practitioners OR GPs"

The articles from Google Scholar had to be published after 2010.

Only the barriers reported in the results section of each article are reported in Table 1 and 2. Any other barriers reported in the introduction were assessed. If two or more articles referred to the same article in their introduction regarding any barriers then this articles was looked up and assessed for relevance. Barriers reported in the result section of this article were then also reported.

Included articles report on sexuality, psychosexual and relationship problems, sexual health issues, sexual difficulties, -concerns, and -satisfaction, sexual function complaints, distressing sexual problems, sexual dysfunctions, pelvic floor dysfunctions, and dyspareunia. Different research populations include: males, females, medical students, psychiatry trainees, physicians, general practitioners, gynaecologists, and psychiatrists of all ages, sexual orientations, and from around the world.

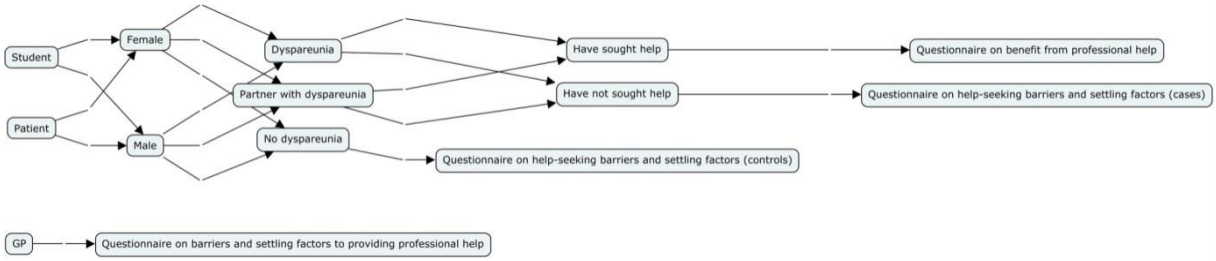
2.2 Study design

The study design concerned a cross-sectional survey study. The study population was tripartite:

- Patients of a general practice situated in the city centre of Amsterdam; the 'Huisartsen Oude Turfmarkt/Bureau Studentenartsen';
- Students that filled out the Studenthealthcheck;
- GPs of the Huisartsen Oude Turfmarkt/Bureau Studentenartsen.

The patients', students', and GPs' exposures and outcomes were cross-sectional assessed, using questionnaires, over a time period of two weeks. See Figure 2 for a visual description of the study design.

Figure 2. Visual description of the study design



2.3 Subjects
Inclusion criteria for students that filled out the Studenthealthcheck were that they had to have had consented to wanting to participate in future research done by the Huisartsen Oude Turfmarkt/Bureau Studentenartsen. Inclusion criteria for the patients of the Huisartsen Oude Turfmarkt/Bureau Studentenartsen were that they had to have been registered and 16 years or older. There were no exclusion criteria for the GPs of the Huisartsen Oude Turfmarkt/Bureau Studentenartsen.

To determine whether someone had pain with intercourse, there had to have been answered "Yes" to all three questions based on the three questions in Plouffe's questionnaire[41]. Plouffe's questionnaire can be found below. Plouffe conducted a study in which the results of his simple questionnaire were compared to a more detailed interview. It was concluded that the three questions were as effective as a detailed inquiry in detecting a sexual problem[41].

Plouffe L Jr. Screening for sexual problems through a simple questionnaire. American Journal of Obstetrics and Gynecology 1985;151(2):166-9.

(1) Are you sexually active?
(2) Are there any problems?
(3) Do you have any pain with intercourse?

Respondents were asked if they had a partner and if this partner had any sexual problems and any pain with intercourse. This was done in order to get a slight idea of if pain with intercourse is discussable. Furthermore, the barriers to help-seeking for pain with intercourse of a partner can be set out against barriers to help-seeking for pain with intercourse for the self.

There was chosen to let respondents imagine an embarrassing problem for themselves. This method provided an opportunity to include more respondents and took away the need to label a certain problem to an embarrassing problem, in order to provide the respondents with a problem for which they would not want to consult their general practitioner about.

2.4 Measuring instruments and procedure
Questionnaire for patients and students
Data collection took place using a questionnaire made up of self-formulated questions, with exception of the questions from Plouffe's questionnaire. The outcome measures were dichotomous; no help-seeking or help-seeking and no pain with intercourse or pain with intercourse. The determinants for help-seeking were set up front, using barriers and settling factors previously reported in scientific literature (see Table 1).

The questionnaire started off with statements regarding the settling factors that were set up front. The statements regarding the settling factors were followed up by the Plouffe questionnaire. Each of the three questions of the Plouffe questionnaire could be answered with either "Yes" or "No". If the patients and students answered "Yes" to all three questions of the Plouffe questionnaire then they were asked if they had sought help for pain with intercourse in the past 6 months. If the respondents did however answer "No" to any of the three questions of the Plouffe questionnaire then they were asked to answer the same questions for their partner. If the patients and students responded positively to having any pain with intercourse or having a partner with pain with intercourse but had not sought help for it then they were referred to the statements regarding the barriers that were set up front. Each statement could be responded to with "Agree", "Slightly agree", "Neither agree nor disagree", "Slightly disagree", and "Disagree", based on the 5-point Likert scale[42]. Respondents who had sought help for pain with intercourse were asked to rate the consultation with the GP on a scale

that ran from 1-10; 1 being very bad and 10 being very good. Furthermore, they were asked to respond to the following statement and question: “I benefitted from the professional help provided by my general practitioner.” and “In what ways have you or have you not benefitted from the professional help provided by the general practitioner for pain with intercourse?” Patients and student who did not have any pain with intercourse or a partner with any pain with intercourse were also referred to statement regarding barriers set up front, however, these statements were formulated to fit an imagined embarrassing problem.

Questionnaire for GPs

Data collection took place using a questionnaire made up of self-formulated questions. The outcome measures were categorical (5-point Likert scale); ““Agree”, “Slightly agree”, “Neither agree nor disagree”, “Slightly disagree”, and “Disagree”. The determinants for providing help were set up front, using barriers and settling factors previously reported in scientific literature (see Table 2).

The questionnaire started with statements regarding the barriers to providing professional help for pain with intercourse that were set up front. The statements regarding the barriers were formulated in such a way that the GPs could form an idea of a situation in which they would either not provide help or provide help. Each statement could be responded to with “Agree”, “Slightly agree”, “Neither agree nor disagree”, “Slightly disagree”, and “Disagree”, based on the 5-point Likert scale. The statement regarding the barriers were followed up by statement regarding settling factors that were set up front. To make sure that the questionnaire did in fact identify as many determinants for providing professional help as possible, the questionnaire ended with the following question: “Are there factors that would either positively or negatively influence you in providing professional help for pain with intercourse? If so, please explain briefly.”

The questionnaires were tested in a pilot. The pilot existed of an informal test, a small scale qualitative test, and experts were consulted. The full questionnaires can be found in Appendix 1 and 2.

The questionnaires were spread among the patients, students, and GPs via e-mail. The e-mail provided them with a link to the anonymous questionnaire in Google Forms. After informed consent, the study population could choose between filling in a Dutch or an English questionnaire. Google Forms was chosen as the medium for collecting the data since it allowed unlimited access to questionnaire replies. The data was statistically analysed using Statistical Packages for the Social Sciences (IBM SPSS Statistics 22).

2.5 Data analysis

Patients and students

Demographics

The statements regarding different settling factors were responded to with one of two or more answering options (see Appendix 1 and 2). This made each determinant dichotomous, nominal, ordinal or continuous. The demographics were split out for Sex/gender and Registered patient/student. The frequencies of reported demographic determinants were expressed in *N* and valid percentages. If a continuous determinant turned out not to be normally distributed, a median and interquartile range were provided.

Sex/gender: male or female
Registered patient/student: patient and no student, student and no patient or both patient and student

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Pain with intercourse

The statements regarding different settling factors were responded to with one of two or more answering options. The demographics are split out for Pain with intercourse. The frequencies of reported demographic determinants were expressed in *N* and valid percentages. If a continuous determinant turned out not to be normally distributed, a median and interquartile range were provided. Furthermore, the statistical significance of the relation between a demographic determinant and Pain with intercourse were expressed with a *p*-value. The test with which the *p*-value was measured is reported. For the majority some kind of Chi-square test was used, except for age; a non-parametric Mann-Whitney test was used. If possible, an OR with corresponding 95%-C.I. was also reported.

Pain with intercourse: no pain with intercourse or pain with intercourse

Help-seeking

The statements regarding different settling were responded to with one of two or more answering options. The demographics are split out for Help-seeking. The frequencies of reported demographic determinants were expressed in *N* and valid percentages. If a continuous determinant turned out not to be normally distributed, a median and interquartile range were provided. Furthermore, the statistical significance of a relation between a demographic determinant and Help-seeking was expressed with a *p*-value. The corresponding test with which the *p*-value was measured is reported. For the majority some kind of Chi-square test was used, except for age; a non-parametric Mann-Whitney test was used. If possible, an OR with corresponding 95%-C.I. was also reported.

Help-seeking: no help-seeking or help-seeking

Benefit from professional help

The statement regarding benefit from professional help was responded to with one of five answering options, according to the 5-point Likert scale. The frequencies of reported answering options were expressed in *N*. The question on rating the consultation was responded to with a grade on a scale from 1-10; 1 being very bad and 10 being very good. The frequencies of reported rating options were expressed in *N*. If the ratings turned out not to be normally distributed, a median and interquartile range were provided.

Barriers to seeking professional help

To provide the reader with information on the distribution of respondents over the Three different problems, descriptive statistics were used. The frequencies of the reported problems were expressed in *N* and valid percentages.

Three different problems: pain with intercourse, imagined other embarrassing problem, or imagined other embarrassing sexual problem

The statements regarding different barriers were responded to with one of five answering options, according to the 5-point Likert scale. The barriers to help-seeking are split out for the Three different problems. The frequencies of reported barriers were expressed in *N* and valid percentages.

To assess the relation between Pain with intercourse and different potential barriers to help-seeking compared to either an Other embarrassing problem or an Other embarrassing sexual problem logistic

regression analyses were performed. The “Agree” response on a barrier for Pain with intercourse was compared to the “Agree” response on a corresponding barrier for either an Other embarrassing problem or an Other embarrassing sexual problem. Two statement regarding barriers to help-seeking were formulated positively. For these statements the “Disagree” responses were compared. A *p*-value, OR and corresponding 95%-C.I. were reported.

Dimensions of the Social Cognitive Theory

The barriers to help-seeking for pain with intercourse were classified by a small panel according to the descriptions of cognitive, behavioural, and environmental factors (see Figure 1) as either cognitive, behavioural or environmental barriers. To provide the reader with information on the different barrier-dimensions to help-seeking, Cognitive, Behavioural, and Environmental barrier-dimensions were formed. The Cognitive barrier-dimension for example, was formed using the statement regarding cognitive barriers (see Table 1), adding them and dividing the results by the amount of cognitive barriers. Since “Agree”, “Slightly agree”, “Neither agree nor disagree”, “Slightly disagree”, and “Disagree” were coded as 0, 1, 2, 3, and 4 respectively the mean “score” on each barrier-dimension is between 0 and 4, 0 being a high score and 4 being a low score. Descriptives of barrier-dimensions to help-seeking were given, split out for the Three different problems.

The barrier-dimensions are set out against each other to assess which barrier-dimension is averagely scored on higher. The difference in mean, 95%-C.I., and the *p*-value, measured using a One Sample T-Test, are reported. The One Sample T-Test was used because the scores on the barrier-dimensions are normally distributed and to test if the mean score of one barrier-dimension differed from the mean score of another.

GPs

The statements regarding different settling factors were responded to with one of two or more answering options (see Appendix 1 and 2). The frequencies of reported demographic determinants were expressed in *N*. The statements regarding different barriers were responded to with one of five answering options, according to the 5-point Likert scale. The frequencies of reported barriers were expressed in *N*.

Dimensions of the Social Cognitive Theory

To provide the reader with information on the different barrier-dimensions to providing help, Cognitive, Behavioural, and Environmental barrier-dimensions were formed. The Cognitive barrier-dimension for example, was formed using the statement regarding cognitive barriers to providing help (see Table 2), adding them and dividing the results by the amount of cognitive barriers. Since “Agree”, “Slightly agree”, “Neither agree nor disagree”, “Slightly disagree”, and “Disagree” were coded as 0, 1, 2, 3, and 4 respectively the mean “score” on each barrier-dimension is between 0 and 4; 0 being a high score and 4 being a low score. Descriptives of barrier-dimensions to providing help was provided.

The dimensions are set out against each other to assess which barrier-dimension is averagely scored on higher. The scores on each dimension are approximately normally distributed, however, since the *N* of the respondents was small there was opted for a One Sample Wilcoxon Signed Rank Test to assess the significance of a difference in mean score of one barrier-dimensions compared to the mean score of another.

3. Results

3.1 Response

2400 Patients of the Huisartsen Oude Turfmarkt/Bureau Studentenartsen were approached to answer the questionnaire on pain with intercourse, barriers to help-seeking, benefit from professional help, and other embarrassing problems. Sixty patients did not receive the e-mail because their inbox was full or their email-address was cancelled. 370 Students from the Studenthealthcheck were approached to answer the same questionnaire. Thirty students did not receive the e-mail because their inbox was full or their email-address was cancelled. In total, 201 respondents have filled out the questionnaire.

Of the 13 GPs that were approached to answer the questionnaire on barriers to providing professional help for pain with intercourse, 7 GPs responded.

3.2 Descriptive statistics

Descriptives of the respondents can be found in Table 3 (see Appendix 7.3 for the full table). The data is split up for Sex/gender. The majority of the respondents is female; 80%. Of the respondents 46% is both patient and student. However, of the males, 45% is only a patient. Age is not normally distributed. Therefore a median age of 24, with an interquartile range of 7 years, is reported. Of the respondents 50% is in a relationship. The majority of the respondents is atheist; 70%. Gross earnings are equally distributed over the total of respondents. Of the respondents who are sexually active and have any sexual problems, 75% has any pain with intercourse. Of the males and females who are sexually active and have any sexual problems, 50% and 79% respectively, have any pain with intercourse. The minority, 20% of the respondents who have any pain with intercourse, sought professional help for it. Of the respondents who have a sexually active partner with any sexual problems, 1% has a partner with any pain with intercourse. Of the males who have a sexually active partner whom has any sexual problems, 75% has a partner with any pain with intercourse. None of these males sought professional help for the pain with intercourse of their partner.

Table 3.0. Descriptives the respondents split up for Sex/gender

	Male		Female		Total	
	%	*N*	%	*N*	%	*N*
Sex/gender	20%	41	80%	160	100%	201
Registered patient/student	20%	40	80%	158	100%	198
- **Patient**	45%	18	27%	42	30%	60
- **Student**	23%	9	24%	38	24%	47
- **Patient and student**	33%	13	49%	78	46%	91
Age	20%	41	80%	160	100%	201
		31 (Median) 25 (IR)		23.5 (Median) 6 (IR)		24 (Median) 7 (IR)
Relationship status	20%	41	80%	160	100%	201
- **Single**	39%	16	42%	67	41%	83
- **In a relationship**	44%	18	52%	83	50%	101
- **Engaged**	0%	0	1%	1	1%	1
- **Married**	17%	7	6%	9	8%	16
Religion	20%	41	80%	160	100%	201
- **Atheist**	73%	30	69%	110	70%	140
- **Agnostic**	2%	1	6%	9	5%	10
- **Buddhist**	2%	1	1%	1	1%	2
- **Christian**	15%	6	17%	27	16%	33
- **Jewish**	0%	0	1%	1	1%	1
- **Muslim**	0%	0	1%	1	1%	1
- **Somethingist**	0%	0	1%	2	1%	2

	Male		Female		Total	
	%	*N*	%	*N*	%	*N*
- Spiritual	2%	1	0%	0	1%	1
- Other	2%	1	2%	3	2%	4
- None of the above	2%	1	4%	6	4%	7
Gross earnings	20%	41	80%	160	100%	201
- 0-200 euros	20%	8	31%	49	28%	57
- 200-500 euros	12%	5	22%	35	20%	40
- 500-1000 euros	22%	9	24%	39	24%	48
- 1000 euros or more	46%	19	23%	37	28%	56
Sexually active	20%	41	80%	160	100%	201
- Yes	83%	34	86%	138	86%	172
- No	17%	7	14%	22	14%	29
Sexual problems	20%	34	80%	138	100%	172
- Yes	29%	10	45%	62	42%	72
- No	71%	24	55%	76	58%	100
Pain with intercourse	14%	10	86%	62	100%	72
- Yes	50%	5	79%	49	75%	54
- No	50%	5	21%	13	25%	18
Help-seeking	9%	5	91%	49	100%	54
- Yes	20%	1	20%	10	20%	11
- No	80%	4	80%	39	80%	43
Partner, sexually active	25%	36	76%	111	100%	147
- Yes	75%	27	74%	82	74%	109
- No	25%	9	26%	29	26%	38
Partner, sexual problems	25%	27	75%	82	100%	109
- Yes	15%	4	1%	1	5%	5
- No	85%	23	99%	81	95%	104
Partner, pain with intercourse	80%	4	20%	1	100%	5
- Yes	75%	3	0%	0	60%	3
- No	25%	1	100%	1	40%	2
Partner, help-seeking	100%	3	0%	0	100%	3
- No	100%	3	0%	0	100%	3

The same descriptives the respondents can be found in Table 4 (see Appendix 7.3 for the full table), but split out for Registered patient/student. Again, 46% of the respondents is both patient and student. The median age for patients is highest with 30 years, with the largest interquartile range of 22 years compared to the medians and interquartile ranges of age for students and both patient and students. Of the patients, 78% has gross earnings of 1000 euros or more per month. Contrarily, 11% of students and 3% of both patient and students have gross earnings of 1000 euros or more per month. In terms of percentages, any pain with intercourse is somewhat equally distributed over patients, students and both patient and students. Of the students, 72% is sexually active. Any pain with intercourse is reported by 77% of sexually active patients, students, and both patient and students. Of the both patient and students, 16% has sought professional help for any pain with intercourse. Furthermore, 27% of patients and 27% of students has sought professional help for pain with intercourse. Of the 3 males who have a partner with any pain with intercourse, 1 is patient and 2 are both patient and student.

Table 4.0. Descriptives the respondents split up for Registered patient/student

	Patient		Student		Patient and student		Total	
	%	*N*	%	*N*	%	*N*	%	*N*
Registered patient/student	30%	60	24%	47	46%	91	100%	198
Sex/gender	30%	60	24%	47	46%	91	100%	198
- **Male**	30%	18	19%	9	14%	13	20%	40
- **Female**	70%	42	81%	38	86%	78	80%	158
Age	30%	60	24%	47	46%	91	100%	198
		30 (Median) 22 (IR)		22 (Median) 3 (IR)		23 (Median) 4 (IR)		24 (Median) 7 (IR)
Relationship status	30%	60	24%	47	46%	91	100%	198
- **Single**	33%	20	47%	22	45%	41	42%	83
- **In a relationship**	50%	30	45%	21	54%	49	51%	100
- **Engaged**	0%	0	2%	1	0%	0	1%	1
- **Married**	17%	10	6%	3	1%	1	7%	14
Religion	30%	60	24%	47	46%	91	100%	198
- **Atheist**	73%	44	66%	31	70%	64	70%	139
- **Agnostic**	3%	2	4%	2	7%	6	5%	10
- **Buddhist**	0%	0	0%	0	2%	2	1%	2
- **Christian**	15%	9	23%	11	14%	13	17%	33
- **Jewish**	2%	1	0%	0	0%	0	1%	1
- **Muslim**	0%	0	2%	1	0%	0	1%	1
- **Somethingist**	2%	1	2%	1	0%	0	1%	2
- **Spiritual**	0%	0	0%	0	1%	1	1%	1
- **Other**	2%	1	0%	0	2%	2	2%	3
- **None of the above**	3%	2	2%	1	3%	3	3%	6
Gross earnings	30%	60	24%	47	46%	91	100%	198
- **0-200 euros**	7%	4	40%	19	36%	33	28%	56
- **200-500 euros**	0%	0	26%	12	31%	28	20%	40
- **500-1000 euros**	15%	9	23%	11	30%	27	24%	47
- **1000 euros or more**	78%	47	11%	5	3%	3	28%	55
Sexually active	30%	60	24%	47	46%	91	100%	198
- **Yes**	85%	51	72%	34	92%	84	85%	169
- **No**	15%	9	28%	13	8%	7	15%	29
Sexual problems	20%	51	20%	34	50%	84	100%	169
- **Yes**	29%	15	44%	15	48%	40	41%	70
- **No**	71%	36	56%	19	52%	44	59%	99
Pain with intercourse	21%	15	21%	15	58%	40	100%	70
- **Yes**	73%	11	73%	11	80%	32	77%	54
- **No**	27%	4	27%	4	20%	8	23%	16
Help-seeking	20%	11	20%	11	60%	32	100%	54
- **Yes**	27%	3	27%	3	16%	5	20%	11
- **No**	73%	8	73%	8	84%	27	80%	43
Partner, sexually active	34%	49	25%	36	41%	59	100%	144
- **Yes**	80%	39	58%	21	78%	46	74%	106
- **No**	20%	10	42%	15	22%	13	26%	38
Partner, sexual problems	37%	39	20%	21	43%	46	100%	106

	Patient		Student		Patient and student		Total	
	%	*N*	%	*N*	%	*N*	%	*N*
- **Yes**	3%	1	0%	0	7%	3	4%	4
- **No**	97%	38	100%	21	94%	43	96%	102
Partner, pain with intercourse	25%	1	0%	0	75%	3	100%	4
- **Yes**	100%	1	0%	0	67%	2	75%	3
- **No**	0%	0	0%	0	33%	1	25%	1
Partner, help-seeking	33%	1	0%	0	67%	2	100%	3
- **No**	100%	1	0%	0	100%	2	100%	3

3.3 Pain with intercourse

Table 5 shows that out of the respondents who have any pain with intercourse, 91% is female, 59% is both patient and student, 57% is in a relationship, and 67% is atheist. Age is not normally distributed so a median age of 24 and an interquartile range of 5 years is provided.

An attempt to provide the reader with prediction models for pain with intercourse failed. None of the settling factors were statistically significance associated with Pain with intercourse. The results of the logistic regression analyses for the relation between Sex/gender or Registered patient/student and Pain with intercourse were however reported. According to Table 6, the odds of any pain with intercourse is 3.8 times higher for females compared to males with a 95%-C.I. from 0.946 to 15.015 and a *p*-value of 0.060.

Table 6. Logistic regression analysis on the effect of Sex/gender on any Pain with intercourse

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
My sex/gender is (female - male)	1.327	0.060	3.769	0.946	15.015
Constant	0.000	1.000	1.000		

According to Table 7.1, the odds of pain with intercourse is exactly the same for students compared to patients with a 95%-C.I. from 0.198 to 5.045 and a *p*-value of 1.000. Furthermore, the odds of pain with intercourse is 1.5 times higher for both patient and students compared to patients with a 95%-C.I. from 0.365 to 5.793 and a *p*-value of 0.595. According to Table 7.2, the odds of pain with intercourse is 0.7 times lower for patients compared to both patient and students with a 95%-C.I. from 0.173 to 2.738 and a *p*-value of 0.595.

Table 7.1. Logistic regression analysis on the effect of Registered patient/student on any Pain with intercourse

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Registered patient/student		0.807			
Registered patient/student (student - patient)	0.000	1.000	1.000	0.198	5.045
Registered patient/student (patient and student - patient)	0.375	0.595	1.455	0.365	5.793
Constant	1.012	0.083	2.750		

Table 7.2. Logistic regression analysis on the effect of recoded Registered patient/student on any Pain with intercourse

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Registered patient/student		0.807			
Registered patient/student (patient - patient and student)	-0.375	0.595	0.688	0.173	2.738
Registered patient/student (student - patient and student)	-0.375	0.595	0.688	0.173	2.738
Constant	1.386	0.000	4.000		

Table 5. Potential covariates for Pain with intercourse

	No pain with intercourse		Pain with intercourse		Total		*p*-value	Test	OR	95%-C.I.
	%	*N*	%	*N*	%	*N*				
Pain with intercourse	25%	18	75%	54	100%	72	-	-	-	-
Sex/gender	25%	18	75%	54	100%	72	0.115	Chi-square Test (Continuity Correction)	3.769	0.946 - 15.015
- **Male**	28%	5	9%	5	14%	10				
- **Female**	72%	13	91%	49	86%	62				
Registered patient/student	23%	16	77%	54	100%	70	0.792	Chi-square Test (Fisher's Exact Test)	-	-
- **Patient**	25%	4	20%	11	21%	15				
- **Student**	25%	4	20%	11	21%	15				
- **Patient and student**	50%	8	59%	32	57%	40				
Age	25%	18	75%	54	100%	72	0.474	Mann-Whitney Test (Exact Sig. (2-tailed))	-	-
		22 (Median) 7 (IR)		24 (Median) 5 (IR)		24 (Median) 7 (IR)				
Relationship status	25%	18	75%	54	100%	72	0.314	Chi-square Test (Fisher's Exact Test)	-	-
- **Single**	17%	3	35%	19	31%	22				
- **In a relationship**	72%	13	57%	31	61%	44				
- **Married**	11%	2	7%	4	8%	6				
Religion	25%	18	75%	54	100%	72	0.306	Chi-square Test (Fisher's Exact Test)	-	-
- **Atheist**	72%	13	67%	36	68%	49				
- **Agnostic**	11%	2	7%	4	8%	6				
- **Christian**	6%	1	15%	8	13%	9				
- **Jewish**	0%	0	2%	1	1%	1				
- **Muslim**	0%	0	2%	1	1%	1				
- **Spiritual**	0%	0	2%	1	1%	1				
- **Other**	11%	2	0%	0	3%	2				
- **None of the above**	0%	0	6%	3	4%	3				
Gross earnings	25%	18	75%	54	100%	72	0.900	Chi-square Test (Fisher's Exact Test)	-	-
- **0-200 euros**	33%	6	28%	15	29%	21				
- **200-500 euros**	22%	4	32%	17	29%	21				
- **500-1000 euros**	22%	4	20%	11	21%	15				
- **1000 euros or more**	22%	4	20%	11	21%	15				

3.4 Help-seeking

Table 8 shows that out of the respondents who have sought professional help, 91% is female, 46% is both patient and student, 55% is in a relationship, and 82% is atheist. Age is not normally distributed so a median age of 25 and an interquartile range of 6 years is provided.

An attempt to provide the reader with prediction models for help-seeking failed. None of the settling factors were statistically significance associated with Help-seeking. The results of the logistic regression analyses for the relation between Sex/gender or Registered patient/student and Help-seeking were however reported. According to Table 9, the odds of seeking professional help is almost exactly the same for females compared to males with a 95%-C.I. from 0.103 to 10.218 and a *p*-value of 0.983.

Table 9. Logistic regression analysis on the effect of Sex/gender on Help-seeking

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
My sex/gender is (female - male)	0.025	0.983	1.026	0.103	10.218
Constant	-1.386	0.215	0.250		

According to Table 10.1, the odds of seeking professional help is exactly the same higher for students compared to patients with a 95%-C.I. from 0.153 to 6.531 and a *p*-value of 1.000. Furthermore, the odds of seeking professional help is 0.494 times lower for both patient and students compared to patients with a 95%-C.I. from 0.096 to 2.532 and a *p*-value of 0.397. According to Table 10.2, the odds of seeking professional help is 2.0 times higher for patients compared to both patient and students with a 95%-C.I. from 0.395 to 10.381 and a *p*-value of 0.397.

Table 10.1. Logistic regression analysis on the effect of Registered patient/student on Help-seeking

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Registered patient/student		0.586			
Registered patient/student (student - patient)	0.000	1.000	1.000	0.153	6.531
Registered patient/student (patient and student - patient)	-0.706	0.397	0.494	0.096	2.532
Constant	-0.981	0.147	0.375		

Table 10.2. Logistic regression analysis on the effect of recoded Registered patient/student on Help-seeking

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Registered patient/student		0.586			
Registered patient/student (patient - patient and student)	0.706	0.397	2.025	0.395	10.381
Registered patient/student (student - patient and student)	0.706	0.397	2.025	0.395	10.381
Constant	-1.686	0.001	0.185		

Table 8. Potential covariates for Help-seeking

	No help-seeking %	*N*	Help-seeking %	*N*	Total %	*N*	*p*-value	Test	OR	95%-C.I.
Help-seeking	80%	43	20%	11	100%	54	-	-	-	-
Sex/gender	80%	43	20%	11	100%	54	1.000	Chi-square Test (Continuity Correction)	1.026	0.103 - 10.218
- **Male**	9%	4	9%	1	9%	5				
- **Female**	91%	39	91%	10	91%	49				
Registered patient/student	80%	43	20%	11	100%	54	0.461	Chi-square Test (Fisher's Exact Test)	-	-
- **Patient**	19%	8	27%	3	20%	11				
- **Student**	19%	8	27%	3	20%	11				
- **Patient and student**	63%	27	46%	5	59%	32				
Age	80%	43	20%	11	100%	54	0.721	Mann-Whitney Test (Exact. Sig. (2-tailed))	-	-
		24 (Median) 5 (IR)		25 (Median) 6 (IR)		24 (Median) 7 (IR)				
Relationship status	80%	43	20%	11	100%	54	1.000	Chi-square Test (Fisher's Exact Test)	-	-
- **Single**	35%	15	36%	4	35%	19				
- **In a relationship**	58%	25	55%	6	57%	31				
- **Married**	7%	3	9%	1	7%	4				
Religion	80%	43	20%	11	100%	54	0.506	Chi-square Test (Fisher's Exact Test)	-	-
- **Atheist**	63%	27	82%	9	67%	36				
- **Agnostic**	9%	4	0%	0	7%	4				
- **Christian**	16%	7	9%	1	15%	8				
- **Jewish**	2%	1	0%	0	2%	1				
- **Muslim**	0%	0	9%	1	2%	1				
- **Spiritual**	2%	1	0%	0	2%	1				
- **None of the above**	7%	3	0%	0	6%	3				
Gross earnings	80%	43	20%	11	100%	54	0.518	Chi-square Test (Fisher's Exact Test)	-	-
- **0-200 euros**	30%	13	18%	2	29%	15				
- **200-500 euros**	28%	12	46%	5	32%	17				
- **500-1000 euros**	23%	10	9%	1	20%	11				
- **1000 euros or more**	19%	8	27%	3	20%	11				

3.5 Benefit from professional help

Of the 11 respondents who have sought professional help for any pain with intercourse, 1 respondent has sought professional help with a sexologist and 10 respondents have sought professional help with a GP. Table 11 shows that out of the 10 respondents who have sought professional help with a GP for any pain with intercourse, 3 agreed with benefitting from it.

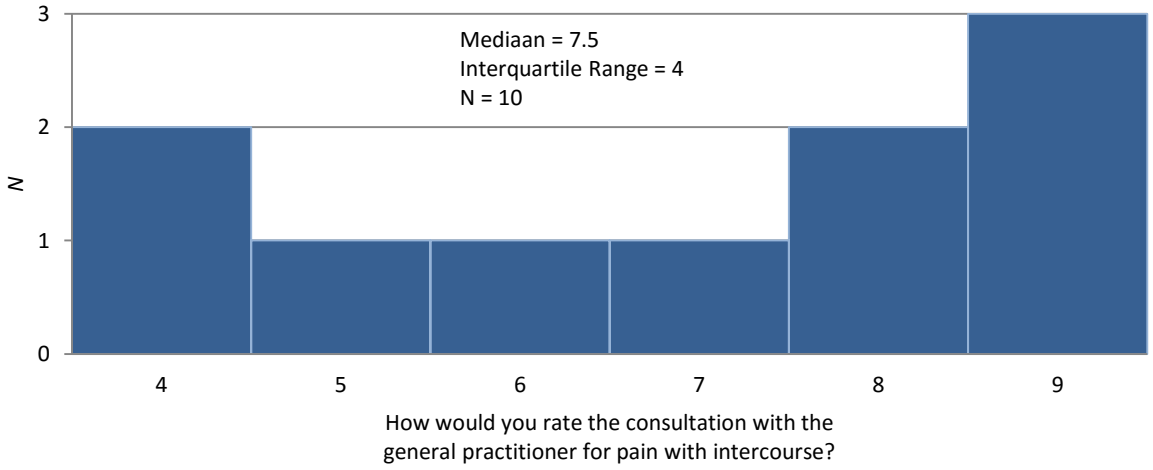
Table 11. Response by means of the 5-point Likert scale on the statement: "I benefitted from the professional help provided by the general practitioner for pain with intercourse."

I benefitted from the professional help provided by the general practitioner for pain with intercourse.					
Agree	**Slightly agree**	**Neither agree nor disagree**	**Slightly disagree**	**Disagree**	**Total**
N	***N***	***N***	***N***	***N***	***N***
3	4	1	1	1	10

The respondents who have sought professional help for pain with intercourse with a GP for any pain with intercourse were then asked in what way they have or have not benefitted from the professional help provided. The answers (translated from Dutch) were varied. Three respondents still experience pain with intercourse: "*There is not yet a lack of pain.*", "*Still experiencing pain.*", and "*More insight into where the problems come from but the complaints have not disappeared.*" One respondent experiences pain with intercourse less frequently: "*Less frequently pain, before always, now sometimes.*" Two respondents received tips: "*I have received tips for different sexual positions etcetera. And I was told that pain with intercourse is more common. I have always thought that pain with intercourse was rare and that something was wrong with me (or the genitals of my partner), but through an open conversation I have gained a lot of insight into this common sexual problem. Furthermore, I was told to actively search for ways to reduce the pain with intercourse: different sexual positions, no climaxing before penetration, prolonged foreplay, not too rough sexual intercourse, etcetera.*" and "*I received tips which I had already tried, because I read them on the internet.*" One respondent received the following kind of help: "*Mental support.*" Lastly, three respondents were referred: "*Referral to a gynaecologist due to proliferation of granulation tissue.*", "*The general practitioner has referred me to a physical therapist.*", and "*Examination at the hospital.*"

Graph 1 shows how the respondents who have sought professional help with a GP for any pain with intercourse have rated the consultation with the general practitioner. Seven out of 10 respondents rated the consultation with a 6 or higher.

Graph 1. Response by means of a rating scale (1 being very bad, 10 being very good) on the question: "How would you rate the consultation with the general practitioner for pain with intercourse?"



3.6 Barriers to seeking professional help

In Table 13.1, 13.2, and 13.3 (see Appendix 7.3) potential barriers to seeking professional help for any pain with intercourse, another embarrassing problem, and another embarrassing sexual problem are set out against answering options of the 5-point Likert Scale. Appendix 7.3 provides a list of the reported embarrassing problems (some of which are translated from Dutch). Table 12 shows the distribution of respondents over the different problems. If respondents answered "Agree", then, in accordance with the literature, the respondent would score on that barrier. However, since "I have a comfortable professional relationship with the general practitioner." and "I have a trusting professional relationship with the general practitioner." are formulated in a positive way, the respondents score on these barriers when "Disagree" was answered. The positively formulated statements are marked in orange.

Table 12. Distribution of respondents over three different problems

	%	*N*
Pain with intercourse	32%	46
Imagined other embarrassing problems	44%	62
Imagined other embarrassing sexual problems	24%	34

Table 14.1 to 43.2 show the ORs, 95%-C.I., and *p*-values for different barriers to seeking professional help for respondents with any pain with intercourse and respondents who have a partner with any pain with intercourse and respondents with an imagined other (sexual) embarrassing problem. See Appendix 7.3 for non-statistically significant results.

Table 15.2 shows that the odds of trying to find out what the cause for the problem is 0.3 times lower for a respondent with pain with intercourse compared to a respondent with another embarrassing sexual problem with a 95%-C.I. from 0.100 to 0.838 and a *p*-value of 0.022.

Table 15.2. Logistic regression analysis on the relation between recoded Three different problems and Trying to find out what the cause for the problem is

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.065			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.337	0.451	0.714	0.297	1.716
Three different problems (pain with intercourse - other embarrassing sexual problem)	-1.238	0.022	0.290	0.100	0.838
Constant	-0.480	0.174	0.619		

Table 16.1 shows that the odds of thinking that the problem is not a medical problem is 9.0 times higher for a respondents with another embarrassing sexual problem compared to a respondent with another embarrassing problem with a 95%-C.I. from 2.886 to 28.071 and a *p*-value of 0.000. Table 16.2 shows that the odds of thinking that the problem is not a medical problem is 0.2 times lower for a respondent with pain with intercourse compared to a respondent with another embarrassing sexual problem with a 95%-C.I. from 0.064 to 0.567 and a *p*-value of 0.003.

Table 16.1. Logistic regression analysis on the relation between Three different problems and Not thinking that the problem is a medical problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.000			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	2.197	0.000	9.000	2.886	28.071
Three different problems (pain with intercourse - other embarrassing problem)	0.536	0.402	1.710	0.488	5.991

Constant	-2.434	0.000	0.088		

Table 16.2. Logistic regression analysis on the relation between recoded Three different problems and Not thinking that the problem is a medical problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.000			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-2.197	0.000	0.111	0.036	0.347
Three different problems (pain with intercourse - other embarrassing sexual problem)	-1.661	0.003	0.190	0.064	0.567
Constant	-0.236	0.494	0.789		

Table 23.1 shows that the odds of lacking confidence in a medical solution for the problem is 4.5 times higher for a respondent with another embarrassing sexual problem compared to another embarrassing problem with a 95%-C.I. from 1.233 to 16.148 and a *p*-value of 0.023. Furthermore, the odds of lacking confidence in a medical solution for the problem is 4.0 times higher for a respondent with pain with intercourse compared to a respondent with another embarrassing problem with a 95%-C.I. from 1.175 to 13.805 and a *p*-value of 0.027. Table 23.2 shows that the odds of lacking confidence in a medical solution for the problem is 0.2 times lower for a respondent with another embarrassing problem compared to a respondent with another embarrassing sexual problem with a 95%-C.I. from 0.062 to 0.811 and a p-value of 0.023.

Table 23.1. Logistic regression analysis on the relation between Three different problems and Lacking confidence in a medical solution for the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.046			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	1.495	0.023	4.462	1.233	16.148
Three different problems (pain with intercourse - other embarrassing problem)	1.393	0.027	4.028	1.175	13.805
Constant	-2.674	0.000	0.069		

Table 23.2. Logistic regression analysis on the relation between recoded Three different problems and Lacking confidence in a medical solution for the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.046			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-1.495	0.023	0.224	0.062	0.811
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.102	0.850	0.903	0.313	2.600
Constant	-1.179	0.004	0.308		

Table 26.2 shows that the odds of talking about the problem with others whom are not health professionals is 10.4 times higher for a respondent with pain with intercourse compared to a respondent with another embarrassing sexual problem with a 95%-C.I. from 1.268 to 84.833 and a *p*-value of 0.029.

Table 26.2. Logistic regression analysis on the relation between recoded Three different problems and Talking about the problem with others whom are not health professionals

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.081			
	1.848	0.085	6.346	0.776	51.896

Three different problems (other embarrassing problem - other embarrassing sexual problem)	2.339	0.029	10.371	1.268	84.833
Three different problems (pain with intercourse - other embarrassing sexual problem)	-3.497	0.001	0.030		
Constant					

Table 31.1 shows that the odds of forgetting to ask about the problem during consultation with the general practitioner is 6.2 times higher for a respondent with pain with intercourse compared to a respondent with another embarrassing problem with a 95%-C.I. from 1.613 to 23.684 and a *p*-value of 0.008. Table 31.2 shows that the odds of forgetting to ask about the problem during consultation with the general practitioner is 5.0 times higher for a respondent with pain with intercourse compared to a respondents with another embarrassing sexual problem with a 95%-C.I. from 1.035 to 24.439 and a *p*-value of 0.045.

Table 31.1. Logistic regression analysis on the relation between Three different problems and Forgetting to ask about the problem during consultation with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.010			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.206	0.826	1.229	0.195	7.741
Three different problems (pain with intercourse - other embarrassing problem)	1.821	0.008	6.181	1.613	23.684
Constant	-2.979	0.000	0.051		

Table 31.2. Logistic regression analysis on the relation between recoded Three different problems and Forgetting to ask about the problem during consultation with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.010			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.206	0.826	0.814	0.129	5.124
Three different problems (pain with intercourse - other embarrassing sexual problem)	1.615	0.045	5.029	1.035	24.439
Constant	-2.773	0.000	0.063		

Table 36.1 shows that the odds of not having a regular general practitioner is 3.1 times higher for a respondent with an embarrassing sexual problem compared to a respondents with another embarrassing problem with a 95%-C.I. from 1.240 to 7.487 and a *p*-value of 0.015. Furthermore, the odds of not having a regular general practitioner is 2.6 times higher for a respondent with pain with intercourse compared to a respondent with another embarrassing problem with a 95%-C.I. from 1.146 to 6.068 and a *p*-value of 0.023. Table 36.2 shows that the odds of not having a regular general practitioner is 0.3 times lower for a respondent with another embarrassing problem compared to a respondent with an embarrassing sexual problem with a 95%-C.I. from 0.134 to 0.806 and a *p*-value of 0.015.

Table 36.1. Logistic regression analysis on the relation between Three different problems and Not having a regular general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.023			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	1.114	0.015	3.048	1.240	7.487
Three different problems (pain with intercourse - other embarrassing problem)	0.970	0.023	2.637	1.146	6.068
Constant	-1.232	0.000	0.292		

Table 36.2. Logistic regression analysis on the relation between recoded Three different problems and Not having a regular general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.023			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-1.114	0.015	0.328	0.134	0.806
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.145	0.750	0.865	0.355	2.109
Constant	-0.118	0.732	0.889		

Table 40.1 shows that the odds of wanting the general practitioner to be of the same sex/gender when consulting them about the problem is 2.9 times higher for a respondent with pain with intercourse compared to a respondent with another embarrassing problem with a 95%-C.I. from 1.265 to 6.522 and a *p*-value of 0.012.

Table 40.1. Logistic regression analysis on the relation between Three different problems and Wanting the general practitioner to be of the same sex/gender as I am when I have to consult them about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.042			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.536	0.250	1.709	0.686	4.256
Three different problems (pain with intercourse - other embarrassing problem)	1.055	0.012	2.872	1.265	6.522
Constant	-1.142	0.000	0.319		

Table 43.1 shows that the odds of when consulting the general practitioner about the problem then I have to talk to my partner about it too is 3.5 times higher for a respondent with pain with intercourse compared to a respondent with another embarrassing problem with a 95%-C.I. from 1.486 to 8.242 and a *p*-value of 0.004.

Table 43.1. Logistic regression analysis on the relation between Three different problems and When I consult the general practitioner about the problem, then I have to talk to my partner about it too

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.015			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.821	0.088	2.273	0.884	5.843
Three different problems (pain with intercourse - other embarrassing problem)	1.253	0.004	3.500	1.486	8.242
Constant	-1.427	0.000	0.240		

3.7 Providing professional help (GPs)

Table 44 shows that out of the 7 respondents 6 answered the question on Ethnicity with “Dutch”. Six out of 7 is heterosexual and 6 out of 7 has had 0-3 relationships that have lasted longer than 6 months. The effect of these settling factors on the different barriers is not assessed since the response is too low. The results would be close to meaningless and could violate the anonymity of the GPs.

Table 44. Descriptives of the GPs

	N
Ethnicity	
- Dutch	6
Sexuality	

- Heterosexual	6
- Homosexual	1
Number of relationships	
- 0-3	6
- 4-6	1

In Table 45 potential barriers to providing professional help for pain with intercourse are set out against answering options of the 5-point Likert Scale. If respondents answered "Agree", then, in accordance with the literature, the respondent would score on that barrier. However, since "I think that pain with intercourse should be more often talked about with patients." and "Since pain with intercourse is not often talked about by patients, I am going to ask them about it even though there is no complaint or request for help for it during a consultation on sexual functioning, contraceptives and or child wish." are formulated in a positive way, the respondents score on these barriers when "Disagree" was answered. The positively formulated statements are marked in orange.

Table 45. Response by means of the 5-point Likert scale on potential barriers to Providing help for pain with intercourse

Barriers to providing help	Agree *N*	Slightly agree *N*	Neither agree nor disagree *N*	Slightly disagree *N*	Disagree *N*
I do not talk about pain with intercourse with a patient whom I lack a comfortable professional relationship with.	0	2	2	2	1
I do not talk about pain with intercourse with a patient whom I lack a trusting professional relationship with.	0	1	2	3	1
I do not talk about pain with intercourse with a patient whom I have a close professional relationship with.	0	0	1	3	3
I do not talk about pain with intercourse with a patient when I lack a reason for talking about it.	5	2	0	0	0
I do not talk about pain with intercourse with a patient when I lack time for talking about it.	1	1	1	2	2
I do not talk about pain with intercourse with a patient who is 65 years or older.	0	0	0	2	5
I do not talk about pain with intercourse with a patient when I think that that patient will deny having pain with intercourse.	0	0	1	2	4
I do not talk about pain with intercourse with a patient when I think that that patient is unwilling to discuss it.	0	2	2	1	2
I do not talk about pain with intercourse with a patient when I think that I will experience difficulties with cultural factors relating to the patient's attitudes and beliefs.	0	1	2	3	1
I do not talk about pain with intercourse with a patient when I think that I will experience difficulties with ethnic factors relating to the patient's attitudes and beliefs.	0	1	3	2	1
I do not talk about pain with intercourse with a patient when I think that I will experience difficulties with religious factors relating to the patient's attitudes and beliefs.	0	1	2	3	1
I do not talk about pain with intercourse with a patient when I think that I will experience language and terminology problems when talking about it.	0	1	2	3	1
I do not talk about pain with intercourse with a patient because I do not know when, what or how to ask about it.	0	0	0	2	5
I do not talk about pain with intercourse with a patient because I lack confidence in talking about it.	0	0	0	2	5
I do not talk about pain with intercourse with a patient because I am inadequately trained to approach it.	0	0	1	1	5
I do not talk about pain with intercourse with a patient because I prefer to refer a patient with pain with intercourse.	0	0	1	1	5

Barriers to providing help	Agree *N*	Slightly agree *N*	Neither agree nor disagree *N*	Slightly disagree *N*	Disagree *N*
I do not talk about pain with intercourse with a patient because I think that pain with intercourse is too complex since it is not merely associated with biological determinants.	0	0	2	1	4
I do not talk about pain with intercourse with a patient because I am uncertain about therapeutic options.	0	0	1	1	5
I do not talk about pain with intercourse with a patient because I am not interested in it.	0	0	0	1	6
I do not talk about pain with intercourse with a patient because I think that the patient will bring it up anyway.	0	0	2	2	3
I do not talk about pain with intercourse with a patient because I get ashamed/embarrassed.	0	0	0	3	4
I do not talk about pain with intercourse with a patient because I am afraid of alienating them.	0	0	1	3	3
I do not talk about pain with intercourse with a patient because I am afraid of offending them.	0	0	0	3	4
I do not talk about pain with intercourse with a patient because I am concerned that it might be regarded as sexual harassment.	0	1	0	2	4
I do not talk about pain with intercourse with a patient because I am uncomfortable with the nature of the patient's sexual tendencies.	0	0	0	3	4
I do not talk about pain with intercourse with a patient who does not request help for it.	0	3	1	2	1
I think that pain with intercourse should be more often talked about with patients.	2	1	4	0	0
Since pain with intercourse is not often talked about by patients I am going to ask them about it even though there is no complaint and or request help for it during a consultation on sexual functioning, contraceptives and or child wish.	1	4	1	1	0

The GPs were then asked if there were factors that would either positively or negatively influence them in providing professional help for pain with intercourse. Three respondents answered (translated from Dutch) the question with: "*No.*" Two respondents answered the question with the factor time: "*If, during a consultation, multiple requests for help are brought up then I have or the patient has to choose. There is a chance that a less complex subject is chosen. Time is thus a factor.*" and "*Time.*" Other answers were: "*It would negatively influence me if a patient is very uneasy about it, if there is a language barrier, if certain beliefs stand in the way. It would positively influence me if asking about sexual health is more or less a standard during STD consultation, or something of the like.*" and "*I notice a positive effect of low threshold asking about pain with intercourse, positive effect of pelvis physical therapy and I often hear from patients that it is very pleasant when a general practitioner actively asks about pain with intercourse with recurrent UTI's, recurrent candida infections, obstipation, and pain with internal examination.*"

3.8 Dimensions of the Social Cognitive Theory

In Table 46, 47, and 48 different barriers are combined into three different dimensions; cognitive, behavioural, and environmental. These three different dimensions are defined according to the Social Cognitive Theory. See Table 1 to see which barrier is assigned to which dimension. Table 46 shows the response by means of a rating scale that runs from 0-4; 0 being a high score and 4 being a low score, on the different barrier-dimensions to seeking professional help for any pain with intercourse. Table 47 shows the response for an imagined other embarrassing problem. Table 48 shows the response for an imagined other embarrassing sexual problem.

Table 46. Response by means of a rating scale (0 being a high score, 4 being a low score) on dimensions of the Social Cognitive Theory composed of different barriers to seeking professional help for any pain with intercourse

Dimensions pain with intercourse	*N*	Minimum	Maximum	Mean	Std. Dev.
Cognitive	46	1.353	3.176	2.168	0.451
Behavioural	46	0.857	3.286	2.146	0.579
Environmental	46	1.250	3.830	2.308	0.626

Table 47. Response by means of a rating scale (0 being a high score, 4 being a low score) on dimensions of the Social Cognitive Theory composed of different barriers to seeking professional help for an Other embarrassing problem

Dimensions imagined other embarrassing problem	*N*	Minimum	Maximum	Mean	Std. Dev.
Cognitive	62	1.091	3.273	2.116	0.560
Behavioural	62	1.429	3.857	2.346	0.545
Environmental	62	1.091	4.000	2.625	0.590

Table 48. Response by means of a rating scale (0 being a high score, 4 being a low score) on dimensions of the Social Cognitive Theory composed of different barriers to seeking professional help for another Embarrassing sexual problem

Dimensions imagined other embarrassing sexual problem	*N*	Minimum	Maximum	Mean	Std. Dev.
Cognitive	34	0.727	3.636	1.992	0.659
Behavioural	34	1.000	3.143	2.366	0.456
Environmental	34	1.182	3.909	2.433	0.656

In Table 49, 50, and 51 the differences in mean, 95%-C.I., and *p*-values are measured for the differences in response by means or a rating scale on the barrier-dimensions. Table 49 shows that the difference in mean score on the cognitive barrier-dimension and on the environmental barrier-dimension to seeking professional help for pain with intercourse is 0.141 with a 95%-C.I. from -0.274 to -0.007 and a *p*-value of 0.040. Table 50, and 51 show that the cognitive and cognitive barrier-dimension, respectively, are scored on statistically significant highest compared to the other barrier-dimension to seeking professional help for an imagined other embarrassing problem or an imagined other embarrassing sexual problem.

Table 49. One Sample T-Test on the differences in mean score on the barrier-dimensions to seeking professional help for any pain with intercourse

Pain with intercourse	Difference in mean	95%-C.I.	*p*-value
Cognitive – Behavioural	0.022	-0.112 - 0.155	0.748
Cognitive - Environmental	-0.141	-0.274 - -0.007	0.040
Behavioural - Environmental	-0.162	-0.334 - 0.010	0.064

Table 50. One Sample T-Test on the differences in mean score on the barrier-dimensions to seeking professional help for an Other embarrassing problem

Other embarrassing problem	Difference in mean	95%-C.I.	*p*-value
Cognitive – Behavioural	-0.230	-0.372 - -0.088	0.002
Cognitive – Environmental	-0.509	-0.651 - -0.367	0.000
Behavioural – Environmental	-0.279	-0.418 - -0.141	0.000

Table 51. One Sample T-Test on the differences in mean score on the barrier-dimensions to seeking professional help for another Embarrassing sexual problem

Other embarrassing sexual problem	Difference in mean	95%-C.I.	*p*-value
Cognitive – Behavioural	-0.374	-0.604 - -0.144	0.002
Cognitive - Environmental	-0.441	-0.671 - -0.211	0.000
Behavioural - Environmental	-0.068	-0.227 - 0.092	0.395

In Table 52, different barriers are also combined into the three different dimensions according to the Social Cognitive Theory. See Table 2 to see which barrier is assigned to which dimension. Table 52 also shows the response by means of a rating scale that runs from 0-4, 0 being a high score and 4 being a low score, on the different barrier-dimensions to providing professional help for pain with intercourse. Table 53 shows, knowing the mean scores on each barrier-dimension, that the environmental barrier-dimension is scored on statistically significant higher compared to the cognitive barrier-dimension to providing professional help for pain with intercourse.

Table 52. Response by means of a rating scale (0 being a high score, 4 being a low score) on dimensions of the Social Cognitive Theory composed of different barriers to providing professional help for pain with intercourse

Dimensions providing professional help	*N*	Minimum	Maximum	Mean	Std. Dev.
Cognitive	7	2.700	4.000	3.429	0.435
Behavioural	7	2.429	4.000	3.020	0.537
Environmental	7	2.000	3.636	2.584	0.525

Table 53. One Sample Wilcoxon Signed Rank Test on the statistical significance of differences in score on the barrier-dimensions to providing professional help for pain with intercourse

Providing professional help	*p*-value
Cognitive – Behavioural	0.061
Cognitive - Environmental	0.017
Behavioural - Environmental	0.063

4. Discussion

This study concerns a cross-sectional survey study on pain with intercourse, seeking professional help, benefit from professional help, barriers to help-seeking, barriers to help-seeking for other embarrassing (sexual) problems, and barriers to providing professional help for pain with intercourse. The study population existed of patients and GPs from the Huisartsen Oude Turfmarkt/Bureau Studentenartsen and students from the Studenthealthcheck. These were the following sub questions:

- "What is the prevalence of pain with intercourse?"
- "What is the difference in odds of pain with intercourse for females compared to males?"
- "What is the prevalence of seeking professional help?"
- "Did patients and students who did seek professional help for pain with intercourse benefit from the professional help that was provided?"
- "What are barriers and settling factors to seeking professional help for pain with intercourse in patients and students?"
- "What are barriers to seeking professional help for other (imagined) embarrassing (sexual) problems in patients and students?"
- "What are barriers and settling factors to providing professional help for pain with intercourse in GPs?"
- "What are the statistically significant highest scored on barrier-dimensions (Social-Cognitive Theory)?"

Prevalence of pain with intercourse

The prevalence rate of pain with intercourse is 27%. This prevalence rate lies within the prevalence rate interval of 3-43%, as reported by van der Meijden & ter Hamsel[12]. The prevalence rate of pain with intercourse in males is 12% and in females is 31%. These prevalence rates do not correspond with the prevalence rates Kedde and colleagues report; 0.7% in males and 4.9% in females[9]. The large difference in prevalence rates might be due to the fact that Kedde reports a prevalence rate of dyspareunia in a PanelClix sample that is composed based on age, sex/gender, level of education, ethnicity, and degree of urbanization[9,43]. The distribution of these demographic factors is equal to the distribution in the Dutch population according to Statistics Netherlands (CBS)[44]. Patients from the Huisartsen Oude Turfmarkt/Bureau Studentenartsen and students from the Studenthealthcheck represent only a small part of the PanelClix sample. The median age in our study is lower compared to the median age in the Dutch population. The percentage of females in our study is higher compared to the percentage of females in the Dutch population; 80% versus 50%[45]. Furthermore, the level of education in our study is probably higher since this study surveyed students from the Studenthealthcheck. Many student with a higher vocational educational level or academic education level are actively encouraged to fill out the Studenthealthcheck questionnaire. The degree of urbanization might also be higher compared to the Dutch population since the actively encouraged students are from colleges and universities situated in Amsterdam, and the Huisartsen Oude Turfmarkt/Bureau Studentenartsen is a general practice for the following Amsterdam zip codes: 1011-1019, 1051-1054, 1071-1078, and 1091-1093[46].

Of the patients and students who has a sexual problem, 77% also has pain with intercourse. Of the males and females who have a sexual problem, 79% and 50% respectively, also have pain with intercourse. The fact that 79% of females has pain with intercourse could support the statement by Kedde and colleagues that the most reported sexual dysfunction in women appears to be dyspareunia[11].

Odds of pain with intercourse and the prevalence of help-seeking

Some new figures regarding pain with intercourse and help-seeking presented themselves. The odds of pain with intercourse is 3.8 times higher for females compared to males and exactly the same for

patients compared to students. The prevalence rate of help-seeking for pain with intercourse is 20%. The odds of help-seeking is almost exactly the same for females compared to males and exactly the same for patients compared to students.

Benefit from professional help

Three out of 10 respondents agreed with benefitting from the professional help that was provided by the general practitioner for pain with intercourse. Four out of 10 respondents slightly agreed. Three out of 10 respondents have been referred to another specialist. Two out of 10 respondents rated the consultation with the general practitioner for pain with intercourse with a 4.

One of the respondents stated being informed about ways to reduce pain with intercourse; different sexual positions, no climaxing before penetration, prolonged foreplay, and not too rough sexual intercourse while one of the barriers to help-seeking for pain with intercourse is personal pain management: cognitive distraction/prolonged foreplay/changing intercourse positions/use of lubricants. Even more strikingly is the facts that continuing sexual contact despite experiencing pain, contributes to the persistence of the problem. So three of the 10 respondents, whom had received insight and tips, might not have been on the way back home with the right kind of professional help.

Preferring to refer a patient with pain with intercourse is one of the barriers to providing professional help in GPs. Although, in this study, no GP agreed or even slightly agreed with not talking about pain with intercourse with a patient because they prefer to refer a patient with pain with intercourse, it is curious to see that 3 out 10 respondents who did seek help for pain with a GP were referred to another specialist.

Barriers (and settling factors) to help-seeking

Demographic determinants to not seeking professional help for pain with intercourse in patients and students are mentioned in the introduction and Table 1. None of the settling factors described by Shifren and colleagues[16], Gott & Hinchliff[31], and Moreira and colleagues[33], including relationship status, age, gross income, and religion, were of statistically significant effect on pain with intercourse or help-seeking. On all barriers to help-seeking for pain with intercourse respondents responded with “Agree” or “Slightly agree” making all the help-seeking barriers found in scientific literature applicable to this study population. On all barriers to help-seeking for an imagined other embarrassing (sexual) problem respondents also responded with either “Agree” or “Slightly agree”.

The hypothesis for the differences in reported barriers to seeking professional help in patients and student with pain with intercourse and other embarrassing problems was a followed: “Barriers that respondents with pain with intercourse report more often compared to respondents with an imagined embarrassing problem are shame/embarrassment, cognitive search for causal attributions, fear of stigma associated with the problem, and demographics of the physician: gender/age. Barriers that respondents with pain with intercourse report more often compared to respondents with an imagined other embarrassing sexual problem are perceiving that the sexual problem can be resolved by themselves, problem identifying/labelling the problem, faith in spontaneous remission, struggling finding professional help, and thinking that the physician cannot help with the problem.”

The difference in odds of trying to find out what the cause is, is statistically significant; 0.3 times lower for a respondent with pain with intercourse compared to a respondent with an imagined other embarrassing sexual problem. The difference in odds of wanting the general practitioner being of the same sex/gender is statistically significant; 2.9 times higher for a respondent with pain with intercourse compared to a respondent with an imagined other embarrassing problem. Problem identifying/labelling the problem was only measured in respondents with pain with intercourse. Therefore, an OR on this barriers could not be measured.

Barriers and settling factors to providing professional help

The only barrier to providing professional help for pain with intercourse that is scored on highly is lacking a reason to talk about it; 7 out of 7 GPs responded with either "Agree" or "Slightly Agree". Curiously, only 3 out of 7 respondents responded with "Agree" or "Slightly agree" to thinking that pain with intercourse should be more often talked about with patients. However, 4 out of 7 indicated that they would ask patients about pain with intercourse, even though there is no complaint and or request for help for it, during a consultation on sexual functioning, contraceptives and or child wish. It seems that the subject of the consultation should be in some relation to pain with intercourse when GPs want to broach the subject. This is reflected in one of the answers to an open question about other factors that would positively or negatively influence the providing of professional help. The respondent indicated that it would positively influence them if asking about sexual health is more or less a standard during STD consultation, or something of the like. Asking about sexual health during a consultation regarding a subject related to sexual health would not only be of positive influence on GPs but also on patients, as indicated by another GP: "*I often hear from patients that it is very pleasant when a general practitioner actively asks about pain with intercourse with recurrent UTI's, recurrent candida infections, obstipation, and pain with internal examination.*"

Barrier-dimensions and recommendations for general practice

The behavioural barrier-dimensions for seeking professional help for pain with intercourse is averagely scored on highest, however not statistically significant different from the cognitive and environmental barrier-dimensions. This is opposite from what was hypothesised, namely, that cognitive and physical abilities and beliefs and attitudes would be of greater influence in not seeking professional help for pain with intercourse compared to physical and verbal responses and social interactions. It does however support the notion that help-seeking depends as much on peoples place in society, as it does on cognitive processes[26].

As is said before, sexual health help-seeking behaviour can be seen as a part of health literacy[28]. Furthermore, the Social Cognitive Theory embeds barriers to help-seeking in a large body of knowledge that describes the way in which these barriers are defined, work, and how to delist them to enhance health (literacy)[25]. The fact that behavioural barriers way heavy on help-seeking can be used in the development of educative prevention material.

Short-comings and recommendations for further research

One of the first short comings of this study originates in the question that arose regarding pain with intercourse: "Why is dyspareunia such a dark kept secret?". In retrospect, it encouraged a kind of tunnel vision regarding help-seeking. The concept of no help-seeking, barriers and settling factors attracted attention while it would have been interesting to also study help-seeking and stimulating determinants for help-seeking. A few stimulating factors have however been tested since, for example, there was asked about relationship status and not just singlehood. Further research into stimulating factors would be valuable, primarily because of the interest in educative prevention material.

Another short-coming would be that this questionnaire did not specifically ask after emotional barriers. This short-coming was identified after the questionnaire was closed and the results were presented to employees of the Huisartsen Oude Turfmarkt/Bureau Studentenartsen. Amidst the employees was a psychologist present, whom pointed out that some of the cognitive barriers might be dependent on emotional processes that are happening, consciously or unconsciously, within a person. Therefore, for further research, we suggest using a theoretical framework which supports the idea of their also being emotional barriers to help-seeking. For now, we would like to remark that the Table 1 and 2 should have said "Cognitive and Emotional barriers", rather than just cognitive barriers.

Furthermore, the way problems which are imagined, embarrassing, and different from pain with intercourse are described is faulty. This is because the questionnaire asked respondents to imagined having a problem they would find embarrassing and did not want to consult your general practitioner about, which turned out to be faulty. Respondents rightfully informed us that it wrongfully suggests that everyone thinks that there are embarrassing problems for which you would not want to visit your GP for. Furthermore, and this is what we then realised, it also suggests that pain with intercourse is an embarrassing problem. Our results have shown that not everyone is ashamed/embarrassed about pain with intercourse.

Lastly, there is the small group of GPs that were asked to fill out the questionnaire. The results found for this group cannot be extrapolated to a bigger population since it only exists of 7 GPs. Furthermore, only a few demographic determinants for GPs were asked after because of the fact that some of these questions, based on the settling factors described in Table 2, would be of too great of an infringement on privacy, even though the questionnaire would be anonymous. Another reason would be that we forgot to ask after demographic determinants that weren't previously mentioned in scientific literature as settling factors to providing professional help.

Other recommendation for further research include descriptive statistics on the response to barriers to help-seeking for pain with intercourse, split out for patients and students. And, the comparison of mean scores on barrier-dimensions to help-seeking for pain with intercourse and mean scores on barrier-dimensions to help-seeking for other embarrassing (sexual) problems. Lastly, and most importantly, we would be interested to see what the actual effects of the different barriers on help-seeking are. That would mean that the barriers would have to be measured in not just respondents with pain with intercourse who have not sought professional help, but also in respondents with pain with intercourse who have sought professional help.

5. Conclusion

If patients with pain with intercourse differ at all from patients with another embarrassing (sexual) problem regarding barriers to help seeking then they do so on the following barriers:

- Talking with others whom are not health professionals,
- Forgetting to ask about the problem during consultation,
- Lacking confidence in a medical solution for the problem,
- When consulting the general practitioner for the problem then they have to talk to their partner about it too,
- Wanting the general practitioner being of the same sex/gender as themselves when consulting the general practitioner for the problem,
- Not having a regular GP.

6. Reflection

I remember searching on the internet for internships. I wanted to find an internship on a subject that I would feel really passionate about. After all, I would have to spend four months working on a research report regarding that subject. I then stumbled upon the website of Huisartsen Oude Turfmarkt/Bureau Studentenartsen. They stated some of the internship subjects that were available for 2015. I called and asked for an e-mail address of whomever I could contact about the internship subjects of 2016. Peter Vonk, director of the general practice, soon responded saying that I was a little too early and that they had not even had the time to have a meeting regarding new internship subjects.

Soon after, I had the possibility to choose from the new subjects and chose, as you surely have seen, pain with intercourse. The subject was right up my alley. A written plan would be the basis for an interview. I was so excited that instead of writing a plan I just filled out the project proposal form that was made available by the VU. The interview went well, I got accepted, completed the proposal and started my internship on February 1th 2016.

It is now May 27th 2016; the official end date of the internship. I have met new people, learned some of the ropes of the trade, conducted my own study and written an elaborate research report. In a time span of just four months.

I have achieved all of my personal learning objectives. My personal learning objectives included:

- Systematically uncovering scientific literature regarding dyspareunia
- Creating a questionnaire
- Conducting a questionnaire
- Putting statistical skills into practice by analysing the results of the questionnaire
- Presenting the study and its results

Uncovering scientific literature does not seem to be so hard until you have to do it systematically. I learned how to use MeSH terms in NCBI and search operators in Google (Scholar). Furthermore, I learned that even for scientific literature, you have to formulate in- and exclusion criteria. The creating of the questionnaire did not go as smoothly as I had hoped. At university, we have previously dealt with dos and don'ts regarding questionnaires, but nothing beats learning from practice. You need to constantly ask yourself: "Am I actually asking what I want to measure?" Claudia was not wrong saying that we truly need to take our time developing the questionnaire. You think that you have an insight into what respondents are going to think when filling out your questionnaire, but you do not. Even though you've looked it through multiple times, had friends, family and other interns look at it, and discussed it with your supervisors. Putting my statistical skills into practice went better that I could have hoped. Largely through repeating SPSS practicums from Methodology I and II while the questionnaire was collecting data. I have always found it very difficult to give a short presentation of a large project. Fortunately, we have had to present our study and its results two times before, on the general practice. I knew now which aspect of the study I could leave out or swiftly mention and which aspects to elaborate on.

I want to thank Claudia van der Heijde, whom I have seen becoming a PhD, for guiding my daily proceedings. You were always able to help me with my study, especially during the development of my questionnaire. No questions of mine were left unanswered. Frans Meijman, my supervisor on site and VU supervisor, with endless knowledge of research and language has helped me many times through constructive criticism. Even when I (more than often wrongfully, I admit) thought I could do it by myself. You also taught me to not be too modest and more often request for help. I want to thank Peter Vonk for providing me the opportunity to perform such an elaborate study from his general

practice, using his extended resources. I very much enjoyed working with all the other interns and Claudia in the attic of the general practice. We've have been taken good care of. Furthermore, you also provided us with an 'achtergrond' GP, in my case, Dorien Beijderwellen. Dorien's enthusiasm has proven to truly be infectious, even in the later stages of my writing and presenting. Lastly, a big thank you to all the other employees of the Huisartsen Oude Turfmarkt/Bureau Studentenartsen; I have felt welcome.

7. Appendices

7.1 Questionnaire for patients and students
E-mail me at n.c.doodkorte@student.vu.nl for the Dutch questionnaire (PDF)

Online (anonymous) questionnaire

Dear reader,
Your response will help you and your general practitioner gain insight into pain during intercourse and help improve the quality of your health care and that of others. I kindly ask you to fill out this questionnaire. Filling out this questionnaire will take you about 10 minutes. NB This questionnaire is also for people who do not experience pain during intercourse. Thank you!

_____

I am a Health and Life sciences student at the VU University. I am currently researching barriers to seeking help for pain with intercourse. All patients of the general practice Huisartsen Oude Turfmarkt/Bureau Studentenartsen and a lot of students will be asked to fill out this questionnaire. My research report will be published on the website of this general practice and possibly as a scientific article.
*Required

1. I am a registered patient of the general practice Huisartsen Oude Turfmarkt/Bureau Studentenartsen. *
Mark only one oval.
Yes
No

2. I am a student. *
Mark only one oval.
Yes
No

3. My age is: *

4. My sex/gender is: *
Mark only one oval.
Male
Female
Other:

5. My relationship status is: *
Mark only one oval.
Single
In a relationship
Married
Widow(er)
Other:

6. My religion is: *
Mark only one oval.
Atheist
Buddhist
Christian

Hindu
Jewish
Muslim
Other:

7. My gross earnings per month are: *
Mark only one oval.
0-200 euros
200-500 euros
500-1000 euros
1000 euros or more

8. Are you sexually active? *
Mark only one oval.
Yes
No *Skip to question 12.*

9. Are there any sexual problems? *
Mark only one oval.
Yes
No *Skip to question 12.*

10. Do you have any pain with intercourse? *
Mark only one oval.
Yes
No *Skip to question 12.*

11. Have you sought professional help for pain with intercourse in the past 6 months?*
Mark only one oval.
Yes *Skip to question 16.*
No *Skip to question 19.*

12. Is your partner sexually active? *
Mark only one oval.
Yes
No *Skip to question 55.*

13. Does your partner have any sexual problems? *
Mark only one oval.
Yes
No *Skip to question 55.*

14. Does your partner have any pain with intercourse? *
Mark only one oval.
Yes
No *Skip to question 55.*

15. Have you sought professional help for pain with intercourse of your partner in the past 6 months? *
Mark only one oval.
Yes *Skip to question 16.*

No *Skip to question 19.*

16. I benefitted from the professional help provided by the general practitioner for pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

17. In what way have you or have you not benefitted from the professional help provided by the general practitioner for pain with intercourse? *

18. How would you rate the consultation with the general practitioner for pain with intercourse? *
Mark only one oval.
very bad 1 2 3 4 5 6 7 8 9 10 very good
Stop filling out this form.

19. I did not know that pain with intercourse could be a sexual problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

20. I have not been properly informed about pain with intercourse by the general practitioner. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

21. I am trying to find out what the cause for pain with intercourse is. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

22. I think that pain with intercourse is associated with child delivery. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

23. I think that pain with intercourse is associated with aging. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

24. I do not think that pain with intercourse is a medical problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

25. I am ashamed/embarrassed about pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Agree

26. I have faith in the spontaneous resolving of pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

27. I do not think that pain with intercourse is a serious problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

28. I am afraid that pain with intercourse is more severe than I thought. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

29. I am insecure about my body. *
Mark only one oval.
Agree

Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

30. I have accepted pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

31. I have no time to spend on caring for pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

32. I think that sexual intercourse is a very important part of life. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

33. I lack confidence in a medical solution for pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

34. I do not think that the general practitioner can help with pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

35. I find it difficult to talk about pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree

Disagree

36. I talk about pain with intercourse with others whom are not health professionals. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

37. I am afraid of stigma associated with pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

38. I try to manage pain with intercourse myself. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

39. I think that I can resolve pain with intercourse myself. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

40. I think that pain with intercourse is associated with the sexual partner. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

41. I struggle with finding professional help for pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

42. I forget to ask about pain with intercourse during consultation with the general practitioner. *

Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

43. I am waiting for the general practitioner to ask about pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

44. I have a comfortable professional relationship with the general practitioner. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

45. I have a trusting professional relationship with the general practitioner. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

46. I have a very close relationship with the general practitioner. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

47. I do not have a regular general practitioner. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

48. I think that the general practitioner does not have a positive attitude toward talking about pain with intercourse. *
Mark only one oval.
Agree

Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

49. I think that the general practitioner is not able to communicate about pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

50. I want the general practitioner to be around the same age as I am when I have to consult them about pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

51. I want the general practitioner to be of the same sex/gender as I am when I have to consult them about pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

52. I think that consulting the general practitioner about pain with intercourse is expensive. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

53. I do not want to bother the general practitioner with pain with intercourse because the general practitioner has a high workload. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

54. When I consult the general practitioner about pain with intercourse, then I have to talk to my partner about it too. *
Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree
Stop filling out this form.

Imagine having a problem you would find embarrassing and did not want to consult your general practitioner about

This embarrassing problem cannot be sexual.

55. What embarrassing problem are you thinking of? *

Keep the embarrassing problem in mind when you answer the following questions

56. I have not been properly informed about the embarrassing problem by the general practitioner. *

Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

57. I am trying to find out what the cause for the embarrassing problem is. *

Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

58. I do not think that the embarrassing problem is a medical problem. *

Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

59. I have faith in the spontaneous resolving of the embarrassing problem. *

Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

60. I do not think that the embarrassing problem is a serious problem. *

Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

61. I am afraid that the embarrassing problem is more severe than I thought. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

62. I am insecure about my body. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

63. I have accepted the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

64. I have no time to spend on caring for the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

65. I lack confidence in a medical solution for the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

66. I do not think that the general practitioner can help with the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree

Neither agree nor disagree
Slightly disagree
Disagree

67. I find it difficult to talk about the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

68. I talk about the embarrassing problem with others whom are not health professionals. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

69. I am afraid of stigma associated with the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

70. I try to manage the embarrassing problem myself. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

71. I think that I can resolve the embarrassing problem myself. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

72. I struggle with finding professional help for the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

73. I forget to ask about the embarrassing problem during consultation with the general practitioner. *

Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

74. I am waiting for the general practitioner to ask about the embarrassing problem. *

Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

75. I have a comfortable professional relationship with the general practitioner. *

Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

76. I have a trusting professional relationship with the general practitioner. *

Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

77. I have a very close relationship with the general practitioner. *

Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly agree
Disagree

78. I do not have a regular general practitioner. *

Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

79. I think that the general practitioner does not have a positive attitude toward talking about the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

80. I think that the general practitioner is not able to communicate about the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

81. I want the general practitioner to be around the same age as I am when I have to consult them about the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

82. I want the general practitioner to be of the same sex/gender as I am when I have to consult them about the embarrassing problem. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

83. I think that consulting the general practitioner about the embarrassing problem is expensive. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

84. I do not want to bother the general practitioner with the embarrassing problem because the general practitioner has a high workload. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree

Disagree

85. When I consult the general practitioner about the embarrassing problem, then I have to talk to my partner about it too. *

Mark only one oval.

Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

7.2 Questionnaire for GPs
E-mail me at n.c.doodkorte@student.vu.nl for the Dutch questionnaire

Online (anonymous) questionnaire

Dear reader,
Your response will help you gain insight into pain during intercourse and help improve the quality of your patients' health care. I kindly ask you to fill out this questionnaire. Filling out this questionnaire will take you about 5 minutes. Thank you!

_____

I am a Health and Life sciences student at the VU University. I am currently researching barriers to seeking help for pain with intercourse. All general practitioners of this general practice will be asked to fill out this questionnaire. My research report will be published on the website of this general practice and possibly as a scientific article.
*Required

1. I do not talk about pain with intercourse with a patient whom I lack a comfortable professional relationship with. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

2. I do not talk about pain with intercourse with a patient whom I lack a trusting professional relationship with. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

3. I do not talk about pain with intercourse with a patient whom I have a close professional relationship with. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

4. I do not talk about pain with intercourse with a patient when I lack a reason for talking about it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

5. I do not talk about pain with intercourse with a patient when I lack time for talking about it. *

Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

6. I do not talk about pain with intercourse with a patient who is 65 years or older. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

7. I do not talk about pain with intercourse with a patient when I think that that patient will deny having pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

8. I do not talk about pain with intercourse with a patient when I think that that patient is unwilling to discuss it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

9. I do not talk about pain with intercourse with a patient when I think that I will experience difficulties with cultural factors relating to the patient's attitudes and beliefs. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

10. I do not talk about pain with intercourse with a patient when I think that I will experience difficulties with ethnic factors relating to the patient's attitudes and beliefs. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

11. I do not talk about pain with intercourse with a patient when I think that I will experience difficulties with religious factors relating to the patient's attitudes and beliefs. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

12. I do not talk about pain with intercourse with a patient when I think that I will experience language and terminology problems when talking about it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

13. I do not talk about pain with intercourse with a patient because I do not know when, what or how to ask about it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

14. I do not talk about pain with intercourse with a patient because I lack confidence in talking about it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

15. I do not talk about pain with intercourse with a patient because I am inadequately trained to approach it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

16. I do not talk about pain with intercourse with a patient because I prefer to refer a patient with pain with intercourse. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree

Slightly disagree
Disagree

17. I do not talk about pain with intercourse with a patient because I think that pain with intercourse is too complex since it is not merely associated with biological determinants. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

18. I do not talk about pain with intercourse with a patient because I am uncertain about therapeutic options. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

19. I do not talk about pain with intercourse with a patient because I am not interested in it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

20. I do not talk about pain with intercourse with a patient because I think that the patient will bring it up anyway. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

21. I do not talk about pain with intercourse with a patient because I get ashamed/embarrassed. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

22. I do not talk about pain with intercourse with a patient because I am afraid of alienating them. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree

Slightly disagree
Disagree

23. I do not talk about pain with intercourse with a patient because I am afraid of offending them. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

24. I do not talk about pain with intercourse with a patient because I am concerned that it might be regarded as sexual harassment. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

25. I do not talk about pain with intercourse with a patient because I am uncomfortable with the nature of the patient's sexual tendencies. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

26. I do not talk about pain with intercourse with a patient who does not request help for it. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

27. I think that pain with intercourse should be more often talked about with patients. *
Mark only one oval.
Agree
Slightly agree
Neither agree nor disagree
Slightly disagree
Disagree

28. Since pain with intercourse is not often talked about by patients I am going to ask them about it even though there is no complaint and or request help for it during a consultation on sexual functioning, contraceptives and or child wish. *
Mark only one oval.
Agree
Slightly agree

Neither agree nor disagree
Slightly disagree
Disagree

29. My ethnicity is: *

30. My sexual orientation is: *

31. The number of relationships I had that have lasted longer than 6 months is: *
Mark only one oval.
0-3
4-6
7-10
more than 10

32. Are there factors that would either positively or negatively influence you in providing professional help for pain with intercourse? If so, please explain briefly. *

7.3 List of reported embarrassing problems (some are translated from Dutch)
Haemorrhoids
Haemorrhoids
Haemorrhoids
Haemorrhoids
Haemorrhoids
Haemorrhoids
Haemorrhoids
Haemorrhoids
Haemorrhoids
Haemorrhoids
If there are substances involved that are not socially accepted (think of (large quantities) of hard drugs, or fetishes
Anal examination
Anal fissure
Anal complaints
Any problems regarding mental health such as panic attacks or anxiety
Bacterial vaginosis
Inverted nipples
Depression
Depression
Dermatillomania
I would only experience this if I thought that the general practitioner could not really help me
A practical component, such as a tight of sensitive foreskin.
A problem for which you visit the general practitioner for the umpteenth time. For example, I often visited the general practitioner for eardrops because I was always touching my ear causing my ear to get infected.
A problem for which my general practitioner would have to look at my genitals
I would find a mental problem most embarrassing. I would however consult the general practitioner, I think.
Envy
Secretion
Not a concrete problem, but something that looks unclean/has a bad smell
Irritated anus
Ruptured anus
Hair on the nipples
Haemorrhoids
Haemorrhoids
Having a rash/suffering from vaginal problems
Something with the genitals? For example: too large labia
Something with my penis
Something that is my own fault?
I can't imagine any problems that I wouldn't dare to visit my general practitioner for. However, I do find some problems to be embarrassing. For example, vaginal or intestinal problems.
I would consult my general practitioner, but after a lot of hesitation: things with which I have to get out of my clothes and/or touched on intimate places.
Itching
Physical abnormalities
More pubic hair near my bikini line and dark hair on my upper lip
Moles in weird spots

Inapplicable, I would always visit the general practitioner if necessary. However, I would find problem in and around intimate zones embarrassing. Or libido problems.
Not daring to walk in a bikini
Being unsure of …
Pain
Pain
Problems with the vagina, smell of it, etc.
Symmastia
Too large labia, suffering from something relating to the anus
Rash or something in the genital area or the anus
Rash in strange places
Vague unclear fatigue problems
Vaginal discharge
Vaginal yeast infection
Vaginal yeast infection
Vaginal yeast infection
Vaginal yeast infection
Vaginal yeast infection causing intercourse to be painful and quite some itchiness
Wounds near the anus
Warts on intimate parts
All embarrassing problems I can think of have something to do with sexuality
Anal sex
Asexual or not
Bleeding after sex
Cannot feel pleasure
Chlamydia
That something is stuck somewhere and I can't get it out
That sex would not have been pleasant (not necessarily painful).
A paraphilia
A STD
A STD
I can't actually think of an embarrassing problem. Perhaps no longer an erection….
Erectile problems
No desire for sex
No or never a desire for sex
He has herpes which very much affects the sex life.
I am single. I don't know anything about my ex partners or future partners. Embarrassing problem have previously been severe cramps during intercourse.
I can't orgasm. Only when I'm on my own using a vibrator.
I wouldn't necessarily think about asking the general practitioner about unclear medical sexual problems. Primarily because I wouldn't really know that that was possible.
Impotence
Irritation of the vagina and vaginismus/sexual aversion
Loss of libido
Difficulty with climaxing
Not climaxing during sex
Not getting aroused anymore by my partner
Partner has difficulty maintaining an erection
Mental
Pimples
STD

STIs
Too tight, not getting wet
Too little sex, porn addiction
Vaginismus
Low sex drive

7.4 Tables of Results

Table 3.1. Descriptives of the respondents split up for Sex/gender (FULL)

	Male %	*N*	Female %	*N*	Total %	*N*	*p*-value	Test	OR	95%-C.I.
Sex/gender	20%	41	80%	160	100%	201	-	-	-	-
Registered patient/student	20%	40	80%	158	100%	198	0.023	Chi-square Test (Linear-by-Linear Association)	-	-
- **Patient**	45%	18	27%	42	30%	60				
- **Student**	23%	9	24%	38	24%	47				
- **Patient and student**	33%	13	49%	78	46%	91				
Age	20%	41	80%	160	100%	201	0.000	Mann-Whitney Test (Exact Sig. (2-tailed))	-	-
		31 (Median) 25 (IR)		23.5 (Median) 6 (IR)		24 (Median) 7 (IR)				
Relationship status	20%	41	80%	160	100%	201	0.114	Chi-square Test (Fisher's Exact Test)	-	-
- **Single**	39%	16	42%	67	41%	83				
- **In a relationship**	44%	18	52%	83	50%	101				
- **Engaged**	0%	0	1%	1	1%	1				
- **Married**	17%	7	6%	9	8%	16				
Religion	20%	41	80%	160	100%	201	0.658	Chi-square Test (Fisher's Exact Test)	-	-
- **Atheist**	73%	30	69%	110	70%	140				
- **Agnostic**	2%	1	6%	9	5%	10				
- **Buddhist**	2%	1	1%	1	1%	2				
- **Christian**	15%	6	17%	27	16%	33				
- **Jewish**	0%	0	1%	1	1%	1				
- **Muslim**	0%	0	1%	1	1%	1				
- **Somethingist**	0%	0	1%	2	1%	2				
- **Spiritual**	2%	1	0%	0	1%	1				
- **Other**	2%	1	2%	3	2%	4				
- **None of the above**	2%	1	4%	6	4%	7				
Gross earnings	20%	41	80%	160	100%	201	0.034	Chi-square Test (Fisher's Exact Test)	-	-
- **0-200 euros**	20%	8	31%	49	28%	57	0.009	Chi-square Test (Linear-by-Linear Association)		
- **200-500 euros**	12%	5	22%	35	20%	40				
- **500-1000 euros**	22%	9	24%	39	24%	48				
- **1000 euros or more**	46%	19	23%	37	28%	56				
Sexually active	20%	41	80%	160	100%	201	0.771	Chi-square Test (Continuity Correction)	1.291	0.510 -3.272

	Male %	N	Female %	N	Total %	N	p-value	Test	OR	95%-C.I.
- Yes	83%	34	86%	138	86%	172				
- No	17%	7	14%	22	14%	29				
Sexual problems	20%	34	80%	138	100%	172	0.147	Chi-square Test (Continuity Correction)	1.958	0.871 -4.403
- Yes	29%	10	45%	62	42%	72				
- No	71%	24	55%	76	58%	100				
Pain with intercourse	14%	10	86%	62	100%	72	0.115	Chi-square Test (Continuity Correction)	3.769	0.946 - 15.015
- Yes	50%	5	79%	49	75%	54				
- No	50%	5	21%	13	25%	18				
Help-seeking	9%	5	91%	49	100%	54	1.000	Chi-square Test (Continuity Correction)	1.026	0.103 - 10.218
- Yes	20%	1	20%	10	20%	11				
- No	80%	4	80%	39	80%	43				
Partner, sexually active	25%	36	76%	111	100%	147	1.000	Chi-square Test (Continuity Correction)	0.943	0.397 -2.239
- Yes	75%	27	74%	82	74%	109				
- No	25%	9	26%	29	26%	38				
Partner, sexual problems	25%	27	75%	82	100%	109	0.013	Chi-square Test (Fisher's Exact Test)	0.071	0.008 -0.667
- Yes	15%	4	1%	1	5%	5	0.013	Chi-square Test (Linear-by-Linear Association)		
- No	85%	23	99%	81	95%	104	0.016	Chi-square Test (Continuity Correction)		
Partner, pain with intercourse	80%	4	20%	1	100%	5	0.819	Chi-square Test (Continuity Correction)	-	-
- Yes	75%	3	0%	0	60%	3				
- No	25%	1	100%	1	40%	2				
Partner, help-seeking	100%	3	0%	0	100%	3	-	-	-	-
- No	100%	3	0%	0	100%	3				

Table 4.1. Descriptives of the respondents split up for Registered patient/student (FULL)

	Patient %	N	Student %	N	Patient and student %	N	Total %	N	p-value	Test	OR	95%-C.I.
Registered patient/student	30%	60	24%	47	46%	91	100%	198	-	-	-	-

	Patient		Student		Patient and student		Total		*p*-value	Test	OR	95%-C.I.
	%	*N*	%	*N*	%	*N*	%	*N*				
Sex/gender	30%	60	24%	47	46%	91	100%	198	0.023	Chi-square Test (Linear-by-Linear Association)	-	-
- **Male**	30%	18	19%	9	14%	13	20%	40				
- **Female**	70%	42	81%	38	86%	78	80%	158				
Age	30%	60	24%	47	46%	91	100%	198	0.000	ANOVA (F-test)	-	-
		30 (Median) 22 (IR)		22 (Median) 3 (IR)		23 (Median) 4 (IR)		24 (Median) 7 (IR)				
Relationship status	30%	60	24%	47	46%	91	100%	198	0.004	Chi-square Test (Fisher's Exact Test)	-	-
- **Single**	33%	20	47%	22	45%	41	42%	83		Chi-square Test (Linear-by-Linear Association)		
- **In a relationship**	50%	30	45%	21	54%	49	51%	100	0.001			
- **Engaged**	0%	0	2%	1	0%	0	1%	1				
- **Married**	17%	10	6%	3	1%	1	7%	14				
Religion	30%	60	24%	47	46%	91	100%	198	0.817	Chi-square Test (Fisher's Exact Test)	-	-
- **Atheist**	73%	44	66%	31	70%	64	70%	139				
- **Agnostic**	3%	2	4%	2	7%	6	5%	10				
- **Buddhist**	0%	0	0%	0	2%	2	1%	2				
- **Christian**	15%	9	23%	11	14%	13	17%	33				
- **Jewish**	2%	1	0%	0	0%	0	1%	1				
- **Muslim**	0%	0	2%	1	0%	0	1%	1				
- **Somethingist**	2%	1	2%	1	0%	0	1%	2				
- **Spiritual**	0%	0	0%	0	1%	1	1%	1				
- **Other**	2%	1	0%	0	2%	2	2%	3				
- **None of the above**	3%	2	2%	1	3%	3	3%	6				
Gross earnings	30%	60	24%	47	46%	91	100%	198	-	- (Insufficient memory)	-	-
- **0-200 euros**	7%	4	40%	19	36%	33	28%	56				
- **200-500 euros**	0%	0	26%	12	31%	28	20%	40				
- **500-1000 euros**	15%	9	23%	11	30%	27	24%	47				
- **1000 euros or more**	78%	47	11%	5	3%	3	28%	55				
Sexually active	30%	60	24%	47	46%	91	100%	198	0.009	Chi-square Test (Fisher's Exact Test)	-	-
- **Yes**	85%	51	72%	34	92%	84	85%	169				
- **No**	15%	9	28%	13	8%	7	15%	29				

	Patient		Student		Patient and student		Total		*p*-value	Test	OR	95%-C.I.
	%	*N*	%	*N*	%	*N*	%	*N*				
Sexual problems	20%	51	20%	34	50%	84	100%	169	0.049	Chi-square Test (Linear-by-Linear Association)	-	-
- **Yes**	29%	15	44%	15	48%	40	41%	70				
- **No**	71%	36	56%	19	52%	44	59%	99				
Pain with intercourse	21%	15	21%	15	58%	40	100%	70	0.792	Chi-square Test (Fisher's Exact Test)	-	-
- **Yes**	73%	11	73%	11	80%	32	77%	54				
- **No**	27%	4	27%	4	20%	8	23%	16				
Help-seeking	20%	11	20%	11	60%	32	100%	54	0.461	Chi-square Test (Fisher's Exact Test)	-	-
- **Yes**	27%	3	27%	3	16%	5	20%	11				
- **No**	73%	8	73%	8	84%	27	80%	43				
Partner, sexually active	34%	49	25%	36	41%	59	100%	144	0.072	Chi-square Test (Fisher's Exact Test)	-	-
- **Yes**	80%	39	58%	21	78%	46	74%	106				
- **No**	20%	10	42%	15	22%	13	26%	38				
Partner, sexual problems	37%	39	20%	21	43%	46	100%	106	0.531	Chi-square Test (Fisher's Exact Test)	-	-
- **Yes**	3%	1	0%	0	7%	3	4%	4				
- **No**	97%	38	100%	21	94%	43	96%	102				
Partner, pain with intercourse	25%	1	0%	0	75%	3	100%	4	1.000	Chi-square Test (Continuity Correction)	1.500	0.674 - 3.339
- **Yes**	100%	1	0%	0	67%	2	75%	3				
- **No**	0%	0	0%	0	33%	1	25%	1				
Partner, help-seeking	33%	1	0%	0	67%	2	100%	3	-	-	-	-
- **No**	100%	1	0%	0	100%	2	100%	3				

Table 13.1. Response by means of the 5-point Likert scale on potential barriers to Help-seeking for Pain with intercourse

Barriers to help-seeking for pain with intercourse	Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree	
	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*
I did not know that pain with intercourse could be a sexual problem.	4%	2	24%	11	11%	5	24%	11	37%	17
I have not been properly informed about pain with intercourse by the general practitioner.	9%	4	13%	6	41%	19	7%	3	30%	14
I am trying to find out what the cause for pain with intercourse is.	15%	7	26%	12	13%	6	13%	6	33%	15
I think that pain with intercourse is associated with child-delivery.	0%	0	4%	2	13%	6	4%	2	78%	36

Barriers to help-seeking for pain with intercourse	Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree	
	%	N	%	N	%	N	%	N	%	N
I think that pain with intercourse is associated with aging.	2%	1	7%	3	7%	3	2%	1	83%	38
I do not think that pain with intercourse is a medical problem.	13%	6	15%	7	26%	12	15%	7	30%	14
I am ashamed/embarrassed about pain with intercourse.	26%	12	35%	16	13%	6	11%	5	15%	7
I have faith in the spontaneous resolving of pain with intercourse.	13%	6	26%	12	7%	3	22%	10	33%	15
I do not think that pain with intercourse is a serious problem.	8%	4	17%	8	11%	5	24%	11	39%	18
I am afraid that pain with intercourse is more severe than I thought.	20%	9	17%	8	22%	10	20%	9	22%	10
I am insecure about my body.	13%	6	33%	15	15%	7	13%	6	26%	12
I have accepted pain with intercourse.	17%	8	33%	15	7%	3	24%	11	20%	9
I have no time to spend on caring for pain with intercourse.	9%	4	26%	12	22%	10	20%	9	24%	11
I think that sexual intercourse is a very important part of life.	54%	25	17%	8	13%	6	9%	4	7%	3
I lack confidence in a medical solution for pain with intercourse.	22%	10	22%	10	17%	8	17%	8	22%	10
I do not think that the general practitioner can help with pain with intercourse.	15%	7	37%	17	17%	8	15%	7	15%	7
I find it difficult to talk about pain with intercourse.	30%	14	26%	12	13%	6	9%	4	22%	10
I talk about pain with intercourse with others whom are not health professionals.	24%	11	39%	18	9%	4	7%	3	22%	10
I am afraid of stigma associated with pain with intercourse.	11%	5	17%	8	22%	10	17%	8	33%	15
I try to manage pain with intercourse myself.	33%	15	41%	19	15%	7	2%	1	9%	4
I think that I can resolve pain with intercourse myself.	15%	7	24%	11	26%	12	26%	12	9%	4
I think that pain with intercourse is associated with the sexual partner.	7%	3	30%	14	24%	11	17%	8	22%	10
I struggle with finding professional help for pain with intercourse.	11%	5	20%	9	37%	17	9%	4	24%	11
I forget to ask about pain with intercourse during consultation with the general practitioner.	24%	11	17%	8	22%	10	4%	2	33%	15
I am waiting for the general practitioner to ask about pain with intercourse.	17%	8	22%	10	15%	7	9%	4	37%	17
I have a comfortable professional relationship with the general practitioner.	39%	18	20%	9	22%	10	7%	3	13%	6
I have a trusting professional relationship with the general practitioner.	41%	19	20%	9	22%	10	4%	2	13%	6
I have a very close relationship with the general practitioner.	11%	5	11%	5	33%	15	17%	8	28%	13
I do not have a regular general practitioner.	44%	20	26%	12	4%	2	2%	1	24%	11
I think that the general practitioner does not have a positive attitude toward talking about pain with intercourse.	4%	2	9%	4	28%	13	9%	4	50%	23
I think that the general practitioner is not able to communicate about pain with intercourse.	0%	0	11%	5	24%	11	11%	5	54%	25
I want the general practitioner to be around the same age as I am when I have to consult them about pain with intercourse.	2%	1	20%	9	15%	7	17%	8	46%	21
I want the general practitioner to be of the same sex/gender as I am when I have to consult them about pain with intercourse.	48%	22	22%	10	7%	3	7%	3	17%	8
I think that consulting the general practitioner about pain with intercourse is expensive.	4%	2	7%	3	24%	11	9%	4	57%	26

Barriers to help-seeking for pain with intercourse	Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree	
	%	N	%	N	%	N	%	N	%	N
I do not want to bother the general practitioner with pain with intercourse because the general practitioner has a high workload.	11%	5	30%	14	7%	3	7%	3	46%	21
When I consult the general practitioner about pain with intercourse, then I have to talk to my partner about it too.	46%	21	26%	12	11%	5	4%	2	13%	6

Table 13.2. Response by means of the 5-point Likert scale on potential barriers to Help-seeking for Other embarrassing problems

Barriers to help-seeking for other embarrassing problems	Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree	
	%	N	%	N	%	N	%	N	%	N
I have not been properly informed about the embarrassing problem by the general practitioner.	10%	6	8%	5	45%	28	8%	5	29%	18
I am trying to find out what the cause for the embarrassing problem is.	31%	19	18%	11	26%	16	10%	6	16%	10
I do not think that the embarrassing problem is a medical problem.	8%	5	13%	8	18%	11	15%	9	47%	29
I have faith in the spontaneous resolving of the embarrassing problem.	18%	11	31%	19	18%	11	10%	6	24%	15
I do not think that the embarrassing problem is a serious problem.	18%	11	29%	18	23%	14	18%	11	13%	8
I am afraid that the embarrassing problem is more severe than I thought.	15%	9	21%	13	21%	13	21%	13	23%	14
I am insecure about my body.	24%	15	33%	20	11%	7	10%	6	23%	14
I have accepted the embarrassing problem.	8%	5	39%	24	26%	16	13%	8	15%	9
I have no time to spend on caring for the embarrassing problem.	11%	7	34%	21	13%	8	24%	15	18%	11
I lack confidence in a medical solution for the embarrassing problem.	7%	4	21%	13	13%	8	21%	13	39%	24
I do not think that the general practitioner can help with the embarrassing problem.	10%	6	18%	11	13%	8	24%	15	36%	22
I find it difficult to talk about the embarrassing problem.	31%	19	37%	23	21%	13	7%	4	5%	3
I talk about the embarrassing problem with others whom are not health professionals.	16%	10	29%	18	13%	8	21%	13	21%	13
I am afraid of stigma associated with the embarrassing problem.	16%	9	27%	17	34%	21	10%	6	15%	9
I try to manage the embarrassing problem myself.	40%	25	32%	20	15%	9	5%	3	8%	5
I think that I can resolve the embarrassing problem myself.	18%	11	31%	19	19%	12	13%	8	19%	12
I struggle with finding professional help for the embarrassing problem.	8%	5	21%	13	19%	12	11%	7	40%	25
I forget to ask about the embarrassing problem during consultation with the general practitioner.	5%	3	16%	10	24%	15	16%	10	39%	24
I am waiting for the general practitioner to ask about the embarrassing problem.	7%	4	23%	14	18%	11	10%	6	44%	27
I have a comfortable professional relationship with the general practitioner.	36%	22	23%	14	21%	13	10%	6	11%	7
I have a trusting professional relationship with the general practitioner.	37%	23	21%	13	24%	15	13%	8	5%	3
I have a very close relationship with the general practitioner.	5%	3	19%	12	34%	21	16%	10	26%	16
I do not have a regular general practitioner.	23%	14	19%	12	13%	8	16%	10	29%	18
I think that the general practitioner does not have a positive attitude toward talking about the embarrassing problem.	7%	4	3%	2	21%	13	23%	14	47%	29

Barriers to help-seeking for other embarrassing problems	Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree	
	%	N	%	N	%	N	%	N	%	N
I think that the general practitioner is not able to communicate about the embarrassing problem.	3%	2	0%	0	21%	13	19%	12	57%	35
I want the general practitioner to be around the same age as I am when I have to consult them about the embarrassing problem.	3%	2	11%	7	18%	11	16%	10	52%	32
I want the general practitioner to be of the same sex/gender as I am when I have to consult them about the embarrassing problem.	24%	15	23%	14	23%	14	5%	3	26%	16
I think that consulting the general practitioner about the embarrassing problem is expensive.	10%	6	5%	3	19%	12	8%	5	58%	36
I do not want to bother the general practitioner with the embarrassing problem because the general practitioner has a high workload.	5%	3	13%	8	11%	7	10%	6	61%	38
When I consult the general practitioner about the embarrassing problem, then I have to talk to my partner about it too.	19%	12	23%	14	16%	10	5%	3	37%	23

Table 13.3. Response by means of the 5-point Likert scale on potential barriers to Help-seeking for Embarrassing sexual problems

Barriers to help-seeking for embarrassing sexual problems	Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree	
	%	N	%	N	%	N	%	N	%	N
I have not been properly informed about the embarrassing problem by the general practitioner.	12%	4	0%	0	41%	14	6%	2	41%	14
I am trying to find out what the cause for the embarrassing problem is.	38%	13	21%	7	15%	5	9%	3	18%	6
I do not think that the embarrassing problem is a medical problem.	44%	15	24%	8	6%	2	6%	2	21%	7
I have faith in the spontaneous resolving of the embarrassing problem.	18%	6	27%	9	9%	3	29%	10	18%	6
I do not think that the embarrassing problem is a serious problem.	21%	7	32%	11	3%	1	32%	11	12%	4
I am afraid that the embarrassing problem is more severe than I thought.	12%	4	15%	5	15%	5	32%	11	27%	9
I am insecure about my body.	18%	6	27%	9	9%	3	27%	9	21%	7
I have accepted the embarrassing problem.	9%	3	32%	11	6%	2	35%	12	18%	6
I have no time to spend on caring for the embarrassing problem.	3%	1	38%	13	18%	6	27%	9	15%	5
I lack confidence in a medical solution for the embarrassing problem.	24%	8	21%	7	24%	8	15%	5	18%	6
I do not think that the general practitioner can help with the embarrassing problem.	18%	6	24%	8	24%	8	18%	6	18%	6
I find it difficult to talk about the embarrassing problem.	47%	16	27%	9	15%	5	3%	1	9%	3
I talk about the embarrassing problem with others whom are not health professionals.	3%	1	50%	17	15%	5	6%	2	27%	9
I am afraid of stigma associated with the embarrassing problem.	18%	6	12%	4	27%	9	24%	8	21%	7
I try to manage the embarrassing problem myself.	32%	11	44%	15	12%	4	3%	1	9%	3
I think that I can resolve the embarrassing problem myself.	18%	6	21%	7	21%	7	27%	9	15%	5
I struggle with finding professional help for the embarrassing problem.	6%	2	27%	9	27%	9	15%	5	27%	9

Barriers to help-seeking for embarrassing sexual problems	Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree	
	%	*N*	%	*N*	%	*N*	%	*N*	%	*N*
I forget to ask about the embarrassing problem during consultation with the general practitioner.	6%	2	24%	8	24%	8	15%	5	32%	11
I am waiting for the general practitioner to ask about the embarrassing problem.	9%	3	21%	7	21%	7	6%	2	44%	15
I have a comfortable professional relationship with the general practitioner.	27%	9	41%	14	21%	7	12%	4	0%	0
I have a trusting professional relationship with the general practitioner.	41%	14	32%	11	18%	6	9%	3	0%	0
I have a very close relationship with the general practitioner.	15%	5	9%	3	27%	9	24%	8	27%	9
I do not have a regular general practitioner.	47%	16	21%	7	3%	1	6%	2	24%	8
I think that the general practitioner does not have a positive attitude toward talking about the embarrassing problem.	9%	3	6%	2	27%	9	21%	7	38%	13
I think that the general practitioner is not able to communicate about the embarrassing problem.	6%	2	6%	2	18%	6	18%	6	53%	18
I want the general practitioner to be around the same age as I am when I have to consult them about the embarrassing problem.	0%	0	9%	3	21%	7	24%	8	47%	16
I want the general practitioner to be of the same sex/gender as I am when I have to consult them about the embarrassing problem.	35%	12	24%	8	6%	2	9%	3	27%	9
I think that consulting the general practitioner about the embarrassing problem is expensive.	3%	1	12%	4	12%	4	27%	9	47%	16
I do not want to bother the general practitioner with the embarrassing problem because the general practitioner has a high workload.	6%	2	21%	7	9%	3	18%	6	47%	16
When I consult the general practitioner about the embarrassing problem, then I have to talk to my partner about it too.	35%	12	9%	3	27%	9	15%	5	15%	5

Table 14.1. Logistic regression analysis on the relation between Three different problems and Not being properly informed about the problem by the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.900			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.219	0.749	1.244	0.326	4.756
Three different problems (pain with intercourse - other embarrassing problem)	-0.118	0.862	0.889	0.236	3.351
Constant	-2.234	0.000	0.107		

Table 14.2. Logistic regression analysis on the relation between recoded Three different problems and Not being properly informed about the problem by the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.900			

Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.219	0.749	0.804	0.210	3.071
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.336	0.652	0.714	0.165	3.085
Constant	-2.015	0.000	0.133		

Table 15.1. Logistic regression analysis on the relation between Three different problems and Trying to find out what the cause for the problem is

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.065			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.337	0.451	1.401	0.583	3.369
Three different problems (pain with intercourse - other embarrassing problem)	-0.901	0.068	0.406	0.154	1.070
Constant	-0.817	0.003	0.442		

Table 17.1. Logistic regression analysis on the relation between Three different problems and Having faith in the spontaneous resolving of the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.781			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-0.007	0.991	0.994	0.332	2.974
Three different problems (pain with intercourse - other embarrassing problem)	-0.363	0.509	0.695	0.237	2.043
Constant	-1.534	0.000	0.216		

Table 17.2. Logistic regression analysis on the relation between recoded Three different problems and Having faith in the spontaneous resolving of the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.781			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	0.007	0.991	1.007	0.336	3.013
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.357	0.570	0.700	0.205	2.396
Constant	-1.540	0.001	0.214		

Table 18.1. Logistic regression analysis on the relation between Three different problems and Not thinking that the problem is a serious problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.299			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.184	0.733	1.202	0.418	3.456
Three different problems (pain with intercourse - other embarrassing problem)	-0.817	0.187	0.442	0.131	1.488
Constant	-1.534	0.000	0.216		

Table 18.2. Logistic regression analysis on the relation between recoded Three different problems and Not thinking that the problem is a serious problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.299			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.184	0.733	0.832	0.289	2.392
Three different problems (pain with intercourse - other embarrassing sexual problem)	-1.001	0.137	0.367	0.098	1.375
Constant	-1.350	0.001	0.259		

Table 19.1. Logistic regression analysis on the relation between Three different problems and Being afraid that the problem is more severe than I thought

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.614			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-0.242	0.707	0.785	0.223	2.768
Three different problems (pain with intercourse - other embarrassing problem)	0.359	0.488	1.432	0.519	3.952
Constant	-1.773	0.000	0.170		

Table 19.2. Logistic regression analysis on the relation between recoded Three different problems and Being afraid that the problem is more severe than I thought

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.614			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	0.242	0.707	1.274	0.361	4.490
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.601	0.354	1.824	0.511	6.512
Constant	-2.015	0.000	0.133		

Table 20.1. Logistic regression analysis on the relation between Three different problems and Being insecure about my body

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.343			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-0.398	0.460	0.671	0.234	1.930
Three different problems (pain with intercourse - other embarrassing problem)	-0.755	0.153	0.470	0.167	1.325
Constant	-1.142	0.000	0.319		

Table 20.2. Logistic regression analysis on the relation between recoded Three different problems and Being insecure about my body

	B	*p*-value	OR	95% C.I. for OR

				Lower	Upper
Three different problems		0.343			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	0.398	0.460	1.489	0.518	4.282
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.357	0.570	0.700	0.205	2.396
Constant	-1.540	0.001	0.214		

Table 21.1. Logistic regression analysis on the relation between Three different problems and Having accepted the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.292			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.098	0.898	1.103	0.247	4.928
Three different problems (pain with intercourse - other embarrassing problem)	0.875	0.149	2.400	0.730	7.892
Constant	-2.434	0.000	0.088		

Table 21.2. Logistic regression analysis on the relation between recoded Three different problems and Having accepted the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.292			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.098	0.898	0.906	0.203	4.049
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.777	0.280	2.175	0.532	8.903
Constant	-2.335	0.000	0.097		

Table 22.1. Logistic regression analysis on the relation between Three different problems and Having no time to spend on caring for the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.417			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-1.435	0.189	0.238	0.028	2.022
Three different problems (pain with intercourse - other embarrassing problem)	-0.290	0.660	0.748	0.205	2.725
Constant	-2.061	0.000	0.127		

Table 22.2. Logistic regression analysis on the relation between recoded Three different problems and Having no time to spend on caring for the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.417			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	1.435	0.189	4.200	0.495	35.672
Three different problems (pain with intercourse - other embarrassing sexual problem)	1.145	0.316	3.143	0.335	29.470
Constant	-3.497	0.001	0.030		

Table 24.1. Logistic regression analysis on the relation between Three different problems and Not thinking that the general practitioner can help with the embarrassing problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.504			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.693	0.265	2.000	0.591	6.768
Three different problems (pain with intercourse - other embarrassing problem)	0.516	0.385	1.675	0.523	5.368
Constant	-2.234	0.000	0.107		

Table 24.2. Logistic regression analysis on the relation between recoded Three different problems and Not thinking that the general practitioner can help with the embarrassing problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.504			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.693	0.265	0.500	0.148	1.692
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.177	0.771	0.838	0.254	2.763
Constant	-1.540	0.001	0.214		

Table 25.1. Logistic regression analysis on the relation between Three different problems and Finding it difficult to talk about the embarrassing problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.217			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.699	0.112	2.012	0.849	4.769
Three different problems (pain with intercourse - other embarrassing problem)	-0.010	0.981	0.990	0.433	2.267
Constant	-0.817	0.003	0.442		

Table 25.2. Logistic regression analysis on the relation between recoded Three different problems and Finding it difficult to talk about the embarrassing problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.217			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.699	0.112	0.497	0.210	1.178
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.709	0.131	0.492	0.196	1.236
Constant	-0.118	0.732	0.889		

Table 26.1. Logistic regression analysis on the relation between Three different problems and Talking about the problem with others whom are not health professionals

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.081			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-1.848	0.085	0.158	0.019	1.289
Three different problems (pain with intercourse - other embarrassing problem)	0.491	0.315	1.634	0.627	4.258
Constant	-1.649	0.000	0.192		

Table 27.1. Logistic regression analysis on the relation between Three different problems and Being afraid of stigma associated with the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.687			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.233	0.687	1.262	0.408	3.906
Three different problems (pain with intercourse - other embarrassing problem)	-0.331	0.578	0.718	0.224	2.306
Constant	-1.773	0.000	0.170		

Table 27.2. Logistic regression analysis on the relation between recoded Three different problems and Being afraid of stigma associated with the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.687			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.233	0.687	0.792	0.256	2.453
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.564	0.388	0.569	0.158	2.048
Constant	-1.540	0.001	0.214		

Table 28.1. Logistic regression analysis on the relation between Three different problems and Trying to manage the problem myself

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.629			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-0.346	0.441	0.708	0.294	1.706
Three different problems (pain with intercourse - other embarrassing problem)	-0.334	0.412	0.716	0.322	1.591
Constant	-0.392	0.130	0.676		

Table 28.2. Logistic regression analysis on the relation between recoded Three different problems and Trying to manage the problem myself

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.629			

Three different problems (other embarrassing problem - other embarrassing sexual problem)	0.346	0.441	1.413	0.586	3.405
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.012	0.981	1.012	0.393	2.607
Constant	-0.738	0.044	0.478		

Table 29.1. Logistic regression analysis on the relation between Three different problems and Thinking that I can resolve the problem myself

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.934			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-0.007	0.991	0.994	0.332	2.974
Three different problems (pain with intercourse - other embarrassing problem)	-0.184	0.728	0.832	0.296	2.343
Constant	-1.534	0.000	0.216		

Table 29.2. Logistic regression analysis on the relation between recoded Three different problems and Thinking that I can resolve the problem myself

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.934			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	0.007	0.991	1.007	0.336	3.013
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.177	0.771	0.838	0.254	2.763
Constant	-1.540	0.001	0.214		

Table 30.1. Logistic regression analysis on the relation between Three different problems and Struggling with finding professional help for the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.727			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-0.339	0.695	0.713	0.131	3.885
Three different problems (pain with intercourse - other embarrassing problem)	0.329	0.620	1.390	0.378	5.116
Constant	-2.434	0.000	0.088		

Table 30.2. Logistic regression analysis on the relation between recoded Three different problems and Struggling with finding professional help for the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.727			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	0.339	0.695	1.404	0.257	7.652
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.668	0.442	1.951	0.355	10.721
Constant	-2.773	0.000	0.063		

Table 32.1. Logistic regression analysis on the relation between Three different problems and Waiting for the general practitioner to ask about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.194			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.339	0.670	1.403	0.295	6.672
Three different problems (pain with intercourse - other embarrassing problem)	1.116	0.085	3.053	0.859	10.848
Constant	-2.674	0.000	0.069		

Table 32.2. Logistic regression analysis on the relation between recoded Three different problems and Waiting for the general practitioner to ask about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.194			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.339	0.670	0.713	0.150	3.389
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.777	0.280	2.175	0.532	8.903
Constant	-2.335	0.000	0.097		

Table 33.1. Logistic regression analysis on the relation between Three different problems and Not having a comfortable professional relationship with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.962			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-19.141	0.998	0.000	0.000	.
Three different problems (pain with intercourse - other embarrassing problem)	0.164	0.782	1.179	0.368	3.775
Constant	-2.061	0.000	0.127		

Table 33.2. Logistic regression analysis on the relation between recoded Three different problems and Not having a comfortable professional relationship with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.962			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	19.141	0.998	205605761.739	0.000	.
Three different problems (pain with intercourse - other embarrassing sexual problem)	19.306	0.998	242321076.336	0.000	.
Constant	-21.203	0.998	0.000		

Table 34.1. Logistic regression analysis on the relation between Three different problems and Not having a trusting professional relationship with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.340			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-18.224	0.998	0.000	0.000	.
Three different problems (pain with intercourse - other embarrassing problem)	1.082	0.142	2.950	0.697	12.487
Constant	-2.979	0.000	0.051		

Table 34.2. Logistic regression analysis on the relation between recoded Three different problems and Not having a trusting professional relationship with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.340			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	18.224	0.998	82142835.455	0.000	.
Three different problems (pain with intercourse - other embarrassing sexual problem)	19.306	0.998	242321364.591	0.000	.
Constant	-21.203	0.998	0.000		

Table 35.1. Logistic regression analysis on the relation between Three different problems and Having a very close relationship with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.272			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	1.221	0.110	3.391	0.758	15.178
Three different problems (pain with intercourse - other embarrassing problem)	0.875	0.249	2.398	0.543	10.597
Constant	-2.979	0.000	0.051		

Table 35.2. Logistic regression analysis on the relation between recoded Three different problems and Having a very close relationship with the general practitioner

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.272			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-1.221	0.110	0.295	0.066	1.320
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.346	0.609	0.707	0.188	2.668
Constant	-1.758	0.000	0.172		

Table 37.1. Logistic regression analysis on the relation between Three different problems and Thinking that the general practitioner does not have a positive attitude toward talking about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.725			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.339	0.670	1.403	0.295	6.672
Three different problems (pain with intercourse - other embarrassing problem)	-0.417	0.639	0.659	0.115	3.763
Constant	-2.674	0.000	0.069		

Table 37.2. Logistic regression analysis on the relation between recoded Three different problems and Thinking that the general practitioner does not have a positive attitude toward talking about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.725			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.339	0.670	0.713	0.150	3.389
Three different problems (pain with intercourse - other embarrassing sexual problem)	-0.756	0.423	0.470	0.074	2.979
Constant	-2.335	0.000	0.097		

Table 38.1. Logistic regression analysis on the relation between Three different problems and Thinking that the general practitioner is not able to communicate about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.828			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.629	0.539	1.875	0.252	13.943
Three different problems (pain with intercourse - other embarrassing problem)	-17.802	0.998	0.000	0.000	.
Constant	-3.401	0.000	0.033		

Table 38.2. Logistic regression analysis on the relation between recoded Three different problems and Thinking that the general practitioner is not able to communicate about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.828			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.629	0.539	0.533	0.072	3.966
Three different problems (pain with intercourse - other embarrassing sexual problem)	-18.430	0.998	0.000	0.000	.
Constant	-2.773	0.000	0.063		

Table 39.1. Logistic regression analysis on the relation between Three different problems and Wanting the general practitioner to be around the same age as I am when I have to consults them about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.948			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-17.802	0.998	0.000	0.000	.
Three different problems (pain with intercourse - other embarrassing problem)	-0.405	0.744	0.667	0.059	7.583
Constant	-3.401	0.000	0.033		

Table 39.2. Logistic regression analysis on the relation between recoded Three different problems and Wanting the general practitioner to be around the same age as I am when I have to consults them about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.948			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	17.802	0.998	53849164.978	0.000	.
Three different problems (pain with intercourse - other embarrassing sexual problem)	17.396	0.998	35899443.319	0.000	.
Constant	-21.203	0.998	0.000		

Table 40.2. Logistic regression analysis on the relation between recoded Three different problems and Wanting the general practitioner to be of the same sex/gender as I am when I have to consult them about the problem

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.042			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.536	0.250	0.585	0.235	1.457
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.519	0.264	1.681	0.676	4.178
Constant	-0.606	0.091	0.545		

Table 41.1. Logistic regression analysis on the relation between Three different problems and Thinking that consulting the general practitioner about the problem is expensive

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.374			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	-1.263	0.252	0.283	0.033	2.453
Three different problems (pain with intercourse - other embarrassing problem)	-0.857	0.308	0.424	0.082	2.205
Constant	-2.234	0.000	0.107		

Table 41.2. Logistic regression analysis on the relation between recoded Three different problems and Thinking that consulting the general practitioner about the problem is expensive

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.374			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	1.263	0.252	3.536	0.408	30.667
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.405	0.745	1.500	0.130	17.253
Constant	-3.497	0.001	0.030		

Table 42.1. Logistic regression analysis on the relation between Three different problems and Not wanting to bother the general practitioner with the problem because the general practitioner has a high workload

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.474			
Three different problems (other embarrassing sexual problem - other embarrassing problem)	0.206	0.826	1.229	0.195	7.741
Three different problems (pain with intercourse - other embarrassing problem)	0.875	0.249	2.398	0.543	10.597
Constant	-2.979	0.000	0.051		

Table 42.2. Logistic regression analysis on the relation between recoded Three different problems and Not wanting to bother the general practitioner with the problem because the general practitioner has a high workload

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.474			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.206	0.826	0.814	0.129	5.124
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.668	0.442	1.951	0.355	10.721
Constant	-2.773	0.000	0.063		

Table 43.2. Logistic regression analysis on the relation between recoded Three different problems and When I consult the general practitioner about the problem, then I have to talk to my partner about it too

	B	*p*-value	OR	95% C.I. for OR	
				Lower	Upper
Three different problems		0.015			
Three different problems (other embarrassing problem - other embarrassing sexual problem)	-0.821	0.088	0.440	0.171	1.131
Three different problems (pain with intercourse - other embarrassing sexual problem)	0.432	0.353	1.540	0.619	3.833
Constant	-0.606	0.091	0.545		

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