

## Article

# Dyadic Satisfaction and Shared Affectivity Are Associated with Psycho-Sexual Functioning in Elderly Men and Women

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**Abstract:** Objectives The quality of sexual life of elderly people represents an understudied topic of sexual medicine and of psycho-sexology. Hence, we aimed to evaluate the association of specific psycho-relational variables, such as intimacy, increased affective gestures towards a partner (AGtP), daily shared activities, and dyadic satisfaction, with the psychosexual wellbeing of elderly people, expressed in terms of sexual satisfaction. Methods: A cohort of elderly people was selected from a sample of a broader study evaluating the role of sexual activity in protecting the emotional wellbeing of a population subjected to quarantine due to the COVID-19 pandemic. Specifically, the presence of sexual dysfunctions, the emotional wellbeing (i.e., absence of anxiety and/or depression), and the quality of the partners' relationships were studied. For the study's purpose, the Sexual Health Inventory for Males (SHIM), the Female Sexual Function Index (FSFI), the Orgasmometer and the Orgasmometer-F, the Generalized Anxiety Disorder scale (GAD-7), the Patient Health Questionnaire (PHQ-9), and the Dyadic Adjustment Scale were adopted. Results: A group of 124 elderly subjects ( $\geq 60$ ) was selected for the study's purposes. Among these, 84% were males (120/124), and 16% were females (20/124). All the subjects declared to be in a stable relationship and to be sexually active during the first lockdown period. Gender differences were found for the Dyadic Satisfaction subscale (males:  $37.04 \pm 6.57$ ; females:  $32.85 \pm 10.04$ ;  $p < 0.05$ ) and the Orgasmometer (males:  $7.64 \pm 1.30$ ; females:  $6.60 \pm 2.46$ ;  $p < 0.01$ ). Linear regression analysis showed the association between higher Orgasmometer scores and: (i) the absence of sexual dysfunctions ( $\beta = -1.213$ ;  $SE = 0.271$ ;  $p < 0.0001$ ), (ii) higher dyadic satisfaction ( $\beta = 0.042$ ;  $SE = 0.019$ ;  $p < 0.05$ ), and (iii) reduced shared activities with partner ( $\beta = -0.463$ ;  $SE = 0.143$ ;  $p < 0.01$ ) and increased affective gestures towards partner (DAS measured AGtP) ( $\beta = 0.595$ ;  $SE = 0.065$ ;  $p < 0.0001$ ). Post hoc analysis of ANCOVA with the Bonferroni correction method showed a significant difference in the Orgasmometer scores between subjects with and without sexual dysfunction (mean difference: 2.102;  $SE = 0.340$ ;  $p_{\text{Bonf}} < 0.001$ ), with healthy subjects reporting higher scores compared to dysfunctional ones. Conclusions: It is reasonable to suppose that, beyond the presence of sexual dysfunctions, the sexual health of elderly people may benefit from the quality of the relationship, and, specifically, from the presence of affective gestures towards the partner and the dyadic satisfaction. To the contrary, the quantity of time spent together, sharing specific activities, may be considered a factor worsening relational and sexual health. These data should be considered during the evaluation of sexual health among elderly people.

**Keywords:** elderly people; sexual health; affectivity and intimacy; dyadic satisfaction



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## 1. Introduction

Although sexual wellbeing is a pivotal aspect of general health, studies in the literature evaluating this aspect in a specific population of elderly people are either lacking or are prevalently oriented towards the individuation of sexual dysfunctions. In fact, these studies are characterized by the adoption of a medical model perspective, which defines a disease following a categorical approach. Therefore, many biological and medical studies attempt to define sexuality in elderly people considering only what is well-functioning or dysfunctional, for instance, aspects due to the presence of specific risk factors, or the inevitable results of the ageing process. An example of this is the milestone study by Feldman and colleagues [1], which demonstrated that erectile dysfunction (ED) is strictly connected with ageing. On the contrary, the body of research about female sexuality is largely oriented towards the evaluation of sexual functioning in relation to specific life stressors, such as abortion, sexual assault and harassment, or sexual desirability, intended as the attempts of the woman to overcome the inevitable physiological changes in the body to maintain the ability to be still considered a sexual being [2,3]. Obviously, for many of these themes, older women cannot be considered an adequate study population. More recently, an effort towards the understanding of sexual functioning in elderly women has been made. Several studies have started to evaluate general sexual functioning in post-menopausal women [4], also demonstrating interest in studying sexuality, and, specifically, coital pain due to vulvo-vaginal atrophy (VVA) following a multifactorial perspective and the biopsychosocial model of interpretation. Unfortunately, ageist stereotypes and beliefs still play an essential role not only in social setting, but also in research [5].

The link between psycho-emotional and relational wellbeing and sexual life is well known. Life stressors, traumas, and the consequent development of emotional problems or psychopathological conditions, together with the perceived quality of the partners' relationships, worsen sexual life across the ages [6–11]. Even more, with the advent of seniority, negative life experiences, such as widowhood, and the higher risk to have organic complications [12] may inevitably worsen emotional wellbeing and sexuality [13]. For this reason, it is surprising that research until today has not studied the relationship between sexual and emotional wellbeing, and the relationship between the quality of dyadic adjustment and sexual functioning in old age. If a general and solid interpretation of the multifactorial impact of specific variables on sexuality exists, among which are hormonal, social, psychological, physical, and relational ones [14–18], it is also clear that quantitative data are, in this regard, lacking.

Based on previous research evidence [19], we hypothesize that psychological nearness and the quality of the relationship may protect elderly people from negative repercussions on psychosexual wellbeing due to the COVID-19 lockdown.

Hence, the main aim of this study was to evaluate the association between some psycho-relational variables, among which are the quality of the dyadic adjustment, the nearness of the partners, and the everyday sharing of the activities, on the sexuality of elderly people. Specifically, the dependent variable of this study was the ability to perceive orgasmic intensity, considered as one of the possible indicators of sexual satisfaction, and the independent variables were “daily shared activities” (DSAs), “affective gestures towards partner” (AGtP), “anxiety”, “depression”, “dyadic satisfaction”, and “presence of sexual dysfunction”.

## 2. Methods

A cohort of elderly people, defined, partly based on the international criteria proposed by the World Health Organization (WHO) [20], as those with an age  $\geq 60$ , was extrapolated from the XXX study, a previous research project of our group dedicated to the study of the psycho-emotional and sexual wellbeing of people during the first lockdown, which happened in the period from March to the last weeks of April 2020 [19]. A brief description of the methodology and of the inclusion/exclusion criteria are presented in Appendix A.

The decision to consider a broader interpretation of elderly people with respect to that proposed by the WHO has been made due to the physiological evidence of a decline in sexual functioning from the age of 60 or higher [21].

The study protocol was built in accordance with the relevant ethical regulations. The institutional ethics committee of the XXX approved the protocol. Each subject spontaneously and voluntarily participated in the research, also giving written informed consent.

For the measures, psycho-emotional wellbeing was evaluated with the Generalized Anxiety Disorder scale (GAD-7) [22] and with the Patient Health Questionnaire (PHQ-9) [23] for generalized anxiety and depression, respectively. As a recall period, both questionnaires adopted the last two weeks before fulfilment of the questionnaire.

The GAD-7 is a brief, validated, and standardized tool assessing the presence of generalized anxiety in several conditions. The evaluation of anxiety is quantified with a Likert scale ranging from 0 (“not at all”) to 3 (“nearly every day”). A cut-off score of  $\geq 10$  indicates the presence of clinically relevant anxiety.

The PHQ-9 is a self-reported, validated, and standardized tool consisting of 9 items evaluating the presence of depression with a Likert scale ranging from 0 (“not at all”), to 3 (“nearly every day”). Again, a cut-off score of  $\geq 10$  indicates the presence of clinically relevant depression.

The actual quality of relationship was evaluated through the Dyadic Adjustment Scale (DAS) [24]. This tool comprises 32 items, which are gathered in four subscales: Dyadic Consensus, Dyadic Satisfaction, Dyadic Cohesion, and Affection Expression. Each subscale score can be used independently of the other subscales, or together. The overall score indicates the global dyadic adjustment.

The evaluation of male sexuality over the preceding six months was performed with the Sexual Health Inventory for Men (SHIM, or IIEF-5) [25,26].

Self-perceived orgasmic intensity was assessed by the male version of the Orgasmometer, a single-item Likert scale, derived from a visual analog scale for pain. This tool assesses the subjective perception of the intensity of the orgasmic experience, with a score ranging from 1 (lowest intensity) to 10 (maximum intensity) [27]. The recall period refers to the four weeks preceding the evaluation.

For the evaluation of female sexual functioning, the Female Sexual Function Index (FSFI) was adopted [28]. This tool, composed of 19 items with 6 possible responses, gathered in six domains, evaluates the phases of the female sexual response cycle over the preceding four weeks. The total cut-off of 26.5 is considered the best predictive value able to distinguish between the presence/absence of female sexual dysfunction. The subjective perception of female orgasmic intensity was assessed with the female version of the Orgasmometer (Orgasmometer-F) [29]. As with its male counterpart, this one-item tool can quantify orgasmic intensity, associated with clitoral or vaginal stimulation, ranging from 1 (lowest intensity) to 10 (the maximum level of intensity).

### 3. Statistical Analysis

The Shapiro–Wilk test was adopted to reject the null hypothesis, and normal distribution of the variables was obtained. A  $p$  value greater than 0.05 was considered as an efficient value for the normal distribution of the data. Normally distributed data were represented as means and standard deviations. Non-normally distributed variables were represented as medians with a 95% confidence interval and a  $\pm 5\%$  margin of error. Dichotomous variables were condensed as frequencies. The Student’s  $t$ -test, Mann–Whitney test, or Chi-squared test were adopted for the comparison of means, medians, or frequencies, respectively.

A linear regression model was adopted to assess the association between the Orgasmometer (as the dependent variable) and demographic and psycho-relational variables.

One-way analysis of covariance (ANCOVA) was performed to assess differences in the Orgasmometer between subjects with and without sexual dysfunction, based on gender, age, BMI, DSAs, AGtP, anxiety, depression, and dyadic satisfaction as covariates. Post hoc analysis was performed considering the Bonferroni correction.

All statistical analyses were performed with the SPSS® statistical analysis software package, version 19.0 (SPSS Inc., Chicago, IL, USA)

#### 4. Results

Descriptive data retrieved from the 124 subjects included in the study are reported in Table 1. Based on gender, the distribution of subjects is strongly unbalanced, with 104 males and only 20 females engaged in a romantic relationship and sexually active at the time of data collecting. More than half of the study sample came from Northern Italy (58.9%), with no significant gender difference ( $p = 0.3$ ). Male and female groups differed significantly regarding mean age (males:  $65.4 \pm 4.4$  years; females:  $62.6 \pm 3.4$  years;  $p < 0.05$ ) and BMI (males:  $25.8 \pm 3.1$  kg/m<sup>2</sup>; females:  $22.5 \pm 2.4$  kg/m<sup>2</sup>;  $p < 0.0001$ ).

**Table 1.** Sample characteristics and univariate comparisons between the male and female subjects of the study sample.

Variable	Overall (N = 124)	Males (N = 104)	Females (N = 20)	Statistics	Effect Size (d or V)
Age	64.98 ± 4.36	65.43 ± 4.39	62.65 ± 3.38	t = 2.681 *	d = 0.65
BMI	25.31 ± 3.24	25.84 ± 3.11	22.53 ± 2.45	t = 4.484 **	d = 1.09
<b>Geographic Area</b>					
North Italy	73 (58.9%)	62 (59.6%)	11 (55.0%)	$\chi^2_3 = 2.03$	
Central Italy	24 (19.4%)	18 (17.3%)	6 (30.0%)		
South Italy	20 (16.1%)	18 (17.3%)	2 (10.0%)		
Outside Italy	7 (5.6%)	6 (5.8%)	1 (5.0%)		
<b>Relational Status</b>					
Engaged	12 (9.7%)	11 (10.6%)	6 (30.0%)	$\chi^2_2 = 0.76$	
Cohabitant	20 (16.1%)	16 (15.4%)	4 (20.0%)		
Married	92 (74.2%)	77 (74.0%)	15 (75.0%)		
<b>Education</b>					
Secondary	44 (35.4%)	38 (36.6%)	6 (30.0%)	$\chi^2_1 = 0.40$	
Graduate	80 (64.6%)	66 (63.4%)	14 (70.0%)		
<b>Daily shared activities</b>					
Strongly decreased	9 (7.3%)	8 (7.7%)	1 (5.0%)	$\chi^2_4 = 5.66$	
Decreased	7 (5.6%)	7 (6.7%)	0		
Unchanged	41 (33.0%)	37 (35.6%)	4 (20.0%)		
Increased	58 (46.8%)	44 (42.3%)	14 (70.0%)		
Strongly decreased	9 (7.3%)	8 (7.7%)	1 (5.0%)		
<b>Affective gestures towards partner</b>					
Strongly decreased	10 (8.1%)	8 (7.7%)	2 (10.0%)	$\chi^2_4 = 1.01$	
Decreased	11 (8.9%)	9 (8.6%)	2 (10.0%)		
Unchanged	62 (50.0%)	54 (51.9%)	8 (40.0%)		
Increased	35 (28.2%)	28 (26.9%)	7 (35.0%)		
Strongly decreased	6 (4.8%)	5 (4.8%)	1 (5.0%)		

\*  $p < 0.05$ , \*\*  $p < 0.0001$ .

No statistically significant difference was found among groups in relational and educational status, as well as in changes during the lockdown period in daily shared activities (DSAs) and affective gestures towards partner (AGtP).

Table 2 shows clinical outcomes and statistical differences between gender groups. Both groups presented similar levels of anxiety and depression, while males had better scores in the Dyadic Satisfaction subscale (males:  $37 \pm 6.6$ ; females:  $32.8 \pm 10$ ;  $p < 0.05$ ) and the Orgasmometer (males:  $7.6 \pm 1.3$ ; females:  $6.6 \pm 2.5$ ;  $p < 0.01$ ) raw scores. Prevalence of

sexual dysfunction assessed with SHIM and FSFI, for men and women, respectively, was 33.8%, with no gender difference in the distribution.

**Table 2.** Clinical outcomes and univariate comparisons between male and female subjects of the study sample.

Variable	Overall (N = 124)	Males (N = 104)	Females (N = 20)	Statistics	Effect Size (d or V)
	n (%) / mean ± SD	n (%) / mean ± SD	n (%) / mean ± SD		
Depression <sup>a</sup>	3.79 ± 3.46	3.61 ± 3.12	4.75 ± 4.88	t = −1.358	
Anxiety <sup>b</sup>	3.89 ± 3.40	3.62 ± 2.94	5.25 ± 5.06	t = −1.983	
Dyadic Satisfaction <sup>c</sup>	36.36 ± 7.36	37.04 ± 6.57	32.85 ± 10.04	t = 2.375 *	d = 0.58
Male Sexual Health <sup>d</sup>		21.24 ± 3.85			
Female Sexual Health <sup>e</sup>			26.89 ± 7.76		
Orgasmic Intensity <sup>f</sup>	7.48 ± 1.58	7.64 ± 1.30	6.60 ± 2.46	t = 2.780 **	d = 0.68

<sup>a</sup> Patient Health Questionnaire-9; <sup>b</sup> General Anxiety Disorder-7; <sup>c</sup> Dyadic Satisfaction Subscale of Dyadic Adjustment Scale (satisfaction subscale scores: range 0–39; cohesion subscale scores: range 0–24); <sup>d</sup> Sexual Health Inventory for Males-7; <sup>e</sup> Female Sexual Function Index-9; <sup>f</sup> male and female Orgasmometer \*  $p < 0.05$  \*\*  $p < 0.01$ .

Due to the little size of the female group, we decided to assess only the Orgasmometer as the dependent variable. The results from linear regression are summarized in Table 3. Higher Orgasmometer scores were found in subjects without sexual dysfunction ( $\beta = -1.2$ ; SE = 0.3;  $p < 0.0001$ ), independent of gender ( $p = 0.2$ ), age ( $p = 0.9$ ), BMI ( $p = 0.8$ ), or psychopathological status (depression:  $p = 0.2$ ; anxiety:  $p = 0.5$ ). Moreover, higher Orgasmometer scores were present in subjects who reported a higher dyadic satisfaction ( $\beta = 0.04$ ; SE = 0.02;  $p < 0.05$ ), who reduced shared activities with their partner ( $\beta = -0.5$ ; SE = 0.1;  $p < 0.01$ ) and had increased affective gestures towards their partner ( $\beta = 0.6$ ; SE = 0.06;  $p < 0.0001$ ). The regression model result was significant ( $p < 0.0001$ ) and explained a considerable proportion of variance (adjusted  $R^2 = 0.3$ ).

**Table 3.** Results of the linear regression for the Orgasmometer scores in the study sample.

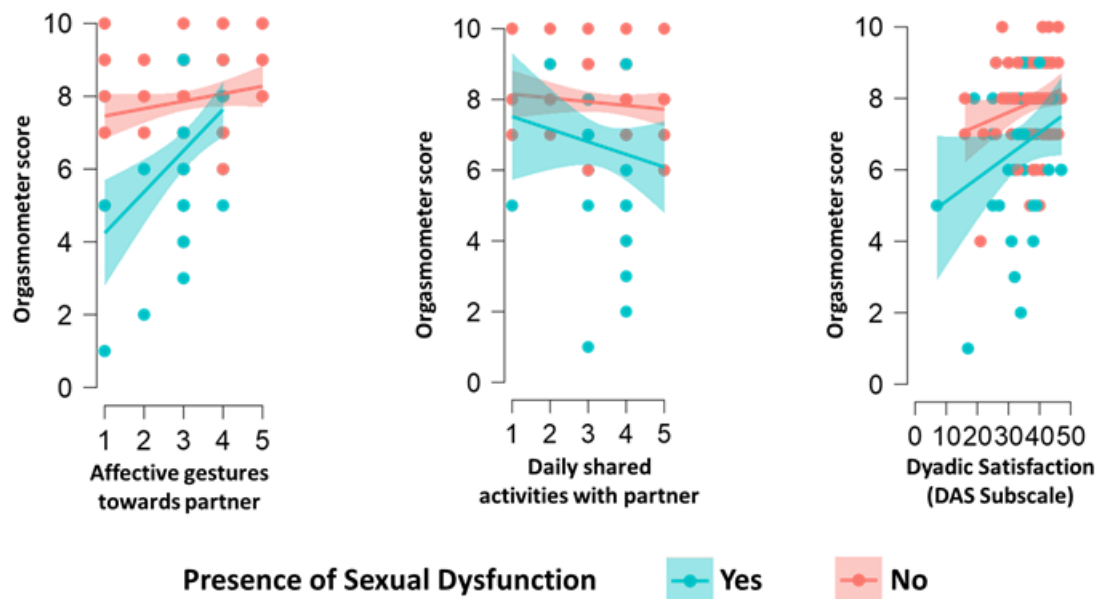
Orgasmometer Scores	$\beta$	SE	$p$	$\eta^2$
(Intercept)	3.818	2.598	0.144	
Presence of sexual dysfunction	−1.213	0.271	<0.0001	0.19
Female gender	−0.470	0.377	0.215	0.03
Age	0.028	0.030	0.958	0.01
BMI	0.033	0.042	0.786	0.00
Daily shared activities with partner	−0.463	0.143	0.002	0.05
Affective gestures towards partner	0.595	0.065	<0.0001	0.07
Depression	−0.088	0.065	0.181	0.01
Anxiety	−0.049	0.067	0.466	0.00
Dyadic satisfaction	0.042	0.019	0.03	0.02

Adjusted R-squared: 0.303, F: 6.94,  $p < 0.0001$

Post hoc analysis of ANCOVA conducted with the Bonferroni correction method highlighted a statistically significant difference in the Orgasmometer scores between subjects with and without sexual dysfunction (mean difference: 2.1; SE = 0.3;  $p_{\text{Bonf}} < 0.001$ ), with healthy subjects reporting higher scores compared to dysfunctional ones. A between-gender statistical difference was found only in the comparison of subjects suffering from sexual dysfunction (mean difference: 2.1; SE = 0.5;  $p_{\text{Bonf}} < 0.001$ ), with males reporting higher scores compared to females.

Three descriptive plots of ANCOVA are summarized in Figure 1. As shown, a higher increment of affective gestures towards partner is associated with higher Orgasmometer scores. In contrast, a higher increment of daily shared activities with partner is associ-

ated with lower Orgasmometer scores. Finally, higher scores in the “Dyadic Satisfaction” subscale of DAS are associated with better Orgasmometer scores.



**Figure 1.** The relationship between Orgasmometer scores and specific variables according to AN-COVA analysis (the boundaries for the colored areas surrounding the lines represent standard errors, (SE)).

## 5. Discussion

To the best of our knowledge, this is the first study demonstrating the association of the dyadic adjustment, and, specifically, of the dyadic satisfaction and the presence of affective gestures towards partner (AGtP) with the ability to experience orgasmic pleasure, and, in general, with the sexual satisfaction of elderly people. In this context we suppose, in fact, that the ability to experience orgasmic pleasure may be interpreted, in some measure, as hypothetical index of sexual health, and, hence, of sexual satisfaction. This result is also associated with the presence/absence of sexual dysfunction. In fact, elderly people suffering from sexual dysfunction showed lower scores in perceived orgasmic intensity. In addition, our data showed that everyday shared activities may represent a factor limiting orgasmic intensity. These data, however, may be considered a result of our interpretation. In fact, we must consider that our population has been evaluated during the first lockdown, where, due to the necessity to prevent COVID-19 infection, people were invited to stay at home. In this situation, it is reasonable to suppose that “forced” cohabitation and shared activities may have contributed to a negative sexual wellbeing, rather than to an improved one. Future data will be necessary to better understand the relationship between everyday shared activities and orgasmic experience.

These data appear particularly important for several reasons. Firstly, our study shows that, during old age, other aspects rather than physiological ones may play a role in determining psychosexual wellbeing. Among these aspects, the affective proximity seems to be able to bridge the physical difficulties related to the inevitable age-related decline in body performance [1,12,30,31], allowing elderly people to experience sexual pleasure and satisfaction. If, on one hand, a broader literature exists on the negative impact of physiological changes on sexual functioning [32,33] or of lifestyle comorbidities affecting sexual health [7,34,35], on the other hand, little attention has been paid towards the importance of other psycho-relational variables in determining the “functioning” of the elderly person during sexual activity [36]. In fact, contrary to the common occidental point of view regarding the sole existence of penetrative sexual activity [37,38], especially for elderly people, or people belonging to populations with specific needs, such as people affected

by intellectual or physical disabilities [39], a broader consideration of sexual activity as an activity characterized by many other behaviours seems to be the best way of thinking. Following this consideration, Muller and colleagues elegantly demonstrated the validity of the so-called “second language of sexuality”, that is, the importance of affection for the couple’s satisfaction [40]. These authors, in fact, showed that satisfaction for the relationship can be predicted, for both males and females, by the importance of affection. Hence, the second language of sexuality may be considered the language of nearness, and of the cohesion, rather than that of the sexual performance.

Another interesting study pointed attention towards specific variables bearing on the relationship happiness and sexual satisfaction of middle-aged and elderly people [36]. The authors found significant gender differences concerning both relationship and sexual satisfaction. For men, relationship satisfaction depended on health, physical intimacy, and sexual functioning. For women, contrary to the common thinking, only sexual functioning predicted relationship satisfaction. Sexual satisfaction was determined by physical intimacy and sexual functioning for both genders. In addition, for men, the frequency of sexual activity played a role in sexual satisfaction, while for women, the duration of the relationship was inversely associated with sexual satisfaction. This last aspect also partly confirms our finding about the negative impact of the time spent together as a couple on the orgasmic intensity, considered as the expression of sexual satisfaction and pleasure. In a similar way, another study focused attention on the factors bearing on the sexual functioning of older women, where, in comparison to younger or adult women, older women reported lower levels of distress due to sexual problems and higher levels of indifference to sexual activity [41].

These data could be interpreted as the result of a gap between male and female sexuality, which manifests itself more strongly during old age. The social male gender stereotype about sexual performance may stigmatize old men, inducing them to follow the medical perspective of a “rehabilitation” of sexual functioning, expressed as the ability to maintain a valid erection, beyond the physiological changes. On the contrary, persisting in the search for male sexual performance, the relational and affective aspects may become less central and important for the quality of the relationship. Hence, the absence of these elements in the couple may lead women to develop indifference towards sexuality, perceived also as a non-distressing result. So, what we can conclude based on our data, is that studies investigating the sexuality of elderly people should not disregard other psychological and relational aspects, which can be necessary for the experience of sexual pleasure and sexual satisfaction. This information also seems to be fundamental for the clinical and the pre-clinical context. In the first case, the presence of sexual difficulties and of sexual distress may be overcome during psycho-sexological treatment, with a focus on the quality of the relationship and on the psychoeducation promoting the awareness that sexual activity may have several interpretations. In the second case, the so-called pre-clinical condition, these data may be helpful to improve communication between the partners and to avoid the “alpha male stereotype”, instead promoting the objectives of intimacy and affection. Obviously, these aims may be achieved with an appropriate formal education included in health professional training curricula [42], and with a valid awareness of referral and treatment options.

This study presents some limits. The first limit is related to the low sample size and to the strong imbalance in the “gender” variable. It is also likely that the online methodology used for data collection during the first national COVID-19 lockdown could have limited participation from non-tech-savvy elderly people. For this reason, our findings must be interpreted cautiously, and the conclusion must be intended as preliminary. Unfortunately, since this study had an observational nature, we could not select specific demographic variables for our sample. Surely, future studies must bridge this significant gap.

## 6. Conclusions

This is the first study demonstrating that orgasmic intensity and, hence, sexual pleasure and satisfaction may be directly linked to dyadic satisfaction and to the presence of affective gestures towards the partner (AGtP). On the contrary, the time spent together with the partner may represent an important limitation. Hence, the quality, rather than the quantity, of the relationship may contribute to the psychosexual health of elderly people. These aspects must be considered as the main goals of the psycho-educational campaigns promoting sexual health in elderly people.

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**Institutional Review Board Statement:** The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee “Comitato Etico del Dipartimento di Psicologia Dinamica e Clinica, University Sapienza of Rome, Rome, Italy (Prot. n. 0000593; 10/07/2020—[UOR: SI000092—Classif. VII/15]).

**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

**Data Availability Statement:** The data presented in this study are available exclusively on request from the corresponding author. The data are not publicly available due to specific restrictions (privacy of subjects).

**Conflicts of Interest:** The authors declare no conflict of interest.

## Appendix A

Due to specific characteristics of the lockdown and of the consequent social isolation, a web-based recruitment modality was considered the best and unique strategy to perform this study. Hence, self-reported questionnaires that included several demographic information and psychometric and sexological measures were uploaded to a dedicated website. Among the inclusion criteria we considered were: age > 18 years, presence of sexual activity during lockdown period, ability to give informed consent, and ability to complete each part of the questionnaire. The website was advertised through social media, radio broadcasts, and interviews in national newspapers.

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