

# Lack of sex bias in the referral letters for patients with inflammatory bowel disease: a mixed methods evaluation

Sunil Samnani<sup>1</sup>, Yasmin Nasser<sup>2,3</sup>, Gurprit Girm<sup>4</sup>, Huneza Nadeem<sup>3</sup>, Laura Targownik<sup>5</sup>, Shannon M. Ruzicky<sup>3,6,\*</sup>

<sup>1</sup>Department of Medicine, Faculty of Health Sciences, McMaster University, Hamilton, ON L8S 4L8,

<sup>2</sup>Snyder Institute for Chronic Diseases, Cumming School of Medicine, University of Calgary, Calgary, AB, T2N 1N4,

<sup>3</sup>Department of Medicine, Cumming School of Medicine, University of Calgary, Calgary, AB, T2N 1N4, Canada,

<sup>4</sup>Department of Surgery, Cumming School of Medicine, University of Calgary, Calgary, AB, T2N 1N4, Canada,

<sup>5</sup>Department of Medicine, Temerty School of Medicine, University of Toronto, Toronto, ON, M5R 0A3, Canada,

<sup>6</sup>Department of Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, AB T2N 1N4, Canada

\*Corresponding author: Shannon M. Ruzicky, Room 1422, Health Sciences Center, 3330 Hospital Drive NW, Calgary, AB T2N 2T9, Canada ([shannon.ruzicky@ucalgary.ca](mailto:shannon.ruzicky@ucalgary.ca)).

## Abstract

**Introduction:** Women with inflammatory bowel disease (IBD) experience greater delays and misdiagnosis than men. Data from other conditions suggest that sex and/or gender bias in the process of referral to speciality care may contribute.

**Methods:** We undertook a mixed methods analysis of 120 referral letters to gastroenterology for people ultimately diagnosed with IBD in Calgary, Alberta. Letters were masked for patient sex and gender prior to analysis. Gastroenterologists who were masked to the objective of the study rated the quality of referral letters and triaged letters for urgency. Two study team members performed a Framework analysis to identify agentic (masculine) and commensal (feminine) adjectives, mentions of caregiving and work roles, and psychosocial history. After analysis, letters were unmasked and findings were compared by patient sex.

**Results:** There were 116 referral letters included in the analysis ( $n = 59$ , 50.9% for male patients). There were no differences in letter quality or triage urgency between male and female patients (median quality 4 [IQR 4–7] and 5 out of 10 [IQR 4–6], respectively, higher scores represent better quality;  $P = .37$ , and  $P = .44$  for triage category). There was no difference in the use of adjectives and mention of caregiving or work roles, psychiatric history, or social history between letters for female and male patients.

**Conclusions:** This mixed methods analysis identified no difference in referral letter language, contents, or quality for female and male patients with IBD. Masked letters were triaged similarly to unmasked letters, suggesting an absence of sex and/or gender bias in the gastroenterology triaging process in our setting.

**Key words:** discrimination; referral letters; inflammatory bowel disease; sex based discrimination.

## Introduction

Patient sex and gender influence the diagnosis of inflammatory bowel disease (IBD). Women experience delays in diagnosis and more common misdiagnosis of Crohn's disease and ulcerative colitis.<sup>1,2</sup> The reason for these delays is unknown; however, greater delays in referral for specialist care have been seen for women in multiple settings,<sup>3</sup> including cardiology,<sup>4,5</sup> neurology,<sup>6,7</sup> and orthopaedic surgery.<sup>8</sup> Evidence suggests that part of these delays may be attributable to the sex or gender bias of the referring physician.<sup>9</sup> For example, healthcare providers assess the severity of pain as less in women than in men<sup>10</sup> and more often evoke functional diagnoses for unexplained symptoms in women.<sup>11</sup> These possible mechanisms of sex and gender bias are notable because symptoms of IBD may mimic disorders of the brain-gut axis such as irritable bowel syndrome (IBS).

Referral to a gastroenterologist for the evaluation of unexplained gastrointestinal symptoms is a key step where sex and gender bias could influence the time to diagnosis for female

patients. Appropriate triaging of incoming referral letters requires referring healthcare providers to accurately describe a patient's symptoms and red flag features of IBD. Differences in the description of symptoms or patient characteristics may lead to inappropriate less acute triaging and delays in diagnosis for female patients. The objective of this study was to assess referral letters for sex and gender bias in the length or content of letters, including a description of a patient's risk factors for IBD, gastrointestinal symptoms, social history, or psychiatric history. The secondary objective was to understand if sex and gender bias influenced triage decisions.

## Methods

This retrospective mixed methods study used qualitative and quantitative assessment to understand differences in referral letter quality and composition by patient sex. The study was approved by the University of Calgary's Conjoint Health Research Ethics Board (REB20-1637).

## Referral letter identification

People in Calgary who need specialist gastroenterology care require a referral from a primary care provider or emergency physician. Referrals are accepted and triaged centrally for all adult gastroenterology clinics in Calgary based on information provided by the referring healthcare provider. There are no templates or checklists for referral letters to gastroenterology in Calgary; referral letters are typically narrative letters describing the patient's presentation and pertinent information as determined by the referring healthcare provider. The triage category, which includes urgent clinic, urgent direct to procedure (DTP), routine clinic, or closed referral, is assigned by a gastroenterologist based on a weekly rotating schedule. The urgent clinic is intended for patients who have severe symptoms (including suspected IBD), urgent DTP is for patients who have rapidly progressive symptoms with few comorbidities that would increase the risk of endoscopic evaluation, and the routine clinic is for patients with gastrointestinal symptoms that are not suspected of leading to severe morbidity or increased mortality. At the time that the letters were triaged, the average wait times for each triage category were 6.1-14.0 weeks for urgent clinic, 6.1-8.5 weeks for urgent DTP, 21.1-89.9 weeks for routine clinic, and >80 weeks for routine DTP.

Using the gastroenterology central access and triage database, we identified a sample of 120 adult patients (60 female and male) who had a new diagnosis of IBD between 2016 and 2019. The study sample was restricted to patients with an ultimate diagnosis of IBD so that differences in outcome (triage status) could be attributed to the exposure (patient sex). At the time of the data pull, there were only binary options for sex in the health system database with no option for intersex, non-binary gender, or transgender people. The original digitized referral letters were obtained for analysis. People who had an established diagnosis of IBD and were being re-referred to a gastroenterologist were excluded. A study team member reviewed all referral letters and removed any sex or gender-identifying data (G.G.; eg, pronouns, names, references to pregnancy or menstruation) before analysis. Masking was tested by having 2 gastroenterologist study team members (Y.N. and L.T.) attempt to guess the sex of the patient based on the masked referral letter.

## Quantitative analysis

Letter length, triage outcome, and referring physician specialty and sex were abstracted from all masked referral letters. Referring physician sex was determined using the College of Physicians and Surgeons of Alberta public registration information, which recorded physician sex as female or male with no non-binary options at the time of this analysis.

Two gastroenterologists (Y.N. and L.T.), who were masked to the patient sex and who were not told that all patients had a final diagnosis of IBD, read all letters and scored letter quality (from 1 to 10, with 1 representing low quality and 10 representing highest quality) and assigned a triage category (urgent clinic, urgent direct to procedure (DTP), routine clinic, routine DTP, or closed referral), similar to methods described by Eskeland et al.<sup>12</sup> The official triage category was compared to the sex-masked triage category to estimate whether patient sex had influenced the original triage decision.

Descriptive statistics are presented for quantitative data. Mann-Whitney *U* test was used to compare medians between

populations, Chi-square tests were used to compare count data between categorical outcomes, and Kruskal-Wallis test were used to compare non-parametric continuous outcomes between groups. Agreement between the 2 gastroenterologist reviewers and the original triage decision was compared using a weighted Cohen's kappa coefficient. Data analysis was performed by Stata (version 18.5).

## Qualitative analysis

After masking, referral letters were uploaded into NVivo (version 12, QRS International) for Framework analysis by 2 study team members (S.S. and S.M.R.). The initial codebook was informed by a literature review of differences in how physicians describe female and male patients<sup>13</sup> and trainees.<sup>14,15</sup> The codebook included adjectives or descriptors used to describe patients, symptom characteristics, references to roles or occupations, and references to lifestyle factors such as smoking or alcohol use (Appendix 1). Adjectives/descriptors were coded as agentic, commensal, or neutral.<sup>16</sup> Agentic adjectives are stereotypically applied to men and include words that describe task functioning (eg, competent and leader) and commensal adjectives are stereotypically applied to women and include words that describe social functioning (eg, caring and trustworthy).<sup>16</sup>

The codebook was then applied independently and in duplicate by 2 study team members (S.S. and S.M.R.). Disagreements in coding were resolved through discussion. After coding, patient sex was unmasked, and the frequency and content of codes were compared between female and male patients by 2 study team members (S.S. and S.M.R.) who presented their conclusions to the entire study team for agreement. S.S. is a man resident physician who practised as a general surgeon prior to residency and S.M.R. is a woman physician with experience in mixed methods and qualitative analysis.

## Results

There were 116 referral letters included in the final analysis ( $n = 59$ , 50.9% for male patients) written by 109 unique referring physicians (Table 1; eTable 4). Most referral letters were written by family ( $n = 84$ , 71.6%) and emergency physicians ( $n = 12$ , 10.3%) (eTable 1). There were more female referring physicians than male referring physicians ( $n = 61$ , 53.0% compared to  $n = 54$ , 46.6%, 1 physician sex was not identified) (Table 1). Most referrals were triaged as an urgent consult ( $n = 75$ , 64.7%). Masking was adequate (eTable 2).

Interrater agreement about letter quality was fair (kappa 0.22, 95% confidence interval [CI] 0.07-0.37) (eTable 3). Median letter quality did not differ between female and male patients (4 [IQR 4-7] and 5 [IQR 4-6], respectively,  $P = .37$ ) (Table 1) or female and male referring physicians (6 [IQR 3-7] and 5 [IQR 4-6], respectively,  $P = 1.00$ ) (eTable 4) for either rater. Letters written for female patients were longer than those written for male patients (median 12 lines of text [IQR 6-24] and 8 lines [IQR 5-13], respectively,  $P = .01$ ) (Table 1) and there was no difference in letter length by primary care provider sex (eTable 4). There was no difference between female and male patient triage categories using original referral letters ( $P = .44$ ) or sex-masked referral letters ( $P = .44$ ) (Table 1).

**Table 1.** Characteristics of referral letters to gastroenterology for patients who had a final diagnosis of inflammatory bowel disease by patient sex.

| Characteristic                            | All letters | Male patients | Female patients | P-value |
|---|-------------|---------------|-----------------|---------|
| Total (n, %)                              | 116         | 59 (50.9)     | 57 (49.1)       | –       |
| Referring physician sex <sup>a</sup>      |             |               |                 |         |
| Male (n, %)                               | 54 (46.6)   | 30 (50.8)     | 24 (42.1)       |         |
| Female (n, %)                             | 61 (52.6)   | 28 (47.5)     | 33 (57.9)       |         |
| Letter quality <sup>b</sup> (median, IQR) | 5 (4-7)     | 5 (4-6)       | 6 (4-7)         | .37     |
| Letter length (median lines of text, IQR) | 9 (5.75-19) | 8 (5-13)      | 12 (6-24)       | .01     |
| Triaging                                  |             |               |                 |         |
| Original triage                           |             |               |                 |         |
| Close consult                             | 0           | 0             | 0               |         |
| Routine clinic consult                    | 75 (64.7)   | 35 (59.3)     | 40 (70.2)       | .44     |
| Urgent clinic consult                     | 11 (9.5)    | 7 (11.9)      | 4 (7.0)         |         |
| Direct-to-procedure                       | 30 (25.9)   | 17 (28.8)     | 13 (22.8)       |         |
| Masked triage                             |             |               |                 |         |
| Close consult                             | 11 (9.5)    | 5 (8.5)       | 6 (10.5)        | .29     |
| Routine clinic consult                    | 10 (8.6)    | 3 (5.1)       | 7 (12.3)        |         |
| Urgent clinic consult                     | 54 (46.6)   | 26 (44.1)     | 28 (49.1)       |         |
| Direct-to-procedure                       | 41 (35.5)   | 25 (42.4)     | 16 (28.1)       |         |

Abbreviation: IQR, interquartile range.

<sup>a</sup>Sex was not identified for 1 physician.<sup>b</sup>Scale from 1 to 10, with 1 being worst quality and 10 being best.**Table 2.** Qualitative characteristics of referral letters to gastroenterology for patients diagnosed with inflammatory bowel disease by patient sex.

| Category   | Male Patients |   | Female Patients |  |
|--|---------------|---|-----------------|--|
|  | N letters (%) | Example   | N letters (%)   | Example  |
| Adjectives and descriptors                           |               |   |                 |  |
| Agentive   | 0             | –   | 0               | –  |
| Commensal  | 0             | –   | 0               | –  |
| Neutral  | 8 (13.6)      |   | 9 (15.8)        |  |
| Positive   | 6 (10.2)      | “Pleasant” [n = 5]; “Reasonable” [n = 1]  | 5 (8.8)         | “Pleasant” [n = 4]; “Compliant” [n = 1]                            |
| Neutral  | 0             | –   | 1 (1.8)         |  |
| Negative   | 3 (5.1)       | “...fired [their] last family doctor”   | 3 (5.3)         | “...[has] poor sleep hygiene”                                      |
| Emotion  | 5 (8.5)       | “tearful”; “anxious”; “concerned” [n = 3]   | 5 (8.8)         | “worry”/“worried”/“worrisome” [n = 3]; “apprehensive”; “concerned” |
| Social history                                       |               |   |                 |  |
| General  | 13 (22.0)     | “...continues to live at home with [their] parents”; “...has a sedentary lifestyle” | 18 (31.6)       | “...is a Christian, not sexually active”; “dances regularly”       |
| History of trauma or abuse                           | 1 (1.7)       | –   | 0               | –  |
| Caregiving roles                                     | 4 (6.8)       | “...has teenaged children”  | 2 (3.5)         | “...is single and has no children”                                 |
| Work roles   | 11 (18.6)     | “...works as a manager at [redacted]”   | 9 (15.8)        | “...has not missed any work”                                       |
| Smoking, drinking alcohol, or using other substances | 20 (33.9)     | “...returned from a treatment facility”   | 18 (31.6)       | “THC to sleep”   |
| Travel or immigration                                | 7 (11.9)      | “...recently moved from [province]”   | 9 (15.8)        | “No recent travel”   |
| Psychiatric history                                  | 13 (22.0)     | “has depression”; “fibromyalgia”  | 14 (24.6)       | “history of an eating disorder”; “[has] complex PTSD”              |

Abbreviations: PTSD, post-traumatic stress disorder; THC, delta-9-tetrahydrocannabinol.

Adjectives and descriptors were uncommon in the sample of referral letters ( $n = 17$ , 14.7%) and occurred equally for male and female patients ( $n = 8/59$ , 13.6% of male patient letters and  $n = 9/57$ , 15.8% of female patient letters) (Table 2).

There were no agentive or commensal adjectives identified in the sample of referral letters. Most descriptors were positive ( $n = 10$ ; eg, “pleasant” and “reliable”) and the 6 negative descriptors were distributed equally between female and

male patient letters (eg, “[has] poor sleep hygiene”). Similarly, emotions were mentioned equally in male and female patient referral letters ( $n = 5$ , 8.5% of male patient letters and  $n = 5$ , 8.8% of female patient letters). Emotions were exclusively used to describe patient worries about their symptoms (eg, “tearful”, “anxious”, and “concerned”).

Psychiatric medications, diagnoses, and/or history were mentioned equally in letters for male ( $n = 13/59$ , 22.0%) and female ( $n = 14/57$ , 24.6%) patients (Table 2). A specific history of trauma or abuse was reported in only 1 letter, for a male patient. Caregiving and work roles were uncommonly mentioned in referral letters for all patients ( $n = 6$ , 5.2% and  $n = 20$ , 17.2%, respectively) and there was no difference in mention of these roles in letters written for male and female patients (Table 2).

## Discussion

This mixed methods evaluation did not identify evidence of sex bias in the quality, triage category, or patient descriptions in referral letters to gastroenterology central triage for patients who were ultimately diagnosed with IBD in a single Canadian centre. The letters written for female patients were longer than those for male patients, though the importance of this finding is uncertain. There was no difference in the triage urgency between the original referral letters and sex-masked letters. In addition, we did not identify a difference in the quality or length of letters written by female or male referring physicians. These reassuring results suggest that referring physicians do not intentionally or unintentionally contribute to less urgent triaging of female or male patients with symptoms suggestive of IBD in our setting.

Based on this analysis, the content and triaging of referral letters for patients with IBD do not explain the observed sex or gender differences in time-to-diagnosis for female patients with IBD in our setting.<sup>1,2</sup> This difference may be explained by other factors; for example, we were unable to identify if there was a difference in the likelihood of referral to gastroenterology by a primary care physician for symptoms of IBD between female and male patients. This type of sex bias has been identified among women with cardiovascular disease, who are less often appropriately referred to cardiac rehabilitation programs,<sup>4</sup> among women with knee osteoarthritis, who are less often appropriately referred for knee replacement,<sup>8</sup> and women with movement disorders, who are less often referred for surgery.<sup>6</sup> Further study is needed to understand if and where sex and gender bias may lead to delays in diagnosis for female patients.

Notably, the majority of referral letters included in this sample were judged as medium to low quality by the study team gastroenterologists. While referral letter quality may not influence triaging decisions,<sup>12,17</sup> including for Canadian patients with IBD,<sup>18</sup> poorer quality referral letters may increase the workload for specialists.<sup>19</sup> Efforts to improve the content of referral letters are ongoing,<sup>12,20</sup> including in our setting.<sup>21</sup> The effect of standardization on potential sex bias in referral letters could be measured as part of the evaluation of these quality improvement projects.

The strengths of this evaluation are the masking of patient sex prior to analysis with an assessment of the quality of masking and the independent, parallel assessments for bias. However, due to limitations in the dataset, we were only able

to examine for associations by patient and physician binary sex. Diagnostic delays and possible bias in referral letters for intersex, non-binary gender, and transgender people are not known. Further, the influence of patient gender, gender expression, and gender concordance<sup>22</sup> on bias in referral letters cannot be assessed by our methods. Lastly, Calgary gastroenterology is accessible only through a central triaging procedure which reduces the generalizability of these results to centres that use group-based or individual physician referral practices.

This mixed methods evaluation of narrative referral letters demonstrates a novel approach to examining sources of bias in the outpatient referral process. Investigators could apply similar approaches to understanding the documented sex and/or gender bias in referrals for other medical issues. The lack of sex and/or gender bias in referral letters for patients ultimately diagnosed with IBD allows us to focus resources on other aspects of access and equity for people with IBD in our setting.

## Supplementary material

Supplementary material is available at Journal of the Canadian Association of Gastroenterology online.

## Acknowledgments

Thank you to Greg Heather for his help accessing referral letters and data for this study.

## Author contributions

S.M.R., L.T., and Y.N. conceived the study design, supervised trainees, analyzed data, and wrote the first draft of the manuscript. S.M.R., S.S., G.G., L.T., Y.N., and H.N. contributed to data collection and analysis. All authors provided revisions to the final draft of the manuscript.

## Funding

None declared.

## Conflicts of interest

Conflict of interest disclosure forms (ICMJE) have been collected for all co-authors and can be accessed as [supplementary material here](#).

## Data availability

Due to the sensitive nature of the data, the raw data (referral letters) for this study are not available.

## References

1. Sempere L, Bernabeu P, Cameo J, et al. Gender biases and diagnostic delay in inflammatory bowel disease: multicenter observational study. *Inflamm Bowel Dis*. 2023;29(12):1886–1894. <https://doi.org/10.1093/ibd/izad001>
2. Khan T. *Women with Inflammatory Bowel Disease Wait Longer for Diagnosis and Treatment, Despite Presenting Earlier with Red-Flag Symptoms Komodo*; 2023 Available from <https://www.komodohealth.com/perspectives/women-inflammatory-bowel-disease>.

3. Kapoor M, Agrawal D, Ravi S, Roy A, Subramanian SV, Guleria R. Missing female patients: an observational analysis of sex ratio among outpatients in a referral tertiary care public hospital in India. *BMJ Open*. 2019;9(8):e026850. <https://doi.org/10.1136/bmjopen-2018-026850>
4. Colella TJE, Gravely S, Marzolini S, et al. Sex bias in referral of women to outpatient cardiac rehabilitation? A meta-analysis. *Eur J Prev Cardiol*. 2015;22(4):423–441. <https://doi.org/10.1177/2047487314520783>
5. Bach DS, Radeva JI, Birnbaum HG, Fournier AA, Tuttle EG. Prevalence, referral patterns, testing, and surgery in aortic valve disease: leaving women and elderly patients behind? *J Heart Valve Dis*. 2007;16(4):362–369.
6. Setiawan M, Kraft S, Doig K, et al. Referrals for movement disorder surgery: underrepresentation of females and reasons for refusal. *Can J Neurol Sci*. 2006;33(1):53–57. <https://doi.org/10.1017/s0317167100004698>
7. Hung PS, Byeon AG, Noorani A, Walker MR, Lorello GR, Hodaie M. Sex differences in patient journeys to diagnosis, referral, and surgical treatment of trigeminal neuralgia: implications for equitable care. *J Neurosurg*. 2023;139(2):463–471. <https://doi.org/10.3171/2022.11.JNS221191>
8. Borkhoff CM, Hawker GA, Kreder HJ, Glazier RH, Mahomed NN, Wright JG. The effect of patients' sex on physicians' recommendations for total knee arthroplasty. *CMAJ*. 2008;178(6):681–687. <https://doi.org/10.1503/cmaj.071168>
9. Colameco S, Becker LA, Simpson M. Sex bias in the assessment of patient complaints. *J Fam Pract*. 1983;16(6):1117–1121.
10. Chen EH, Shofer FS, Dean AJ, et al. Gender disparity in analgesic treatment of emergency department patients with acute abdominal pain. *Acad Emerg Med*. 2008;15(5):414–418. <https://doi.org/10.1111/j.1553-2712.2008.00100.x>
11. Hamberg K, Risberg G, Johansson EE, Westman G. Gender bias in physicians' management of neck pain: a study of the answers in a Swedish national examination. *J Womens Health Gend Based Med*. 2002;11(7):653–666. <https://doi.org/10.1089/152460902760360595>
12. Eskeland SL, Rueegg CS, Brunborg C, Aabakken L, de Lange T. Electronic checklists improve referral letters in gastroenterology: a randomized vignette survey. *Int J Qual Health Care*. 2018;30(6):450–456. <https://doi.org/10.1093/intqhc/mzy057>
13. Daley A. Narrating genders in psychiatric inpatient chart documentation. In: Pilling Ada MD, ed. *Interrogating Psychiatric Narratives of Madness*. Springer Nature; 2021.
14. Filippou P, Mahajan S, Deal A, et al. The presence of gender bias in letters of recommendations written for urology residency applicants. *Urology*. 2019;134:56–61. <https://doi.org/10.1016/j.urology.2019.05.065>
15. Turrentine FE, Dreisbach CN, St Ivany AR, Hanks JB, Schroen AT. Influence of gender on surgical residency applicants recommendation letters. *J Am Coll Surg*. 2019;228(4):356–365e3. <https://doi.org/10.1016/j.jamcollsurg.2018.12.020>
16. Szczesny S, Nater C, Eagly AH. Agency and communion: their implications for gender stereotypes and gender identities. In: *Agency and Communion in Social Psychology*. Routledge; 2019: 103–116.
17. Nymoen M, Biringer E, Hetlevik O, Thorsen O, Assmus J, Hartveit M. The impact of referral letter quality on timely access to specialised mental health care: a quantitative study of the reliability of patient triage. *BMC Health Serv Res*. 2022;22(1):735. <https://doi.org/10.1186/s12913-022-08139-3>
18. Mathias H, Heisler C, Morrison J, Currie B, Phalen-Kelly K, Jones J. Examining the association between referral quality, wait time and patient outcomes for patients referred to an IBD specialty program. *J Can Assoc Gastroenterol*. 2020;3(4):154–161. <https://doi.org/10.1093/jcag/gwz002>
19. Thorsen O, Hartveit M, Baerheim A. The consultants' role in the referring process with general practitioners: partners or adjudicators? A qualitative study. *BMC Fam Pract*. 2013;14:153. <https://doi.org/10.1186/1471-2296-14-153>
20. Eskeland SL. *Appropriateness and Quality of Referral Letters in Gastroenterology*. University of Oslo; 2017.
21. Link S. *QURE Resources Specialist Link*; 2021. Accessed August 29, 2024. Available from: <https://www.specialistlink.ca/quire-checklist>
22. Jacobson R, Joel D. Self-reported gender identity and sexuality in an online sample of cisgender, transgender, and gender-diverse individuals: an exploratory study. *J Sex Res*. 2018;56(2):249–263. <https://doi.org/10.1080/00224499.2018.1523998>