



## Sexual function problems and help seeking behaviour in Britain: national probability sample survey

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**What is already known on this topic**

Little is known about the prevalence of sexual dysfunction in people attending their general practice and whether such problems are recognised by doctors

Controversy exists about defining sexual dysfunction in terms of health and disease

**What this study adds**

22% of men and 40% of women received at least one ICD-10 diagnosis of sexual dysfunction according to stringent clinical criteria

Older women with poorer physical and psychological function and who were dissatisfied with their sex life were more likely to have a ICD-10 diagnosis of sexual dysfunction, as were bisexual men

Although similar findings have been reported in men who report same sex behaviour,<sup>21</sup> to our knowledge no other population study has focused specifically on sexual problems in bisexual as distinct from homosexual men.

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Competing interests: None declared.

Ethical approval: Two London local research ethical committees approved the study.

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## Sexual function problems and help seeking behaviour in Britain: national probability sample survey

Catherine H Mercer, Kevin A Fenton, Anne M Johnson, Kaye Wellings, Wendy Macdowall, Sally McManus, Kiran Nanchahal, Bob Erens

Editorial by Ogden  
See also p 423

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The need for estimates of the extent of sexual function problems in the general population has become more urgent given recent debates surrounding the identification and definition of “sexual dysfunction,” the increased availability of pharmacological interventions, and possible changes in our expectations of what constitutes sexual function and fulfilment.<sup>1</sup> We report results from the national survey of sexual attitudes and lifestyles (Natsal 2000).

### Participants, methods, and results

Natsal 2000 was a stratified probability sample survey done between May 1999 and February 2001 of 11 161 men and women aged 16-44 years resident in

Britain.<sup>2,3</sup> The response rate was 65.4%. A computer assisted self interview asked participants about their sexual lifestyles and attitudes. We asked questions about their experience of sexual problems based on those used in the US national health and social life survey,<sup>4</sup> which measured the main dimensions of sexual dysfunction, as defined in ICD-10 (international classification of diseases, 10th revision). We analysed data in STATA accounting for the sample's stratification, clustering, and weighting.<sup>2,3</sup>

A total of 34.8% of men and 53.8% of women who had at least one heterosexual partner in the previous year reported at least one sexual problem lasting at least one month during this period (table). The most common problems among men were lacking interest

Self reported problems related to sexual function by people who had at least one heterosexual partner in the previous year. Values are prevalences (95% confidence interval)

Problem	Lasted at least one month in past year		Lasted at least six months in past year	
	Men	Women	Men	Women
Lack of interest in sex	17.1 (15.8 to 18.4)	40.6 (39.2 to 42.1)	1.8 (1.4 to 2.3)	10.2 (9.4 to 11.1)
Anxious about performance	9.0 (8.1 to 10.0)	6.7 (6.0 to 7.5)	1.8 (1.4 to 2.2)	1.5 (1.1 to 1.9)
Unable to experience orgasm	5.3 (4.6 to 6.1)	14.4 (13.4 to 15.4)	0.7 (0.5 to 1.1)	3.7 (3.2 to 4.4)
Premature orgasm	11.7 (10.6 to 12.9)	1.3 (1.0 to 1.7)	2.9 (2.4 to 3.6)	0.2 (0.1 to 0.3)
Painful intercourse	1.7 (1.3 to 2.2)	11.8 (10.9 to 12.9)	0.3 (0.2 to 0.5)	3.4 (2.9 to 3.9)
Unable to achieve or maintain erection	5.8 (5.0 to 6.6)	—	0.8 (0.6 to 1.1)	—
Trouble lubricating	—	9.2 (8.4 to 10.1)	—	2.6 (2.2 to 3.2)
At least one problem	34.8 (33.1 to 36.4)	53.8 (52.3 to 55.2)	6.2 (5.4 to 7.1)	15.6 (14.6 to 16.7)
At least one problem excluding lack of interest in sex	24.1 (22.6 to 25.6)	29.0 (27.7 to 30.4)	5.0 (4.3 to 5.8)	8.9 (8.1 to 9.8)
At least two problems	10.5 (9.5 to 11.6)	19.1 (18.0 to 20.3)	1.4 (1.0 to 1.8)	4.1 (3.6 to 4.8)
At least two problems excluding lack of interest in sex	6.8 (6.0 to 7.7)	10.3 (9.4 to 11.2)	1.2 (0.9 to 1.6)	1.9 (1.5 to 2.3)
Base (weighted, unweighted)*	4888, 3980	4826, 5530	4877, 3972	4818, 5518

\*The base for sexual problems lasting longer than six months is slightly smaller than the base for any sexual problems reflecting non-response to the question which asked how long problems had lasted.

in sex, premature orgasm, and anxiety about performance; and among women, inability to experience orgasm and painful intercourse.

Persistent sexual problems—lasting at least six months in the previous year—were less prevalent among men (6.2%) than among women (15.6%). The most common persistent problem among men was premature orgasm and among women, lack of interest in sex.

Among people who had sexual problems, 32.5% (95% confidence interval 29.7% to 35.3%) of men and 62.4% (60.4% to 64.3%) of women avoided sex because of their problems. Only 10.5% (8.8% to 12.4%) of men and 21.0% of women (19.3% to 22.7%) with problems in the previous year sought help. People with persistent problems were more likely to have sought help (20.5% (15.8% to 26.3%) of men and 31.9% (28.4% to 35.5%) of women). Among people seeking help, 63.8% (54.6% to 72.1%) of men and 74.3% (70.1% to 78.1%) of women consulted their general practitioner, and 9.2% (5.3% to 15.4%) of men and 4.8% (3.2% to 7.2%) of women sought help at a genitourinary clinic.

## Comment

Problems of sexual function are relatively common, but persistent problems are much less so. Inconsistent definitions make comparing prevalences with other studies difficult. Given the broad spectrum of problems, we have not sought to define clinical “dysfunction” but rather to describe the range of problems of sexual function in the population and to use duration of problems and avoidance of sex as indicators of severity. We asked specifically about problems that lasted more than one month in the previous year; but whether, for example, lacking interest in sex can be considered as “dysfunction” is questionable since it was reported by two fifths of women and one fifth of men.

Few people sought help with their problems reflecting how severity varies, and how the need for professional intervention depends on the perceived importance to the patient and the underlying causes. Seeking help also reflects awareness of the availability

of advice and treatment; more men present with sexual problems at genitourinary clinics since the licensing of sildenafil.<sup>5</sup> People who often seek help consult their general practitioner but given the limited time and resources in this setting, such problems may be accorded low priority.

Our data have implications for improving relationship education, counselling, medical education, and doctors’ professional development; raising public awareness of the range and location of services available for managing sexual problems; and re-examining the nature of “sexual dysfunction” and how best to tackle it.

Contributors: CHM was the lead writer of this paper and did all statistical analyses. KAF, AMJ, KW, and BE were coinvestigators and designed, implemented, and managed the study and prepared the manuscript. SMcM, KN, and WM also prepared the manuscript. CHM is guarantor.

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Competing interests: None declared.

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## Endpiece

### Angry

Anyone can be angry—that is easy. But to be angry with the right person, to the right degree, at the right time, for the right purpose, and in the right way—this is not easy.

Aristotle, *Nicomachean Ethics*

John Spencer, consulting psychiatrist, north Derbyshire

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**What is already known on this topic**

Psychological stress has been implicated as a determinant of disease activity in multiple sclerosis

Evidence on the relation between stressful events and exacerbations of multiple sclerosis is lacking

A recent report of the American Academy of Neurology emphasised the need to obtain tightly defined prospective data

**What this study adds**

Patients with multiple sclerosis who experience a stressful event are subsequently at increased risk of an exacerbation of their disease

Stress and infection are independently associated with the risk of an exacerbation

**Stress and infection and the risk of an exacerbation**

Certain types of psychological stress can suppress immune reactions, leading to an increased susceptibility to infections.<sup>23</sup> This would confound the positive association we found between stress and exacerbations. However, we found no evidence of an increase in infections after stressful events in this study. Stress and infection were independently associated with the risk of exacerbation. It will not be easy to tackle these factors in individual patients, because infections and stressful events cannot simply be eradicated from patients' lives. The knowledge that stressful events are associated with disease activity adds important information to the limited insight that patients and their caregivers have on this unpredictable disease.

We thank the late Monica van der Hoven, who performed secretarial and organisational tasks for this study, and to D Dippel for critical reading of the manuscript.

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**Corrections and clarifications**

*Sexual function problems and help seeking behaviour in Britain: national probability sample study*

We inadvertently omitted from the main text (but not from the table) one of the main findings of this study by Catherine Mercer and colleagues (23 August, pp 426-7). We should have mentioned that the most common problem among women, as among men, was a lack of interest in sex. Also, in the final sentence of the penultimate paragraph, a misplaced word ("often") changed the sense: the sentence should have said that people who seek help for their sexual function problems often consult their general practitioner.

*Wrong heading on BMJ cover*

We misrepresented on the cover of the issue of 2 August the paper by Michael J Radcliffe and colleagues (Enzyme potentiated desensitisation in treatment of seasonal allergic rhinitis: double blind randomised controlled study. *BMJ* 2003;327:251-4). Our heading suggested that desensitisation (of any type) for allergies does not work, whereas the paper by Radcliffe and colleagues referred specifically to enzyme potentiated desensitisation. Traditional desensitisation does in fact work for certain indications (for example, bee and wasp venom anaphylaxis; severe simple, grass pollen hay fever; and severe cat allergy). Unfortunately, we repeated our error in the first sentence of the summary in "This Week in the BMJ."

*National survey of use of hospital beds by adolescents aged 12 to 19 in the United Kingdom*

An error in the figure in this paper by R M Viner has recently been brought to our attention—a couple of years after publication (*BMJ* 2001; 322:957-8). The legend within the graph should indicate that the top two curves relate to male inpatients (blue) and female inpatients (red) and that the bottom two relate to male and female day case patients (green and orange respectively).

*"Terminal sedation" different from euthanasia, Dutch ministers agree*

In this news article by Tony Sheldon, we attributed the wrong sex to the Dutch health minister (30 August, p 465). Clémence Ross is in fact a woman.