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,[21] to our knowledge no other population study has focused specifically on sexual problems in bisexual as distinct from homosexual men.

We thank Josephine Woolf for her collaboration in obtaining funding; Alice Gladwin, Monique Cloherty, and Üta Drescher for their assistance in collecting the data; and Bob Blizard for his statistical advice on the project.

Contributors: See bmj.com

Funding: health service research project grant provided by the Wellcome Trust (reference 991026); the North and Central Thames Research Network (NoCTeN) provided service support costs involved with the recruitment at the general practices.

Competing interests: None declared.

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

1 Reynolds CF, Frank E, Thase ME, Houck PR, Jennings JR, Howell JR, et al. Assessment of sexual function in depressed, impotent, and healthy men: factor analysis of a brief sexual function questionnaire for men. *Psychiatry Res* 1987;24:231-50.
2 Daker-White G. Reliable and valid self-report outcome measures in sexual dysfunction: a systematic review. *Arch Sex Behav* 2002;31:197-209.
3 Taylor JF, Rosen RC, Leiblum SR. Self report assessment of female sexual function. *Arch Sex Behav* 1994;23:627-43.
4 Kinsey AC, Pomeroy WB, Martin CE. *Sexual behaviour in the human male.* Philadelphia, PA: Saunders, 1948.
5 World Health Organization. *International statistical classification of disease and related health problems, 10th revision.* Geneva: WHO, 1992.
6 Ware JE, Kosinski M, Keller SD. A 12-item short-form health survey construction of scales and preliminary tests of reliability and validity. *Med Care* 1996;34:220-33.
7 Goldberg D, Williams D. *A user's guide to the general health questionnaire.* Windsor: NFER-Nelson, 1988.
8 Ewing JA. Detecting alcoholism: the CAGE questionnaire. *JAMA* 1984;252:1905-7.
9 Finkelhor D. Child sexual abuse. In: Rosenberg ML, Fenley MA, eds. *Violence in America—a public health approach.* New York: Oxford University Press, 1991:79-94.
10 Crenshaw TL, Goldberg JP. *Sexual pharmacology—drugs that affect sexual function.* New York: Norton, 1996.
11 McCormick A, Fleming D, Charlton J. *Morbidity statistics from general practice—fourth national morbidity study 1991-1992.* London: OPCS, HMSO, 1995.
12 Peach C. *Ethnicity in the 1991 census—the ethnic minority populations of Great Britain.* Volume 2. London, Stationery Office, 1998:206-21.
13 Johnson AM, Mercer CH, Erens B, Copas AJ, McManus S, Wellings K, et al. Sexual behaviour in Britain: partnerships, practices and HIV risk behaviours. *Lancet* 2001;358:1835-42.
14 Laumann EO, Paik A, Rosen R. Sexual dysfunction in the United States: prevalence and indicators. *JAMA* 1999;281:537-44.
15 Akkus E, Kadioglu A, Esen A, Doran S, Ergen A, Anafarta K, et al. Prevalence and correlates of erectile dysfunction in Turkey: a population based study. *Eur Urol* 2002;41:298-304.
16 Mirone V, Imbimbo C, Bortolotti A, Di Cintio E, Colli E, Landoni M, et al. Cigarette smoking as a risk factor for erectile dysfunction: results from an Italian epidemiological study. *Eur Urol* 2002;41:294-7.
17 Tiefer L. Sexology and the pharmaceutical industry: the threat of co-optation. *J Sex Res* 2000;37:273-83.
18 Moynihan R. The making of a disease: female sexual dysfunction. *BMJ* 2003;236:45-7.
19 Mercer CH, Fenton KA, Johnson AM, Wellings K, Macdowell W, McManus S, et al. Self reported sexual function problems and help seeking behaviour: results from a British probability sample survey. *BMJ* 2003 (in press).
20 Humphery S, Nazareth I. GPs' views on their management of sexual dysfunction. *Fam Pract* 2001;18:516-8.
21 Moreira ED, Najjar Abdo CH, Barreto Torres E, Lisboa Lobo CF, Saraiva Fittipaldi JA. Prevalence and correlates of erectile dysfunction: results of the Brazilian study of sexual behaviour. *Urology* 2001:58:583-8.

(Accepted 5 June 2003)

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

Editorial by Ogden
See also p 423

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

Centre for Infectious Disease Epidemiology, Department of Primary Care and Population Sciences and Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, London WC1E 6AU

Catherine H Mercer *research fellow*

Anne M Johnson *professor*

continued over

BMJ 2003;327:426–7

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.[1] 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.[2 3] 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,[4] 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.[2 3]

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)

	Lasted at least one month in past year		Lasted at least six months in past year	
Problem	**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.[5] 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.

Funding: Medical Research Council, Department of Health, Scottish Executive, and National Assembly for Wales.

Competing interests: None declared.

1 Moynihan R. The making of a disease: female sexual dysfunction. *BMJ* 2003;326:45-7.
2 Johnson AM, Mercer CH, Erens B, Copas AJ, McManus S, Wellings K, et al. Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. *Lancet* 2001;358:1835-42.
3 Erens B, McManus S, Field J, Korovessis C, Johnson AM, Fenton K, et al. *National survey of sexual attitudes and lifestyles II: technical report*. London: National Centre for Social Research, 2001.
4 Laumann EO, Gagnon JH, Michael RT, Michaels S. *The social organisation of sexuality: sexual practices in the United States*. Chicago: University of Chicago Press, 1994.
5 Kell P. The provision of sexual dysfunction services by genitourinary medicine physicians in the UK, 1999. *Int J STD AIDS* 2001;12:395-7.

(Accepted 7 July 2003)

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

HIV/STI Division, Communicable Disease Surveillance Centre, Health Protection Agency, London NW9 5EQ
Kevin A Fenton *consultant epidemiologist*
Centre for Sexual and Reproductive Health Research, School of Hygiene and Tropical Medicine, London WC1E 7HT
Kaye Wellings *director*
Wendy Macdowall *research fellow*
Kiran Nanchahal *medical statistician*
National Centre for Social Research, London EC1V 0AX
Sally McManus *senior researcher*
Bob Erens *health research group director*
Correspondence to: C H Mercer cmercer@gum.ucl.ac.uk