Sexual dysfunction in primary medical care: prevalence, characteristics and detection by the general practitioner*

Simon Read, Michael King and James Watson

Abstract

Background Despite the recent focus on sexual behaviour and AIDS, there are almost no data on the prevalence of sexual dysfunction within primary care settings.

Method One hundred and seventy patients attending a general practice participated in a questionnaire survey of the prevalence and characteristics of sexual problems. The detection rate of the general practitioners (GPs) and indicators in the patient notes were also investigated.

Results Thirty five per cent of the men (n = 22) reported some form of specific sexual dysfunction: premature ejaculation was identified in 31 per cent of the men; 17 per cent experienced erectile dysfunction, which was associated with current medication, a high mean annual attendance and increasing age. The prevalence of sexual dysfunction in the women was 42 per cent (n = 41); vaginismus was reported by 30 per cent of the sample; 23 per cent of the women suffered from anorgasmia. General sexual dissatisfaction was more common than specific dysfunction; 68 per cent (n = 66) of the women and 75 per cent (n = 54) of the men reported at least one problem with dissatisfaction, avoidance, infrequency or non-communication. The large majority of the sample (70 per cent) considered sexual matters to be an appropriate topic for the GP to discuss. Despite this, sexual problems were recorded in only 2 per cent of the GP notes.

Conclusions This study confirms the high prevalence of sexual disorders in the population. Many of these problems are concealed from GPs. Predictors in patients’ notes could help GPs to detect those patients with more serious problems.

Keywords: sexual dysfunction, epidemiology, general practice

Introduction

Sexual health is one of the five key areas adopted by the Government as part of its Health of the nation strategy. Sexual dysfunction is an important aspect of this which is often neglected because the emphasis is more frequently placed on infection and contraception. Very little information is available about the extent of these problems in general practice. Golombok et al.1 in a study of 60 attendees reported that although sexual problems were relatively common, few were reported to the doctor. Courtney2 reported that of 100 general practitioner (GP) attendees with sexual problems only 18 per cent complained directly, 46 per cent had psychological symptoms and 36 per cent had presented with physical symptoms principally related to the genito-urinary system, gastro-intestinal tract or skin.

Whether patients regard GPs as a relevant source of information about sexual issues is also relatively unknown. Spence3 in a study of GP attendees’ attitudes towards a range of problems reported that 75 per cent of them considered it appropriate to discuss sexual problems with their GP. It appears that GPs find it difficult to discuss sexual issues with their patients or take an accurate sexual history because they feel uncomfortable about the subject and lack adequate instruction in sexuality.4 Our aim was to determine the prevalence and characteristics of sexual problems in people attending their GP, indicators in their records that might alert the GP to a sexual problem and the rate of detection by the GP.

Method

The sample

Patients attending a general practice surgery were chosen as the population to be surveyed because the aims of the study went beyond simply assessing the prevalence of sexual dysfunction. Patients expect to engage in discussion about confidential matters when they attend their GP and are more likely to respond positively to research in this setting. It is well known that 98 per cent of the population is registered with a GP. Thus
using a population of patients registered with GPs also approximates to the profile of the wider community. One limitation of using only GP attendees, however, is that men tend to be underrepresented. The study was conducted in one general practice in north London situated in an area with a wide range of ethnicity and socio-economic class.

**Questionnaire distribution and collection**

On the basis of interviewer availability, days were selected over five months during which consecutive attendees to the practice were asked to take part. All subjects were asked to sign a consent form which also gave access to their GP medical records. Patients who could not read English, were too ill or aged under 18 years were excluded. In total, 182 questionnaires were distributed.

**Questionnaire format and content**

The questionnaire comprised 46 questions divided into four sections. Section A contained 11 demographic questions including age, marital status, ethnicity and occupation. Section B contained questions concerning the types of problems that patients feel are appropriate to discuss with their GPs, taken from Spence’s study. Section C contained the specifically sexual questions, which were taken from the Golombok Rust Inventory of Sexual Satisfaction (GRISS) and adapted to be applicable to both heterosexual and homosexual couples. This section consists of 28 questions all answered on a five-point scale from ‘always’ through ‘usually’, ‘sometimes’ and ‘hardly ever’ to ‘never’. It gives overall sexual dysfunction scores separately for men and women and also gives a profile for the individual on six subscales (for both men and women) comprising impotence and premature ejaculation in the man, anorgasmia and vaginismus in the woman, and infrequency, non-communication, non-sensuality, avoidance and dissatisfaction for both men and women. Acceptable reliability and validity has been demonstrated under a variety of circumstances.

Section D contained two questions, designed for the study, concerning firstly sexual orientation and secondly masturbation. A contact address for information or help was given at the bottom of the questionnaire.

**Records**

Data were collected from the practice records of each patient on a standardized proforma and quantified in terms of number of consultations for sexual, physical and psychological problems in the past year; number of referrals for sexual, physical and psychological help in the past five years; and current medication with known sexual side effects.

**Analysis**

The completed questionnaires were analysed using the Statistical Package for the Social Sciences (SPSS PC version 6.0). Analyses employed in this study were basically descriptive. Cases were identified according to conservative cut-off points based on clinical relevance (see Appendix). Comparisons among levels of demographic variables such as age, sex, and social class were examined using the $\chi^2$ statistic and Student’s t-test. Logistic regression was used in a search for independent predictors of sexual problems as identified by scores on GRISS.

**Results**

**Response rate**

In all, 189 people were approached of whom 170 completed questionnaires. Twelve questionnaires were handed in with Section C (Sexual Problems) deleted and seven people refused to take part, a response rate of 90 per cent. There was no sex difference between non-responders and responders; however, the non-responders were slightly older (mean age 53). Subject characteristics are listed in Table 1.

**Sexual function**

**General dysfunction**

Sixty eight per cent of the women and 75 per cent of the men had at least one problem with infrequency, avoidance, non-sensuality, non-communication and dissatisfaction (Table 2). Equal numbers of men and women usually avoided or refused sex (10 per cent) and hardly ever or never became easily anxious (Table 3).

**Table 1 Demographic data of study sample (n = 182; men n = 78, women n = 104)**

<table>
<thead>
<tr>
<th>Age</th>
<th>% Men</th>
<th>% Women</th>
<th>% Tot</th>
<th>Marital</th>
<th>% Men</th>
<th>% Women</th>
<th>% Tot</th>
<th>Social class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>Single</td>
<td>36</td>
<td>38</td>
<td>37</td>
<td>Professional I</td>
</tr>
<tr>
<td>25-34</td>
<td>25</td>
<td>18</td>
<td>33</td>
<td>Married</td>
<td>52</td>
<td>46</td>
<td>49</td>
<td>Intermediate II</td>
</tr>
<tr>
<td>35-44</td>
<td>22</td>
<td>22</td>
<td>22</td>
<td>Divorced/ separated</td>
<td>12</td>
<td>14</td>
<td>13</td>
<td>Skilled III-N</td>
</tr>
<tr>
<td>45-54</td>
<td>15</td>
<td>16</td>
<td>16</td>
<td>Widowed</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>Skilled III-M</td>
</tr>
<tr>
<td>55-64</td>
<td>14</td>
<td>5</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Part skilled IV</td>
</tr>
<tr>
<td>&gt;65</td>
<td>12</td>
<td>6</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Unskilled V</td>
</tr>
<tr>
<td>Mean</td>
<td>43</td>
<td>37</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Retired</td>
</tr>
<tr>
<td>(SD)</td>
<td>(16.1)</td>
<td>(13.1)</td>
<td>(15)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Unclassified</td>
</tr>
</tbody>
</table>

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sexually aroused (7 per cent). Twenty-eight percent of the sample had a problem with communicating about sex. The vast majority of both men and women (81 per cent and 87 per cent, respectively), however, were usually or always satisfied with their sexual relationship.

Specific dysfunction: men
Thirty-five per cent \((n = 25)\) of the men had at least one specific dysfunction. Premature ejaculation was reported by 31 per cent \((n = 22)\) of the sample (see Table 3). Erectile dysfunction occurred in 17 per cent \((n = 12)\) of the sample and 3 per cent \((n = 2)\) were unable to achieve an erection under any circumstances. The men with erectile dysfunction were significantly older than the comparison subjects \((MD = 17.6\) years, \(t\) \(\text{equal} = 3.79, df = 70, p < 0.001\)) and tended to be in a lower social class bracket \((\text{IHM-V 33.3 per cent vs I-IIINM 7.3 per cent, } \chi^2 = 7.29, df = 1, p = 0.007)\). In addition, these men had a significantly higher mean annual attendance than the comparisons \((MD = 2.9, t \text{equal} = 2.85, df = 70, p = 0.006)\) and were more likely to be taking medication with known sexual side-effects \((33.3\% \text{ per cent vs 11.1 per cent, } \chi^2 = 4.8, df = 1, p = 0.028)\).

Specific dysfunction: women
The prevalence of sexual dysfunction in the women was 42 per cent \((n = 41)\). Vaginismus was a problem to 30 per cent \((n = 29)\) of the sample, and 8 per cent \((n = 8)\) reported that any form of penetration was impossible. Twenty-three per cent of the sample had at least one problem with anorgasmia. Seven per cent \((n = 7)\) of the women were completely anorgasmic and 20 per cent \((n = 20)\) of the sample reported situational anorgasmia (Table 4).

Number of problems per subject
Sixty-seven per cent of the men and women with a sexual problem indicated a disturbance in more than one area.

Association with demographic variables and indicators in GP notes
A logistic regression analysis indicated that independent contributions to the presence of at least one sexual problem were made by current medication \((B = 1.102, \ p = 0.032, R^2 = 0.1108, \text{ odds ratio 3.1})\). Other demographic variables (age, gender, marital status and social class) and indicators (mean annual attendance and sexual orientation) were not significantly associated with a higher risk of a sexual problem.

GP notes as indicators of sexual dysfunction
Sexual dysfunction was recorded in the notes of only 2 per cent of the sample. There was no mention of any sexual dysfunction in the notes of the 25 most severely affected individuals (GRISS score: men >35, women >46).

Perception of physician's role in dealing with sexual problems
Responses to Section B indicated that 70 per cent \((n = 139)\) of the subjects thought that sexual difficulties were appropriate problems to discuss with the GP (69 per cent of the men; 70 per cent of the women).

Table 3 General sexual problems \((men n = 72; missing data = 6; women n = 98; missing data = 6)\); numbers, with percentages given in parentheses

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Men ((n = 72))</th>
<th>Women ((n = 98))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercourse less than twice a week</td>
<td>45 (34)</td>
<td>31 (30)</td>
</tr>
<tr>
<td>Frequently weeks with no sex at all</td>
<td>31 (22)</td>
<td>34 (33)</td>
</tr>
<tr>
<td>Non-sensuality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislike touching partner's genitals</td>
<td>10 (7)</td>
<td>21 (21)</td>
</tr>
<tr>
<td>Dislike partner touching your genitals</td>
<td>7 (5)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Communication (about sexual relationship)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not tell partner what you like/dislike</td>
<td>12 (9)</td>
<td>12 (12)</td>
</tr>
<tr>
<td>Do not ask partner what they like/dislike</td>
<td>28 (20)</td>
<td>20 (20)</td>
</tr>
</tbody>
</table>

Table 4 Anorgasmia and vaginismus \((n = 98; missing data = 6)\)

<table>
<thead>
<tr>
<th>Anorgasmia</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete anorgasmia</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Anorgasmic with partner</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Anorgasmic during intercourse</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Anorgasmic via clitoral stimulation</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Vaginismus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penetration by partner impossible</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Penetration by partner causes discomfort</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Finger insertion causes discomfort</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Partner cannot penetrate very far</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
Qualitative data

Patients were asked open questions concerning two areas: whether there were any topics they would not wish to discuss with their doctor and whether there had ever been a question that they wished he or she had asked. Some of the statements about sexual matters have been included in Table 5.

Discussion

The results of this study suggest that sexual dysfunction is a significant area of hidden morbidity among general practice patients. There is a high prevalence of sexual dysfunction in men and women of all ages and this is in agreement with the community and general practice literature.1,8–11,15,16,18–22 The association between sexual dysfunction and current medication highlights the impact that biological factors have on sexual dysfunction. This was the only significant predictor of sexual problems and it can only be presumed that apparent effects of age and social class are mediated by whether the patient takes medication or not. Doctors therefore need to be alert to this possibility and to ask about the sexual side effects of relevant medication (such as antidepressants and cimetidine). This not only provides a good predictor to the presence of sexual problems but also a straightforward way to begin discussing them.

Although the underlying neurophysiological mechanisms of sexual difficulties are different the study indicates that sexual problems are overlapping. This is in agreement with the literature,17,21,22 suggesting a mixture of biological and psychological aetiologies and arguing for a common psychological background of sexual dysfunction.

Despite the high prevalence of problems, most patients report being 'satisfied' with their sexual relationship and rarely open up to their GP. This agrees with the results of other surveys.1,15,16,21,22 Sexual satisfaction may be relatively independent of sexual function and have a different psychological background. This may be one of the reasons why GPs are apparently infrequently approached for help with sexual problems. Patients may hold back from initiating discussion about sexual matters for other reasons.3,8 Perhaps the older, sicker patients on medication expect to have a few sexual difficulties. Communication about sex was often poor and it may be that patients have similar problems when talking to their doctor. Improving communication skills may be the key to successful sex therapy programmes.1,8

The problems identified by the study are amenable to simple interventions which can be performed by the GP in the practice setting or by referral to a specialist clinic. The means of identifying those patients with more serious sexual problems could involve the use of the predictors outlined earlier.

Methodological aspects

The study was limited in surveying only one practice and because of the small sample. The findings therefore need to be regarded as a pilot study in an under-researched area. Despite this, there was a high response rate and the setting was private and confidential. The measurement tool was reliable and valid, and the results are based on clear operational definitions.

Further research

The prevalence of sexual dysfunction found in this study was such as to suggest that GPs should be alert to detecting it. Further research in the form of a large-scale, multicentre study within the United Kingdom is needed to gather further information about these important issues. This would be the first such study to be carried out in the United Kingdom and would be of clear value.

Acknowledgements

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References

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14 Hunt, M. *Sexual behaviour in the 70s*. Chicago, IL: Playboy, 1974.


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**Appendix**

Each problem area on the GRISS is assessed by two to four questions. Criteria were identified for what constitutes a ‘problem’ in each area and a cut-off point was designated accordingly. A conservative approach to identification of cases was used. Whenever there was doubt the subject was not included as a ‘problem’. For example, for the questions concerning erectile dysfunction, only a response of ‘usually’ or ‘always’ to one of the following questions was used as meeting the criteria for a ‘problem’:

Example of a question dealing with: erectile dysfunction.

(a) Do you fail to get an erection?

(b) Do you get an erection during foreplay with your partner?
   (criteria: ‘never’, ‘hardly ever’)

(c) Do you lose your erection during intercourse?