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Sexual Difficulties and Associated Sexual Distress in Flanders (Belgium): A Representative Population-Based Survey Study

Lies Hendrickx, PhD, Luk Gijs, PhD, and Paul Enzlin, PhD

ABSTRACT

Introduction: Because severity and duration of sexual impairment and any distress caused by the sexual impairment are not assessed in most epidemiologic studies on sexual dysfunction, the available prevalence rates are probably an overestimation.

Aims: To provide prevalence estimates of severe and persistent sexual difficulties that cause personal distress and to explore the association between personal sexual distress and avoidance of sex, help-seeking behavior, and sexual satisfaction.

Methods: This study used home-based computer-assisted personal interviewing and computer-assisted self-interviewing of a representative, randomly selected, population-based cross-sectional sample of 651 Flemish men and 695 women 14 to 80 years old.

Main Outcome Measures: Prevalence of sexual difficulties, prevalence of sexual dysfunctions (ie, sexual difficulties causing personal distress), and association of sexual distress with avoidance of sex, help-seeking behavior, and sexual satisfaction.

Results: In this sample, 43.5% of women (95% CI =39.7−47.3) and 34.8% of men (95% CI =31.3−38.3) reported a moderate to severe sexual difficulty. When considering the diagnostic criteria of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (ie, minimum duration of 6 months and presence of personal sexual distress), prevalence rates decreased to 19.0% in women (95% CI =16.0−22.0) and to 15.1% in men (95% CI =12.4−17.8). Sexual distress was associated with more sexual dissatisfaction and greater sexual avoidance. Sexual distress also was associated with help-seeking behavior, although most individuals with distressing sexual difficulties had not sought help.

Conclusion: Although sexual difficulties per se are quite prevalent, severe and persistent sexual difficulties causing sexual distress are far less common. Despite sexual distress being associated with avoidance of sex and lower sexual satisfaction, most people tend not to seek help for their sexual problem, even when being distressed by the problem.

Key Words: Prevalence; Age; Sexual Dysfunction; Sexual Distress; Population-Based

INTRODUCTION

Epidemiologic studies have indicated that 40% to 45% of adult women and 20% to 30% of adult men have at least one sexual difficulty.[1] More specifically, epidemiologic studies across Europe have found that 23% to 51% of women and 17% to 42% of men report at least one sexual difficulty (in the study by Christensen et al.,[2] the presence of sexual dysfunction was based on participants who "often" or "every time" experienced an impairment in sexual functioning), with more women than men reporting a sexual difficulty.[2−8] Some studies also have focused on the association between sexual difficulties and age. For men, only erectile difficulties have been consistently associated with age, showing an increase from 50 to 60 years of age.[1] Difficulty with premature ejaculation often is assumed to occur mostly in young inexperienced men,[9−11] but recent Western epidemiologic studies have suggested a decrease with age,[3,12] no association with age,[13,14] and even an increase with age.[4,15] Studies also have been inconsistent for the association between age and other sexual difficulties: for example, lack of desire and absent or delayed orgasm have been found to increase (especially from 50 to 60 years of age) and remain stable across ages.[3,4,6,13−16] For

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Institute for Family and Sexuality studies, Department of Neurosciences, KU Leuven, Leuven, Belgium

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female sexual difficulties, most European studies have suggested no association with age for desire difficulties and absent or delayed orgasm and an increase with age for lubrication difficulties (for reviews, see Fugl-Meyer et al[1] and Hayes and Dennerstein[17]). In contrast, most studies have found dyspareunia to decrease with age (especially from 30 years of age).[1,17]

At least three remarks can be stated about these prevalence estimates. First, several investigators have suggested revising the impairment criteria of sexual disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), particularly for female sexual disorders.[18–27] These investigators have suggested that (i) other criteria are needed to describe female sexual disorders and (ii) new sexual impairments, such as lack of responsive sexual desire (ie, lack of the ability to respond with sexual desire to sexual initiatives of the partner) and lack of subjective arousal (ie, lack of the subjective feeling of being aroused), should be addressed in future studies.[18–27] Until recently, few epidemiologic studies have included some of these variables.[3,12] Second, although impairment criteria have been assessed regularly, the associated distress criterion has not received much attention in epidemiologic research. Nevertheless, the few studies that have assessed sexual distress have indicated that not all sexual difficulties cause sexual distress.[2,4,5] Third, because terms such as *sexual disorder, sexual dysfunction,* and *sexual problem* were often used to refer to sexual difficulties, there has been concern that many epidemiologic studies have reported inflated rates of sexual dysfunctions, thereby overestimating the need for treatment.[28] This is striking because since the publication in 1994 of the fourth edition of the *DSM* (*DSM-IV*), the diagnosis of a sexual disorder has been based on the presence of an impairment in sexual functioning in terms of sexual desire, sexual arousal, orgasm, or pain and distress about these impairments.[29] In this article, the term *sexual difficulty* is used for any sexual impairment regardless of sexual distress, whereas the term *sexual dysfunction* refers to sexual difficulties associated with sexual distress. The term *sexual distress* refers to distress from a specific sexual difficulty.

Estimates of sexual dysfunctions are important for sexual and general health policies because studies on the association between sexual difficulties and sexual satisfaction have shown mixed results, with some studies suggesting low associations between sexual difficulties and sexual satisfaction and others finding sexual difficulties are major predictors of sexual satisfaction.[30,31] A possible explanation for these mixed results is that sexual distress rather than the sexual difficulty per se could be a crucial predictor of sexual satisfaction. Indeed, it has been suggested that women with an assigned diagnosis of a sexual difficulty who also perceived they had a problem reported the lowest levels of sexual satisfaction and that women without a diagnosis and without a perceived sexual problem reported the highest levels of sexual satisfaction.[28]

AIMS

To overcome these gaps, a representative population-based survey (the Sexpert survey) was set up to determine prevalence rates of sexual difficulties and sexual dysfunctions in Flanders (the northern Dutch-speaking part of Belgium with approximately 6 million inhabitants). A second goal was to investigate the association of sexual distress with avoidance of sex and help-seeking behavior in men and women with a sexual difficulty. We expected individuals with a distressing sexual difficulty to avoid sex more often and to seek professional help more often compared with persons with a nondistressing sexual difficulty. A third goal was to assess the association of a sexual impairment and/or sexual distress with sexual satisfaction. Based on the study by King et al,[28] we expected that sexual dissatisfaction would be more strongly associated with the experience of distress than with the experience of a sexual difficulty.

METHODS

Participants

The present study used data from the Sexpert survey, a large representative survey on sexuality, sexual health, and relationships in Flanders.[32] The survey contained extensive information on sexual health characteristics and biomedical, psychological, demographic, and sociocultural correlates. A two-step sampling technique was for the random selection of respondents 14 to 80 years old from the Belgian National Register. Permission of the Commission for the Protection of Personal Privacy was obtained. (The Commission for the Protection of Privacy, better known as the Privacy Commission, is an independent body ensuring the protection of privacy when personal data are processed. The Privacy Commission was established by the Belgian Federal House of Representatives on December 8, 1992 [ie, the Privacy Act]).[33] First, random cluster sampling with replacement was used to select 240 geographic units (postal codes) in Flanders. The probability of selection was proportional to the number of inhabitants in each postal code. Second, to increase statistical power in three predefined age categories, we used a stratified sample implying that one third of the sample consisted of young adults (14–25 years old), one third consisted of middle-age adults (26–49 years old), and one third consisted of older adults (50–80 years old). Individual respondents were randomly selected from these predefined age categories.

Selected respondents were visited at their home by a trained professional interviewer from a specialized market research company. When contacting a potential respondent, the interviewer assessed the eligibility of the possible participant (ie, being physically and mentally competent to complete a questionnaire and being able to read and speak Dutch). After informed consent was obtained, data were gathered by face-to-face interviews with a combination of computer-assisted personal interviewing and computer-assisted self-interviewing. In particular, all sensitive (ie, sexuality-related) information was gathered in a computer-assisted self-interviewing setup so that respondents never had to share private information about their sexuality with the interviewer. Data were collected from February 2011 through February 2012.

In total, 5,609 respondents were selected and each received a letter of invitation with information about the Sexpert study.