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Sexual Function in 16- to 21-Year-Olds in Britain

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A B S T R A C T

Purpose: Concern about young people's sexuality is focused on the need to prevent harmful outcomes such as sexually transmitted infections and unplanned pregnancy. Although the benefit of a broader perspective is recognized, data on other aspects of sexuality, particularly sexual function, are scant. We sought to address this gap by measuring the population prevalence of sexual function problems, help seeking, and avoidance of sex in young people.
Methods: A cross-sectional stratified probability sample survey (Natsal-3) of 15,162 women and men in Britain (response rate: 57.7%), using computer-assisted self-interviews. Data come from 1875 (71.9%) sexually active, and 517 sexually inactive (18.7%), participants aged 16–21 years. Measures were single items from a validated measure of sexual function (the Natsal-SF).
Results: Among sexually active 16- to 21-year-old participants, 9.1% of men and 13.4% of women reported a distressing sexual problem lasting 3 months or more in the last year. Most common among men was reaching a climax too quickly (4.5%), and among women was difficulty in reaching climax (6.3%). Just over a third (35.5%) of men and 42.3% of women reporting a problem had sought help, but rarely from professional sources. Among those who had not had sex in the last year, just >10% of young men and women said they had avoided sex because of sexual difficulties.
Conclusions: Distressing sexual function problems are reported by a sizeable minority of sexually active young people. Education is required, and counseling should be available, to prevent lack of knowledge, anxiety, and shame progressing into lifelong sexual difficulties.

IMPLICATIONS AND CONTRIBUTION

This nationally representative data from Britain shows that distressing sexual function problems are not uncommon in young people (aged 16–21 years). In sex education and sexual health services, professionals need to acknowledge the importance of sexual well-being and provide opportunities for young people to raise and discuss their concerns.

Professional interest in young people's sexual behavior is most often driven by concern to prevent the harms of sex, primarily unplanned pregnancy and sexually transmitted infection (STI) transmission [1–3] and, increasingly, nonconsensual sex. Qualitative work suggests that young people themselves are equally concerned with issues affecting their sexual well-being. They may be anxious about their sexual orientation or identity [4], feel social pressure to consent to activities they dislike or find painful [5], or struggle against norms that make it difficult to admit to experiences that are less than ideal [6,7].

While issues around volition, sexual identity, and sexual reputation have been quite well documented, less is known

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about problems young people might have with sexual response and function. This is partly because sexual function problems are assumed to be more relevant to older adults. Sexual function is defined as an individual's ability to respond sexually or to experience sexual pleasure [8] and sexual function problems are those that interfere with these. Population prevalence studies of sexual function problems typically include participants as young as 16 or 18 years, but often use broad age categories, up to 29 years [9] and rarely provide specific detail on young people under 24 years [10–12]. Few studies have focused specifically on early adulthood, and these have not generally used nationally representative data [13,14].

There is increasing recognition that sexual health should be considered broadly [15,16], and the holistic definition endorsed by WHO—"a state of physical, emotional, mental and social well-being in relation to sexuality" [17]—is steadily gaining currency. In young people, sexual health includes "positive developmental contributions of sexuality, as well as the acquisition of skills pertinent to avoiding adverse sexual outcomes" [18]. There is evidence that goals relating to sexual satisfaction and pleasure shape both risk taking and risk-reduction practices [16,19]. For instance, fears about erectile functioning among young men have been shown to contribute to resistance to condom use [20] and to inconsistent use [21]. Good sexual health in adolescents is associated with risk reduction behaviors, such as condom use and sexual abstinence [18], and sexual function in adults is inversely associated with risk behavior [22]. Interventions that safeguard pleasure may therefore be more effective than those that ignore this aspect [16,23]. The current lack of data on sexual function in young people limits efforts to address sexual health holistically and reinforces the belief that sexual function and well-being are less relevant to prevention interventions targeting young people [1,24].

We have previously reported on the prevalence of sexual function problems in adults aged 16–74 years using data from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) [22]. Here, we use this same data set to address the gap in empirical data on sexual function problems (including those that cause distress), help seeking about one's sex life, and avoidance of sex because of problems, in young people aged 16–21 years in Britain.

Methods

Participants and procedure

We present data from 16- to 21-year-old participants in Natsal-3, a stratified probability sample survey of 15,162 men and women aged 16–74 years in Britain, interviewed between September 2010 and August 2012. We focus on the early adulthood period and the early stages of sexual careers before young people "settle" into longer term partnerships and sexual habits. We used a multistage, clustered, and stratified probability sample design, with the U.K. Postcode Address File as the sampling frame and postcode sectors (n = 1,727) selected as a primary sampling unit. Within each primary sampling unit, 30 or 36 addresses were selected at random, and within each household, an eligible adult was selected using a Kish grid. After weighting to adjust for unequal probabilities of selection, the Natsal-3 sample was broadly representative of the British population as described by 2011 Census figures [25].

Participants were interviewed at home by a trained interviewer, using a combination of computer-assisted face-to-face and computer-assisted self-interview (CASI) for the more sensitive questions. The interviewer was present and available to help while participants completed the CASI but did not view answers. At the end of the CASI sections, answers were "locked" into the computer and were inaccessible to the interviewer. The interview lasted for about an hour, and participants received £15 as a token of appreciation. The survey instrument underwent thorough cognitive testing and piloting [26].

The overall response rate was 57.7% of all eligible addresses (64.8% among participants aged 16–44 years). The cooperation rate (proportion of respondents at eligible addresses where contact was made agreeing to take part in the survey) was 65.8%. Details of the survey methodology are published elsewhere [25,27]. Natsal-3 was approved by the Oxfordshire Research Ethics Committee A. Participants provided oral consent for interviews.

Outcome measures

Participants reporting vaginal, oral, or anal sex with one or more partner in the past year were classified as "sexually active" and asked whether they had experienced any of a list of eight difficulties with their sex life lasting 3 months or longer in the past year. These were lacked interest in having sex, lacked enjoyment in sex, felt anxious during sex, felt physical pain as a result of sex, felt no excitement or arousal during sex, did not reach a climax (experience an orgasm) or took a long time to reach a climax despite feeling excited or aroused, reached climax (experienced an orgasm) more quickly than you would like, had an uncomfortably dry vagina (asked of women only), and had trouble getting or keeping an erection (asked of men only). For each item, they endorsed (responded yes), participants were then asked how they felt about the problem (response options: not at all distressed; a little distressed; fairly distressed; very distressed). We also asked how long they had experienced the difficulty and how often symptoms occurred (data not presented in this article).

All sexually experienced participants (those who had ever had a sexual experience), regardless of their sexual activity in the last year, were asked to appraise their sex life overall, including whether they had avoided sex because of sexual difficulties experienced by themselves or their partner (agree strongly, agree, neither agree nor disagree, disagree, disagree strongly). Participants agreeing strongly or agreeing were then presented with the same list of problems and asked to indicate which, if any, had caused them to avoid sex. Additional response options were as follows: "my partner had one (or more) sexual difficulty" and "none of these things caused me to avoid sex." Multiple responses were allowed. Participants were also asked if they felt distressed or worried about their sex life using a five-point Likert scale. Finally, participants were asked whether they had sought help or advice regarding their sex life from any of a list of sources in the last year, and if yes, to select all that apply. These options were subsequently grouped as family member/friend, media/self-help (includes information and support sites on the internet; self-help books/information leaflets; self-help groups; helpline), and professional (includes general practitioner/family doctor; sexual health/genito-urinary medicine/STI clinic; psychiatrist or psychologist; relationship counselor; other type of clinic or doctor), or have not sought any help. These items come