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Sexual problems and associated help-seeking behavior patterns: Results of a population-based survey in France

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Objectives: To report the sexual activity, the prevalence of sexual problems and related help-seeking behavior among adults in France.
Methods: A telephone survey was conducted in 2001 and 2002. Interviews were based on a standardized questionnaire including demographic details, overall health, relationships, and sexual behaviors, attitudes and beliefs.
Results: A total of 1500 individuals (750 men, 750 women) aged 40 to 80 years completed the survey. Eighty-one percent of men and 65% of women had engaged in sexual intercourse during the 12 months preceding the interview. Premature ejaculation (16%) and erectile dysfunction (15%) were the most frequently reported sexual problems among men. Lack of sexual interest (21%) and a lack of sexual pleasure (18%) were the most frequently reported ones among women. Only 10% of men and 8% of women had been asked by a doctor about possible sexual problems during a routine visit in the last 3 years.
Conclusions: Many middle aged and older men and women in France report continued sexual interest and activity. Although a number of sexual problems are seen in this population, only a minority of individuals seek medical help for these disorders. This is largely due to believing that the problem is not serious, not being bothered by the problem, and/or a lack of awareness of available treatments.

Key words: epidemiology, health surveys, prevalence, sex, sexual problems.

Introduction

The prevalence of sexual problems among middle-aged and older adults has been investigated in a number of European countries.[1–7] The studies reported to date have mostly focused on the prevalence of male sexual problems of erectile dysfunction and early ejaculation and their related risk factors and there have been fewer studies of female sexual dysfunction.[8–10] There is also a lack of information on the frequency of sexual activity and the importance of sexual relationships among mature men and women, although the few published studies that have examined sexuality in these age groups have reported that sexual interest and activity persist into middle and older age.[11–13]

The existing studies of the prevalence and correlates of sexual problems in European countries have used a variety of different study designs and definitions, making valid cross-national comparisons difficult. Moreover, there are currently no published studies comparing sexual activity and the ways in which individuals attempt to manage their sexual problems across a number of different countries.

The Global Study of Sexual Attitudes and Behaviours (GSSAB) was a population survey of 27 500 men and women aged between 40 and 80 years in 29 countries representing many world regions.[14–18] In the present paper, we report data obtained from the respondents in France, and compare the sexual activity, the prevalence of sexual problems and help-seeking behaviors in this country with those seen in the rest of Europe.

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Methods

Using a random-digit dialing sampling design, computer-assisted telephone interviews (CATIs) were carried out in France and in other southern (Spain, Italy) and northern (Austria, Belgium, Germany, Sweden, UK) European countries during 2001 and 2002. The respondents were randomly selected by asking for the man or woman in the household between 40 and 80 years of age (participants were interviewed by interviewers of the same gender). Women and men were sampled in approximately equal numbers.

The questionnaire requested information concerning demographics, general health, relationships, and sexual behaviors, beliefs and attitudes. The subjects were asked if they had engaged in sexual intercourse during the previous year and the presence of sexual dysfunction was assessed by means of two sequential questions. The respondents were first asked whether they had ever experienced one or more of the sexual problems listed in Table 2 for a period of 2 months or more during the previous year, and those who answered positively were then asked to specify if they experienced it 'occasionally', 'sometimes' or 'frequently'.

We used logistic regression to investigate potential factors associated with selected sexual dysfunction. In these analyses, the presence of a sexual dysfunction was coded only for those respondents who reported experiencing the problem frequently or periodically, while those who indicated that they experienced the problem only occasionally were recoded to indicate no sexual dysfunction.

The subjects who reported having a sexual problem were asked whether they had sought help or advice from a series of sources. The listed options included: 'Talked to partner', 'Talked to a medical doctor (other than a psychiatrist)', 'Looked for information anonymously (in books/magazines or on the internet)', 'Talked to family member or friend', 'Taken prescription drugs/devices or talked to pharmacist', 'Talked to psychiatrist or psychologist or marriage counselor', 'Talked

to a clergy person or religious adviser', 'Called a telephone help line', 'Other – please specify'. More than one source could be indicated.

The subjects with sexual problems who did not consult a physician were asked why they had not done so, and offered a list of 14 possible reasons (from which they were to indicate all that applied). The reasons included attitudes and beliefs regarding the sexual problem and the patient–doctor relationship. All respondents (irrespective of whether they reported any sexual problems) were also asked 'During a routine office visit or consultation in the past 3 years, has your physician asked you about possible sexual difficulties without you bringing it up first?' (Yes/No) and 'Do you think a doctor should routinely ask patients about their sexual function?' (Yes/No).

The categorization of household income as 'low', 'medium' or 'high' was based on the distribution of income in each country in order to make it possible to compare nations with different absolute mean incomes.

The prevalence of a specific characteristic was calculated by dividing the number of cases by the corresponding population. The denominator for the calculation of the prevalence of sexual problems was the number of sexually active people (i.e. at least one episode of intercourse during the previous year). The prevalence estimates were age-standardized using the age distribution of the French population (by gender when appropriate), and are given with their confidence intervals.[19]

Results

Characteristics of the study population

Overall, 8990 individuals were contacted, 2690 of whom were not eligible to participate. Of the 6300 eligible individuals, 3924 refused to participate at introduction, while 876 interrupted the interview. A total of 1500 individuals (750 men and 750 women) completed the survey, for a response rate of 23.8%. Table 1 presents selected characteristics of the study population standardized for the age distribution of the French population. The majority of the subjects were married or involved in an ongoing partnership (70.8% of men and 64.5% of women) (Table 1). Approximately one-half of the men (46.3%) and one-third of the women (34.9%) were employed. Overall, more than one-half of the men (66.1%) and women (61.7%) said they were in good or excellent general health.

The majority of men (81.1%) and women (65.1%) said that they had had sexual intercourse during the 12 months preceding the interview; and 43.2% of men and 26.4% of women engaged in sexual intercourse more than once a week.

Table 1 Selected characteristics of the study population, France, 2001–2002 (percentage; age-standardized)

	Men (n = 750)	Women (n = 750)
Age group (years)		
40–49	27.5	28.5
50–59	28.5	26.9
60–69	22.9	22.8
70–80	21.1	21.7
Relationship status		
Married or ongoing partnership	70.8	64.5
Divorced/separated without sex partner	12.8	10.7
Widowed without sex partner	5.6	19.2
Single without sex partner	10.8	5.6
Urban residential setting	77.6	78.7
Education		
Primary school or less	18.4	24.7
Secondary/high school	38.7	38.2
At least some college	42.9	37.1
Household income		
Low	28.6	41.8
Medium	44.4	39.1
High	27	19.1
Current employment status		
Employed	46.3	34.9
Unemployed	6.7	0
Homemaker	1.5	16.1
Retired	45.5	44.5
Religion		
Christian/Jew	72.3	82.2
Muslim	4.2	1.1
Buddhist or other Asian	0.1	0.3
Atheist	22.9	16
Other, specified	0.4	0.4
Good to excellent general health†	66.1	61.7
Intercourse in the last 12 months	81.1	65.1
Intercourse more than once a week	43.2	26.4

†Self-reported 'good' or 'excellent' general health (*vs* 'fair' or 'poor').

Prevalence of sexual problems

Early ejaculation was the most common male sexual problem in France (Table 2). The problem was experienced by 16.0% of sexually active men (8.8% experienced the problem frequently or periodically). Difficulty achieving or maintaining an erection (15.0%) and a lack of sexual interest (13.0%) were the next most common male sexual problems, while an inability to reach orgasm (9.9%) and a lack of pleasure in sex (7.4%) were reported less often. Pain during sexual intercourse was reported by only 3.6% of sexually active men in France. Overall, the prevalence of the various male sexual problems in France was similar to that seen in other European regions, although early ejaculation was somewhat less common in France than in the rest of Europe, and erectile difficulties slightly more common.

A lack of sexual interest was the most common female sexual problem and was reported by 20.9% of sexually active women in France (Table 2). A lack of pleasure in sex (17.8%), an inability to reach orgasm (15.8%) and difficulty becoming adequately lubricated (14.3%) were the next most common problems, while pain during intercourse was experienced by only 9.6% of sexually active women in France. Approximately two-thirds of the women who reported each of these problems said that they experienced it frequently or periodically. The prevalence of all sexual problems, except for lubrication difficulties, was lower among sexually active women in France than in other southern European countries (Italy and Spain). The prevalence of all of the listed female sexual problems in France was generally quite similar to that seen in northern Europe.

Help-seeking behavior patterns

The prevalence of selected help-seeking behaviors for sexual problems among men and women in France are summarized in Table 3 (values for men and women from other European regions are also shown for the purpose of comparison). Overall, patterns of help-seeking behavior

Table 2 Age-standardized prevalence of sexual problems in men and women by severity, 2001–2002 (percentage and 95% confidence interval)

	France	Southern Europe	Northern Europe
Men			
Early ejaculation	16.0 (13.1, 19.3)	23.6 (21.5, 25.8)	21.1 (19.3, 22.9)
Occasional	7.2 (5.3, 9.7)	8.7 (7.3, 10.2)	10.4 (9.1, 11.7)
Periodic	7.8 (5.7, 10.2)	10.8 (9.3, 12.4)	7.4 (6.3, 8.6)
Frequent	1.0 (0.4, 2.2)	3.9 (3.0, 4.9)	3.3 (2.6, 4.1)
Erectile difficulties	15.0 (12.2, 18.2)	11.7 (10.2, 13.4)	13.1 (11.7, 14.6)
Occasional	6.0 (4.2, 8.3)	4.3 (3.4, 5.5)	5.0 (4.1, 6.0)
Periodic	7.6 (5.6, 10.1)	5.3 (4.2, 6.5)	5.3 (4.4, 6.4)
Frequent	1.4 (0.6, 2.7)	1.9 (1.3, 2.7)	2.7 (2.0, 3.4)
Lack of sexual interest	13.0 (10.3, 16.0)	12.9 (11.2, 14.6)	12.4 (11.0, 13.8)
Occasional	6.4 (4.5, 8.7)	6.7 (5.5, 8.0)	5.5 (4.6, 6.6)
Periodic	4.7 (3.1, 6.7)	5.1 (4.1, 6.3)	4.2 (3.4, 5.2)
Frequent	1.9 (1.0, 3.4)	1.1 (0.6, 1.7)	2.6 (1.9, 3.3)
Inability to reach orgasm	9.9 (7.6, 12.6)	12.7 (11.1, 14.5)	8.7 (7.6, 10.0)
Occasional	3.3 (2.0, 5.1)	6.0 (4.9, 7.3)	3.7 (3.0, 4.6)
Periodic	5.4 (3.7, 7.5)	4.8 (3.8, 6.0)	3.4 (2.7, 4.3)
Frequent	1.2 (0.5, 2.5)	1.7 (1.1, 2.4)	1.5 (1.0, 2.1)
Sex not pleasurable	7.4 (5.4, 9.8)	9.8 (8.3, 11.3)	7.7 (6.6, 8.9)
Occasional	3.9 (2.5, 5.9)	4.1 (3.2, 5.2)	3.2 (2.5, 4.0)
Periodic	2.7 (1.6, 4.4)	4.0 (3.1, 5.1)	2.6 (2.0, 3.4)
Frequent	0.4 (0.2, 1.7)	1.6 (1.0, 2.3)	1.7 (1.2, 2.4)
Pain during sex	3.6 (2.2, 5.5)	4.8 (3.8, 6.0)	2.9 (2.2, 3.7)
Occasional	1.9 (0.9, 3.4)	2.0 (1.4, 2.9)	1.4 (1.0, 2.0)
Periodic	1.5 (0.7, 2.9)	1.9 (1.2, 2.6)	1.2 (0.8, 1.7)
Frequent	0.2 (0.0, 1.0)	0.6 (0.3, 1.2)	0.3 (0.1, 0.6)
Women			
Lack of sexual interest	20.9 (17.3, 24.9)	32.4 (29.9, 35.1)	25.3 (23.3, 27.4)
Occasional	6.0 (4.0, 8.5)	10.5 (8.9, 12.4)	8.9 (7.6, 10.3)
Periodic	9.4 (6.9, 12.4)	14.4 (12.5, 16.4)	11.1 (9.7, 12.7)
Frequent	5.5 (3.7, 8.0)	7.3 (5.9, 8.9)	5.3 (4.3, 6.5)
Sex not pleasurable	17.8 (14.4, 21.5)	23.3 (21.0, 25.8)	16.6 (14.9, 18.5)
Occasional	5.6 (3.7, 8.1)	8.2 (6.8, 9.9)	7.4 (6.2, 8.8)
Periodic	9.0 (6.6, 12.0)	11.4 (9.7, 13.3)	6.4 (5.3, 7.7)
Frequent	3.2 (1.8, 5.2)	3.5 (2.5, 4.6)	2.6 (1.9, 3.5)
Inability to reach orgasm	15.8 (12.6, 19.4)	27.2 (24.8, 29.8)	17.0 (15.3, 18.9)
Occasional	5.3 (3.5, 7.8)	8.7 (7.2, 10.4)	7.0 (5.8, 8.3)
Periodic	7.5 (5.3, 10.2)	12.0 (10.3, 13.9)	6.8 (5.6, 8.1)
Frequent	3.0 (1.6, 5.0)	6.4 (5.1, 7.9)	3.3 (2.5, 4.2)
Lubrication difficulties	14.3 (11.2, 17.9)	16.6 (14.6, 18.8)	18.7 (16.9, 20.7)
Occasional	4.1 (2.5, 6.4)	4.2 (3.2, 5.5)	5.8 (4.7, 7.1)
Periodic	7.4 (5.2, 10.2)	7.0 (5.7, 8.6)	7.0 (5.8, 8.4)
Frequent	2.8 (1.5, 4.8)	5.3 (4.1, 6.7)	5.9 (4.8, 7.1)
Pain during sex	9.6 (7.1, 12.7)	13.2 (11.3, 15.1)	8.8 (7.5, 10.3)
Occasional	2.8 (1.5, 4.7)	4.1 (3.1, 5.3)	3.7 (2.9, 4.7)
Periodic	3.8 (2.3, 6.0)	6.0 (4.7, 7.4)	3.2 (2.4, 4.1)
Frequent	3.0 (1.6, 5.0)	2.9 (2.1, 4.0)	2.0 (1.4, 2.7)

Based on reports from sexually active respondents. Percentage in the first row of each panel indicates the regional average of the sexual dysfunction, defined as an experience of dysfunction for a period of 2 months or more. The difference between the overall estimate and the sum of the three levels of severity of sexual dysfunction indicates the proportion who failed to specify the level of severity. All prevalence estimates are adjusted according to the age distribution of the total of sexually active men and women in this sample from France. Northern Europe includes Austria, Belgium, Germany, Sweden, and the UK. Southern Europe includes Italy, and Spain.

were similar for men and women in France. Of the respondents who were sexually active and reported at least one sexual problem, 32.9% of men and 26.4% of women had not taken any action (i.e. they had not sought any help). Taking no action was considerably less common in France than in the rest of Europe. Talking to their partner was the most common action taken by both men and women (52.2% and 54.1%, respectively) in France, while 16.7% of men and 20.5% of women reported talking to a family member or friend. Seeking social support

Table 3 Prevalence of selected help seeking behaviors for sexual problems by gender, 2001–2002 (percentage and 95% confidence interval)

	France	Southern Europe	Northern Europe
Men			
Help seeking behaviors for sexual problems			
Talked to partner	52.2 (45.5, 58.8)	46.1 (42.3, 49.9)	40.4 (37.4, 43.4)
Talked to medical doctor	35.1 (28.9, 41.7)	17.3 (14.6, 20.4)	18.7 (16.3, 21.2)
Talked to family member/friend	16.7 (12.1, 22.2)	9.2 (7.1, 11.6)	6.3 (4.9, 7.9)
Looked for information anonymously (in books/magazines or via telephone help-line/Internet)	13.6 (9.4, 18.7)	13.6 (11.1, 16.4)	11.7 (9.8, 13.8)
Taken drugs/used devices or talked to pharmacist	11.8 (8.0, 16.8)	9.8 (7.6, 12.2)	10.0 (8.2, 12.0)
Talked to psychiatrist, psychologist or marriage counselor	7.0 (4.1, 11.1)	4.1 (2.7, 5.8)	3.2 (2.2, 4.4)
Talked to a clergy person or religious adviser	0.9 (0.1, 3.1)	1.3 (0.6, 2.5)	0.5 (0.2, 1.1)
Sought no help from a health professional	*63.6 (57.0, 69.8)*	*80.2 (77.0, 83.1)*	*80.2 (77.6, 82.6)*
No action taken	*32.9 (26.8, 39.4)*	*41.6 (37.8, 45.4)*	*47.3 (44.2, 50.4)*
Women			
Help seeking behaviors for sexual problems			
Talked to partner	54.1 (47.3, 60.8)	48.6 (45.1, 52.0)	39.6 (36.7, 42.5)
Talked to medical doctor	39.5 (33.0, 46.3)	21.9 (19.2, 24.9)	19.4 (17.1, 21.8)
Talked to family member/friend	20.5 (15.3, 26.4)	14.4 (12.1, 16.9)	11.7 (9.8, 13.7)
Taken drugs/used devices or talked to pharmacist	17.7 (12.9, 23.4)	14.1 (11.8, 16.7)	14.1 (12.1, 16.3)
Looked for information anonymously (in books/magazines or via telephone help-line/Internet)	17.3 (12.5, 22.9)	12.2 (10.0, 14.6)	14.0 (12.0, 16.2)
Talked to psychiatrist, psychologist or marriage counselor	5.0 (2.5, 8.8)	3.9 (2.7, 5.4)	2.5 (1.7, 3.6)
Sought no help from a health professional	*58.2 (51.4, 64.8)*	*76.6 (73.5, 79.4)*	*78.0 (75.5, 80.4)*
No action taken	*26.4 (20.7, 32.7)*	*38.6 (35.3, 42.0)*	*44.6 (41.6, 47.5)*

Based on reports from respondents complaining of at least one sexual problem. All prevalences are adjusted according to the age distribution of the total of sexually active men and women in this sample from France. Northern Europe includes Austria, Belgium, Germany, Sweden, and the UK. Southern Europe includes Italy, and Spain.

from a partner, family or friends was somewhat more common in France than in the rest of Europe.

Approximately one-third of men (35.1%) and women (39.5%) reported talking to a medical doctor about their sexual problem(s). Even though these values are about twice as high as those reported in the rest of Europe, the majority of men (63.6%) and women (58.2%) in France had not sought any help or advice from a health professional.

Factors associated with seeking medical help for sexual problems

Some of the factors that might be associated with seeking medical help for sexual problems among men and women in France were investigated using logistic regression and the results of these analyses are summarized in Table 4. Increasing age and level of education did not appear to significantly influence help-seeking behavior among either men or women. Certain sexual problems were associated with a greater likelihood of seeking medical help. Erectile difficulties in men (odds ratio [OR] 2.56, $P \leq 0.05$) and lubrication difficulties in women (OR 3.23, $P \leq 0.05$) were significant correlates of seeking medical help for sexual problems. The only other significant correlates were: among men, having been asked by a doctor about possible sexual difficulties during a routine visit in the past 3 years (OR 4.68, $P \leq 0.01$); and among women, being very or somewhat dissatisfied with sexual function (OR 3.51, $P \leq 0.05$).

Attitudes and beliefs about diagnosis and treatment of sexual problems

The most common reasons for not consulting a doctor about sexual problems, cited to a similar extent among both men and women in France, were a belief that it is a normal part of aging or being comfortable as he/she is (87.2% of men and 84.2% of women), thinking it is not very serious or waiting for the problem to go away (72.3% of men and 72.2% of women), and thinking that a doctor cannot do much or that it is not a medical problem (57.4% of men and 55.6% of women) (Table 5). In each case, these reasons showed a considerably higher prevalence among men and women in France compared with other European regions. Substantially more women than men cited being uncomfortable talking to their doctor or that their doctor was a close friend or the wrong gender (45.1% of women and 22.5% of men). These values showed some interesting differences between France and other European regions. Feelings of discomfort or embarrassment about talking to their medical doctor were cited rather less frequently by men in France than in southern Europe. However among women in France, a lack of access to or affordability of medical care showed a prevalence similar to that seen in other European regions, while the prevalence of feelings of discomfort or embarrassment about talking to their medical doctor was similar to that reported in southern Europe but much higher than in northern Europe. Thinking that their doctor was uneasy talking about sex was cited as a reason for non-consultation by only 12.8% of men and 9.8% of women in France. Only about 10% of the men and women in France had been asked by a doctor about

Table 4 Factors associated with seeking medical help for sexual problems by gender, France, 2001–2002

	Men	Women
Age (years)		
40–49	Reference	Reference
50–59	1.28 (0.49, 3.35)	1.51 (0.62, 3.63)
60–69	0.95 (0.33, 2.71)	0.82 (0.25, 2.68)
70–80	1.96 (0.63, 6.12)	0.35 (0.06, 2.30)
Education		
Primary school or less	Reference	Reference
Secondary/high school	1.58 (0.59, 4.22)	1.37 (0.39, 4.83)
At least some college	1.37 (0.49, 3.87)	2.28 (0.64, 8.07)
High/medium household income (vs low)	0.46 (0.21, 1.00)	0.79 (0.35, 1.81)
Sexual problems		
Erectile difficulties	2.56 (1.27, 5.17)*	
Early ejaculation	0.97 (0.48, 1.95)	
Lack of sexual interest	0.75 (0.37, 1.52)	0.80 (0.37, 1.73)
Inability to reach orgasm		0.38 (0.16, 0.89)
Lubrication difficulties		3.23 (1.34, 7.78)*
General sexual attitudes		
Have been asked by a doctor about possible sexual difficulties in a routine visit in the past three years	4.68 (1.51, 14.47)**	2.83 (0.95, 8.44)
Think a doctor should routinely ask patients about sexual function	1.40 (0.96, 2.84)	1.52 (0.66, 3.51)
Very/somewhat dissatisfied with sexual function	0.69 (0.14, 3.43)	3.51 (1.05, 11.75)*
Belief that decreased ability to perform sexually would significantly affect self-esteem	0.86 (0.38, 1.94)	1.03 (0.40, 2.68)
Belief that sex is a extremely/very important part of overall life	2.41 (0.64, 9.06)	1.03 (0.19, 5.70)
Think it is OK to use medical treatment for sexual problems	1.57 (0.74, 3.32)	2.14 (0.95, 4.84)
Think that older people no longer want/have sex	1.27 (0.60, 2.68)	0.74 (0.31, 1.77)
Belief in religion guiding sex	0.71 (0.29, 1.73)	1.73 (0.68, 4.41)

*$P \leq 0.05$; **$P \leq 0.01$. Odds ratios and 95% confidence intervals from logistic regression. Based on reports from respondents complaining of at least one sexual problem.

possible sexual difficulties during a routine visit in the past 3 years (10.1% of men and 8.4% of women). However, about 40% of men (45.7%) and women (37.6%) thought that a doctor should routinely ask patients about their sexual function. This attitude was similarly prevalent in France and in other European regions.

Discussion

Published reports of the sexual problems experienced by mature adults in France have largely focused on the prevalence of male erectile dysfunction and associated lower urinary tract symptoms.[1,5,20] We believe that this is the first study to report population-level data from middle-aged and older men and women in France concerning sexual activity, the prevalence of several male and female sexual problems and associated help-seeking behaviors. Moreover, the cross-national population sample of the GSSAB, together with the use of a common method of data collection mean that direct comparisons between France and other countries and regions are possible.

The standardized, structured GSSAB questionnaire was given by telephone interview. Face-to-face interviews were not used because it was deemed that they may cause respondents to feel embarrassed when talking about private and sensitive issues, or may make them feel obliged to give socially desirable answers.[21] Only a sexual problem that persisted with moderate to higher frequency, that is, one that was reported to occur periodically or frequently, was defined as 'sexual dysfunction'. This method is equivalent to using two sequential screening tests, and minimizes the false positive rate; however, it means that the prevalence of sexual dysfunction is likely to have been underreported in the GSSAB, in comparison with studies that have used more sensitive (and less specific) methods. This appears to be the case for the prevalence of male erectile dysfunction, for in the French cohort of GSSAB the overall prevalence of erectile difficulties was 15.0% (9.0% reported that they experienced the problem frequently or periodically), which is lower than in currently published studies of men in France aged over 18 years.[1,5,20]

The overall response rate in France (23.8%) was low, which raised concerns about the possible introduction of bias into our estimates of the prevalence of sexual behaviors and problems. However, the prevalence of various self-reported health conditions such as hypertension, diabetes and smoking in the GSSAB respondents in France (data not shown here) was consistent with published national figures.[22–24] Therefore, it seems likely that participants refused to participate in the study simply because they did not wish to undergo a telephone interview, and this is unlikely to have introduced a bias in the data. These findings also indicate that the GSSAB study sample was broadly representative of the French population.

Only about one-third of the men and women in the GSSAB sample in France who had experienced a sexual problem had consulted a medical doctor about this problem. A published study has reported an even lower rate for men in France with erectile dysfunction, in which just 22.2% reported seeking medical advice and furthermore, 63% said that they found it difficult to talk to their physician about sexuality.[20] The authors commented on the importance of physicians taking the lead in this matter and opening a dialogue on sexual problems. Our

Table 5 Attitudes, behaviors and beliefs about diagnosis and treatment for sexual problem by gender, 2001–2002 (percentage and 95% confidence interval)

	France	Southern Europe	Northern Europe
Men			
Reasons for not consulting a doctor about the experienced sexual problem†			
Normal with aging/I am comfortable the way I am	87.2 (80.7, 92.1)	56.6 (52.4, 60.8)	73.6 (70.5, 76.6)
Did not think it was very serious/Waiting if problem goes away	72.3 (64.3, 79.3)	45.9 (41.7, 50.1)	69.1 (65.9, 72.2)
Doctor cannot do much/Do not think it is a medical problem	57.4 (49.0, 65.5)	31.0 (27.2, 35.0)	40.6 (37.2, 44.0)
Do not have a regular physician/Doctor is expensive	27.0 (20.1, 34.9)	27.5 (23.8, 31.4)	22.5 (19.7, 25.5)
Not comfortable talking to a MD/MD is a close friend/MD is the wrong gender	22.5 (18.0, 33.1)	37.9 (33.9, 42.1)	24.9 (22.1, 28.0)
Doctor uneasy to talk about sex	12.8 (7.9, 19.3)	5.3 (3.6, 7.5)	9.1 (7.2, 11.2)
Have been asked by a doctor about possible sexual difficulties in a routine visit in the past three years‡	10.1 (8.1, 12.5)	6.1 (5.0, 7.3)	7.0 (6.0, 8.0)
Think a doctor should routinely ask patients about their sexual function‡	45.7 (42.1, 49.4)	49.6 (47.2, 52.0)	44.4 (42.5, 46.3)
Women			
Reasons for not consulting a doctor about the experienced sexual problem†			
Normal with aging/I am comfortable the way I am	84.2 (76.9, 90.0)	62.3 (58.4, 66.0)	68.2 (65.0, 71.2)
Did not think it was very serious/Waiting if problem goes away	72.2 (63.7, 79.6)	49.8 (45.8, 53.7)	63.6 (60.4, 66.7)
Doctor cannot do much/Do not think it is a medical problem	55.6 (46.8, 64.2)	30.9 (27.3, 34.6)	40.7 (37.5, 44.0)
Not comfortable talking to a MD/MD is a close friend/MD is the wrong gender	45.1 (36.5, 54.0)	43.2 (39.4, 47.1)	24.9 (22.2, 27.9)
Do not have a regular physician/Doctor is expensive	24.1 (17.1, 32.2)	31.5 (27.9, 35.2)	21.7 (19.1, 24.6)
Doctor uneasy to talk about sex	9.8 (5.3, 16.1)	8.6 (6.6, 11.1)	7.3 (5.7, 9.2)
Have been asked by a doctor about possible sexual difficulties in a routine visit in the past three years‡	8.4 (6.5, 10.6)	5.2 (4.3, 6.4)	8.4 (7.4, 9.5)
Think a doctor should routinely ask patients about their sexual function‡	37.6 (34.1, 41.2)	40.7 (38.4, 43.0)	36.0 (34.2, 37.8)

†Based on reports from respondents complaining of at least one sexual problem who have not consulted a doctor. ‡Based on all respondents. All prevalence estimates are adjusted according to the age distribution of the total of sexually active men and women in this sample from France. Northern Europe includes Austria, Belgium, Germany, Sweden, and the UK. Southern Europe includes Italy, and Spain.

findings show that doctors in France – in common with the rest of Europe – rarely ask patients about their sexual health during a routine consultation, even though this would be welcomed by a substantial proportion of men and women and would appear to encourage medical help-seeking for sexual problems, at least in men (men who had been asked by a doctor about possible sexual difficulties in a routine visit in the past 3 years were significantly more likely to seek medical help for sexual problems).

We conclude that in France, as in other European regions, men and women continue to show sexual interest and activity well into middle age and beyond, in spite of the high prevalence of a number of sexual problems. Only a minority of individuals seek medical help for the sexual difficulty that they experience, largely because they do not perceive it to be a problem or because they are not aware that any medical treatments are available. These findings highlight the importance of physicians asking their patients about possible sexual problems during routine visits and offering them advice on the treatment options that are currently available.

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