Türk Psikiyatri Dergisi 2010;
Turkish Journal of Psychiatry

Investigation of Sexual Problems in Married People Living in the Center of Konya

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Abstract

Objective: *Sexual problems are widely encountered in community. While studies clinically performed concerning sexual peoblems in Turkey exist, there are no field studies related to sexual problems witnessed in both men and women. In this study, sexual problems in married population and the level of their sexual knowledge have been tried to be investigated.*

Method: *The cosmos of the study consisted of the whole married population between the ages of 18 and 60 and living in the province of Konya. Sociodemografic Information Form and Golombok-Rust Inventory of Sexual Satisfaction were performed in 945 subjects accepting to take part in the study and appropriate.*

Results: *Average age rate of the males taking part in the study was 38.5±9.5 and the same rate of women was 34.2±9.8. According to the findings provided via GRISS, the rate of erectile dysfunction (ED) in men was 14.5 %, the rate of premature ejeculation (PE) 29.3 %, the rate of anorgasmia in women was found to be 5.3 %, and the rate of vaginismus to be 15.3 %.*

Conclusion: *Prevalence rates of PE, ED and anorgasmia in our sample was parallel to those provided from other countries at same age group. Vaginismus rate in our study is higher compared to other studies.*

Key Words: *Sexuality, sexual dysfunctions, marriage*

INTRODUCTION

At the turn of the 20th century, Freud obtained the first theoretical data about sexuality from patients of psychoanalysis. Sexuality was considered a taboo subject to be discussed or researched until the Kinsey's survey was published. The second turning point in the study of sexuality was the survey performed by Masters and Johnson. As a result of these surveys, the responses the participants gave to sexual arousals were observed objectively and the stages of sexual arousal were recorded. According to Masters and Johnson, the sexual arousal cycle has four parts; arousal, plateau, orgasm, and resolution. Kaplan added the desire dimension and defined a three-phase sexual response. The DSM-IV classification which is based on Kaplan's model defined the sexual dysfunctions. According to DSM-IV, sexual dysfunction is characterized by the dysfunction at one of the phases of sexual cycle or pain during sexual intercourse (Yetkin and İncesu 1998, Kaplan 1987, American Psychiatric Association 1994). A great many factors are effective in the formation of sexual dysfunctions. Hawton described the psychogenic problems concerning erection in three stages. These factors are applicable to all sexual dysfunctions.

a) Preparatory factors: Very repressive parents, bad intra-family relations, inadequate or incorrect notions concerning sex, psychosocial developmental problems and traumatic sexual intercourse.

b) Starting factors: Pregnancy and birth, bad relations between couples, loss of atthractiveness of a spouse, adultery, unsuccesful intercourse, traumatic sexual inter-

Received: 04.10.2008 - **Accepted:** 12.01.2010

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course, as a reaction to organic diseases, ageing, unrealistic expectations from sexuality, sexual dysfunction in the spouse, depression and anxiety.

c) Sustaining factors: Performance anxiety, communication disorders between the couples, fear of intimacy, inadequate or false sexual knowledge, limited fore-play and other psychiatric disorders.

Kayır and Şahin made a point of focusing on the family and the effect of restrictive and inadequate sexual education in developing sexual dysfunctions. Kayır and Sahin claim that the way the family views sexuality and interpersonal relations is important for psychosocial development. Sexuality may be regarded as a taboo or overtly despised in the family. For a great many people, sexuality is about bad jokes heard in adolescence from friends or inadequately information from them. However a new study performed among male adolescents, proves that the role of family and pornographic publications increase for sexual knowledgeability (Kayır and Şahin 1998, Çatin et all. 2008). Sexuality has not long been a subject of interest for researchers. Spector and Carey, in a study they made in 1990, recorded just 23 field surveys that had been carried out until that time. In another study by Simons and Carey in 2001, the number of surveys was 52. The drug therapy developed for erectile dysfunction, in particular, aroused interest in research on sexual disorders. In our country, the common reasons given for referring patients to either of the two sexual dysfunction centers are vaginismus in women and erectile dysfunction in men (Sungur 1998, Kayır 1995). Yetkin and Saatçioğlu, in a study on 70 men who had presumed themselves to be functioning normal sexually found that 74% had sexual problems, mostly on reaching orgasm (Yetkin and Saatçioğlu 1998). In another study made among men with sexual dysfunctions, the study group was found to be more anxiety-prone than the normal population (Taştan et all. 2005). A study by Eşsizoğlu et al. found that religious factors affected sexual intercourse and sexual beliefs (Eşsizoğlu et al 2009). There have been numerous studies on limited populations and clinical settings concerning sexual problems and behaviors, No field survey about the prevalence of sexual disorders and related factors, involving both sexes had previously been made in Turkey. As a result, we were inclined to carry out such a survey.

METHOD

Sampling

The cosmos of the study is men and women between the ages of 18-60 living in the Konya city center. The prevalence of erectile dysfunction and premature ejaculation in the over-18 age group was found to be between 4-14.7% and 4-66%, while incidence of vaginismus and female orgasmic disorder was at 0.5-1%, and 5-12%. While in western societies vaginismus is rare, in Turkey it is the most common reason for visiting sexual dysfunction outpatient clinics (Laumann et al. 1999, Ventegodt 1998, Parazzini et al. 2000, Heruti et al. 2004, Fugl-meyer and Sjögren Fugl-Meyer 1999, Ventegodt 1998, Aschka et al. 2001, Kadri et al. 2002, Simons and Carey 2001, Spector and Carey 1990, Sungur 1998, Kayır 1995). As a result of these findings the sample size for erectile dysfunction/ premature ejeculation in men and orgasmic dysfunction/ vaginismus in women is supposed to be at least 5% among the population. To reach the target the formulation is calculated to have a 0.5% deviation and 95% confidence interval with 80% study power. Because both sexes were surveyed, the group effect is regarded as 2 and the design effect is regarded as 2. According to these calculations in the 18-60 age range, sample size had to be at least 976. Cluster volume is specified as 20 and was planned to reach 49 clusters. The population size obtained from the primary health care clinic household forms was taken as a basis for settlement areas. Settlement areas (clusters) were calculated and located by using a population-based systematic cluster sampling method. Even though the study sample was calculated to be 976, of 1100 person was reached to be tought of possible data missing,108 refused to take part in the survey (9.8%). 47 subject were left out of the survey because of insufficent data or for not meeting the study standards. Finally 475 men and 470 women were included in the study.

Data Collection

The survey was carry out between June and August 2006. Surveyors were chosen from Selçuk University Meram Medical School interns and Specialist Psychiatric residents. Surveyors were briefed concerning the administration of the questionnaire forms. Male surveyors interviewed male participants, female surveyors interviewed female participants. The Head office was chosen as the starting point at each cluster and house numbers were followed until reaching 20 people. Those who were not at home were bypassed and if the house numbers were not enough in that street, the next street was chosen in a clockwise rotation.

Data Gathering Tools

1) Sociodemografic Information Form: In this form questions concerning issues such as sex, education, occupation, length of time married, number of children, the

way in which respondents were married, their information sources for sexual matters and where they ask for advice when they have sexual problems were asked. For the question inquiring whether respondents had had premarital sex, the tick boxes: "No sexual experience", "brothel" or "someone special" were provided. For the question of how respondents married, the boxes "by consent" and "through a match-maker"were presented. Tick boxes for the question of source of sexual information were: "family", "friend", "books-mass media" and "other". For the question "where do you ask for advice when you have sexual problems, the boxes", "I do not ask advice", " hodja-religious person", "private doctor", "hospital" and "other" were available. For those who answered that they go to private doctors or hospitals a sub-directory of thick boxes namely: " family physician ", "gynecologist", "internal medicine", "urology", "psychiatry" or "no idea" were presented.

2) Golombok-Rust Inventory of Sexual Satisfaction (GRISS): This test was devised to assess the quality of sexual relations and sexual dysfunction in heterosexual couples (Rust and Golombok 1986). Different questionnaires are available for men and women. Erectile dysfunction and premature ejeculation for men, and anorgasmia and vaginismus for women are special subscales. For each step there is a Likert-type 5 degree answer key is available. The options for answering are "never", " seldom", " sometimes", "generally"and " always". Raw points are converted to standart points between 1 and 9, and points above 5 refer to a sexual problem. The safety and reliability of the Turkish questionnaire was tested by Tuğrul et al. on men and women (Tuğrul et al. 1993). The same study was carried out made by Gülçat only men alone (Gülçat 1995).

Criteria for participation in the survey

1. To be living in the city of Konya
2. To be married
3. To be between ages 18-60
4. To be volunteering for the survey.

Statistical Analysis

After the data was gathered it was entered into the SPSS 13 pocket program. The total points and sub scale points interviewees received from GRISS were compared with t-test. In variables which have more than two categories, the comparison of GRISS subscale points is made by one way variance analysis (ANOVA). In assessing ANOVA results, the Tukey test is used for multi task comparison for further analysis. In relation to age, length of time married, the number of children and the GRISS subscale points analysis, the Pearson correlation test is used.

FINDINGS

The mean age of the 945 men and women who took part in the survey was 36.3±9.9 years. Of these, 470 were women (49.7%), and 475 were men (50.3%). The mean marriage-length was 14.4±10.0 years, the mean number of children in a family was 2.24±1.35. 86.2% of the women were housewives. Table 1 shows the sociodemographic characteristic of the participants (Table 1).

Characteristic sexual background

45.1% of men stated they had had no premarital sexual experience, 28% of men had first experienced sexual intercourse in a brothel. Almost all of the women stated that they had not experienced premarital sex (99.4%). 33.9% of participants had married as a result of a love affair and 66.1% of them had married through the assistance of a match-maker. Even though there was not such a choice on the survey form, 24.4% of men and 31.1% of women indicated their best man or bridesmaid as their source of sexual education. Most of the participants said they would go to a private doctor in the event of a sexual problem. Women mostly chose gynecologists, whereas men chose urologists for such problems (Table 2).

TABLE 1. Sociodemographic Characteristics of the participants

	Men	Women	Total
Age Groups	n (%)	n (%)	n (%)
18-29	102 (21.5)	161 (34.2)	263 (%27.8)
30-39	165 (34.7)	182 (38.7)	347 (%36.7)
40-49	125 (26.3)	91 (19.4)	216 (%22.8)
50-60	83 (17.5)	36 (7.6)	119 (%12.6)
Place of Birth			
Metropole	165 (34.7)	253 (53.8)	418 (%44.2)
Village	142 (29.9)	99 (21.0)	241 (%25.5)
County	131 (27.6)	87 (18.5)	218 (%23.0)
Town	37 (7.8)	31 (6.6)	68 (%7.2)
Education			
İlliterate	2 (0.4)	22 (4.7)	24 (%2.5)
Literate without schooling	3 (0.6)	19 (4.0)	22 (%4.6)
Primary School	302 (63.5)	280 (59.5)	582 (%61.5)
High School	86 (18.1)	85 (18.0)	171 (%18.1)
University	82 (17.1)	64 (13.6)	146 (%15.4)
Occupation			
Housewife	-	405 (86.2)	405 (%42.9)
Worker	175 (36.9)	4 (0.8)	179 (%18.9)
Employee	91 (19.1)	42 (8.9)	133 (%14.1)
Self-employed	129 (27.1)	3 (0.6)	132 (%14.0)
Retired	60 (12.6)	9 (1.9)	69 (%15.3)
Unemployed	9 (1.9)	1 (0.2)	10 (%1.1)
Farmer	9 (1.9)	-	9 (%0.9)
Student	1 (0.2)	6 (1.2)	7 (%0.7)

TABLE 2. Sexual information source and where do the participants apply for sexual advice

Questions	Men n (%)	Women n (%)	Total n (%)
Sexual İnformation Source			
Friends	198 (%41.7)	112 (%23.8)	310 (%32.8)
Bestman-Bridemaid	116 (%24.4)	146 (%31.1)	262 (%27.7)
Book-Media	114 (%24.0)	84 (%17.8)	198 (%20.9)
Family	18 (%3.8)	30 (%6.4)	48 (%5.1)
All	24 (%5.1)	17 (%3.6)	41 (%4.3)
No Source	5 (%1.1)	81 (%17.2)	86 (%9.1)
Advice for Sexual Problems			
Private Doctor	199 (%41.9)	247 (%52.6)	446 (%47.2)
Hospital	213 (%44.8)	144 (%30.6)	357 (%37.8)
Not Advice	39 (%8.2)	50 (%10.6)	89 (%9.4)
Religious Person	5 (%1.1)	11 (%2.3)	16 (%1.7)
Other	19 (%4.0)	18 (%3.8)	37 (%3.9)
Specialty			
Gynecology	-	266 (%56.6)	266 (%28.1)
Psychiatry	89 (%18.7)	100 (%21.2)	189 (%20.0)
Urology	166 (%34.9)	-	166 (%17.6)
Not Advice	38 (%8.0)	54 (%11.4)	92 (%9.7)
Family Physician	50 (%10.5)	21 (%4.5)	71 (%7.5)
İnternal Medicine	24 (%5.1)	3 (%0.6)	27 (%2.9)
No İdea	108 (%22.7)	26 (%5.5)	134 (%14.2)

The Prevalence of Sexual Problems

When the raw points from GRISS were converted erectile dysfunction and premature ejeculation in men and anorgasmia and vaginismus rates in women were calculated. GRISS converted points for the 18-60 age group are 14.5% for erectile dysfunction, 29.4% for premature ejeculation, 5.3% for anorgasmia and 15.3% for vaginismus (Table 3). When the mean values of the GRISS total points and subscale points are compared between the two sexes, women received higher scores in the sexual satisfaction, avoidance, non-sensuality, and infrequency and men received scores significantly higher on non-communication subscales (Table 4).

When the GRISS subscale raw points are correlated with the age, length of marriage, and number of children in the family of participants, there is a positive correlation with erectile dysfunction and premature ejeculation in men according to age, length of marriage, and number of children (with erectile dysfunction p=0.00, r=0.251; p=0.00, r=0.271; p=0.00, r=0.163 respectively; with premature ejeculation p=0.00, r=0.168; p=0.00, r=0.181; p=0.002, r=0.140 respectively) (Table 5).

The negative correlation between female vaginismus subscale points and age, length of marriage, and the number of children was (p=0.00 r=-0.193; p=0.00, r=-0.228; p=0.00, r=-0.247 respectively), While points for anorgasmia decrease significantly with age and length of period married, there was no significant relationship with the number of children in the family (p=0.039, r=0.095; p=0.01 r=0.112; p=0.16, r=0.064 respectively) (Table 5).

One-way variance analysis is performed separately for men and women. When raw points from GRISS subscales for different age groups are compared with

TABLE 3. The frequency sexual dysfunctions of the participants in relation to their age group related GRISS converted cut off points comparison of GRISS subscale and comparison of total raw points

	Age Groups				Total	F (Sd1, Sd2), p
	18-29	30-39	40-49	50-60		
	N (%) Mean.±Sd	N (%) Mean.±Sd	N (%) Mean.±Sd	N (%) Mean.±Sd	N (%) Mean.±Sd	
Premature Ejeculation	21 (%20.6) 5.02±3.65	42 (%25.5) 5.38±3.305	41 (%32.8) 6.07±2.96	35 (%42.2) 6.63±3.53	139 (%29.4) 5.70±3.37	4.57 (3, 471), 0.004a
Ercetile Dysfunction	10 (%9.8) 2.59±2.29	12 (%7.3) 2.38±1.83	20 (%16.0) 2.94±2.29	27 (%32.5) 4.37±3.06	69 (%14.5) 2.92±2.40	14.75 (3, 471), 0,000b
Vaginismus	35 (%21.7) 5.46±3.32	22 (%12.1) 4.20±2.98	11 (%12.1) 4.30±2.94	4 (%11.1) 3.83±2.95	72 (%15.3) 4.62±3.14	6.18 (3, 466), 0.000c
Anorgasmia	8 (%5.0) 5.75±3.20	5 (%2.7) 5.10±2.95	8 (%8.8) 6.23±3.67	4 (%11.1) 7.11±3.25	25 (%5.3) 5.70±3.25	5.26 (3, 466), 0.001d
GRISS total point (Men)	26.52±7.86	27.73 8.37	29.09±8.19	31.34±10.28	28.46±8.70	5.47 (3, 941), 0.001e
GRISS total point (Women)	40.48±7.04	39.80±5.63	43.13±6.72	45.28±7.15	41.10±6.67	10.95 (3, 941), 0.000f

a. 18-29 and 30-39 age group < 40-49 and 50-60 age group, b. 50-60 age group > 18-29, 30-39 and 40-49 age group, c. 18-29 age group > 30-39, 40-49 and 50-60 age group, d. 30-39 age group < 40-49 and 50-60 age group, e. 50-60 age group > 18-29, 30-39 age group, f. 40-49 and 50-60 age group > 18-29 and 30-39 age group

TABLE 4. The Comparison of the average of GRISS subscale and total points of the participants according to each sex

	Men	Women	t (sd), p
	Mean.±sd	Mean.±sd	
Frequency	3.73±1.28	4.27±1.61	5.73 (892), 0.000
Communication	4.75±1.96	3.19±1.62	9.03 (913), 0.000
Satisfaction	3.54±2.92	8.77±2.85	27.80 (943), 0.000
Avoidance	1.83±2.15	7.54±1.86	43.44 (926), 0.000
Sensuality	5.96±2.22	6.48±2.06	3.73 (939), 0.000
Premature Ejeculation	5.70±3.37	-	-
Ercetile Dysfunction	2.92±2.39	-	-
Vaginismus	-	4.62±3.14	-
Anorgasmia	-	5.69±3.25	-
GRISS total	28.46±8.70	41.10±6.67	25.07 (888), 0.000

ANOVA, premature ejeculation mean scores are lower in the 18-29 and 30-39 male age groups than in other age groups. In the 50-60 age group the mean score for erectile dysfunction is higher than in the other groups (F (4.57, Sd1=3, Sd2=471), p=0.004; F(14.75, Sd=3, Sd2=471), p=0.000 respectively) (Table 3). When the same analysis was performed on female participants, 18-29 age group mean scores in the vaginismus subscale were higher in the 18-29 age group than in other age groups and the 30-39 age group anorgasmia subscale saw lower scores than other age groups (F(6.18, Sd1=3, Sd2= 466), p=0.000; F(5.26, Sd1=3, Sd2= 466), p=0.001respectively) (Table 3).

When GRISS subscale points are compared according to educational levels, in men there is a difference in premature ejeculation points and in women there is a difference in vaginismus and anorgasmia points (F (8.74, Sd1=4, Sd2=470), p=0.000; F(3.57, Sd1=4, Sd2=4659), p= 0.007; F(3.94, Sd1=4, Sd2=465), p=0.004 respectively) (Table 6). The literate without schooling group had higher scores for premature ejeculation, vaginismus, and anorgasmia than the illiterate group, primary school graduates group, high school graduates group and the university graduates group. Except for the literate without schooling group, there was no significant difference between the groups regarding premature ejeculation, vaginismus or anorgasmia scores (Table 6). There was no correlation between erectile dysfunction and education levels (F (0.174, Sd1=4, Sd2= 470), p=0.139) (Table 6).

DISCUSSION

Particularities of Sexual Experience

Our findings show that premarital sexual experience has a very low rate of occurrence among women. This result implies that virginity is still very important in our society and women do not seek out premarital sexual experience. Underreporting of premarital sexual experience by women may have contributed to this result. People still marry through the agency of matchmakers and this shows that traditional values are still important. As an information source for sexual knowledge friends the bridesmaid or best man are usually given. This is a sign that sexuality is still a taboo and is not discussed in the family. The validity of sexual information from friends is a subject of discussion. When asked " What would you

TABLE 5. Correlation age, length of marriage, and the number of children in the family with GRISS subscales of the participants

		Age	Marriage Duration	The number of Child	Vaginismus	Anorgasmia	Premature Ejeculation
Age	r	-					
	p						
Length of Marriage	r	0.890**	-				
	p	0.000					
The number of Children	r	0.562**	0.645**	-			
	p	0.000	0.000				
Vaginismus	r	-0.193**	-0.228**	-0.247**	-		
	p	0.000	0.000	0.000			
Anorgasmia	r	0.095*	0.112*	0.064	0.128**	-	
	p	0.039	0.015	0.166	0.006		
Premature Ejeculation	r	0.168**	0.181**	0.140**	-	-	-
	p	0.000	0.000	0.002			
Ercetile Dysfunction	r	0.251**	0.271**	0.163**	-	-	0.160**
	p	0.000	0.000	0.000			0.000

** p<0.01, * p<0.05

TABLE 6. The frequency sexual dysfunctions in relation with schooling years GRISS converted cut off points and comparison of GRISS subscale and total raw points

	Education					F (Sd1, Sd2), p
	İlliterate	Literate without schooling	Primary School	High School	University	
	N (%) Mean.±Sd	N (%) Mean.±Sd	N (%) Mean.±Sd	N (%) Mean.±Sd	N (%) Mean.±Sd	
Premature Ejeculation	1 (50.0) 6.50±2.12	3 (100.0) 12.67±4.04	107 (35.4) 6.17±3.49	17 (19.8) 4.86±3.06	11 (13.4) 4.60±2.53	8.74 (4, 470), 0.000a
Erectile Dysfunction	0 (0.0) 3.50±0.71	2 (66.7) 6.33±6.51	50 (16.6) 2.95±2.58	9 (10.5) 2.87±2.07	8 (9.8) 2.71±1.72	1.74 (4, 470), 0,139
Vaginismus	2 (9.1) 4.77±3.58	6 (31.6) 6.42±4.18	37 (13.2) 4.30±2.97	12 (14.1) 4.59±3.15	15 (23.4) 5.48±3.11	3.57 (4, 465), 0.007b
Anorgazmi	6 (27.3) 7.86±4.63	0 (0.0) 5.26±3.00	13 (4.6) 5.78±3.14	6 (7.1) 5.66±3.49	0 (0.0) 4.78±2.54	3.94 (4, 465), 0.004c
GRISS total points (Men)	28.00±1.41	45.33±22.48	28.92±8.94	27.48±8.25	27.18±6.92	3.84 (4, 940), 0.004d
GRISS total points (Women)	46.00±8.02	43.42±6.35	41.03±6.62	40.71±7.013	39.53±5.12	4.65 (4, 940), 0.001e

a. Literate without schooling > İlletare, primary school, high school, university
b. Literate without schooling > İlliterare, primary school, high school, university
c. Literate without schooling > İlliterate, primary school , high school , university
d. Literate without schooling > primary school, high school, university
e. İlliterate > primary school, high school , university

do for a possible sexual problem", the answer of "medical doctor" is good sign that people are thinking in the right direction.

The Prevalence of Sexual Disorders

In many surveys, the prevalence of erectile dysfunction in the over 18 age group was found to be 4-14.7% (Laumann et al. 1999, Ventegodt 1998, Parazzini et al. 2000, Heruti et al. 2004, Fugl-meyer and Sjögren Fugl-Meyer 1999). In all the surveys, erectile dysfunction rates increase with age, in studies over age group 40 the prevalence of both moderate and severe erectile dysfunction is between 12% and 36% (Colson et al.. 2006, Lauman et al. 2005, Shirai et al. 1999, Feldman et al. 1994, Kongkanad et al. 2000, Akkus et al. 2002, Green et al. 2001, Blanker et al. 2001). Premature ejeculation rates in all groups over age 18 vary between 4% and %66 (Laumann et al. 1999, Ventegodt 1998, Aschka et al. 2001, Fugl-Meyer and Sjögren Fugl-Meyer 1999). In our study, the rates of erectile dysfunction and premature ejeculation are accordance with those quoted in other studies of the same age groups.

The prevalence of anorgasmia in women was found to be 5-12% in various studies. These rates are in accordance with the rates we found in our study (Laumann et al. 1999, Kadri et al. 2002, Ventegodt 1998, Fugl-Meyer and Sjögren Fugl-Meyer 1999, Simons and Carey 2001, Spector and Carey 1990). The rate of vaginismus in our study is significantly higher than the studies in Northern Europe (%0.5-6.8) but is similar to the results of a study undertaken in Morocco (12%), (Kadri et al. 2002, Simons and Carey 2001, Ventegodt 1998).

Definitions of erectile dysfunction, vaginismus and anorgasmia are not made directly in accordance with the diagnostic criteria guidelines of ICD and DSM, but indirectly from scores obtained by GRISS. Our results should not be considered as indicating the prevalence of sexual dysfunction rather, but the as prevalence of individuals having sexual problems. Our assessment tools being different than others, may explain why our rates for vaginismus were higher than in other studies. Another explanation may be that cultural factors like false sexual information and beliefs, sexual taboos and lack of sexual education may be the underlying, sustaining causes of sexual disorders (Kadri et al. 2002, Kayır and Sahin 1998). The higher scores of male participants on the sexual communication subscale may cause us to think men are less open to sexual communication. One reason for this may be that culturally men are not encouraged to express their feelings openly and sexual matters should not be discussed openly. Why female participants received significantly higher scores in GRISS total points and satisfaction, avoidance, sensuality and frequency subscales points may have more than one reason. Premature ejeculation rates being high in men could be the reason why sexual satisfaction rates are low in women. Sexual myths that perpetuate the belief

that women should not initiate sexual activity or become active during sex may also affect satisfaction.

Factors That Affect Sexual Disorders

Erectile Dysfunction rates increase with age, as confirmed in many studies (Laumann et al. 1999, Ventegodt 1998, Laumann et al. 2005, Parazzini et al. 2000, Shirai et al. 1999, Feldman et al. 1994, Akkus et al. 2002, Fugl-Meyer and Sjögren Fugl-Meyer 1999). This fact can be explained by age-related physiological changes, disease, and increased drug taking for various reasons. There are studies that show premature ejeculation rates increase, decrease, or remain stable with age (Laumann et al. 1999, Jannini et al. 2005, Corona et al. 2004, Dunn et al. 1998, Fasolo et al. 2005). In our study, premature ejeculation rates increase with age. Younger participants can engage in a second act of intercourse after the first one which involves a longer interval between the commencement of sexual intercourse and ejeculation and therefore such people do not regard premature ejeculation as a problem. In two different surveys performed in Sweden and Denmark, there no correlation between vaginismus and age was found. (Fugl-Meyer and Sjögren Fugl-Meyer 1999, Ventegodt 1998). In our survey, scores obtained on the vaginismus subscale decrease with age. This can be explained by the fact that some marriages with vaginismus end in divorce, and therefore, vaginismus rates drop in the marriages that survive. Another explanation may be that with increased age and years of marriage fear of sexual intercourse lessens. There are surveys which emphasizes the claim that anorgasmia increases or decreases with age and there are surveys that show there is no significant correlation between them. (Laumann et al. 1999, Ventegodt 1998, Laumann et al. 2005, Hisaue et al. 2005, Fugl-Meyer and Sjögren Fugl-Meyer 1999, Öberg and Sjögren Fugl-Meyer 2005, Lunde et al. 1991). Our survey indicates that the scores from the anorgasmia subscale increase with age. Increased age with increased disease rates and increased drug taking along with the onset of menopause may explain why anorgasmia increases with age.

There are two surveys that conclude that anorgasmia and vaginismus rates decrease or do not change at all in connection with school education (Laumann et al. 1999, Öberg and Sjögren Fugl-Meyer 2005). When the correlation between premature ejeculation and years of schooling correlation is analysed; one study indicates that premature ejeculation rates is decrease in accord with the length of time spent in school whereas in another study premature ejeculation rates increase according to years of schooling (Laumann et al. 1999, Laumann et al. 2005). In our survey of in the literate without schooling group, anorgasmia, premature ejeculation and vaginismus scores are higher than in the other educational level groups. While there is no difference between the illiterate group and the group with higher education as to subscale points, the rates beeing higher in the literate without schooling group make us think that schooling years is not the effective determinant for all three sexual disorders. Small sample size of our the literate without schooling and illiterate groups may also have affected the results.

As a result, this survey proves that sexual disorders are common in the community. It is clear that sexual education does not take place in the family. The national education system should be used more effectively for sexual education. There is a need for more comprehensive surveys, including larger population groups, to be made in order to assess the prevalence of sexual disorders and related factors.

Limitations of the Survey

1. This survey can not be generalized to the whole population because it took place in just one city and was carried out among married couples only.
2. Participants were asked if they had a chronic disease or were taking drugs for this reason and therefore, sexual disorders due to such causes are not excluded
3. In defining sexual dysfunction scores from GRISS are taken as a a basis. Therefore the rates show only those with sexual disorders.
4. In filling out the questionnaires, the surveyors helped by reading questions to the illiterate group. This situation may have affected the results.

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