Characteristics of Male Sexual Dysfunction Subjects from a Sociocultural Perspective: Analysis of 18 Years

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ABSTRACT

Objective: Sociocultural factors may have significant effects on sexual behavior. Research in different cultures may contribute to our understanding of sexuality and sexual dysfunction. The study aims to present the sociodemographic characteristics and clinical symptomatology of male sexual dysfunctions in a Turkish sample.

Method: Subjects who were referred to the Sexual Dysfunction Unit in the Psychiatry Department of Gulhane Military Medical Academy, Turkey, during September 1986-November 2008 have been included in the study. The subjects' presenting complaints, diagnostic distribution, and socio-demographic characteristics were analyzed retrospectively.

Findings: Out of 1226 cases, 903 males' data were evaluated. The diagnostic distribution of subjects were as following: Erectile disorder due to psychological factors 60.2%, erectile disorder due to organic factors 18.9%, premature ejaculation 10.7%, sexual desire disorder 3.8%, orgasmic disorder 0.7%, and other disorders 5.7%. On the other hand, the subjects' presenting complaints were erectile inadequacy 50.1%, erectile failure 26.0%, premature ejaculation 11.7%, low sexual desire 9.2%, and retarded ejaculation 1.0%, other 1.9%.

Discussion: In this study the male/female ratio was 7/1, in favor of males which may reflect sociocultural values attributed to sexuality. The incidence of erectile dysfunction was higher, whereas premature ejaculation, orgasmic disorder and sexual desire disorder was lower compared with literature.

Conclusion: These findings may be related to cultural effects influencing the acceptance of sexual dysfunctions, and were discussed in the light of sociocultural factors.

Keywords: sexual dysfunction, prevalence, erectile disorder, premature ejaculation, orgasmic disorder, sexual desire disorder

ÖZET

Sosyokültürel Açıdan Cinsel İşlev Bozukluğu Olan Erkeklerin Özellikleri: 18 Yılın Değerlendirmesi

Amaç: Sosyokültürel faktörlerin cinsel davranış üzerine belirgin bir etkisi vardır. Farklı kültürler üzerinde yapılan araştırmalar cinselliği ve cinsel işlev bozukluğunu anlamamıza katkıda bulunabilir. Bu araştırma ile bir Türk örnekleminde erkek cinsel işlev bozukluğunda klinik belirtiler ve sosyodemografik özelliklerin sunulması amaçlanmıştır.

Yöntem: Eylül 1986-Kasım 2008 tarihleri arasında Gülhane Askerî Tıp Fakültesi Psikiyatri Anabilim Dalı bünyesinde yer alan Cinsel İşlev Bozukluğu bölümüne başvuran olguların yakınmaları, tanı dağılımları ve sosyodemografik özellikleri geriye dönük olarak değerlendirilmiştir.

Bulgular: 1226 olgudan 903 erkek cinsel işlev bozukluğu olgusu değerlendirildi. Olguların tanı dağılımı şöyleydi: Psikojen faktörlere bağlı sertleşme bozukluğu %60.2, organik faktörlere bağlı sertleşme bozukluğu %18.9, erken boşalma %10.7, cinsel istek bozukluğu %3.8, orgazm bozukluğu %0.7 ve diğer cinsel işlev bozuklukları %5.7. Öte yandan, yetersiz penis sertleşmesinden yakınan olgular %50.1 oranındaydı, sertleşme olmaması %26.0, erken boşalma %11.7, azalmış cinsel istek %9.2 ve gecikmiş boşalma %1, diğer yakınmalar ise %1.9 olarak tesbit edildi.

Tartışma: Bu çalışmada erkek/kadın oranı 7 olarak hesaplandı. Bu oranın erkeklerin lehine olması cinselliğe atfedilen sosyokültürel değerlerin bir yansıması olabilir. Literatürle karşılaştırıldığında sertleşme bozukluğu sıklığı daha yüksekti. Oysa erken boşalma, orgazm bozukluğu, cinsel istek bozukluğu literatüre göre daha düşüktü.

Sonuç: Bu bulguların cinsel işlev bozukluğunun kabulünü etkileyen kültürel etkilerle ilişkili olabileceği, sosyokültürel faktörler göz önüne alınarak tartışılmıştır.

Anahtar Kelimeler: cinsel işlev bozukluğu, sıklık, sertleşme bozukluğu, erken boşalma, orgazm bozukluğu, cinsel istek bozukluğu

INTRODUCTION

Sociocultural factors may have significant effects on sexual behavior. In reviews on sexuality in Turkey cultural aspects influencing sexuality were emphasized (Aydin and Gulcat 2001, Aydin and Gulcat 2004). Although there is an increase in the number of studies conducted in the last years, most of our current information regarding prevalence of sexual dysfunctions in sex therapy clinics come from studies in Western Europe and North America. For this reason, it is particularly important to study different populations to compare and understand cultural effects on sexuality and sexual dysfunction.

Different studies were made in clinical and community samples. There is evidence that prevalence of erectile dysfunction in Sub-Saharan Africa, the Middle East, and South Asia is similar to that in the United States and Western Countries (Khalaf and Levinson 2003), but studies in sex therapy centers is limited. A previous population based study in Turkey found moderate and severe erectile dysfunction to be 36% and an increase in prevalence rate associated with age (Akkus et al. 2002). In a non-clinical sample, Gulcat (1995) found that 30% of male subjects had varying degrees of sexual function problems.

Two major review papers on the epidemiology of sexual dysfunction (Spector and Carey 1990, Simons and Carey 2001) analyzed 75 studies between years 1940-1999 indicating that in the early studies male erectile disorders appeared more commonly as the presenting problem in sexual dysfunction clinics, whereas premature ejaculation seemed to be more widespread in the community. Inhibited male orgasm was less common, both in the community and clinical settings.

Earlier studies on the prevalence rates of male sexual disorders in clinical samples are summarized in Table-1.

The Prevalence of Sexual Disorders

Male Erectile Disorders: Male erectile dysfunction is the most common presenting complaint for males in sexual dysfunction clinics, ranging between 1-70%. The lowest rate was found by Jindal and Dhall (1990) as 1% (n=200). However Jindal and Dhall's findings depended on interviews with female partners in an infertility clinic. Goldmeier et al. (1997), using Golombok-Rust Inventory of Sexual Satisfaction (GRISS), found erectile dysfunction prevalence to be 19% (n=106). Catalan et al. (1992) found erectile dysfunction as 22% in HIV[-] (n=23) and 38% in HIV[+] (n=16) gay men. Verma et al. (1998) found 23.6% had erectile dysfunction (n=964). Rosser et al. (1997) found current erectile problem to be 15%, and lifetime prevalence to be 46% in a homosexual sample (n=197). Metz and Seifert (1990) found erectile dysfunction to be 29% in a combined clinical and community sample (n=61). Bhui et al (1994) found the prevalence of erectile dysfunction in Asians to be 50% (n=18) and in the British subjects to be 47% (n=17).

Frank et al. (1976), Bancroft and Coles (1976), and Hawton (1982) found the prevalence of erectile disorder to be 36% (n=25), 41.8% (n=98) and 53% respectively.

Masters and Johnson (1970) further categorized erectile difficulties as primary or secondary and reported that 50% of men requesting treatment experience secondary, and only 8% primary erectile dysfunction. Renshaw's (1988) (n=1071) finding was 48% and 3.5% in the same order. Warner and Bancroft (1987) found erectile failure to be 50% (n=533).

In Turkey, Kayir (1995) found erectile dysfunction comorbid with other disorders as 70% (n=75). Özgen et al (1993) found the prevalence of erectile dysfunction due to psychological factors as 50.8%, erectile dysfunction due to organic factors 30.7% (n=114). In a

Table 1. Summary of Research on Male Sexual Dysfunctions

	n		Male Erectile Disorder %	Premature Ejaculation %	Male Orgasmic Disorder %	Sexual Desire Disorders %
Jindal	200		1	8	---	---
Goldmeier	106		19	22	---	---
Catalan	23	HIV(--)	22	4	9	61
	16	HIV(+)	16	0	38	75
Verma	964		23.6	77	0.6	---
Rosser	197	current	15	19	16	16
		lifetime	46	44	39	49
Metz	61		29	65	10	39
Bhui	18	Asians	50	11	0	0
	17	British	47	0	6	12
Frank	29	marital ther	27	38	17	---
	25	sex ther	36	60	8	---
Bancroft	98		41.8	23.5	9.1	---
Hawton	137		53	15	7	7
Masters & Johnson	*	***primary	8	46	4	---
	790	secondary	50			
Renshaw	**	***primary	3.5	21.3	3.4	31.7
	1071	secondary	48			
Warner	533		50	13	5	7
Özgen	114		81.5	18.5	0	0
Kayir	75		70	20	2	6
Uguz	40		55	35	---	5

* total number of dysfunctional cases
** married couples seeking sex therapy
*** primary/secondary is related only with male erectile disorder

recent study by Uguz et al (2004) found erectile dysfunction to be 55% (n=40).

Premature Ejaculation: The prevalence range of premature ejaculation in sexual dysfunction clinics is extremely high. Bhui et al. (1994) found the prevalence to be 0% in British subjects and Verma et al. (1998) as 77.6%. The highest finding of premature ejaculation was from Northern India by Verma followed by Metz and Seifert (1990) who found premature ejaculation to be 65% in a combined clinical and community sample. Most other studies reported the prevalence of premature ejaculation to be between 8-24%. An interesting finding is that premature ejaculation does not appear to be higher among individuals attending sexual dysfunction clinics than primary care settings (Simons and Carey 2001).

Jindal and Dhall (1990) found premature ejaculation rates depending upon interviews with female partners to be 8%. Goldmeier et al. (1997) using GRISS, found premature ejaculation to be 22%. Catalan et al. (1992) found lower percentages, 4% in HIV[-] and 0% in HIV[+] (n=16) gay man. Rosser (1997) found current premature ejaculation to be 19%, and lifetime prevalence to be 49% in a homosexual sample. Bhui (1994) found the prevalence in Asians to be 11%.

Premature ejaculation prevalence was 46% in Masters and Johnson (1970), 23.5% in Bancroft and Coles (1976), 15% in Hawton (1982), 21.3% in Renshaw (1988), and 13% in Warner and Bancroft (1987) studies. Frank et al. (1976) found premature ejaculation prevalence to be 38% in males seeking marital therapy and 60% in those seeking sex therapy.

Table 2. Diagnoses and Primary Complaints of Subjects

Diagnoses (n=903)	n	%	Complaints%	Primary	Secondary
Erectile Disorder (due to psychological factors)	544	60.2	Erectile inadequacy	50.1	14.4
Erectile Disorder (due to organic factors)	171	18.9	Erectile failure	26.0	5.8
Premature Ejaculation	97	10.7	Premature ejaculation	11.7	22.6
Orgasmic Disorder	6	0.7	Low sexual desire	9.2	39.4
Sexual Desire Disorder	34	3.8	Retarded ejaculation	1.0	7.6
Other	51	5.7	Orgasm problems	0.2	9.9
			Penis size	1.7	0.2
Total	903	100	Total	100	100

The Turkish studies by Kayir and Özgen et al found the prevalence of premature ejaculation 20% and 18.5% respectively if only premature ejaculation is considered (Kayir 1995, Özgen et al 1993). But if comorbid conditions are added the rates of Kayir increase to 42%. Uguz et al. (2004) found premature ejaculation to be 35%.

Male Orgasmic Disorder: The prevalence of male orgasmic disorder is less than both erectile disorder and premature ejaculation. Except Catalan's (1992) study which found orgasmic disorder to be 38% in HIV[+] gay men, the range is between 0-17 percent. Prevalence in HIV[-] gay men was found to be 9% (Catalan et al. 1992). Rosser et al. (1997), Frank et al. (1976), Metz and Seifert (1990), Bancroft and Coles (1976) and Hawton (1982) found the prevalence of male orgasmic disorder to be 16%, 8-17%, 10%, 9.1%, 7%, respectively.

Lower prevalence rates were found by Warner and Bancroft (1987), Masters and Johnson (1970), Renshaw (1988), Kayir (1995), and Verma et al. (1998) which are 5%, 4%, 3.4%, 2%, 1%, 0.6%, respectively. The estimate from Bhui et al. (1994) was 0% for Asians and 6% for the British.

Hypoactive Sexual Desire Disorder: Hypoactive sexual desire disorder was reported to be less than other sexual disorders in previous studies, while prevalence ranges between studies was quite wide. Bhui et al. (1994) found the prevalence 0% in Asians and Catalan et al. (1992) found the prevalence 61% in HIV[-] gay and 75% in HIV[+] gay men. Metz and Seifert (1990) and Renshaw (1988) found the prevalence rates to be 39% and 31.7%, respectively. The rates reported by Metz and Seifert were obtained from a combined clinical and community sample. Rosser et al. (1997) found a lower rate (16%) of hypoactive sexual desire disorder in nonclinical gay subjects. The difference between findings may be related to different patient populations. Except Renshaw's and Metz's studies, the prevalence range of primary desire disorders in sex therapy centers are between 0-12 percent. These are 0% and12% by Bhui et al. (1994), 7% by Hawton (1982), 7% by Warner and Bancroft (1987), 6% by Kayir (1995), 5% by Uguz et al. (2004).

This study aims to describe the prevalence, the sociodemographic characteristics and complaints of male sexual dysfunctions in a Turkish clinical sample and to discuss results in light of sociocultural factors.

METHOD

Subjects who were referred to the Sexual Dysfunctions Unit of Psychiatry Department of Gulhane Military Medical Academy (GMMA) during September 1986-November 2004 were included in the study. The total number of subjects was 1226 (154 couples, 66 females and 1006 males). Of the 154 couples, 62 had problems related with the male partner, 81 related with female partner and 11 related with both partners. The total number of males who applied to the sexual dysfunction unit during 18 years was 1079 (1006+62+11) and females was 158 (66+81+11).

Out of the 1079 males 903 (83.7%) were eligible to be included in this retrospective analysis. The age range of the sample was 17-86 (mean; 38.39±13.98). The mean ages and standard deviations according to diagnostic categories are given in Table-6.

The evaluation process consisted of a standard psychiatric interview, after which the organic and psychogenic factors contributing to sexual complaints were examined in the following order:

Table 3. Primary Complaints According Diagnostic Categories

%	Erectile inadequacy	Erectile failure	Premature ejaculation	Low sexual desire	Retarded ejaculation	Orgasm problems	Penis size
Erectile Disorder (due to psychological factors)	57.1	27.6	7.5	5.6	1.0	0.2	1.0
Erectile Disorder (due to organic factors)	51.7	34.4	3.3	4.0	0.7	0	6.0
Premature Ejaculation	31.9	11.0	54.9	1.1	1.1	0	0
Orgasmic Disorder	50.0	0	16.7	16.7	0	16.7	0
Sexual Desire Disorder	5.9	0	0	94.1	0	0	0

1. Physical and genital examination,
2. Neurological and neurophysiologic examination,
3. Penile/Brachial Index and/or Doppler US for the evaluation of the vascular system,
4. Neuroendocrine (prolactin, FSH, LH, total and free testosterone) tests,
5. Intracavernosal vasoactive agent injection (ICVAI),
6. Psychological tests.

Subjects whose sexual dysfunction was fully explained by the direct physiological effects of a general medical condition were classified as sexual dysfunction due to organic factors.

The initial interviews were made by a resident in psychiatry after which each case was evaluated by at least two psychiatrists at the Sexual Dysfunction Unit of Psychiatry Department of Gulhane Military Medical Academy (GMMA). A detailed semi structured interview and examination questionnaire as used (GMMA Psychiatry Department Sexual Disorders Interview and Examination Questionnaire) which included questions on sociodemographic background, sexual history, complaints and relations with partner. The questionnaire was updated several times during 18 years (1986-2004) but the main structure has been conserved. After 1995, most of the patients were also interviewed by using Structured Clinical Interview of Disease-Patient (SCID-P) for differential diagnosis of sexual dysfunction which was not better accounted for by another Axis I disorder.

Subjects also received one or more of psychological tests which included the MMPI, Eysenck Personality Inventory, Beck Depression Scale, State-Trait Anxiety Inventory (STAI), Maudsley Obsessive-Compulsive Check List, Ilter-Kiper Aggression Inventory, SCL-90-R, and Golombok-Rust Inventory of Sexual Satisfaction (GRISS).

The complaints, diagnoses, and socio-demographic characteristics were analyzed retrospectively.

FINDINGS

Out of 1226 referrals, 903 male subjects' data were evaluated (Table-2). Diagnoses were distributed as erectile disorder due to psychological factors 60.2%, erectile disorder due to organic factors 18.9%, premature ejaculation 10.7%, sexual desire disorder 3.8%, orgasmic disorder 0.7%, and other 5.7% (including sexual dysfunctions better accounted for by another axis-I disorder 2.4% and subjects with no diagnosis 3.2%).

Primary complaints were erectile inadequacy of 50.1%, erectile failure 26.0%, premature ejaculation 11.7%, low sexual desire 9.2%, and retarded ejaculation 1.0%, orgasm problems 0.2% and penis size 1.7%. 51% (n=464) of the subjects had secondary complaints. Those were low sexual desire 39.4%, premature ejaculation 22.6%, erectile inadequacy 14.4%, orgasm problems 9.9%, retarded ejaculation 6.7%, erectile failure 5.8%, and penis size 0.2%.

In Table 3 and 4, primary and secondary complaints according to diagnostic categories are listed. Pri-

Table 4. Secondary Complaints According Diagnostic Categories

%	Erectile inadequacy	Erectile failure	Premature ejaculation	Low sexual desire	Retarded ejaculation	Orgasm problems	Penis size
Erectile Disorder (due to psychological factors)	11.3	6.0	21.4	44.7	7.5	8.6	0.4
Erectile Disorder (due to organic factors)	5.3	5.3	26.6	36.2	11.7	14.9	0
Premature Ejaculation	20.4	7.4	31.5	33.3	1.9	5.6	0
Orgasmic Disorder	25.0	0	0	50.0	25.0	0	0
Sexual Desire Disorder	57.1	3.6	14.3	3.6	0	0	0

mary complaints were mostly in accordance with diagnoses. For erectile dysfunction the primary complaint was erection problems (84.7%) although some subjects described it as a decrease in sexual desire, and some as ejaculation before erection. The highest secondary complaint for erectile disorder was low sexual desire (44.7%). For subjects with more than one complaint the first complaint was usually erectile problem. In subjects with low sexual desire, secondary complaint was mostly (57.1%) erectile inadequacy.

Some subjects (n=20) had up to four complaints (Table-5). The total number of complaints of 903 subjects was 1450; 49.2% was related with erectile problem followed by 20.1% complaints related with low sexual desire, 14.9% orgasmic problems and 14.8% premature ejaculation.

Table 5. Percentage of All Complaints

	Frequency (n)	Percent (%)
Erectile inadequacy	477	32.9
Erectile failure	236	16.3
Premature ejaculation	215	14.8
Low sexual desire	292	20.1
Retarded ejaculation	53	3.7
Orgasm problems	162	11.2
Penis size	15	1.0
Total	1450	100

The mean age of subjects, mean years of marriage and education according to diagnostic groups are shown in Table 6. Compatible with the literature, the mean age of erectile disorder due to organic factors was higher than other diagnostic groups (46.02±15.96).

46.4% of the sexual desire disorders group had college and higher education while it was 30.9% for subjects with premature ejaculation, 27.9% for erectile disorders due to psychological factors, 25.8% erectile disorders due to organic factors. This finding shows that education level was higher in sexual desire disorders group compared to other diagnostic groups.

In Table-7 the marital status of subjects was summarized. 70% of the whole sample was married while the highest percentage of marriage was observed in the premature ejaculation group (84.5%).

In Table-8 time interval (in months or years) between the beginning of complaints and referral to the sexual dysfunction unit is shown. For the whole sample the mean referral time after the symptoms began were 0-6 months 31.5%, 7-12 months 20.9%, 2-5 years 22.2% and 6 years and more 25.3%. While the mean percentage of referral in first 6 months was 31.5% for the whole sample it was only 12.5% for sexual desire disorder subjects. The rates in the first year of referral were 52.4% and 31.3% for respectively.

Table 6. Age, Years of Marriage and Education According Diagnostic Categories

	Mean Age	Mean years of marriage	Elementary School %	Secondary School %	High School %	College or higher %
Erectile Disorder (due to psychological factors)	36.31 ± 13.00	16.35 ± 12.20	22.7	10.3	39.1	27.9
Erectile Disorder (due to organic factors)	46.03 ± 15.96	26.69 ± 13.67	27.7	8.2	38.4	25.8
Premature Ejaculation	37.20 ± 12.26	15.33 ± 11.77	17.0	4.3	47.9	30.9
Orgasmic Disorder	31.50 ± 9.04	7.00 ± 1.41	40.0	40.0	20.0	0
Sexual Desire Disorder	37.40 ± 12.41	17.36 ± 10.80	10.7	7.1	35.7	46.4
Total	38.39 ± 13.98	18.22 ± 17.00	22.5	9.3	39.7	28.5

DISCUSSION

In this study the male/female ratio of referral for sexual dysfunction was 7 to 1 (1079/158=6.83) in favor of males. The percentage of male applicants was 87.3% (1079/1237). Verma et al. (1998) reported similar results in Northern India, 96% of their sample were males. On the other hand Warner and Bancroft (1987) reported almost equal male/female referrals. Taken together these findings indicate that women are less inclined to seek professional help for sexual problems in non-Western countries, which may be related to eastern as well as Turkish cultural values still emphasizing modesty in female sex role and behavior (Aydin and Gulcat 2001, Aydin and Gulcat 2004).

The incidence of erectile dysfunction was found as the most common presenting problem, which is compatible with the literature. The percentage of erectile disorders due to psychological factors was 60.2% which is one of the highest seen in the literature. If the erectile disorders due to organic factors are added the rate is 79.1%. Although the previous reports on the prevalence of erectile dysfunction in clinical samples ranges between 1% and 70%, studies from sexual dysfunction units yield to higher results. Frank et al (1976) found the prevalence of erectile disorder to be 36%, Bancroft and Coles (1976) 41.8%, and Hawton (1982) 53%. Masters and Johnson (1970) reported that 50% of men requesting treatment experience secondary erectile dysfunction and only 8% primary. Renshaw (1988) found it to be 48% and 3.5% in the same order. Warner and Bancroft (1987) found erectile failure to be 50%. Previous studies in Turkish clinical samples also found high percentages of erectile disorders. Kayir (1995) found the prevalence to be 70%, Özgen et al. (1993) 81.5%, and Uguz et al. (2004) 55%.

The high prevalence of erectile dysfunction may be related to Turkish males' attitudes toward sexual problems. As a necessary physical condition for male's sexual functioning, as well as a symbol of masculinity, the high rates of referral for erectile dysfuncti-

Table 7. Marital Status According Diagnostic Categories

%	Single	Married	Divorced/Widowed
Erectile Disorder (due to psychological factors)	30.3	65.1	4.6
Erectile Disorder (due to organic factors)	16.8	77.0	6.2
Premature Ejaculation	13.4	84.5	2.1
Orgasmic Disorder	33.3	66.7	0
Sexual Desire Disorder	27.6	72.4	0
Total	25.5	70.0	4.5

Table 8. Period between First Complaint & Referral According Diagnostic Categories

%	0-6 Months	7-12 Months	2-3 Years	6& More Years
Erectile Disorder (due to psychological factors)	35.4	17.7	22.2	24.7
Erectile Disorder (due to organic factors)	28.3	28.9	18.8	24.2
Premature Ejaculation	25.0	25.0	20.7	18.6
Orgasmic Disorder	33.3	16.7	16.7	33.3
Sexual Desire Disorder	12.5	18.8	46.9	21.9
Total	31.5	20.9	22.2	25.3

ons may be the primary reason for Turkish males seeking help for this problem rather than problems related to premature ejaculation and low sexual desire. This may also be reflected in the relatively short time between the appearance of the symptoms and referral for the clinic help. 35.4% of the subjects with erectile disorder attended the sexual dysfunction unit during the first 6 months the symptoms started. The rates were 25.0% for premature ejaculation and 12.5% for sexual desire disorder. Referral rates in the first year were 53.1%, 50.0% and 31.3%, respectively.

The prevalence of premature ejaculation was found to be 10.7% in this study. Most studies have found premature ejaculation prevalence to be between 8-24% (Bancroft and Coles 1976, Hawton 1982, Renshaw 1988, Warner and Bancroft 1987, Özgen et al. 1993, Kayir 1995). The range of prevalence of premature ejaculation in sexual dysfunction clinics is wide. There are extremely high rates like 77% by Verma et al. (1998) and 65% by Metz and Seifert (1990) as well as extremely low rates such as 0% by Bhui et al. (1994). The prevalence of premature ejaculation was 46% according to Masters and Johnson (Masters and Johnson 1970). Our finding is within general ranges but near the lower limit. The rather low prevalence rates of premature ejaculation in our clinical samples may reflect male's attitudes toward women's sexual satisfaction which is more or less dependent on the duration of sexual intercourse, at least in the classical sense.

Orgasmic disorder was less common in our sample, which was found to be 0.7%. The rate of orgasmic disorder was between 0-17 percent in the literature (Frank et al. 1976, Bancroft and Coles 1976, Hawton 1982, Metz and Seifert 1990, Rosser et al. 1997). Prevalence rate was lower in studies by Warner (1987), Masters and Johnson (1970), Renshaw (1988), Kayir (1995), and Verma et al. (1988) which were 5%, 4%, 3.4%, 2%, 1%, 0.6%, respectively. Our sample was near the lower ranges; more similar with the findings of Verma from Northern India, and previous studies from Turkey (Özgen et al. 1993, Kayir 1995, Uguz 2004). These findings may be related with cultural effects influencing the acceptance of orgasmic problems in men.

The rate of sexual desire disorder was 0-12% in previous studies (Hawton 1982, Warner and Bancroft 1987, Bhui et al. 1994, Kayir 1995, Uguz 2004). As mentioned in previous section, sexual desire disorder rates were higher in studies with gay subjects (Catalan et al. 1992, Rosser 1997) and in couples who seek sexual therapy (Renshaw 1988). In this study the prevalence of sexual desire disorder was found 3.8% which is near lower limits of prevalence like orgasmic disorders in our sample.

According to our findings it can be claimed that erectile problems are of primary importance for Turkish males seeking help for sexual dysfunction; more important than problems related to premature ejaculation, orgasmic disorders or low sexual desire.

For diagnosed erectile dysfunction, erection problem is mostly the primary (84.7%) and low sexual desire the secondary (44.7%) complaint. For subjects who had more than one complaint, the first complaint was erectile problem before other sexual function complaints. In sexual desire disorders group, the most often seen secondary complaint was erectile inadequacy. This may also be related with cultural factors. Considering socioculturel discourse that relates masculinity with sexual function, even if the primary complaint is low sexual desire, it is expressed in contest of erectile problem.

The education level was higher in sexual desire disorders group in our sample. This might be related to a number of social factors. High educated people with sexual desire problems may be more often demanding professional help. On the other hand sexual desire disorder may be more prevalent in the educa-

ted population. Another possibility is that higher educated people may be able to describe their complaints more accurately. Further research in this area is needed to understand underlying factors that explain education level and sexual desire problems for those that are referred to sexual dysfunction units.

The higher prevalence of premature ejaculation in married couples may be explained by married men seeking treatment more often, then singles. It may also be related to single subjects' not being concerned with or not being aware of this problem. Another possibility could be that single subjects do no always have sexual partners, women being sexually restricted under the traditional values in the Turkish culture.

CONCLUSION

Research on sexuality is mostly conducted in Western countries. The present study aimed to understand the characteristics of sexual dysfunctions in a culture which embodies both western and eastern values. It also aims to discuss similarities and differences across different cultures. The study focused on complaints, diagnoses, and socio-demographic characteristics of male sexual dysfunctions at a sexual dysfunctions unit in Turkey. Erectile dysfunction was found to have the highest prevalence rates followed by premature ejaculation, sexual desire disorder, and orgasmic disorder. The prevalence of erectile disorder was one of the highest in literature. All other sexual disorders were in the lower range compared to studies in other countries. Considering the low number of studies on sexuality in Turkey, it is hoped to contribute to our understanding about cultural effects on sexual dysfunctions.

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