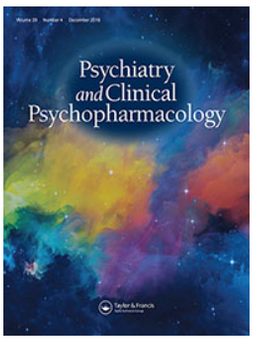

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ABSTRACT

OBJECTIVE: To evaluate the validity and reliability parameters of the Turkish version of the Sexual Complaints Screener for Men (SCS-M) which is a promising brief measure to assess sexual problems in daily practice.

METHODS: A cross-sectional study was conducted online. Data was collected through an online validated and content specific questionnaire via self-reporting. In total, 230 male participants between the ages of 18 and 25 submitted the questionnaire. SCS-M was translated into Turkish and applied with the International Index of Erectile Function, the Short Form Health Survey (SF-36). The p-value was evaluated statistically significant at $p < 0.05$.

RESULTS: The average age of participants was 21.89 ± 2.08. The Cronbach alpha internal consistency coefficient of the scale was 0.818. Correlation analysis between SCS-M, IIEF and IIEF sub-scales were statistically significant.

CONCLUSION: Turkish version of the SCS-M presented good psychometric parameters. SCS-M is a valid and reliable measure for the screening and evaluation of sexual complaints. It was additionally identified as a valuable contributor to the short measures in assessing male sexual problems in research and clinical practice.

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Male sexual dysfuntions; sexual problems; validity; reliability; self report

Introduction

Sexuality is a complex concept combining biological, sociocultural and psychological factors [1]. Desire, arousal, and orgasm are the major domains of sexual response, which may be influenced by a variety of factors [2,3]. The combination of these domains is often called the sexual response cycle [4]. Sexual functions including desire, arousal, and orgasm may be negatively affected by psychological, medical, physiological, and relational problems [5,6]. The prevalence rate of the Turkish data for male sexual dysfunctions was found to be 43.4% and of the 43.4%, 7.3% had low desire, 59.7% erectile and 52.7% had and orgasm/ejaculation problems, respectively [7].

There is a limited number of well established and validated scales which can be used to evaluate sexual dysfunctions in Turkish. The most frequently used scales for the assessment of male sexual functioning are the International Index of Erectile Function (IIEF) [8], the Golombok Rust Inventory of Sexual Satisfaction (GRISS) [9] and the Arizona Sexual Experiences Scale (ASEX) [10]. The most widely utilized one among them is the IIEF, which is used as a standardized measure of erectile function, orgasm, desire, sexual and overall sexual satisfaction, relies on self-reporting and consists of 15 items. The IIEF has been extensively recognized and used as the international standard measure for assessing male sexual dysfunctions. For the reasons stated above, the IIEF was utilized in the current study for comparison and correlation.

A brief questionnaire consistent with current diagnostic guidelines can provide valuable information in a short period of time for evaluating sexual function and needs for further assessment. Clinicians who are less familiar with sexual health and issues relating to sexual dysfunction can benefit from an easily applicable scale. In addition, the use of shorter and more comprehensible tools can be expected to lessen the burden of assessment clients, making the assessment more effective and efficient.

The International Society for Sexual Medicine (ISSM) has recognized the need for a brief measurement scale for the assessment of sexual problems and created the Sexual Complaint Scale for Men (SCS-M) [11]. The scale is informed by epidemiological research. This comprehensive self-reporting tool addresses all areas of sexual functioning, such as sexual interest/desire, arousal, premature and delayed ejaculation, sexual pain, anxiety relating to penis size and form, and sexual satisfaction. The SCS-M consists of 10 questions which assess a variety of factors that influence sexual functioning in the last six months and additionally focuses on personal distress.

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To date, SCS-M has not been tested for its validity or reliability in any language. The aim of this study is to evaluate the validity and reliability parameters of the Turkish version of the SCS-M, a promising scale expected to be used frequently in daily clinical practice for sexual complaints in a sample of male participants ($n = 230$).

Material method

Participants

The study was prepared as an online survey which took approximately 20 min to complete. Data was collected online through validated self-report questionnaires between December 2015 and March 2016. A total of 230 male identified participants aged between 18 and 25 voluntarily completed the survey. The research was conducted by the members of the European Federation of Sexology's Youth Committee; hence the age of participants was chosen to reflect the working areas of the committee. According to the literature, the number of the individuals should be at least ten times higher than the number of the questions in the scale to conduct the validity and reliability study [12]. Our sample size corresponded with the numbers required in the literature. At the stage of recruitment, no further inclusion or exclusion criteria were imposed on the sample in order for the sample to represent the general youth population.

Operation

Researchers contacted the authors of the scale by e-mail to request permission for use and adaptation into Turkish. The Institutional Review Board approval date was 21 January 2015, protocol number 2/2015. The scale was translated from English to Turkish by three psychiatrists fluent in English, with specializations in sexual dysfunctions and therapy. The main text was then translated into English again by a psychiatrist who was blind to the research and procedure, after which, the translated English version was translated into Turkish again for the second time. After completing the individual translations, the translators reviewed the translation and agreed on the final text. Then the agreed translation was pilot-tested on 15 volunteers to check for comprehension, potential misinformation or misunderstandings. No negative feedback was reported by the volunteers and no further revision was made on the final scale. Due to the absence of negative feedback in the pilot study, the questionnaire was made public with a dedicated link. Participants were recruited from social media announcements, and through word of mouth and were asked to be between 18 and 25 years old and volunteered to contribute to the study. No other exclusion or inclusion criteria including educational place or status were implemented to represent general youth population without discrimination. The questionnaire which was designed to have an introduction page on which information about the purpose of the study, types of questions, and confidentiality was listed. Additionally, the voluntary nature of participation was clearly outlined, along with participants' rights to withdraw from the study at any point.

Informed consent was received through participants ticking a box that stated: "accept". The button was located below the study information and the informed consent piece and would not allow participants to pass to the questionnaire section. Participants' ethical rights were protected in accordance with the Declaration of Helsinki.

Upon passing the information and informed consent portion of the online document, participants were directed to a page where their sociodemographic information (age, sex, educational status), psychiatric and medical histories, and information on their substance and alcohol use was collected. In addition, participants were asked to complete the IIEF Form, the Quality of Life Form (SF36) and the SCS-M Form.

Data collection tools

Socio-demographic form; was specifically developed by researchers to gather information about participants such as age, gender, sexual orientation, marital status, level of education, psychiatric and medical history, alcohol and substance use.

SCS-M Form; was developed by the Standards Committee of the International Society for Sexual Medicine based on clinical and research experiences of professionals [11]. It is a sex-specific screening tool that assesses men's sexual complaints in six months leading to the assessment. The scale consists of ten items with the first seven questions having two sections each, nine of which are rated on a Likert-like scale, one item requiring a written response. Sexual dysfunction questions consist of two main parts: the first part is stated as "a" in the beginning portion of each question, whereas the sexual distress of specific dysfunction is identified as "b" part of the particular question. The first part identified as "part a" measures the frequency or degree of the specific sexual dysfunction or issue identified, and the second part, identified as "part b" evaluates the level of distress experienced due to the particular sexual problem present. The first seven part a and part b questions are rated on a five-point Likert scale (0 = "never" to 4 "almost all the time/always" and 0 = "not at all a problem" to 4 = "a very great problem", respectively), and the eighth question is rated on a six-point Likert scale (0 = "very unsatisfying" to 5 = "very satisfying"). The ninth question is an open-ended question which asks further information about the sexual life of the respondent. The tenth question asks if the patient needs any further exploration of sexual problems which can be used as a leeway for the patient/

participant to talk about other sexuality or sexual health-related topics they deem necessary

IEFF; was developed by Rosen and colleagues to assess sexual functioning in men [8]. It has been translated into Turkish by the Turkish Andrology Association and is one of the most commonly applied scales for sexually active men. IEFF evaluates sexual functioning, erectile functions, orgasmic functions, sexual desire, sexual satisfaction and overall satisfaction. It is a self-reported measure, consists of 15 items, and uses the Likert scale for evaluation.

The Quality of Life Questionnaire (SF-36); The Turkish validity and reliability of SF-36 was constructed by Koçyiğit and colleagues [13] and was developed to measure the quality of life [14]. The questionnaire consists of 36 items measuring quality of life during the four weeks leading up to time of evaluation across eight areas: Physical health group consists of physical function, role limitations due to physical problems, pain, the general perception of health and mental health group consists of, role limitations due to mental health group, energy/vitality, social function, emotional problems.

Statistical analysis

Data collected through online forms were transferred to the IBM SPSS Statistics 20 package programme. The sociodemographic data's mean, standard deviation, and percentages were calculated and analyzed. The internal consistency of the scale was examined by the Cronbach alpha test and the item-total score correlations by the Pearson correlation test. The cross-validity of the scale was assessed by Pearson correlation. Descriptive factor analysis was applied to the validity of the scale. In all analyses, $p \leq 0.05$ was considered statistically significant.

Results

The mean age of participants in the study was 21.89 ± 2.08. The findings of the SCS-M were examined under two headings; validity and reliability.

Reliability; the reliability of the SCS-M was assessed by the Cronbach's alpha internal consistency coefficient. The scale's Cronbach alpha internal consistency coefficient was 0.818. Cronbach Alpha internal consistency coefficient increased to 0.841 due to the deletion of question 8a (During the last 6 months, my sexual life has been: Very unsatisfying, Unsatisfying, Rather unsatisfying, Rather satisfying, Satisfying, Very Satisfying) which was the highest internal consistency levels. The item-total test correlation coefficients were also found to be higher than the 0.30 cut-off point in 14 out of the 15 items. In addition, the correlation coefficient of the majority of the items was found to be higher than 0.50. These results indicate that the scale has a high internal consistency (Table 1).

Validity; Correlations analysis with other scales for the validity of SCS-M are presented in Table 2. Correlation analysis between SCS-M and IIEF subscales including erectile function, orgasmic function, sexual desire, intercourse satisfaction, overall satisfaction and total scores were statistically significant (0.366, 0.236, 0.150, 0.347, 0.256 and 0.358 respectively). Sexual desire subscale of the IIEF had the lowest correlations with total scores of the SCS-M scale (r:0.150, $p = 0.023$). The correlation analysis between the SCS-M and SF-36 subscales were statistically significant except for two subscales. These results showed the validity of the scale.

An explanatory factor analysis was conducted to examine the construct validity of SCS-M. Barlett Sphericity and Kaiser-Meyer-Olkin (KMO) were applied for the analytical suitability of the data. The sample suitability coefficient was 0.743 and the Chi-square value of the Barlet-Sphericity test was

Table 1. Item and reliability analyses results of sexual complaints screener for men.

Items	Corrected item-total correlation		Cronbach Alpha if item deleted	Factor value
	r	*p*		
1a) Some men experience lack of or low sexual interest/desire in sex. Has this happened to you during the last 6 months?	0.323	**<0.001****	0.819	0.257
1b) Has this been a personal problem for your?	0.486	**<0.001****	0.802	0.706
2a) Some men find that they need much more sexual stimulation to achieve an erection than they needed in the past. Has this happened to you during the last 6 months?	0.553	**<0.001****	0.808	0.419
2b) Has this been a personal problem for your?	0.599	**<0.001****	0.794	0.796
3a) Some men have difficulties in obtaining and/or maintaining hard erection lasting long enough for sexual activity. Has this happened to you in the last 6 months?	0.627	**<0.001****	0.803	0.513
3b) Has this been a personal problem for your?	0.621	**<0.001****	0.790	0.838
4a) Some men cannot control their sexual excitement so that they cum (ejaculate) before or shortly (within approximately 2 min) after penetration. Has this happened to you during the last 6 months?	0.632	**<0.001****	0.808	0.414
4b) Has this been a personal problem for your?	0.645	**<0.001****	0.793	0.743
5a) Some men have difficulty ejaculating or reaching orgasm with sexual activity. Has this happened to you during the last 6 months?	0.630	**<0.001****	0.806	0.423
5b) Has this been a personal problem for your?	0.566	**<0.001****	0.797	0.716
6a) Some men are concerned about the size and/or shape of their penis. Has this happened to you?	0.254	**<0.001****	0.823	0.265
6b) Has this been a personal problem for your?	0.391	**<0.001****	0.811	0.541
7a) Some men experience pain during or shortly after sexual activity. Has this happened to you during the last 6 months?	0.616	**<0.001****	0.804	0.459
7b) Has this been a personal problem for your?	0.531	**<0.001****	0.800	0.703
8a) During the last 6 months , my sexual life has been: Very unsatisfying, Unsatisfying, Rather unsatisfying, Rather satisfying, Satisfying, Very Satisfying	0.326	**<0.001****	0.841	0.104

Table 2. Correlations of sexual complaints screener for men scores with SF-36 and IIEF.

			Mean ± SS	*r*	*p*
Sexual Complaints Screener for Men scores			24.40 ± 8.86	1	
IIEF		Erectile Function	12.89 ± 7.72	0.366	<0.001**
		Orgasmic Function	5.73 ± 3.89	0.236	<0.001**
		Sexual Desire	6.67 ± 2.10	0.150	0.023*
		Intercourse Satisfaction	5.09 ± 5.17	0.347	<0.001**
		Overall Satisfaction	5.90 ± 2.81	0.256	<0.001**
		IIEF Total	36.30 ± 18.64	0.358	<0.001**
SF36	Physical health	Physical functioning	83.95 ± 22.83	−0.221	0.001**
		Role-physical	64.13 ± 21.06	−0.177	0.007**
		Bodily pain	80.40 ± 19.16	−0.124	0.060
		General health	64.89 ± 18.89	−0.197	0.003**
	Mental health	Vitality	55.40 ± 17.86	−0.258	<0.001**
		Social functioning	71.79 ± 23.27	−0.125	0.058
		Role-emotional	52.75 ± 42.82	−0.195	0.003**
		Mental health	62.03 ± 16.74	−0.216	0.001**

IIEF: International Index of Erectile Functions, SF36: Quality of Life Questionnaire

1906.305; indicating that the results obtained were suitable for factor analysis. Factor analysis resulted in an eigenvalue of 4.833 and explained 32.22% of the total variance with the single-factorial structure. Factor loadings of the items are presented in Table 1.

Discussion

SCS-M reliability was assessed by the Cronbach alpha internal consistency coefficient. The scale's Cronbach alpha internal consistency coefficient was 0.818. The scale's high internal consistency coefficients were shown, and the internal consistency was found to be adequate. Measurement tools that can be used in the research should have at least 0.70 reliability level [15], the reliability level of all the SCS-M was significant and higher. Cronbach Alpha internal consistency coefficient had a minor increase to 0.841 due to the deletion of question 8a which measures sexual satisfaction during the last 6 months. All of the other questions measure dyfunctions and distress, this could be the reason of this increase in the internal consistency after the removal of the sexual satisfaction parameter.

An exploratory factor analysis was conducted to examine the construct validity of SCS-M. The results obtained indicated that our data were suitable for factor analysis. International Index of Erectile Function (IIEF) and Short Form- 36 (SF-36) were used for correlation analysis for the SCS-M validity. According to item-total correlation analysis interpretation of the items which were .30 or higher significantly distinguish measured parameters [16]. In this regard, the correlation analysis between all sub-scales of SCS-M and IIEF were statistically significant whereas SF-36's sub-scales were significantly correlated except for the Pain and Social Function subscales. Additionally, there was lower level of correlation between sexual desire subscale of the IIEF and SCS-M total scores which might be due to young age of the participants and/or IIEF evaluate last 4 weeks whereas SCS-M evaluate last 6 monts. These results indicated the validity of the Turkish version of SCS-M.

The negative correlation coefficient indicated an inverse relationship between the variables. A negative correlation was found between SCS-M's and SF-36's subscales. This meant an increase in sexual complaints, an adverse effect on the quality of life, and thus a consistent reflection of the literature [17,18]. Although studies for urogenital pain in men found pain in the genital area and sexual dysfunction to coexist [17], no correlation between sexual complaints and the general pain was found in the current study. The two questions on pain and social functioning included in the SF-36 scale assesses pain in general terms and lacks an assessment of urogenital or sexual pain. This finding was in alignment with the findings of the current study which found no statistically significant correlation between sexual complaints and pain.

It is important to note recognize and highlight that SCS-M should neither be considered a sufficient diagnostic tool used to exclusively diagnose sexual dysfunctions nor an endpoint measurement for specific sexual dysfunction for clinical trials. Additionally, according to DSM-5, PE is defined as ejaculation occurring in a persistent or recurrent pattern within approximately 1 min following penile-vaginal intercourse, and earlier than the male client/patient wishes to ejaculate [19]. SCS-M defines the cut-off period for assessing PE to be 2 min or less. This could potentially weaken the specificity of the screener yet did not change sensitivity. It is important to mention that 90% of men diagnosed with PE, ejaculate within one minute after starting penile-vaginal intercourse, and those who ejaculate within two minutes account for the almost 100%. Despite the DSM-5's one-minute duration criteria for PE, a study conducted with 1587 participants found the median IELT (min) to be 1.8 min for men experiencing PE and 7.3 min for non-PE subjects ($P < 0.0001$). The mean IELT was 3 min for PE compared to 9.2 min for non-PE patients [19]. In daily clinical practice, it is not uncommon for men who ejaculate within 5–10 min following penile-vaginal intercourse to present with complaints about PE, while some experiencing PE from a clinical point of view present with not complaints regarding PE. With these considerable variations in mind, it is essential from the operational standpoint to use a clear definition with well-defined characteristics and a generally accepted time frame in

order to distinguish men with clinically diagnosable PE from those perceiving themselves as experiencing PE. As the first tool available in Turkish that uses a 6-month duration for assessing sexual dysfunctions, which is concurrent with the DSM-5 criterion. Furthermore, this screener allows clinicians and researchers to assess the frequency of the problem experienced and distress accosted with the problem, both of which are factors included in DSM-5. Finally, SCS-M is a valuable tool not only in assessing sexual pain, delayed ejaculation, penile size and shape concerns, but acting as a gateway for clinicians to more openly communicate with patients about their sexual and well-being.

One of the limitations of our study was to be conducted in the non-randomized sample. Additionally, recruitment in young mean age might cause a bias in the representativeness of our sample. The validity of the scale relied on comparison with IIEF scores and was not controlled with a clinical diagnosis of Male Sexual Dysfunctions. Our results were not comparable with any other versions of the SCS-M because this was the first study assessed psychometric properties of SCS-M.

SCS- M is a brief, novel, easy to fill the questionnaire, parallel with the DSM-5 in terms of symptomatology. Therefore, this screener can also be easily used by clinicians who do not hold sexuality and sexual health-related specializations. This tool can be utilized to foster an opportunity for facilitating communication about sexual problems between clients/patients and clinicians. Additionally, it can also allow researchers who work with larger populations to assess sexual problems in an effective and time-efficient manner.

To sum up, SCS-M is a valid and reliable measure for screening and evaluating sexual complaints. It is also a valuable contribution to the short measures for the assessment of male sexual problems. Having respectable psychometric values and a modest number of questions, the scale will enable quick screening of male sexual problems, sexual side effects of treatments and treatment outcomes of sexual problems. By using SCS-M, more people can be reached, assessed faster, and will be more likely have an opportunity to seek out clinical assistance for their sexual problems. It is an easy, short and extensive self-reporting assessment tool for sexual dysfunctions which encompasses all major steps of sexual dysfunction, including distress.

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We recognize that answering questions about sexual health and sexual dysfunctions may be deemed private and taboo, and answers difficult to collect on the researcher's end. For this reason, we would like to thank young adults who took time to participate in this research.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Appendix

Erkek Cinsel Şikayet Taraması

Bu anket sizin son 6 ay içinizdeki cinsel deneyimlerinizle ilgili sorulardan oluşmaktadır. Her soruyu sizin deneyiminizi en iyi şekilde ifade eden şıkkı işaretleyerek cevaplayınız. *Cinsellik; cinsel doyum ve hazı amaçlayan herhangi bir aktivitedir. Cinsellik kavramının muhakkak cinsel birleşmeyi (vajinal veya anal) içermesi gerekli değildir.

1a) Bazen erkeklerde cinsel ilgi/istek azalabilir veya yok olabilir. Cinsel ilgi/istekle ilgili olarak son 6 ay içinde böyle bir durum yaşadınız mı? *
0. Hiç bir zaman / neredeyse hiç bir zaman
1. Nadiren
2. Ara sıra
3. Sıklıkla
4. Neredeyse her zaman / her zaman

1b) Bu durum sizin için sorun oluşturdu mu?
0. Kesinlikle sorun oluşturmadı
1. Küçük bir sorun oluşturdu
2. Orta düzeyde bir sorun oluşturdu
3. Önemli bir sorun oluşturdu
4. Çok büyük bir sorun oluşturdu

2a) Bazen erkekler geçmiş cinsel deneyimleriyle karşılaştırdığında penislerinde aynı sertleşmeyi oluşturmak için daha önce ihtiyaç hissettikleri cinsel uyarıcılardan daha fazlasına gerek duyarlar. Son 6 ay içinde hiç böyle bir durum yaşadınız mı? *
0. Cinsel aktivitede bulunmadım
0. Hiç bir zaman / neredeyse hiç bir zaman
1. Nadiren
2. Ara sıra
3. Sıklıkla
4. Neredeyse her zaman / Her zaman

2b) Bu durum sizin için sorun oluşturdu mu?
0. Kesinlikle sorun oluşturmadı
1. Küçük bir sorun oluşturdu
2. Orta düzeyde bir sorun oluşturdu
3. Önemli bir sorun oluşturdu
4. Çok büyük bir sorun oluşturdu

3a) Bazen erkekler cinsel aktiviteyi sağlamak ya da uzun bir süre devam ettirmek için yeterli olacak düzeyde sertleşme sağlamakta güçlük çekerler. Son 6 ay içinde böyle bir durum yaşadınız mı? *
0. Cinsel aktivitede bulunmadım
0. Hiç bir zaman / neredeyse hiç bir zaman
1. Nadiren
2. Ara sıra
3. Sıklıkla
4. Neredeyse her zaman / Her zaman

3b) Bu durum sizin için sorun oluşturdu mu?
0. Kesinlikle sorun oluşturmadı
1. Küçük bir sorun oluşturdu
2. Orta düzeyde bir sorun oluşturdu
3. Önemli bir sorun oluşturdu
4. Çok büyük bir sorun oluşturdu

4a) Bazen erkekler cinsel birleşme öncesinde veya cinsel birleşmenin başında (ilk 2 dakikasında) heyecanlarını kontrol edemeyerek boşalırlar. Son 6 ay içinde böyle bir durum yaşadınız mı? *
0. Cinsel aktivitede bulunmadım
0. Hiç bir zaman / Neredeyse hiç bir zaman
1. Nadiren
2. Ara sıra
3. Sıklıkla
4. Neredeyse her zaman / Her zaman

4b) Bu durum sizin için sorun oluşturdu mu?
0. Kesinlikle sorun oluşturmadı
1. Küçük bir sorun oluşturdu
2. Orta düzeyde bir sorun oluşturdu
3. Önemli bir sorun oluşturdu
4. Çok büyük bir sorun oluşturdu

5a) Bazen erkekler cinsellik sırasında boşalmakta veya orgazma ulaşmakta zorluk çekerler. Son 6 ay içinde böyle bir durum yaşadınız mı? *
0. Cinsel aktivitede bulunmadım
0. Hiç bir zaman / Neredeyse hiç bir zaman
1. Nadiren
2. Ara sıra
3. Sıklıkla
4. Neredeyse her zaman / Her zaman

5b) Bu durum sizin için sorun oluşturdu mu?
0. Kesinlikle sorun oluşturmadı
1. Küçük bir sorun oluşturdu
2. Orta düzeyde bir sorun oluşturdu
3. Önemli bir sorun oluşturdu
4. Çok büyük bir sorun oluşturdu

6a) Bazen erkekler penislerinin boyut ve/ya şekliyle ilgili olarak endişelenirler. Böyle bir durum yaşadınız mı? *
0. Hiç bir zaman / Neredeyse hiç bir zaman
1. Nadiren
2. Ara sıra
3. Sıklıkla
4. Neredeyse her zaman / Her zaman

6b) Bu durum sizin için sorun oluşturdu mu?
0. Kesinlikle sorun oluşturmadı
1. Küçük bir sorun oluşturdu
2. Orta düzeyde bir sorun oluşturdu
3. Önemli bir sorun oluşturdu
4. Çok büyük bir sorun oluşturdu

7a) Bazen erkekler cinsellik sırasında veya hemen sonrasında ağrı hissederler. Son 6 ay içinde böyle bir durum yaşadınız mı? *
0. Cinsel aktivitede bulunmadım
0. Hiç bir zaman / Neredeyse hiç bir zaman
1. Nadiren
2. Ara sıra
3. Sıklıkla
4. Neredeyse her zaman / Her zaman

7b) Bu durum sizin için sorun oluşturdu mu?
0. Kesinlikle sorun oluşturmadı
1. Küçük bir sorun oluşturdu
2. Orta düzeyde bir sorun oluşturdu
3. Önemli bir sorun oluşturdu
4. Çok büyük bir sorun oluşturdu

8) Son 6 ay içinde cinsel hayatım: *
0. Hiç tatmin edici olmadı
1. Tatmin edici olmadı
2. Pek tatmin edici olmadı
3. Kısmen tatmin edici oldu
4. Tatmin edici oldu
5. Çok tatmin edici oldu

9) Cinsel hayatınızla ilgili olarak paylaşmak istediğiniz başka bir şey var mı? Son 6 ay içinde cinsel aktivitede bulunmadıysanız lütfen nedeni açıklayınız.

10) Doktorunuzun (danışmanızın) başka cinsel güçlükler ya da sorunlarla ilgili olarak sizinle daha detaylı bir görüşme yapmasını ister miydiniz? *
0. Hayır
1. Şuanda değil
2. Evet