



RESEARCH ARTICLE

Comparison of Attachment Styles, Childhood Traumas and Psychological Flexibility in Individuals with and without Sexual Dysfunction

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ABSTRACT

This study compares psychological flexibility, childhood traumas, and attachment styles between those with and without sexual dysfunction. In this study, causal comparison model was used. The population of this study consists of individuals with and without sexual dysfunction. The sample of the study consisted of 50 individuals with sexual dysfunction by purposive sampling method and 50 individuals without sexual dysfunction by random sampling method, totaling 100 individuals. Sociodemographic Information Form, Golombok-Rust Sexual Satisfaction Scale, Childhood Psychological Trauma Scale, Psychological Flexibility Scale and Inventory of Experiences in Close Relationships-II were used as data collection tools. In the findings of the study, sexual satisfaction and psychological flexibility of individuals without sexual dysfunction were found to be significantly higher than individuals with sexual dysfunction. At the same time, it has been determined that individuals with sexual dysfunction have experienced more childhood traumas and have a higher rate of developing anxious and avoidant attachment styles than individuals without sexual dysfunction. In this context, it is recommended to focus on psychological aid programs in order to increase the level of psychological flexibility in individuals with sexual dysfunction and to raise awareness of childhood traumas and attachment styles.

In Turkish Republic North Cyprus (TRNC) talking about sexuality and sexuality-related problems are often considered taboo, so it is seen as a difficult area to talk about. In the Turkish Republic of Northern Cyprus (TRNC), cultural, religious, and social factors contribute to the perception of sexuality and related topics as taboo. The traditional family structure may consider discussions about sexuality within the family as inappropriate or unnecessary, leading to a culture of silence across generations. Influenced by Islamic culture, the belief that sexuality is a private matter and should not be discussed openly in public is reinforced, making it difficult for individuals to express concerns about sexual health or seek support (Akalpler ve Eroğlu, 2015).

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Research indicates that sexual dysfunctions may be related to traumatic experiences in childhood and individuals' attachment styles. In a study conducted by Van Berlo and Ensink (2000), it was found that childhood traumas have lasting effects on adult sexual functioning, with individuals who have a history of sexual trauma being more likely to experience low sexual desire, painful intercourse, and orgasm disorders. Similarly, Uluyol's (2019) study revealed that individuals who experienced neglect or abuse in childhood are more prone to developing anxious and avoidant attachment styles, which in turn increases the risk of sexual dysfunctions. Individuals with an anxious attachment style tend to experience intense insecurity and a need for approval in their relationships, which can heighten sexual performance anxiety and contribute to sexual dysfunctions. On the other hand, individuals with an avoidant attachment style tend to avoid emotional intimacy, making it difficult for them to establish a healthy sexual relationship with their partners. These findings provide a significant foundation for understanding the impact of childhood traumas and attachment styles on sexual health. Research has shown that childhood traumas have a strong relationship with sexual dysfunctions. In the study conducted by Van Berlo and Ensink (2000), it was determined that individuals who experienced trauma during childhood were more likely to suffer from problems such as low sexual desire, orgasm disorders, and painful intercourse in adulthood. Similarly, Uluyol (2019) emphasized that childhood traumas trigger anxious and avoidant attachment styles, which in turn can lead to sexual dysfunctions in adulthood. Attachment styles also have a significant impact on sexual functioning. According to a study by Mikulincer and Shaver (2016), individuals with an anxious attachment style tend to seek constant approval from their partners, which can lead to sexual performance anxiety and negatively affect sexual satisfaction. On the other hand, individuals with an avoidant attachment style may struggle to establish a healthy sexual relationship due to their tendency to avoid emotional intimacy. Psychological flexibility refers to an individual's ability to cope with stress and tolerate negative life experiences (Kashdan & Rottenberg, 2010). It has been observed that individuals with sexual dysfunctions have lower levels of psychological flexibility, making it difficult for them to cope with their traumatic past and leading to increased anxiety and avoidance responses in their sexual lives (Bond et al., 2011). Examining these three variables together will provide a holistic approach to understanding the origins of sexual dysfunctions and contribute significantly to the literature. Therefore, considering the limitations of existing research, it is believed that this study will shed light on the field.

Sexuality is not just a biological activity performed for the continuity of the lineage, but rather a specific and complex activity that includes cognitive, cultural, behavioral, moral characteristics and is shaped by sexual myths; it has psychological, sociological and biological characteristics (Türkseven, Söylemez, & Dursun, 2020). Sexual function is the whole of the sexual reactions that occur during these reaction processes, including physiological, psychological and social reactions to any sexual stimulus (Şişman, 2020). Since sexual function is a biopsychosocial process, it has many components. For this reason, it requires a multidisciplinary evaluation (Doğan, 2011). Sexual function, which is considered taboo and private, has gradually begun to break taboos with the realization of its importance and thus has become a frequently addressed topic in today's research (CETAD, 2006). Although sexual dysfunction is the most common psychiatric disorder in women and men, it is less treated than other psychiatric disorders (Kumkale, 2015). Although sexual dysfunctions are not life-threatening, they significantly affect people's quality of life and lead to deterioration (Demir, Parlakay, Gök, & Esen, 2007).

People can be exposed to trauma at every stage of life from birth to death. One of these phases is childhood (Gençoğlu, 2021). Childhood is the most important developmental period in which personality is formed and the foundations for adulthood are laid. For this reason, children's exposure to damaging events during their developmental stages may cause various psychological problems in adulthood (Kutlubay, 2022).

Sexuality is a very important part of romantic relationships. The attachment styles of couples are one aspect that may influence sexual life in romantic partnerships (Brassard, Shaver, Lussier, 2007). Attachment is a two-sided relationship since it is a process in which two people fulfill each other's needs in the form of a mutual exchange (Tüzün & Sayar, 2006). For this reason, deterioration in the attachment process can affect both couples, negatively affecting their romantic relationships and thus their sexual relationships, and lead to sexual dysfunctions (Sımk, 2022). Attachment, which is a critical factor in understanding human relationships, is closely linked to sexuality. Attachment styles (secure, anxious, and avoidant) significantly influence individuals' romantic relationships and sexual satisfaction (Brassard, Shaver, & Lussier, 2007). Attachment is a two-sided relationship since it is a process in which two people fulfill each other's needs in a mutual exchange

(Tüzün & Sayar, 2006). For instance, anxious attachment is often associated with heightened dependence and fear of rejection, which can contribute to difficulties in achieving emotional and sexual intimacy. Avoidant attachment, on the other hand, is linked to discomfort with closeness and emotional detachment, leading to reduced sexual satisfaction and increased sexual dysfunction (Mikulincer & Shaver, 2016; Uluyol, 2019). Studies suggest that individuals with insecure attachment styles are more likely to experience lower sexual arousal, satisfaction, and pleasure, which may further exacerbate sexual dysfunctions (Fricker & Moore, 2002; Holmes & Johnson, 2022).

Moreover, childhood traumas have a profound effect on attachment styles, and this relationship plays a pivotal role in sexual health. Childhood is the most critical developmental stage where personality is formed, and the foundations for adulthood are laid. Adverse childhood experiences, such as abuse or neglect, can disrupt the development of secure attachment and lead to insecure attachment patterns in adulthood. These patterns, in turn, have been shown to mediate the relationship between childhood traumas and sexual dysfunctions (Ribeiro, Silva, & Carvalho, 2021; Stevenson, McDermott, & Willis, 2022).

Psychological flexibility, which is another variable of the research, is the ability to accept events beyond one's control as they are, to be determined to maintain behaviors that will enrich one's life, and to change the behaviors that need to be changed in line with one's own values (Çalışkan, 2020).

Sexual dysfunctions, childhood traumas, problems in attachment styles and decreased psychological flexibility, which are very common in the society, affect the individual himself/herself first, then the person with whom he/she is in a romantic relationship and his/her social environment. As a result, it can lead to many physical, emotional and social problems and cause an important public health problem. For this reason, comparing the effects of these four variables on each other may facilitate the understanding and solution of the problem by providing a different perspective on sexual dysfunctions. In this context, the aim of the study is to examine the comparison of attachment styles, childhood traumas and psychological flexibility in individuals with and without sexual dysfunction.

Method

Participants

There are two groups in the study: those with and those without sexual dysfunction. The sample of the study consists of 50 volunteers aged 18 and over with sexual dysfunction and 50 individuals without sexual dysfunction who live in Kyrenia and Nicosia and apply to the urology, psychiatry, obstetrics and gynecology departments of 3 hospitals in the Nicosia Region and 2 hospitals in the Kyrenia region of the Turkish Republic of Northern Cyprus.

Sociodemographic Characteristics of the Research Sample and Descriptive Statistics on Research Variables

When Table 1 is examined, it is seen that 50% of the healthy individuals participating in the study were male, 50% were female, 34% were bachelor, 66% were married, 40% were high school graduates or lower, 40% were undergraduates, 20% were postgraduates, 48% had good economic income, 48% had moderate economic income, and 4% had high economic income, 80% had an ongoing romantic relationship, 20% did not have an ongoing romantic relationship, 2% had a psychological disorder, 98% did not have any psychological disorder, 100% did not use any psychiatric medication, 10% had a chronic disease, 90% did not have any chronic disease.

Of the individuals with sexual dysfunction who participated in the study, 50% were male, 50% were female, 46% were bachelor, 54% were married, 36% were high school graduates or lower, 50% were undergraduates, 14% were postgraduates, 44% had good economic income, 50% had moderate economic income, and 6% had high economic income, 62% had an ongoing romantic relationship, 38% did not have an ongoing romantic relationship, 6% had a psychological disorder, 94% did not have any psychological disorder, 6% used a psychiatric drug, 94% did not use any psychiatric drug, 18% had a chronic disease, 80% did not have any chronic disease.

Table 1. Distribution of healthy individuals and individuals with sexual dysfunction according to sociodemographic characteristics

	Healthy		With SD		X ²	P
	N	%	N	%		
Age	36,78±9,35		36,00±8,53			0,607
Gender						
Male	25	50	25	50	0,000	1,000
Female	25	50	25	50		
Marital Status						
Bachelor	17	34	23	46	1,500	0,221
Married	33	66	27	54		
Education						
Highschool graduates or lower	20	40	18	36	1,190	0,551
Undergraduate	20	40	25	50		
Postgraduate	10	20	7	14		
Economic Income Group						
Good	24	48	22	44	0,307	0,858
Moderate	24	48	25	50		
High	2	4	3	6		
Ongoing romantic relationship						
Yes	40	80	31	62	3,934	0,047
No	10	20	19	38		
Any psychological disorder						
Yes	1	2	3	6	a	0,617
No	49	98	47	94		
Any psychiatric medication						
Yes	0	0	3	6	a	0,242
No	50	100	47	94		
Any chronic disease						
Yes	5	10	9	18	1,427	0,232
No	45	90	40	80		

a: Fischer exact test

Data Collection Tools

Sociodemographic Information Form: It is a form created by the researcher and structured to access sociodemographic information about the participants. This form, which will be used in the research, includes questions such as gender, age, education level, marital status.

Golombok-Rust Sexual Satisfaction Scale: This scale developed by Golombok and Rust (1986) was adapted into Turkish by Tuğrul, Öztan, & Kabakçı (1993). It is a 5-point Likert-type scale consisting of 28 questions. The scale has two dimensions. While the overall total score serves to measure the level of sexual functioning, the sub-dimensions allow for the measurement of problems occurring in various dimensions of sexual intercourse (Tuğrul, et al., 1993). In summary, the increase in the scores obtained from the scale indicates an increase in sexual function problems (Uluyol, 2019).

In the original Golombok-Rust Sexual Satisfaction Inventory, Cronbach's alpha values were 0.94 for women and 0.87 for men . In the reliability studies of the Turkish version of the Golombok-Rust Inventory, the total correlation coefficients of the questions varied between -0.04 and 0.76 for problematic and non-problematic men and between 0.18 and 0.74 for problematic and non-problematic women. In the total overall score, Cronbach's alpha coefficient was 0.92 for men and 0.91 for women (Tuğrul, Öztan, & Kabakçı, 1993).

Childhood Psychological Trauma Scale: This scale developed by Bernstein, Fink, Handelsman, & Foote (1994) was adapted into Turkish by Şar, Öztürk & İkikardeş (2012). It is a 5-point Likert-type scale consisting of 28 items. It consists of five sub-dimensions. The increase in the scores obtained from the sub-dimensions indicates an increase in the trauma in the relevant sub-dimension. In the original version of the scale, Cronbach Alpha values were found to be between .79 and .94 (Alpay, Aydın, & Bellur, 2017).

In the Turkish adaptation phase, the construct validity of the scale was examined and Bartlett's test of sphericity was found to be significant. At the same time, the KMO coefficient was found to be .84. In the reliability study, the Cronbach Alpha reliability coefficient of the scale was .93 and the Guttman half test coefficient was .97 (Gençoğlu, 2021).

Experiences in Close Relationships-Revised (ECR-R): The scale developed by Fraley, Waller & Brennan (2000) was adapted into Turkish by Selçuk, Günaydın, Sümer & Uysal (2005). It is a 7-point Likert-type scale consisting of two sub-dimensions (anxious and avoidant attachment) and 36 questions. Some questions in the scale are reverse scored. The sub-dimensions range from 18-126 points. The anxiety score in the scale is determined by the average of the odd-numbered questions and the avoidance score is determined by the average of the even-numbered questions. In the validity and reliability studies, as a result of the factor analysis, it was determined that the sub-dimensions of the scale related to attachment had a two-factor structure and the validity of the scale was supported. At the same time, the Cronbach's alpha coefficients of the sub-dimensions of the scale, which have a high level of internal consistency, were found to be .90 for the avoidance sub-dimension and .86 for the anxiety sub-dimension (Selçuk, Günaydın, Sümer, & Uysal, 2005).

In the original study of the scale, it was determined that the two-factor structure defined 44.36% of the total variance and the anxious attachment sub-dimension of the scale ($\alpha = .83$) and the avoidant attachment sub-dimension ($\alpha = .85$) had high internal consistency coefficients (Kırimer, Akça, & Sümer, 2014).

Psychological Flexibility Scale: Karakuş and Akbay (2020) adapted the Francis, Dawson & Golijani-Moghaddam (2016) scale into Turkish. It has 28 questions and 5 sub-dimensions on a 7-point Likert-type scale. The score that can be obtained from the scale is in the range of 28-196. As the scores obtained from the sub-dimensions increase, the level of psychological flexibility increases. In the original scale, Cronbach's α value for the overall scale was .91 (Francis, et al., 2016).

In the Turkish version of the scale, the Cronbach Alpha internal consistency reliability coefficient was found to be .79. (Meşe, 2021).

Process

Before collecting the data to be used in the study, permission was obtained from the Ethics Committee of Near East University (YDÜ/SB/2022/1360 (09.11.2022)). Data were collected from individuals with sexual dysfunction who applied to urology, psychiatry, obstetrics and gynecology departments of private and public hospitals in TRNC. The data of individuals without sexual dysfunction were collected on a voluntary basis from individuals who were not diagnosed with any sexual disorders or who did not have any problems about sexual disorders. The response time of the scales took an estimated 20-25 minutes. Data were collected on a voluntary basis and face-to-face. It took an average of 3 months to collect the data.

Data Analysis

Statistical Data Analysis for Social Sciences (SPSS) 26.0 package program was used to analyze the data. The reliability of the participants' responses to the scales used in the study was examined by Cronbach's alpha test and it was found that the alpha coefficient was 0.958 for the Childhood Psychological Trauma Scale (CTQ), 0.874 for the Psychological Flexibility Scale (PFQ) and 0.934 for the Experiences in Close Relationships-Revised (ECR-R). The distribution of healthy individuals and individuals with sexual dysfunction according to their sociodemographic characteristics was given in the cross tabulation and compared with the Perason chi-square test.

The normal distribution of the Childhood Psychological Trauma Scale (CTQ), Psychological Flexibility Scale (PFQ) and Inventory of Experiences in Close Relationships-II scores of healthy individuals and individuals with sexual dysfunction were examined by Shapiro-Wilk test and it was determined that they did not show normal distribution. For this reason, the research hypotheses were compared with nonparametric tests. Childhood Psychological Trauma Scale (CTQ), Psychological Flexibility Scale (PFQ) and Inventory of Experiences in Close Relationships-II scores of healthy individuals and individuals with sexual dysfunction were compared with Mann-Whitney U test.

Results

Comparison of Individuals with and without Sexual Dysfunction and Research Variables

Table 2. Comparison of SSS Scores of Healthy Individuals and Individuals with Sexual Dysfunction

	Group	n	\bar{x}	S	M	SO	Z	P
Frequency	Healthy	50	1,74	1,37	2	31,17	-6,725	0,000*
	With SD	50	4,58	1,80	5	69,83		
Communication	Healthy	50	1,06	1,30	0	33,99	-5,838	0,000*
	With SD	50	3,56	2,13	3	67,01		
Satisfaction	Healthy	50	1,88	2,12	1	28,04	-7,786	0,000*
	With SD	50	8,66	3,15	9	72,96		
Avoidance	Healthy	50	0,56	1,05	0	28,56	-7,777	0,000*
	With SD	50	5,8	3,26	6	72,44		
Touching	Healthy	50	0,78	1,49	0	32,82	-6,361	0,000*
	With SD	50	5,04	3,45	6	68,18		
Pre-ejaculation Vaginismus	Healthy	50	1,24	1,61	1	31,47	-6,663	0,000*
	With SD	50	7,16	4,15	8	69,53		
Impotence Anorgasmia	Healthy	50	1,96	2,03	1	27,23	-8,054	0,000*
	With SD	50	8,5	2,71	8,5	73,77		
Sexual Satisfaction Scale	Healthy	50	9,22	8,65	7,5	26,57	-8,252	0,000*
	With SD	50	43,3	12,19	44,5	74,43		

* $p < 0,05$

When Table 2 is examined, the Frequency, Communication, Satisfaction, Avoidance, Touching, Premature ejaculation/Vaginismus, Empotence /Anorgasmia scores of individuals with sexual dysfunction were statistically significantly higher than the Frequency, Communication, Satisfaction, Avoidance, Touching, Premature ejaculation/Vaginismus, Empotence /Anorgasmia scores of healthy individuals. Sexual Satisfaction Scale general scores of individuals with sexual dysfunction were found to be statistically significantly higher than Sexual Satisfaction Scale general scores of healthy individuals.

Table 3. Comparison of CTQ Scores of Healthy Individuals and Individuals with Sexual Dysfunction

	Group	n	\bar{x}	S	M	SO	Z	P
CTQ-Emotional Abuse	Healthy	50	6,44	2,20	5,00	34,45	-5,636	0,000*
	With SD	50	10,88	4,31	10,50	66,55		
CTQ-Physical Abuse	Healthy	50	5,60	1,40	5,00	39,36	-4,370	0,000*
	With SD	50	8,62	4,11	7,00	61,64		
CTQ-Sexual Abuse	Healthy	50	5,46	1,69	5,00	40,51	-4,298	0,000*
	With SD	50	8,60	4,77	5,00	60,49		

Table 3. (Continued)

CTQ-Physical	Healthy	50	6,82	2,11	6,00	37,34		
Neglect	With SD	50	10,34	4,10	10,00	63,66	-4,609	0,000*
CTQ-Emotional	Healthy	50	8,24	3,30	7,50	30,28		
Neglect	With SD	50	15,88	4,57	15,50	70,72	-7,001	0,000*
Childhood Psychological	Healthy	50	46,08	13,76	42,00	30,97		
Trauma Scale (CTQ)	With SD	50	77,60	21,22	83,00	70,03	-6,736	0,000*

* $p < 0,05$

When Table 3 is examined, the Emotional Abuse, Physical Abuse, Sexual Abuse, Physical Neglect and Emotional Neglect scores of individuals with sexual dysfunction and the overall scores of the CTQ were found to be statistically significantly higher than the Emotional Abuse, Physical Abuse, Sexual Abuse, Physical Neglect and Emotional Neglect scores of healthy individuals and the overall scores of the CTQ.

Table 4. Comparison of PFQ Scores of Healthy Individuals and Individuals with Sexual Dysfunction

	Group	n	\bar{x}	S	M	SO	Z	P
PFQ- Values and behavior in line with values	Healthy	50	60,28	9,28	63,00	61,10		
	With SD	50	49,94	13,99	51,00	39,90	-3,658	0,000*
PFQ-Being in the moment	Healthy	50	27,40	5,29	30,50	54,23		
	With SD	50	25,42	6,91	27,50	46,77	-1,298	0,194
PFQ-Acceptance	Healthy	50	17,60	4,38	17,50	50,21		
	With SD	50	18,36	7,84	18,50	50,79	-0,100	0,920
PFQ-Contextual self	Healthy	50	14,76	3,17	15,00	65,00		
	With SD	50	10,82	3,84	11,00	36,00	-5,022	0,000*
PFQ-Dissociation	Healthy	50	13,86	2,57	14,00	64,56		
	With SD	50	11,06	3,16	11,00	36,44	-4,878	0,000*
Psychological Flexibility Scale (PFQ)	Healthy	50	133,90	19,21	139,00	62,84		
	With SD	50	115,60	21,81	114,00	38,16	-4,255	0,000*

* $p < 0,05$

When Table 4 was examined, it was determined that there was a statistically significant difference between the Psychological Flexibility Scale (PFQ) general scores of healthy individuals and individuals with sexual dysfunction who participated in the study and the scores they received from the Values and behavior in line with values, Contextual self and Dissociation sub-dimensions of the scale ($p < 0,05$). Behavior in line with values and values, Contextual self and Dissociation scores and PFQ general scores of healthy individuals were found to be statistically significantly higher than the Behavior in line with values and values, Contextual self and Dissociation scores and PFQ general scores of individuals with sexual dysfunction.

Table 5. Comparison of ECR-R Scores of Healthy Individuals and Individuals with Sexual Dysfunction

	Group	n	\bar{x}	S	M	SO	Z	P
ECR-R Anxious	Healthy	50	2,69	0,82	2,67	34,60		
	With SD	50	3,82	1,08	3,83	66,40	-5,482	0,000*
ECR-R Avoidant	Healthy	50	2,07	0,66	1,89	30,29		
	With SD	50	3,71	0,95	3,97	70,71	-6,968	0,000*

* $p < 0,05$

When Table 5 was examined, it was found that there was a statistically significant difference between the Anxious and Avoidant scores of healthy individuals and individuals with sexual dysfunction who participated in the study ($p < 0.05$). Anxious and Avoidant scores of individuals with sexual dysfunction were statistically significantly higher than Anxious and Avoidant scores of healthy individuals.

Discussion

In this section, the findings are discussed in the light of the findings obtained and in line with the existing research in the literature. In this study, it was aimed to examine the comparison of attachment styles, childhood traumas and psychological flexibility in individuals with and without sexual dysfunction, taking into account the information provided in the light of the literature.

As a result of the analyzes conducted within the scope of the research, firstly, it was determined that there was a difference in the sexual satisfaction levels of individuals with and without sexual dysfunction. However, it was determined that individuals without sexual dysfunction had significantly higher levels of sexual satisfaction than individuals with sexual dysfunction. It is thought that individuals with sexual dysfunction may have a harder time focusing on satisfaction during sexual intercourse due to the possibility of triggering performance anxiety, worry, anticipatory anxiety, and past unsuccessful experiences during sexual experience. Alkan (2008) and Kumkale (2015) also obtained similar data supporting the data of this study in their studies. Wei, Zhang, and Li (2021) found that sexual satisfaction levels are closely related to individuals' psychological well-being and stated that anxiety has a negative effect on sexual satisfaction. Dimitropoulos et al. (2023) revealed that anxiety levels directly affect sexual satisfaction.

Many researchers have found that there is a strong relationship between sexual dysfunction and trauma (Goodman, Koss, & Russo, 1993; Van Berlo & Ensink, 2000). In the study, it was determined that there was a significant difference in the level of childhood traumas of individuals with and without sexual dysfunction. In addition, it was determined that individuals with sexual dysfunction had higher levels of childhood traumas than individuals without sexual dysfunction. Hallward and Ellison (2001) and Wang et al. (2023) reported that childhood traumas are a factor in sexual dysfunctions, and Geryan Çervatoğlu (1998) reported that the incidence of depression, anxiety disorders and sexual dysfunctions is high in individuals who were sexually abused as children (Geryan Çervatoğlu, 1998). It is thought that childhood traumas have a negative impact on sexuality, as in many other areas, during adulthood. Additionally, Ribeiro, Silva, and Carvalho (2021) stated that childhood traumas have a negative impact on sexual functioning in adulthood, leading to decreased sexual satisfaction, while Stevenson et al. (2022) emphasized that adversities experienced in childhood show a strong link with sexual health problems in adulthood. There are not enough studies on sexual dysfunction and psychological flexibility in the domestic literature. However, in studies conducted abroad, it has been determined by various researchers that sexual dysfunction and vulvovaginal pain are related to psychological flexibility. With this and similar studies, it was concluded that high levels of psychological flexibility cause more sexual function and less sexual dysfunction (Boerner & Rosen, 2015; Chisari et al. 2021; Maathz, 2022). In this direction, similar to the literature, it was determined that there was a differentiation in the psychological flexibility levels of individuals with and without sexual dysfunction. However, it was found that individuals without sexual dysfunction had higher levels of psychological flexibility than individuals with sexual dysfunction. Lee, Lee, and Kim (2021) emphasized that psychological flexibility is directly related to sexual satisfaction and that the Acceptance and Commitment Therapy (ACT) method is effective in solving problems in this area. In addition, Păsărelu et al. (2022) stated that ACT-based therapies provide positive results in individuals with sexual dysfunction. Psychological flexibility appears as a perspective on life and a psychological life skill, therefore, it is thought that having high psychological flexibility in sexuality will be a preventive factor for the emergence of sexual dysfunction.

In the study, it was found that there was a differentiation between attachment styles of individuals with and without sexual dysfunction. In addition, it was found that the rate of anxious and avoidant attachment styles in individuals with sexual dysfunction was higher than in individuals without sexual dysfunction. Kingsberg and Janata (2007) found that individuals with anxious and avoidant attachment styles experienced less sexual satisfaction and more sexual dysfunction as a result of their research. Uluyol (2019) found that insecure attachment style may cause an increase in sexual dysfunction problems. In addition, it has been supported by various studies that individuals with anxious and avoidant attachment styles are associated with lower levels of sexual arousal, pleasure and satisfaction (Morrison, Urquiza, & Goodlin Jones, 1997; Fricker & Moore,

2002). Roberts, Birnbaum, and Mikulincer (2021) found that insecure attachment styles have a negative impact on sexual satisfaction and function, while Holmes and Johnson (2022) found that secure attachment styles are associated with higher levels of satisfaction. These studies contribute to a deeper understanding of the relationship between attachment styles and sexual function.

Conclusions

As a result, in the research finding, sexual satisfaction and psychological flexibility of individuals without sexual dysfunction were found to be significantly higher than individuals with sexual dysfunction. At the same time, it was determined that individuals with sexual dysfunction had experienced more childhood traumas and also had a higher rate of developing anxious and avoidant attachment styles compared to individuals without sexual dysfunction.

According to the result we obtained from our research findings, it is thought that individuals having high levels of psychological flexibility will enable them to develop effective coping strategies in the face of difficult traumatic events, develop unconditional acceptance towards themselves, develop better attachment styles and have a better sexual functioning. For this reason, it is recommended that clinical assistance programs should be prepared for people with low psychological flexibility levels and work on increasing their psychological flexibility levels.

Recommendations

Recommendations for Researchers

This study was conducted on a sample of 100 participants, 50 with sexual dysfunction and 50 without sexual dysfunction, comparing attachment styles, childhood traumas, and psychological flexibility in individuals with and without sexual dysfunction. It is recommended that the data obtained as a result of the study to be repeated on a larger sample in order to increase the generalizability of the data.

It is thought that new studies conducted in a comparative manner between different cultural groups or different countries and cities in order to reduce the effect of cultural differences on the research data will shed light on the inconsistency in the literature.

In the literature review conducted, regarding the study, it was seen that the research on the concept of psychological flexibility was limited. It is thought that increasing the research examining psychological flexibility in terms of different sociodemographic characteristics and variables will make a significant contribution to the insufficient literature on this subject.

Recommendations for the State

Authorized institutions such as hospitals, public education centers, universities, etc. are thought that organizing seminars in places to provide information about sexual dysfunctions, childhood traumas, attachment styles and psychological flexibility concepts and in addition to ensuring that individuals in need can access support services more easily will be beneficial.

Recommendations for Clinicians

According to the results obtained from our research findings, it was determined that psychological flexibility has a significant relationship with sexual dysfunction, attachment styles and childhood traumas. According to the results obtained from our research findings, it is thought that individuals with a high level of psychological flexibility will enable them to develop effective coping strategies in the face of difficult traumatic events, develop unconditional acceptance towards themselves, develop better attachment styles and have better sexual function. For this reason, it is recommended that clinical assistance programs should be prepared for individuals with low levels of psychological flexibility and work on increasing their levels of psychological flexibility.

Limitations

The study is limited to the hospitals where the data was collected. Some participants did not want to be included in the study because sexuality was seen as a taboo. The study conducted is limited to the questions included in the data measurement tools and the responses given by the participants to the questions. In the study where the evaluation was made regarding sexuality, it is thought that the participants may be biased and this situation

may create methodological limitations. The results of the study are limited to the data analysis methods determined by the researcher.

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