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Marital Life, Sexual Myths, and Depressive Symptoms as Predictors of Sexual Satisfaction in Married Women: A Cross-Sectional Study

Pelin Göksel

pelin.goksel@omu.edu.tr

Ondokuz Mayıs University

Feyza Yılmaz

Samsun Mental Health and Diseases Hospital

Research Article

Keywords: sexual satisfaction, sexual myth, marital life, depressive symptom, married women

Posted Date: September 4th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10534567/v1

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Additional Declarations: No competing interests reported.

Abstract

Objective

This study aimed to examine the associations of depression severity, marital life, and sexual myths with sexual satisfaction in married women presenting with depressive complaints.

Methods

This cross-sectional study included 150 married women aged 18–45 years who presented to a psychiatry outpatient clinic with active depressive complaints. Participants were assessed using a sociodemographic and clinical data form, the Hamilton Depression Rating Scale (HDRS), the Marital Life Scale (MLS), the Golombok-Rust Inventory of Sexual Satisfaction (GRISS) Female Form, and the Sexual Myths Scale (SMS). Correlation and multiple linear regression analyses were performed to identify factors associated with sexual function problems.

Results

Higher GRISS total scores were significantly associated with lower marital life satisfaction, greater depression severity, and stronger belief in sexual myths. In the final regression model, marital life, sexual myths, education level, spouse's education level, and the family's prohibitive attitude toward sexuality significantly predicted GRISS total scores and explained 34.4% of the variance. Depression severity did not remain an independent predictor.

Conclusion

In married women presenting with depressive complaints, sexual dissatisfaction was independently predicted by marital, cognitive-cultural, and family-related factors, rather than the severity of depression

Introduction

In contemporary psychological literature, marriage is conceptualized as a deep and complex human relationship grounded in intimacy and companionship, in which two individuals facilitate life through mutual empathy, compassion, and effective communication.[1] Spouses adapt to marriage - which is also a major life transition and potential crisis point - through their ability to communicate effectively, resolve problems that arise between them, and derive pleasure from shared activities.[2] Although numerous dynamics determine marital adjustment, mutual commitment, empathic communication, shared experiences, and a satisfying sexual life are among the most fundamental predictors of this process.[3]

Sexual satisfaction is a multidimensional biopsychosocial construct that interacts with individuals' psychological well-being, relationship dynamics, and internalized cultural beliefs.[4] A satisfying sexual relationship plays an important role in the positive relationship between spouses and enhances marital adjustment; conversely, a harmonious marital experience helps maintain a healthy sexual life.[5] Research on women's sexual satisfaction has been increasing, and studies indicate that relationship satisfaction is a strong predictor of sexual satisfaction.[4] Poor communication with the spouse, problems in the sharing of responsibilities, and the perception of sexuality as taboo may prevent women from attaining sufficient sexual satisfaction.[6] Another point emphasized in the literature is that sexual dissatisfaction is more common among women than men, and among married women than unmarried women.[7,8] This necessitates the assessment of marital dynamics when investigating sexual satisfaction.

Sexual satisfaction in women is also influenced by psychosocial factors and psychiatric disorders. Recent studies emphasize that depressive disorders are substantially more common in women than in men and that psychosocial stressors play a determining role in this pattern.[9] In addition to the traditional expectation that women assume caregiving roles and responsibility for household tasks, women's increasing participation in paid employment in the modern era has made marital life a more intense source of stress for women. Marital problems have been reported to affect women's mental health more strongly than men's, thereby increasing rates of depression in women and contributing to sexual dissatisfaction. [10,11]

Although women's sexual satisfaction is known to be directly influenced by marital life and cultural norms, particularly sexual myths, comprehensive studies on this topic remain quite limited in our country.[12] The resulting psychological and sexual problems affect not only the individual, but also the family and the fundamental dynamics of society. Based on this need, the aim of the present study was to examine the effects of depression severity, marital life, and sexual myths on sexual satisfaction in married women aged 18–45 years.

Methods

Study Procedure and Participants

Married women aged 18–45 years who presented to the outpatient clinic of Samsun Mental Health and Disorder Hospital with active depressive complaints (e.g., low mood and loss of pleasure) were included in the study. No formal psychiatric diagnosis or episode assessment was performed for the participants; instead, the subjective complaints and clinical presentation at the time of admission were accepted as the inclusion criterion. Because of the possibility of causing sexual dysfunction, individuals who had used psychotropic medication within the previous 6 months, pregnant or breastfeeding women, and those using regular medication (e.g., anti-inflammatory drugs or hormonal medications) were excluded.

Based on the descriptive cross-sectional study by Ikican et al., which examined the relationship between marital adjustment, sexual satisfaction, and depressive symptoms in women, a power analysis indicated that at least 130–150 participants were required for multiple regression analyses including 8–10 independent variables, with a 95% confidence level and 80% statistical power. Accordingly, the target sample size for the present study was set at 150 participants.[13]

Data were collected between January 1, 2026 and May 4, 2026.

The study was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was obtained from the Ondokuz Mayıs University Clinical Research Ethics Committee on December 18, 2025 (Decision No: 2025/616). Written informed consent was obtained from all participants.

Data Collection Instruments

A multidimensional assessment battery was used for data collection. Basic sociodemographic information, such as participants' age, educational level, and number of children, as well as clinical information, such as whether they had a diagnosis of any psychiatric disorder and whether they used any regular medication, were obtained using a Sociodemographic and Clinical Data Form prepared by the clinician. Depression severity was assessed using the Hamilton Depression Rating Scale (HDRS), the Turkish validity and reliability study of which was conducted by Akdemir and colleagues in 1996.[14,15] To assess participants' level of satisfaction with marital life, the Marital Life Scale (MLS), developed by Esin Tezer (1996), was used; higher scores indicate higher marital satisfaction.[16] To determine the quality of sexual intercourse, sexual dysfunction, and the severity of sexual problems, the Female Form of the Golombok-Rust Inventory of Sexual Satisfaction (GRISS), whose Turkish validity and reliability study was conducted by Duyan and Duyan (2014), was administered.[17,18] Finally, to determine individuals' level of belief in sexual myths, the Sexual Myths Scale (SMS), developed by Golbasi et al. (2016) and consisting of 28 items and eight subdimensions, was used.[19]

Statistical Analysis

Data were analyzed using SPSS (Statistical Package for the Social Sciences). The normality of continuous variables was evaluated using the Kolmogorov-Smirnov and Shapiro-Wilk tests. Participants' sociodemographic and clinical characteristics were described using frequencies, percentages, means, and standard deviations. Spearman correlation analysis was performed to determine the direction and strength of the relationships among the study variables. To identify factors predicting women's sexual satisfaction, multiple linear regression analysis was conducted with sexual satisfaction as the dependent variable and marital adjustment, sexual myths, and depression level as independent variables.

In addition, the moderating role of depression level in the relationship between marital adjustment and sexual satisfaction was examined using hierarchical regression analysis. To evaluate the moderation effect, the interaction term between marital adjustment and depression level was included in the model. Statistical significance was set at $p < .05$ for all analyses.

Results

A total of 150 married women participated in the study. The mean age of the participants was 35.9 ± 6.0 years, and the mean duration of marriage was 11.0 ± 7.7 years. The majority were university graduates (54.0%) and were currently employed (66.7%). Most of the sample had at least one child (79.3%), and half of the participants were smokers (50.0%). Regarding marriage type, 72.6% of participants had married after a dating period, whereas 27.4% had married through an arranged marriage. Descriptive statistics for continuous sociodemographic and marital characteristics are presented in Table 1, and the distribution of categorical sociodemographic characteristics is presented in Table 2.

Table 1
Descriptive statistics for continuous sociodemographic and marital characteristics

Variable	N	Mean	SD	Median	Min-Max
Age	150	35.89	6.0	36.0	19.0–45.0
Height (cm)	150	163.34	5.9	163.0	150.0-176.0
Weight (kg)	150	66.97	12.43	66.0	44.0-118.0
Number of children	150	1.43	1.03	1.0	0.0–4.0
Marriage number	150	1.08	0.27	1.0	1.0–2.0
Duration of marriage (years)	150	10.97	7.73	10.0	1.0–31.0
Spouse's age	150	38.47	6.69	37.5	21.0–55.0
SD: standard deviation					

Table 2
Distribution of categorical sociodemographic characteristics

Variable	Category	n	%
Education level	Primary/secondary education	35	23.3
	High school	34	22.7
	University	81	54.0
Employment status	Not employed	50	33.3
	Employed	100	66.7
Smoking	No	75	50.0
	Yes	75	50.0
Alcohol use	No	94	62.7
	Yes	56	37.3
Exercise	No	106	70.7
	Yes	44	29.3
Medication use	No	93	62.0
	Yes	57	38.0
Presence of children	No	31	20.7
	Yes	119	79.3
Marriage type	Arranged marriage	40	29.4
	Dating	106	72.6
Spouse's education level	Primary/secondary education	16	10.7
	High school	53	35.3
	University	81	54.0
Income level	< 25	7	4.7
	25–100	82	54.7
	> 100	61	40.7

When sexual experience and clinical history characteristics were evaluated, 67.3% of the participants reported that their first sexual experience occurred after marriage. Of the participants, 22.7% stated that their family had provided information about sexual issues, whereas 40.7% reported that their family had adopted a prohibitive attitude toward sexuality. In terms of clinical history, 20.0% of the sample reported a history of trauma, while a history of depression and a psychiatric diagnosis were reported by 45.3% of

the participants. These findings indicate a notable distribution of variables related to sexual experience, family attitudes, and psychiatric history in the sample. The distribution of sexual experience and clinical history characteristics is presented in Table 3.

Table 3
Distribution of sexual experience and clinical history characteristics

Variable	Category	N	%
First sexual experience after marriage	No	49	32.7
	Yes	101	67.3
Family provided information about sexual issues	No	116	77.3
	Yes	34	22.7
Negative family attitude toward sexual issues	No	89	59.3
	Yes	61	40.7
Trauma history	No	120	80.0
	Yes	30	20.0
History of depression	No	82	54.7
	Yes	68	45.3
Psychiatric disorder	No	82	54.7
	Yes	68	45.3

Examination of scale scores showed that the mean HAM-D score was 18.81 ± 6.20. The mean Marital Life Scale score was 33.69 ± 10.42, and the mean Sexual Myths Scale score was 41.64 ± 11.90. The mean GRISS total score was 4.30 ± 4.87. Among the subdimensions, the highest mean score was observed for avoidance (4.75 ± 1.78), whereas the lowest mean score was observed for satisfaction (3.53 ± 1.77). These findings suggest that depressive symptoms should be evaluated together with marital life, beliefs related to sexual myths, and domains of sexual functioning in this sample. Descriptive statistics for scale and subscale scores are presented in Table 4.

Table 4
Descriptive statistics for scale and subscale scores

Variable	N	M	SD	Median	Min-Max
HDRS	150	18.81	6.2	18.0	8.0–36.0
MLS	150	33.69	10.42	37.0	10.0–50.0
SMS	150	41.64	11.9	40.0	9.0–94.0
GRISS total	150	4.3	4.87	3.0	1.0–54.0
Frequency	150	3.98	1.91	3.5	1.0–9.0
Communication	150	4.13	2.33	4.0	1.0–9.0
Satisfaction	150	3.53	1.77	3.0	1.0–8.0
Avoidance	150	4.75	1.78	5.0	1.0–9.0
Touch	150	3.88	2.45	3.0	1.0–9.0
Vaginismus	150	4.01	1.69	4.0	1.0–8.0
Anorgasmia	150	3.65	1.46	3.0	1.0–9.0

HDRS: Hamilton Depression Rating Scale; MLS: Marital Life Scale; SMS: Sexual Myths Scale; GRISS: Golombok-Rust Inventory of Sexual Satisfaction; M: mean; SD: standard deviation

When variables associated with the GRISS total score were examined, the strongest relationship was observed with the Marital Life Scale score. Considering that higher GRISS total scores indicate poorer sexual functioning, sexual function problems decreased as marital life scores increased ($r = -0.743$, $p < .001$). In contrast, as depression severity (HAM-D; $r = 0.583$, $p < .001$) and belief in sexual myths (SMS; $r = 0.522$, $p < .001$) increased, the GRISS total score also increased, indicating more pronounced sexual function problems. In addition, education level, spouse's education level, the family's prohibitive attitude, number of children, duration of marriage, marriage type, alcohol use, family provision of information, and exercise were significantly associated with the GRISS total score. Spearman correlation results for variables associated with the GRISS total score are presented in Table 5.

Table 5
Spearman correlation results for variables associated with the GRISS total score

Variable	N	Spearman r	p	p_FDR
MLS	150	-0.743	< .001	< .001
HAM-D	150	0.583	< .001	< .001
SMS	150	0.522	< .001	< .001
Education level	150	-0.459	< .001	< .001
Spouse's education level	150	-0.429	< .001	< .001
Family's prohibitive attitude	150	0.415	< .001	< .001
Number of children	150	0.407	< .001	< .001
Duration of marriage	149	0.399	< .001	< .001
Marriage type	146	-0.374	< .001	< .001
Alcohol use	150	-0.345	< .001	< .001
Family information	150	-0.343	< .001	< .001
Exercise	150	-0.343	< .001	< .001
Presence of children	150	0.313	< .001	< .001
History of depression	150	0.298	< .001	< .001
Employment status	150	-0.283	< .001	< .001
Psychiatric disorder	150	0.274	< .001	.001
Income level	150	-0.257	.001	.002
First sexual experience after marriage	150	0.256	.002	.002
Spouse's age	148	0.222	.007	.009
Age	150	0.206	.011	.014
Smoking	150	0.194	.018	.020
Trauma history	150	0.169	.039	.042
Medication use	150	0.144	.078	.082
BMI	150	0.139	.091	.091

HAM-D: Hamilton Depression Rating Scale; MLS: Marital Life Scale; SMS: Sexual Myths Scale; GRISS: Golombok-Rust Inventory of Sexual Satisfaction; BMI: body mass index

In the multiple linear regression analysis conducted to determine the variables predicting the GRISS total score, the initial model was statistically significant (Table 6). In the initial model, marital life, level of belief in sexual myths, education level, and the family's prohibitive attitude emerged as significant predictors, whereas depression severity was not found to be an independent predictor. The final model obtained using the backward elimination method was also statistically significant and explained 34.4% of the variance in the GRISS total score (Table 7). In the final model, the Marital Life Scale score, Sexual Myths Scale score, education level, spouse's education level, and the family's prohibitive attitude remained significant predictors. The strongest predictor in the model was the Marital Life Scale score; as marital life scores increased, GRISS total scores decreased. In contrast, as belief in sexual myths and the family's prohibitive attitude increased, GRISS total scores increased, indicating more pronounced sexual function problems. VIF values in the final model ranged from 1.30 to 3.06, indicating no serious multicollinearity problem.

Table 6
Initial multiple linear regression model predicting the GRISS total score

Variable	B	SE	β	t	p	95% CI
MLS	-0.183	0.043	-0.389	-4.231	< .001	-0.268, -0.097
HDRS	0.088	0.068	0.111	1.294	.198	-0.046, 0.222
SMS	0.077	0.037	0.188	2.120	.036	0.005, 0.150
Number of children	0.203	0.476	0.043	0.427	.670	-0.738, 1.144
Duration of marriage	-0.001	0.060	-0.001	-0.009	.993	-0.120, 0.118
Education level	2.518	0.777	0.423	3.240	.002	0.981, 4.055
Spouse's education level	-1.628	0.857	-0.226	-1.900	.060	-3.322, 0.067
Family's prohibitive attitude	1.803	0.831	0.181	2.171	.032	0.160, 3.446
Marriage type	0.505	1.090	0.046	0.463	.644	-1.651, 2.661
Exercise	0.217	0.947	0.020	0.229	.819	-1.656, 2.089
Alcohol use	-1.335	0.859	-0.131	-1.554	.123	-3.034, 0.365

Note. B = unstandardized coefficient; SE = standard error; β = standardized beta coefficient; CI = confidence interval. HDRS: Hamilton Depression Rating Scale; MLS: Marital Life Scale; SMS: Sexual Myths Scale; GRISS: Golombok-Rust Inventory of Sexual Satisfaction

In the final model obtained using the backward elimination method, MLS, SMS, education level, spouse's education level, and the family's prohibitive attitude remained significant predictors. The final model was statistically significant, $R^2 = .344$, adjusted $R^2 = .322$, $F(5, 144) = 15.13$, $p < .001$. The strongest predictor in the model was the MLS score. MLS and spouse's education level negatively predicted the GRISS total

score, whereas SMS, education level, and the family's prohibitive attitude positively predicted the GRISS total score.

Table 7
Final multiple linear regression model predicting the GRISS total score

Variable	B	SE	β	t	p	95% CI
MLS	-0.211	0.036	-0.451	-5.857	< .001	-0.282, -0.140
SMS	0.082	0.034	0.201	2.441	.016	0.016, 0.149
Education level	2.082	0.695	0.353	2.995	.003	0.708, 3.456
Spouse's education level	-1.619	0.773	-0.226	-2.094	.038	-3.147, -0.091
Family's prohibitive attitude	1.618	0.783	0.164	2.067	.040	0.071, 3.165

Note. B = unstandardized coefficient; SE = standard error; β = standardized beta coefficient; CI = confidence interval. In the final model, VIF values ranged from 1.30 to 3.06 and did not indicate a serious multicollinearity problem. MLS: Marital Life Scale; SMS: Sexual Myths Scale; GRISS: Golombok-Rust Inventory of Sexual Satisfaction

Discussion

This study examined the associations of sexual function problems with depression severity, marital life, sexual myths, and sociodemographic/clinical variables in married women aged 18–45 years who presented to a psychiatry outpatient clinic with depressive complaints. The findings showed that the strongest association with the GRISS total score was observed for marital life. Considering that higher GRISS scores indicate more pronounced sexual function problems, sexual function problems decreased as satisfaction with marital life increased. Depression severity and level of belief in sexual myths were also significantly associated with sexual function problems. However, depression severity did not remain an independent predictor in the multiple regression analysis; in the final model, marital life, level of belief in sexual myths, education level, spouse's education level, and the family's prohibitive attitude toward sexuality significantly predicted sexual function problems. These findings indicate that sexual function problems among married women with depressive complaints should be addressed not only in relation to mood symptoms, but also together with the quality of the marital relationship, cognitive/cultural beliefs about sexuality, and early sexual socialization processes.

The strongest finding of the study was that marital life was the most prominent predictor of sexual function problems. This result is consistent with a broad body of literature demonstrating a strong link between relationship satisfaction, sexual satisfaction, and sexual functioning. In the systematic review by Rausch and Rettenberger on predictors of sexual satisfaction in women, relationship satisfaction and frequency of sexual interaction were identified as among the most consistent predictors of women's

sexual satisfaction.[4] Similarly, Byers' longitudinal study showed that the relationship between relationship satisfaction and sexual satisfaction is maintained over time.[20] In the actor-partner interdependence model study by Vowels and Mark, relationship satisfaction was also reported to be a variable that may precede sexual satisfaction.[21] Taken together, these studies indicate that the emergence of marital life as the strongest predictor in the present study is expected and consistent with the literature.

Studies conducted in Turkey also support the reciprocal relationship between marital satisfaction and sexual life. Comez Ikican et al. reported that as women's general mental health deteriorated and their risk of depression increased, marital adjustment decreased and the tendency toward sexual function problems increased. [13] In Yilmaz Dinc's study of married individuals, sexual dissatisfaction negatively predicted marital adjustment, whereas forgiveness was identified as a positive predictor of marital adjustment. [22] In the study by Ak and Balci Celik among married women, sexual quality of life positively predicted marital satisfaction, whereas estrangement from the spouse negatively predicted marital satisfaction; these two variables together explained a substantial proportion of the variance in marital satisfaction. [23] These findings suggest that sexual problems in married women should be considered not merely as an individual dysfunction but also as a relational problem intertwined with the quality of the marital relationship.

The significant association between depression severity and sexual function problems observed in the present study is consistent with the literature. Depressive symptoms such as anhedonia, decreased energy, psychomotor retardation, feelings of worthlessness, and impaired body image may adversely affect sexual desire, arousal, orgasm, and satisfaction. [24] Galati et al. emphasized that sexual dysfunction, depression, and marital dissatisfaction are interrelated and bidirectional processes.[11] Nevertheless, it is noteworthy that depression severity did not remain an independent predictor in the regression analysis in our study. This finding suggests that although depression is associated with sexual function problems, this relationship may substantially overlap with marital life and cognitive-cultural variables related to sexuality. Indeed, meta-analytic findings showing that marital quality is associated with physical and mental health demonstrate the importance of the relational context for individuals' overall well-being.[10] Thus, the finding that depression was significant at the correlational level but did not remain an independent predictor in the present study suggests that its effect may emerge indirectly through factors such as marital satisfaction and sexual myths.[25,26]

According to our findings, the family's prohibitive attitude toward sexuality remained a significant predictor in the final model. The coding of sexuality during childhood and adolescence as "shameful," "sinful," or "dangerous" may make it difficult for sexual intimacy within marriage to be experienced as safe and satisfying, while also laying the groundwork for the persistence of inadequate knowledge and sexual myths. [23] When considered together with the high avoidance scores among the GRISS subdimensions in our study, this finding suggests that prohibitive family attitudes may limit women's ability to relax, allow themselves to experience pleasure, and communicate openly with their partner

during sexual experiences, thereby increasing avoidance, anxiety, and guilt. Therefore, the evaluation of sexual function problems should take into account not only current relationship dynamics, but also the individual's early learning experiences and core beliefs regarding sexuality.

The findings of this study have important clinical implications. In psychiatry outpatient settings, sexual function problems among married women presenting with depressive complaints are often overlooked or regarded solely as a consequence of depression. However, the present findings indicate that these problems are associated not only with depression severity, but also with psychosocial and relational variables such as marital satisfaction, sexual myths, and family attitudes. Therefore, clinical evaluations should address depressive symptoms together with sexual function, the marital relationship, communication between spouses, sexual knowledge, and cognitive processes in a holistic manner. In addition, the exclusion of psychotropic medication use indicates that the observed sexual function problems cannot be explained solely by biological factors and highlights the importance of psychosocial dimensions. Accordingly, interventions should not be limited to reducing individual symptoms, but should be planned within a comprehensive framework that includes couple-focused approaches, psychoeducation, cognitive restructuring, and sexual therapy. In conclusion, sexual function problems in married women presenting with depressive complaints should be regarded not merely as an extension of depression treatment, but as a multidimensional intervention target encompassing relational and cognitive dimensions.

This study has several limitations. First, because of its cross-sectional design, causal relationships among the variables cannot be established. Dissatisfaction with marital life may increase sexual function problems, but sexual function problems may also reduce marital satisfaction; similarly, depressive symptoms may be both a cause and a consequence of these processes. Second, because the study was conducted in a single center and with a clinical sample presenting with depressive complaints, the findings cannot be directly generalized to married women in the general population. Third, because sensitive topics such as sexuality, family attitudes, and the marital relationship were assessed through self-report, the possibility of social desirability bias and underreporting should be considered. Fourth, the inclusion of only women prevented the assessment of spouses' sexual functioning, depression, marital satisfaction, sexual myths, and sexual communication. However, sexual functioning and marital satisfaction are reciprocal processes shaped at the couple level. Finally, the absence of a formal psychiatric diagnostic interview and the assessment of depressive symptoms using scale scores should also be considered as limitations.

Declarations

Clinical trial number

Not applicable.

Funding:

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Author Contribution

PG contributed to the conceptualization and design of the study, methodology, statistical analysis, interpretation of the findings, supervision, and writing and critical revision of the manuscript. FY contributed to participant recruitment, data collection, data curation, literature review, and preparation of the original manuscript draft. Both authors read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work

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