RESEARCH ARTICLE

Coping styles for sexual dysfunction and stress among married women of reproductive age: a cross-sectional study from Turkiye

Serpil Ozdemir[1], Burcu Yilmaz[2], Kazim Emre Karasahin[3], Cigdem Yuksel[4]

Abstract

Objective: To identify sexual dysfunction in married women of reproductive age, and to examine its relationship with stress coping styles.

Method: The cross-sectional, descriptive study was conducted between February and June 2019 at the obstetrics and gynaecology outpatient clinic of Gulhane Training and Research Hospital in Ankara, Turkiye. The sample comprised married women aged 18-49 years who had an active sexual life over the preceding month, and were neither pregnant nor in the postpartum phase. Data was collected using the Female Sexual Function Index, and the Stress Coping Styles Scale. Data was analysed using SPSS 22.

Results: There were 216 women with mean age 33.58±6.77 years. The mean Female Sexual Function Index score was 22.29±6.08. The mean Stress Coping Styles Scale subscale scores were: self-confident 20.71±3.53, helpless 18.07±4.27, submissive 12.13±3.00, optimistic 13.70±2.35, and seeking social support 11.89±2.01. The total Female Sexual Function Index score had a positive, significant correlation with self-confidence (r=0.15; p=0.03) and seeking social support subscales (r=0.18; p=0.01) and a negative, significant correlation with submissive subscale (r=-0.17; p=0.02) of the Stress Coping Styles Scale.

Conclusion: Establishing awareness among women about sexual dysfunction and improving effective coping styles may contribute to improved sexual health among women.

Key Words: Sexuality, Female, Sexual dysfunction, Coping strategies.

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Introduction

The term "sexual health" refers to the healthy physiological functions of the individual and also encompasses the individual's mental, emotional and social wellbeing.[1,2] Sexual dysfunction (SD), as defined by the World Health Organisation (WHO) in the International Classification of Diseases-103, is the inability to participate in a sexual relationship that will meet the expectations of the individual in providing satisfaction.[3] The worldwide prevalence of SD ranges from 23% to 78.3% for higher prevalence in women (23-78%) compared to men (30-50%).[4-8]

Many organic, psychosocial and cultural factors cause SD in women. Organic factors include age, menopause, cancer, surgery, cardiovascular disease, diabetes, obesity and the use of various drugs.[6,9,10] Psychosocial factors include education level, income level, peer-to-peer communication, self-perception, traumatic sexual experience, anxiety, depression and psychiatric disorders.[4,5] Family attitude towards women sexuality since early childhood, gender inequalities in society, and cultural taboos and religious dogmas related to virginity and marriage are listed as the cultural aetiological factors.[11-14] Generally in the Eastern culture, but also in many other parts of the world, women's curiosity about sexuality, willingness to participate in or to initiate a sexual relationship, obtaining pleasure from a sexual relationship, and loss of women virginity before marriage are considered to contradict the norms of society, which consequently suppresses women sexuality. These factors also lead to difficulties in diagnosing SD in women.[10,11,15] The severity of SD tends to increase in women when it is not diagnosed and treated timely. Over time, women with SD experience feelings of inadequacy which causes low self-esteem, and impaired body image.[15,16] SD also elevates emotional stress levels that may result in depression.[4,15,17] The presence of SD, particularly in married women, may lead to deterioration in spousal and family relationships, and may provide a basis for social problems that may result in divorce.[16] All these factors affect the psychological and social wellbeing of women negatively and reduce their quality of life.[11] Moreover, women with SD do not generally perceive the impairments in their sexual relationships as a health

[1]Department of Public Health Nursing, University of Health Sciences, [2,3]University of Health Sciences, Gulhane Education and Research Hospital, [4]Department of Mental Health Nursing, University of Health Sciences, Ankara, Turkiye.

Correspondence: Serpil Ozdemir. Email: serpilozdemir327@gmail.com

ORCID ID: 0000-0003-0952-3337

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problem owing to lack of knowledge, cultural doctrines, and social attitudes.[13-15] Also, they do not demand help for sexual health either because they are not aware of the existence of a sexual problem or because of shame and anxiety, fear of stigma, and worries about the healthcare personnel's negative attitudes.[12-15]

Women who do not have access to medical care for SD attempt to cope with this problem on their own. They try to deal with the stress caused by SD either by using effective coping styles or ineffective coping styles which may lead to impairment of wellbeing over time.[4,11,15,18] Health professionals can improve women's wellbeing only after identifying ineffective coping styles for SD and related stress, and by providing adequate sexual healthcare. For this purpose, several studies have sought to determine the incidence of SD and factors affecting it.[4,17,19] However, studies on the coping styles used by women in dealing with SD and its associated stress are limited.[18] The current study was planned to identify SD in married women of reproductive age, and to examine its relationship with stress coping styles.

Subjects and Methods

The cross-sectional, descriptive study was conducted between February and June 2019 at the obstetrics and gynaecology outpatient clinic of Gulhane Training and Research Hospital in Ankara, Turkey. The hospital provides services to approximately 30,000 women per year. The sample comprised married women aged 18-49 years who had an active sexual life over the preceding month, and were neither pregnant nor in the postpartum phase, and did not score above the Female Sexual Function Index (FSFI) cut-off value of 26.55. Those not meeting the inclusion criteria as well as those in the menopause phase, those having a systemic and/or chronic disease, and women with verbal or literal communication barriers were excluded.[10,17,20]

Approval was received from the University of Health Sciences Turkey Non-Interventional Research Ethics Committee and the Medical Specialist Education Board of the Provincial Health Directorate. Simple random sample selection method was used in the study and the sample size was determined by taking mean SD prevalence of - 50%[4,17] with 95% confidence level and 7% error margin.[21]

After taking written informed consent from the participants, data was collected through face-to-face interview in a private room in the outpatient clinic. Data collection tools included a predesigned demographic characteristics form, the FSFI, the Stress Coping Styles Scale (SCSS) and a Visual Analogue Scale (VAS). The completion of forms took approximately 30 minutes per subject.

The 32-item demographic characteristics form was based on literature.[4-6,9,10] The FSFI was developed in 2000[20] to evaluate participants' sexual function over the preceding 4 weeks. It has 19 items spread over 6 subscales; desire, arousal, lubrication, orgasm, satisfaction and pain. Each item is scored 0-5. The total score is obtained by multiplying each of the subscale scores with the respective coefficient of each subscale; desire 0.6, arousal and lubrication 0.3, and orgasm, satisfaction and pain 0.4.[20] The total score ranges 2-36, with higher scores indicating better sexual functions. The cut-off point of the scale is 26.55 points, with scores that are equal to or lower than the cut-off point indicating the existence of SD.[22] Cronbach alpha (α) value of the Turkish version of the scale is 0.95.[23]

The SCSS was developed in 1980[24] to evaluate individuals' coping styles for stress. In the original version of the scale, the items were scored on a 4-point Likert scale, and the scale had 66 items and 7 subscales. The short form of SCSS in Turkish, already checked for validity and reliability,[25] has 30 items spread over 5 subscalesl self-confident (7 items), optimistic (5 items), helpless (8 items), submissive (6 items), and seeking social support (4 items). The subscales can be scored independently. Each item is scored 1-4. Items 1 and 9 on the scale are reverse coded. A high score obtained from a subscale indicates that the specific style defined in that specific subscale is used more frequently in coping with stress. The self-confident, optimistic and social support-seeking styles are considered effective coping attitudes, whereas the helpless and submissive styles are considered ineffective.

VAS was used to determine the participants' sexual satisfaction level gained in sexual intercourse episodes over the preceding 4 weeks. VAS was scored 0-10, ranging from 'not satisfied at all' to 'very satisfied'.

Data was analysed using SPSS 22. Categorical variables were presented as frequencies and percentages, while continuous variables were summarised as mean ± standard deviation. Kolmogorov-Smirnov test was used to check data normality. Spearman correlation analysis was used to determine the relationship between continuous variables. $P \leq 0.05$ was taken as significant.

Results

Of the 450 women approached, 227(50.44%) met the inclusion criteria. Of them, 11(4.84%) were excluded because of incomplete demographic sheets. As such, the study was completed by 216(95.15%) women who had a mean age of 33.58±6.77 years (range: 19-49 years). Of the participants, 174(80.6%) had received education for at least 8 years. Participants' marriage types were forced

Table-1: General characteristics of the participants (n = 216).

Variables	Mean (SD)	Min.	Max.
Age of participants (years)	33.58 ± 6.77	19	49
Age of first sexual intercourse(years)	20.65 ± 8.39	16	42
Sexual intercourse satisfaction score	6.13 ± 2.4	0	10
Number of pregnancies	1.38 (1.42)	0	10
Number of living children	1.03 (1.0)	0	4
Variables		**n**	**%**
Educational status of participants			
≤8 years (primary and secondary school)		42	19.4
>8 years (high school and upper)		174	80.6
Economic status			
Income is more than expenses		42	19.4
Income is equal to expenses		136	63.0
Income is less than expenses		38	17.6
Marriage types			
Forced marriage		31	14.4
Arranged marriage		38	17.5
Love marriage		139	64.4
Marriage of convenience		8	3.7

SD: Standard deviation, Min: Minimum, Max: Maximum.

marriage 31(14.4%), arranged marriage 38(17.6%), love marriage 139(64.4%), and marriage of convenience 8(3.7%). The mean score for sexual intercourse satisfaction was 6.13±2.4 (range: 0-10) (Table 1.)

Overall, 96(44.4%) women reported participating in sexual intercourse 2-3 times a week in the preceding 6 months, 188(87%) had not experienced any sexual complaints ever, and 194(89.8%) had never been admitted to any health centre for sexual health issues. The most common factors negatively affecting the participants' sexual lives were pain during sexual intercourse 43(19.9%), urinary tract infections 37(17.1%), vaginal tract infections 34(15.7%) and vaginal dryness 34(15.7%). There were 55(25.5) participants who considered sexual intercourse as an "obligation of marriage", whereas 152(70.4%) reported that sexual intercourse was "an act that strengthens the marriage bond".

In case of experiencing a problem with sexual function in the future, 162(75%) subjects said they would seek medical advice, 78(36.1%) would perform an online search, 18(8.3%) would participate in sexual intercourse even if they did not like to, 15(6.9%) would use lubricants, 15(6.9%) would engage in physical exercise to feel good, and 11(5.1%) would pray, while 23(10.6%) of the participants said they did not foresee having any such problems in the future (Table 2).

The mean total FSFI score was 22.29±6.08 (range: 2.20-26.49). The mean SCSS subscale scores were: self-

Table-2: Sexual characteristics of the participants (n = 216),

Variables	n	%.
Frequency of sexual intercourse in the last six months		
Four times a week and above	13	6.0
Twice or three times a week	96	44.4
Once per week	59	27.3
Once or twice a month	33	15.3
More than two months	8	3.7
No sexual intercourse	7	3.2
Family attitudes towards talking about sexuality before marriage		
Talking about sexuality was forbidden.	32	14.8
Sexuality issues weren't on the agenda.	155	71.8
Conversations about sexuality were considered usua l.	13	6.0
Information about sexuality was provided	16	7.4
Have you ever had any complaints about your sexual functions?		
Yes	2	13.0
No	188	87.0
Have you ever admitted to any health centre due to any sexual health issues?		
Yes	22	10.2
No	194	89.8
Can you easily talk to your friends about sexual issues?		
Yes	112	51.9
No	104	48.1
Can you easily talk to health care professionals about sexual issues?		
Yes	163	75.5
No	53	24.5
Have you received training from health professionals about sexual health? *n folded		
Yes	56	25.9
No	160	74.1
For me, sexual intercourse…		
Strengthens my marriage bond	152	70.4
Strengthens the love bond between spouses	90	41.7
Is necessary to be healthy	69	31.9
Is the obligation of marriage	55	25.5
Is pleasant and relaxing	46	21.3
I live without it easily; I do not feel the lack.	20	9.3
Is a basic life requirement	13	6.0
Is tiring and laborious	10	4.6
Is something I don't enjoy	3	1.4
Is disgusting	2	0.9
In your opinion, what are the conditions affecting your sexual health? *		
I don't think my sexual function is impaired	91	42.1
Pain during sexual intercourse	43	19.9
Urinary tract infection	37	17.1
Vaginal tract infection	34	15.7
Vagina dryness	34	15.7
Premature ejaculation of partner	27	12.5
Prefers not to answer	16	7.4
Urinary incontinence	10	4.6
Having problems in social life with husband	6	2.8
Erectile dysfunction	4	1.9
What would you do if you experience a problem with your sexual functions in the future? *		
I would see a doctor/nurse	162	75.0

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I would get information from the internet	78	36.1
I do not think I will have problems with my sexual functions	23	10.6
I would participate in sexual intercourse even if I don't like to	18	8.3
I would use a lubricant	15	6.9
I would engage in physical exercise to feel good	15	6.9
I would pray to God	11	5.1

*n folded

confident 20.71±3.53 (range: 7-28), helpless 18.07±4.27 (range: 8-29), submissive 12.13±3.00 (range: 6-20), optimistic 13.70±2.35 (range: 5-19), and seeking social support 11.89±2.01 (range: 5-16) (Table 3).

Table-3: Mean scores of FSFI and SCSS subscales.

Scales	Mean ± SD	Range of score
Desire	3.34 ± 0.80	1.2–6
Arousal	4.79 ± 1.70	0–6
Lubrication	5.19 ± 1.69	0–6
Orgasm	2.77 ± 1.06	0–6
Satisfaction	3.15 ± 1.03	0–6
Pain	3.03 ± 1.17	0–6
FSFI total score	22.29 ± 6.08	2–36
Self-confident style	20.71 ± 3.53	7–28
Helpless style	18.07 ± 4.27	8–32
Submissive style	12.13 ± 3.00	6–24
Optimistic style	13.70 ± 2.35	5–20
Seeking of social support style	11.89 ± 2.01	5–16

SD: Standard deviation, FSFI: Female sexual function index, SCSS: Stress coping styles scale.

FSFI scores were lower for participants who had received formal education for <8 years (z=2.00; p=0.05). FSFI scores of those who could talk comfortably with their friends (z =2.34; p=0.02) and healthcare personnel (z=2.17; p=0.03) about sexual issues were significantly higher than those who did not. The participants who did not have sexual intercourse for >2 months had lower FSFI scores compared to the others (z=45.46; p=0.01). FSFI scores of those hailing from families in which sexual matters were forbidden to talk about and those where sexual issues were not on the agenda of family talk were significantly lower than those in families with positive attitudes (z=14.25; p=0.01). The SCSS scores related to submissive style of coping indicated that the participants who did not receive training on sexual health scored significantly higher than those who received training (z=2.42; p= 0.02). The social support score of the participants who could easily talk to their friends about sexual issues was higher than the participants who could not (z=2.42; p=0.02).

The total FSFI score had a positive, significant correlation with self-confidence (r=0.15; p=0.03) and seeking social support subscales of SCSS (r=0.18; p=0.01) and a negative, significant correlation with the submissive subscale (r=-0.17; p=0.02) of SCSS (Table 4).

Discussion

Although SD is a common health problem that affects life significantly, women rarely demand solutions to sexual problems because sexuality is commonly accepted as a difficult topic to discuss and is riddled with misinformation.[12,15] The current study also showed that SD was a major issue in the sample since all participants scored equal or below the FSFI cut-off point defined, indicating that they all had SD. This high rate can be explained by a variety of variables, but in the current study, another finding concerning the types of marriages among participants was of significance, as about 35% participants were not in a love marriage, which, according to literature, can lead to SD.[12,16] However, none of the participants reported any sexual problems. The participants also mentioned that they had pain, vaginal dryness, premature ejaculation of the partner, and erectile dysfunction during sexual intercourse. And the FSFI scores of the participants who did not engage in sexual activity for >2 months were lower than the others. Moreover, the mean sexual satisfaction score of the participants for the preceding 4 weeks was moderate. This means women in the study were not even aware that they had sexual problems, and felt satisfied. This finding is quite striking and it may be related to cultural taboos, religious dogmas, restrictions, and resistance to information-seeking, talking or complaining about sexuality among women in Islamic culture.[11,13,14]

Table-4: Correlation between FSFI scores and SCSS subscale scores.

Scales	FSFI		Self-confident		Helpless style		Submissive style		Optimistic style	
	r	p	r	p	r	p	r	p	r	p
Self-confident	.151	.027*	-							
Helpless style	-.079	.250	-.256	.001*	-					
Submissive style	-.165	.015*	-.292	.001*	.569	.001*	-			
Optimistic style	-.058	.393	.424	.001*	-.043	.527	-.010	.879	-	
Seeking of social support style	.183	.007*	.290	.001*	-.228	.001*	-.374	.001*	.094	.167

r: Spearman correlations, FSFI: Female sexual function index, SCSS: Stress coping styles scale.

According to present findings, FSFI scores were lower for participants who had an education <8 years, whose families refused to put sexual issues on the agenda of family talks, or forbid any discussion about sexual matters, and those who did not feel comfortable talking about sexual issues with their friends and healthcare personnel. Moreover, most of the participants stated that they would seek help from health professionals if they experienced a sexual problem in the future. However, given the fact that they were not aware of their SD status, the feedback about asking for help from health professionals in case of a sexual problem seems worth thinking about. When these findings are evaluated together, it can be thought that the low education level of the participants and their inability to communicate with their families, friends and healthcare professionals about sexuality cause a lack of knowledge, and, therefore, it can be thought that it creates difficulties in recognising or articulating their sexual health problems. Such a situation prolongs the treatment process and causes SD to become chronic, and negatively affects the quality of life of women.[13,14,17]

Nearly half of the participants in the current study also shared that they accepted sexual intercourse as an obligation, something not needed, tiring and laborious, did not enjoy and even found it disgusting. All these expressions may well indicate the presence of SD. These findings may be explained within the cultural context, where women are expected to be inexperienced about sexual intercourse before marriage, obedient to their husband's demands in marriage, and to get over the problems they face to keep the marriage going. All these are taken as the main indicators of a morally good wife.[11,13,14]

Being unaware of sexual problems or avoiding talking about sexual issues may constitute an impediment to the diagnosis and treatment of SD, which is supported by the finding of this study in which the majority of the participants did not seek healthcare support. Women do not seek medical care for SD because of low level of awareness, limited knowledge of sexuality and sexual intercourse, and not considering sexual problems as serious health problems.[5,11,13]

In addition to many accompanying problems, SD itself increases stress levels.[4,15] Considering that the increased stress level also negatively affects sexual functioning, this situation seems to be turning into a vicious cycle, and in such a scenario, the importance of coping styles becomes evident.[26,27]

Effective coping styles, like self-confident, optimistic, seeking social support, help reduce stress, while ineffective coping styles, like helpless and submissive, increase stress. In the current study, participants' FSFI scores increased when self-confidence and seeking social support increased, and it decreased when submissive coping styles were used. Keeping in mind the fact that all individuals experienced sexual dysfunction in the current study, the findings suggest that those who employ ineffective coping styles had more severe symptoms than those who used effective coping styles. Among the participants who did not receive training on sexual health significantly higher submissive style scores were noted, and participants who easily talked to their friends about sexual issues had higher social support scores. When taken together, these findings point to the importance of interventions in SD management, like supporting women to receive sexual training and also supporting building a social environment where they may talk about sexuality. The efficacy of interventions can be improved further by identifying and improving effective coping mechanisms of women, which would enable healthcare professionals to provide tailored treatment. Literature also supports that SD is considered an important stress factor in women, and its treatment involves multidisciplinary interventions, usually including psychological approaches.[2,19] Similar to the current findings, Che Ya et al.[18] reported that the provision of emotional support to women affected their FSFI scores. Further, the reassuring relationship between healthcare professionals and women with SD plays a key role in the treatment of SD.[2]

In terms of limitations, the current study included women who were sexually active, married and were visiting the gynaecology and obstetrics outpatient clinic. Sexually active but unmarried women were not included because of cultural limitations.

Conclusion

All the participants scored equal or below the FSFI cut-off point, indicating that they all had SD. The FSFI scores increased when self-confidence and seeking-social support styles increased, and they decreased when submissive coping styles were used.

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Author's Contributions

SO: Concepts, design, definition of intellectual content, literature search, clinical studies, data acquisition, data analysis, statistical analysis, manuscript preparation, manuscript editing, manuscript review, guarantor.

BY: Concepts, design, definition of intellectual content, data acquisition, data analysis, statistical analysis, manuscript preparation, manuscript editing, guarantor.

KEK: Concepts, design, definition of intellectual content, data acquisition, data analysis, statistical analysis, manuscript preparation, manuscript editing, manuscript review, guarantor.

CY: Concepts, design, definition of intellectual content, data acquisition, data analysis, statistical analysis, manuscript preparation, manuscript editing, manuscript review, guarantor.