Original Article

Impact of Perceived Social Support and Depression in Married Turkish Women on the Sexual Quality of Life: An Online Survey

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Abstract

Background: Sexual life is very important for people's physical health, psychological health, and reproductive health. Depression and social support are among the factors that affect the quality of sexual life. **Aim:** The present study aimed to determine the impact of perceived social support on the sexual quality of life and depression in married women between the ages of 18 and 49. **Materials and Methods:** A total of 976 married women aged 18 to 49 were included in this cross-sectional study in which an online data collection method was used Sexual Life Quality Scale, Multidimensional Perceived Social Support Scale, and Beck Depression Scale, which were used as data collection tools. Statistical analysis used: Analyses were performed using SPSS version 26.0. Descriptive statistics were used for number, percentage, mean, and standard deviation, as well as independent group *t*-test, correlation, and regression analysis. The "Enter" model was used in the logistic regression analysis. **Results:** It was established that nearly one-third of married women aged 18-49 had low levels of perceived social support and sexual quality of life, and almost half of them experienced symptoms of depression. The quality of sexual life was 3.6 times (P = 0.001) lower in those with low social support and 1.6 times (P = 0.024) lower in those with depression. **Conclusion:** Considering the fact that women's sexual problems, low social support and depression are important predictors of sexual quality of life, special attention should be paid to increasing social support to women, handling women's sexual problems more carefully, and detecting and treating such problems.

Keywords: *Depression, quality of life, sexual health, social support, women*

Introduction

Sexual quality of life was defined as whether the woman was satisfied with sexual intercourse. Sexual life quality is an important factor affecting women's reproductive health, physical health, psychological health, and social life.[1-3]

In the literature, there are limited studies related to the impact of social support on the quality of sexual life and depression in married women.[4-6] It is believed that the present research shall contribute to the literature by determining the characteristics of married women, evaluating their social support and depression status, and establishing women's needs for their sexual health, depression, and social support.

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Materials and Methods

Design and sample

The population of this cross-sectional study consisted of all married women aged 18-49 who could be reached throughout Turkey. The sample size of the study was determined as 974 women, with a known score of 52.21 ± 17.29 using the G*Power 3.1.7 program, within two standard deviations, with a power of 95%.[7] Study participants included women between the ages

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of 18 and 49, who consented to fill out the data forms and used social media tools. Considering the data losses, data collection was stopped when a total of 1012 women, 3% more than the sample size determined, were reached. After the data were checked, 26 women who did not meet the inclusion criteria were excluded from the research and the study was completed with the participation of a total of 976 women.

Procedure

Data collection forms the research, which were created using Google and delivered to the participants via the researchers' e-mail and social media accounts (WhatsApp, Facebook, Instagram, and Twitter). Before the participants started to fill out the forms, they were provided with online information about the research and their written consent for participation was obtained. Research data were collected between January and March 2022 based on a self-reported survey. Pregnant and sexually inactive women going through menopause were not included in the study. It was ensured that the participants answered only once and the questionnaires were checked daily; and incomplete questionnaires were removed as a result of careful quality control.

Sexual quality of life is a condition that affects not only women but also men. However, studies have generally been conducted with women. Therefore, the scales, which are objective measurement tools to measure the quality of sexual life, are for women. Therefore, women were included in the study using existing scales.

Outcome measures

The following types of measurement tools were used for all participants:

Personal information form

The form consisted of 20 questions related to sociodemographics (7 questions), sexual health (7 questions), and obstetric characteristics (6 questions).

The multidimensional scale of perceived social support (MPSSS)

The scale was originally developed by Zimet *et al*.[8] in 1988 and adapted into Turkish by Eker and Arkar in 1995.[9] MSPSS was revised by Eker *et al.* in 2001. This final revised version of the scale was used in the present study.[10] It is an easy-to-understand scale that can be easily followed by individuals with a low level of education. It subjectively assesses the adequacy of social support from a Significant Other, Family, and Friends. The scale consists of three subscales, namely, a Significant Other (1, 2, 5, 10), Family (3, 4, 8, 11), and Friends (7, 6, 9, 12), each addressing a different source of support. The scale includes a total of 12 questions, four in each subscale. Each scale dimension is scored on a 7-point scale, ranging from (1) very strongly disagree to (7) very strongly agree. Scale subdimension scores are obtained by summing the scores of the four items in the subscales. The total score of the scale is calculated by adding the scores obtained from the subscales. A minimum of four points and a maximum of 28 points are obtained for each subscale, and a minimum of 12 and a maximum of 84 points for the total scale. A high score indicates high perceived social support. The total Cronbach's alpha coefficient of the scale revised by Eker *et al.* was 0.89. It was 0.92 for the Significant Other subscale, 0.85 for the Family subscale, and 0.88 for the Friends subscale.[10] In the present study, on the other hand, Cronbach's alpha coefficient of the scale was found to be 0.96 for the total scale. It was 0.93 for the Significant Other subscale, 0.95 for the Family subscale, and 0.95 for the Friends subscale.

Sexual quality-of-life questionnaire (SQOL)

The questionnaire was developed by Symonds[11] in 2005 and Turkish validity studies were carried out by Tuğut and Gölbaşı in 2010 for women aged 18-65.[12] The Sexual Quality-of-Life Questionnaire is a useful scale for assessing the sexual quality of life of Turkish women. The six-point Likert-type questionnaire consists of 18 items. The total score that can be obtained from the scale items ranges between 18 and 108. Some items (1, 5, 9, 13, 18) are reversed before calculating the total score. The scale score (raw score from the scale-18) is converted to 100 using the formula ×100/90. To give an example, the converted scale score of a participant with a raw score of 63 is (63-8) x100/90 = 50. Higher scores indicate better female sexual quality of life.[11,12] The reliability coefficient (Cronbach's alpha value) of the scale is 0.83,[11,12] and it is determined as 0.93 in the present study.

Beck depression inventory (BDI)

The inventory was first published by Beck in 1961.[13] Turkish validity and reliability studies were conducted by Hisli (1989).[14] BDI is a self-report inventory used to assess cognitive, emotional, somatic, and motivational symptoms of depression. It was developed to determine depression risks and to measure the level and intensity of depressive symptoms. In the 21-question multiple-choice inventory, a value of 0 to 3 is assigned for each answer. The lowest score that can be obtained from the scale is 0, and the highest score is 63. Scores on the scale increase from minimal to severe. As for the intensity of the inventory, the standard scores are as follows 0-9 = Minimal, 10-16 = Mild, 17-29 = Moderate, and 30-63 = Severe.[14,15] The Cronbach Alpha coefficient of the scale is 0.80,[14] and it is 0.91 in this study.

Data analysis

Analyses were performed using SPSS version 26.0. Descriptive statistics were used for number, percentage, mean, and standard deviation, as well as independent group *t*-test, correlation, and regression analysis. The "Enter" model was used in the logistic regression analysis. While creating the regression model, 0-9 points were converted into no-depressive symptoms for the depression variable and depressive symptoms ≥10 points were converted into dichotomous data as mild, moderate, and severe. For the multidimensional perceived social support variable, those with an average score of below 42.0 were considered as low, and those with a score of 42.0 and above as moderate/high social support. For the sexual quality-of-life variable, those with a scale score below 54.0 were considered as low and those with a score of 54.0 and above as moderate/high. The statistical significance level of the data was accepted as $P < 0.05$.

Ethical approval

The study was conducted according to the guidelines of the Declaration of Helsinki. Ethical approval was from Manisa Celal Bayar University Medical Dean of Faculty of Medicine Health Sciences Ethics Committee (2022/1137).

Results

The mean age of the study group was 35.45 ± 8.47, and 49.1% of them were over 35 years old. More than half of the women and their spouses were high school graduates (57.7%, 57.6%, respectively). The percentage of participants who stated that they were living in an extended family was 11.6. 54.8% of the women and 8.7% of their spouses were unemployed, and the rate of women who stated that their income was less than their expenses was 26.3%. The percentage of women with poor health perception was 43.0%, the percentage of women who had psychological and physical problems in themselves and their spouses was 17.6% and 14.0%, respectively, and the percentage of those who had sexual health problems was 14.0% and 10.1%, respectively. 81.1% of women had not received any sexual health education and 88.8% had fewer than three sexual intercourses per week. Half of the women (50.1) who participated in the study were using a traditional family planning method. The percentage of women who had an unintended pregnancy was 29.8%, and the percentage of those who had an abortion was 10.1%. The vast majority of women (84.3%) delivered at least once and 24.1% had at least two children. 36.7% of the women had more than two pregnancies [Table 1].

The mean score for sexual quality of life for women was 77.88 ± 20.69. An evaluation of the sexual quality-of-life questionnaire revealed that increasing scores were indicative of higher sexual quality of life. Taking into account the minimum and maximum scores that could be obtained from the questionnaire (18-108), women's level of sexual quality of life was found to be high. Nevertheless, the rate of women who scored lower than half (54 points) of the maximum sexual quality-of-life questionnaire score (108 points) was 15.7%. The mean scores for women obtained from the scales were 62.19 ± 21.62 for social support, namely, 22.14 ± 7.37 for Family Subscale, 20.20 ± 7.97 for Friends Subscale, 19.85 ± 8.24 for Significant Other Subscale. An evaluation of the social support questionnaire revealed that increasing scores were indicative of higher social support. Taking into account the minimum and maximum scores that could be obtained from the questionnaire (12-84), women's level of sexual quality of life was found to be high and they received the highest support from their families. Nonetheless, the rate of women who scored lower than half (84 points) of the maximum sexual quality-of-life questionnaire score (108 points) was 21.5%. The mean depression score of women was 10.51 ± 9.44. An evaluation of the depression inventory revealed that increasing scores were indicative of higher depression intensity. Scores to be obtained from the depression inventory ranged between 0 and 63. About half of the women (46.1%) displayed depressive symptoms. Percentage distribution by category showing the intensity of depressive symptoms was as follows: The rate of women with mild depressive symptoms was 24.9% (n = 526), the rate of moderate depressive symptoms was 16.1% (n = 157), and the rate of severe depressive symptoms was 5.1% (n = 50) [Table 2].

The percentage of women whose income was less than their expenses and who had low quality of sexual life (23.6%) was found to be significantly lower ($P < 0.05$). This percentage was also lower for those with poor health perception (22.04%), those with psychological or physical problems in themselves and their spouses (29.7, 27.0, respectively), and those experiencing the highest rates of sexual health problems (42.4, 40.3, respectively) [Table 3]. Women who used a traditional family planning method (18.6%), those who had an unintended pregnancy (20.3%), those who had an abortion (27.3%), and those who had more than two pregnancies (19.3%) had lower quality sexual life ($P < 0.05$) [Table 3]. Sexual quality of life was significantly lower in women with low levels of social support (35.7%) ($P < 0.05$) [Table 3]. Sexual quality of life was significantly lower in women who displayed depressive symptoms (23.3%) ($P < 0.05$) [Table 3].

Table 1: The distribution of women by descriptive characteristics

Variables	*n*	%
Age group		
18-35	497	50.9
36-49	479	49.1
Educational level		
High school and below	563	57.7
Above high school	413	42.3
The educational level of spouse		
High school and below	562	57.6
Above high school	414	42.4
Type of family		
Nuclear	863	88.4
Extended and others	113	11.6
Work status		
Yes	441	45.2
No	535	54.8
Work status of spouse		
Yes	891	91.3
No	85	8.7
Income perception		
Income less than expenses	258	26.4
Income equal to or more than expenses	718	73.6
Health perception		
Good	556	57.0
Fair or poor	420	43.0
Presence of a physical or mental illness		
Yes	172	17.6
No	804	82.4
Presence of a physical or mental illness in spouse		
Yes	137	14.0
No	839	86.0
Number of pregnancies		
≤2	618	63.3
>2	358	36.7
Number of children		
≤2	741	75.9
>2	235	24.1
Unintended pregnancies		
Yes	291	29.8
No	685	70.2
Abortion		
Yes	99	10.1
No	877	89.9
Delivery		
Yes	823	84.3
No	153	15.7
Type of last delivery (*n*=823)		
Normal and assisted	392	47.6
Cesarean	431	52.4
Family planning (FP) method used		
Modern FP methods (pills, IUD, monthly injectables, condoms)	487	49.9
Traditional FP methods (withdrawal and others)	489	50.1
Presence of sexual problems		
Yes	99	10.1

Contd...

Table 1: Contd...

Variables	*n*	%
No	877	89.9
Presence of sexual problems in spouse		
Yes	67	6.9
No	909	93.1
Frequency of sexual intercourse per week		
3 times or fewer	867	88.8
>3 times	109	11.2
Sexual health education		
Yes	184	18.9
No	792	81.1
Total	976	100.0

Table 2: Mean social support, depression, and sexual quality-of-life scale scores of women

	n	%	Mean±SD
SQOL* total score			77.88±20.69
Below average (54↓)	153	15.7	
Average and above (54↑)	823	84.3	
MPSSS** total score			62.19±21.62
Below average (42↓)	210	21.5	
Average and above (42↑)	766	78.5	
Family score			22.14±7.37
Friends score			20.20±7.97
Significant Other score			19.85±8.24
BDI*** total score			10.51±9.44
Depressive Symptoms None (0-9)	526	53.9	
Depressive Symptoms Mild (10-16)	243	24.9	
Depressive Symptoms Moderate (17-29)	157	16.1	
Depressive Symptoms Severe (30-63)	50	5.1	

*SQOL: Sexual Quality of Life Questionnaire **MPSSS: The Multidimensional Scale of Perceived Social Support, ***BDI: Beck Depression Inventory

According to the correlation analysis between the scales displayed in Table 4, the quality of sexual life decreased as the depression scale score increased (r = 0.416, $P < 0.001$) [Table 4]. A moderate positive correlation existed between the quality of sexual life and social support total scale score, Family and Friends subscale scores (r = 0.373, $P < 0.001$, r = 0.417, $P < 0.001$; r = 0.324, $P < 0.001$, respectively) [Table 4].

The logistic regression analysis revealed that the quality of sexual life was 2.7 times ($P = 0.001$) lower in women with sexual problems [Table 5]. The quality of sexual life was 1.6 times ($P = 0.024$) lower in those who displayed depressive symptoms [Table 5]. The logistic regression analysis revealed that the quality of sexual life was 3.6 times lower in those with low social support ($P = 0.001$) [Table 5].

Discussion

In this large-sample study, it was determined that the social support levels of the women were good, the symptoms of depression were common, and the sexual quality of life was moderate. Moreover, some sociodemographic, sexual health, and obstetrics variables were found to be effective in the quality of sexual life in the study. In our study, it was also found that social inefficiency and the presence of depression decreased the quality of sexual life. Many studies asserted that the lack of social support was a significant finding that triggered the decrease in the quality of sexual life. As is well known, lack of social support has an impact on many health problems and mental health. All the same, lack of social support also impacts the quality of sexual life by triggering depression. In studies conducted in various developed and developing countries, it was established that social support prevented harmful effects of stress and depression and made a positive contribution to the quality of sexual life.[4,16,17] It was observed in our study that low-income level was the only sociodemographic characteristic that decreased the sexual quality of life. In the same manner, many studies have revealed that income level is an important characteristic determining

Table 3: The relationship between descriptive characteristics, social support, depression level, and sexual quality of life in women

Variables	Sexual Quality of Life*				Statistical analysis	
	High		Low			
	*n***	%***	*n***	%***	χ^2	*P*
Age						
18-35	428	86.1	69	13.9	2.463	0.117
36-49	395	82.5	84	17.5		
Educational level						
High school and below	352	85.2	61	14.8	0.445	0.505
Above high school	471	83.7	92	16.3		
The educational level of a spouse						
High school and below	475	84.5	87	15.5	0.038	0.845
Above high school	348	84.1	66	15.9		
Type of family						
Nuclear	732	84.8	131	15.2	1.391	0.238
Extended	91	80.5	22	19.5		
Work status						
Yes	363	82.3	78	17.7	2.461	0.117
No	460	86.0	75	14.0		
Work status of spouse						
Yes	754	84.6	137	15.4	0.698	0.404
No	69	81.2	16	18.8		
Income perception						
Income less than expenses	197	76.4	61	23.6	16.84	0.001
Income equal to or more than expenses	626	87.2	92	12.8		
Health Perception						
Good	497	89.4	59	10.6	25.072	0.001
Fair or poor	326	77.6	94	22.4		
Presence of a physical or mental illness						
Yes	121	70.3	51	29.7	30.848	0.001
No	702	87.3	102	12.7		
Presence of a physical or mental illness in spouse						
Yes	100	73.0	37	27.0	15.480	0.001
No	723	86.2	116	13.8		
Number of pregnancies						
2 or fewer	534	86.4	84	13.6	5.536	0.019
>2	289	80.7	69	19.3		
Number of Children						
2 or fewer	633	85.4	108	14.6	2.824	0.093
>2	190	80.9	45	19.1		
Unintended pregnancies						
Yes	232	79.7	59	20.3	6.633	0.010
No	591	86.3	94	13.7		
Abortion						
Yes	72	72.7	27	27.3	11.208	0.001
No	751	85.6	126	14.4		
Delivery						
Yes	694	84.3	129	15.7	0.000	0.997
No	129	84.3	24	15.7		
Type of last delivery (n=823)						
Normal and assisted	331	84.4	61	15.6	0.007	0.996
Cesarean	363	84.2	68	15.8		
Family Planning (FP) Method Used						
Modern FP methods (pills, IUD, monthly injectables, condom)	425	87.3	62	12.7	6.378	0.012

Contd...

Table 3: Contd...

Variables	Sexual Quality of Life*				Statistical analysis	
	High		Low			
	*n***	%***	*n***	%***	χ^2	*P*
Traditional FP methods (withdrawal and others)	398	81.4	91	18.6		
Presence of sexual problems						
Yes	57	57.6	42	42.4	59.632	0.001
No	766	87.3	111	12.7		
Presence of sexual problems in spouse						
Yes	40	59.7	27	40.3	32.993	0.001
No	783	86.1	126	13.9		
Frequency of sexual intercourse per week						
3 times or fewer	730	84.2	137	15.8	0.092	0.761
>3 times	93	85.3	16	14.7		
Sexual education						
Yes	153	83.2	31	16.8	0.235	0.628
No	670	84.6	122	15.4		
Social support						
High	688	89.8	78	10.2	81.276	0.001
Low	135	64.3	75	35.7		
Depressive symptoms						
Yes	345	76.7	105	23.3	37.035	0.001
No	478	90.9	48	9.1		

*54.0 points and lower scores were grouped as "low sexual quality of life (negative result)," and scores higher than 54.0 were classified as "high quality of sexual life (positive result)" by taking the cutoff point of the mean score of the scale as 54.0. **Unspecified data were not included in the table. ***Row percentage

Table 4: Correlation between sexual quality of life and scores obtained from depression and social support scales

Variables	Sexual Quality of Life		
	X±SS	*r**	*P*
Sexual Quality of Life	77.88±20.69	1	-
Social support	62.19±21.62	0.373	<0.001
Family (1)	22.14±7.37	0.417	<0.001
Friends (2)	20.20±7.97	0.324	<0.001
A Significant Other (3)	19.85±8.24	0.291	<0.001
Depression	10.51±9.44	-0.416	<0.001

*Pearson correlation

Table 5: Sexual quality of life and factors related to the beck depression inventory

Independent variables	Dependent variable Sexual Quality of Life		
	OR	95% CI	*P*
Presence of sexual problems in women	2.72	1.51-4.88	0.001
Social Support Scale	3.65	2.45-5.43	0.001
Beck Depression Inventory	1.61	1.06-2.45	0.024

the quality of sexual life.[7,18,19] Women with low health perception in our study had lower sexual quality of life. Additionally, the quality of sexual life of women who reported that they or their spouses had a psychological or physical health problem was also low. The quality of sexual life of couples who had a sexual health problem was negatively affected. According to numerous studies conducted, the fact that couples had any health problems was an important factor that reduced the sexual quality of life, which was an anticipated outcome.[1,18,20,21] Sexual dysfunction is a common problem among couples in our country as well as in many other countries.[20-22] The fact that sexual dysfunctions have an impact on the quality of sexual life is an expected finding. Despite the lack of any national data showing how common sexual problems are in our country, it has been established that sexual problems are quite prevalent [45%] according to two local studies conducted in different years.[23,24] The most common problems reported in these studies included decreased sexual interest/desire, sexual arousal disorders, orgasmic disorders, dyspareunia, vaginismus, and sexual anxiety.[23,24] Although sexual problems are prevalent, it has been revealed in studies conducted in our country and elsewhere in the world that they cannot be detected early and treated properly.[18,25-29] Early detection and proper treatment of sexual health problems are quite important in improving the quality of sexual life. In underdeveloped countries in particular, it is a well-known fact that sexual problems are not discussed with social support sources [spouse, family, friends, etc.] and health workers, are not questioned, are regarded as taboo and are not diagnosed. Therefore, it is quite hard to detect and treat sexual problems, and untreated sexual

problems give rise to a decrease in the quality of sexual life. For this reason, to increase the quality of sexual life, health professionals find it important to question and treat these sexual problems and to provide health care services together with sexual health services when they encounter fertile and sexually active women aged 15-49 during any service such as pregnancy or child follow-up.[18,25-29] If sexual problems are not detected and treated properly, they have the potential not only to give rise to mental and social problems but also to decrease the quality of sexual life.[18,20-22]

In our study, the sexual quality of life was low for women who had more than two pregnancies, used traditional family planning methods, had unintended pregnancies, and had abortions. According to the data obtained from a national survey covering Turkey, namely, the 2018 Turkey Demographic and Health Survey (TDHS 2018), 59.5% of married women use traditional methods and experience unintended pregnancies. Lack of access to effective family planning services and the use of traditional family planning methods cause unwanted, recurrent and unintended pregnancies [the rate of using traditional family planning method: 59.5%]. 25% of women in Turkey have an unintended pregnancy that results in delivery.[30-32] The reason for that is the fact that a section of society believes that abortion is a sin in Turkey, which is a traditional Muslim country. This unwanted excessive fertility in turn increases the postpartum childcare burden of women. Women avoid sexual intercourse out of fear of getting pregnant especially when they do not use effective family planning methods. Consequently, it is believed that these anxieties and fears are likely to affect the quality of sexual life.[1,27,32] Hence, it is important for women to use an effective method in increasing the quality of their sexual life. Then again, it is common knowledge that women still experience serious problems in accessing modern methods in our country and many other developing countries.[33,34]

Likewise in our study, the sexual quality of life was lower in women with low social support and depressive symptoms. Social support is an important determinant of sexual quality of life and depression. Strengthening the social support systems of women increases the quality of sexual life and acts as a protective factor against depressive symptoms. Therefore, social support systems of women particularly in developing countries should be screened for depression using community screening programs, their sexual problems should be questioned, and their susceptibility to depression should not be overlooked.[35-38]

Conclusions

It has been concluded in the present study that strengthening the social support systems of women, using effective family planning methods, preventing unwanted pregnancies, questioning, detecting, and treating sexual problems and depression symptoms are quite important in increasing the quality of sexual life. Sexual problems, which are regarded as taboo and not talked about openly in society, should be questioned primarily in women with low socioeconomic status but the high number of children. It is of great importance to increase the sexual quality of life by providing assistance to women with sexual problems and solving their problems.

Sexual quality of life is a condition that affects both genders. It is recommended that scales related to the quality of sexual life in men should be developed and disseminated, and studies should be conducted to evaluate the quality of sexual life of men and should not be neglected.

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Author contributions

Concepts, U.Y. and C.G.; Design, U.Y. and C.G; Definition of intellectual content, Y.C.O.; Literature search Y.C.O. and Z.B.A, Data acquisition, Y.C.O. and C.G.; Data analysis, Y.C.O; Statistical analysis, Y.C.O., C.G., and U.Y; Manuscript preparation, Y.C.O, C.G., and Z.B.A.; Manuscript editing, U.Y., Z.B.A., Y.C.O., and C.G.; Manuscript review, Z.B.A., Y.C.O., and C.G; and project administration, C.G. and U.Y. All authors have read and agreed to the published version of the manuscript.

Compliance with ethical standards

The Ethics Committee of Medical Faculty, Manisa Celal Bayar University, granted ethical approval to our study (No.: E 229182 dated 24.01.2022). Before the participants started to fill out the forms, they were provided with online information about the research and their written consent for participation was obtained.

Consent to participate

Written consent was obtained from all participants included in the study.

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Nil.

Conflicts of interest

There are no conflicts of interest

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