ORIGINAL ARTICLE

Investigation of Sexual Function and Its Relationship with Spiritual Health and Religious Attitude in Iranian Women: A Descriptive Study

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Received: 10 July 2024
Revised: 11 August 2024
Accepted: 15 September 2024

Abstract

Background: Sexual function is the result of a complex relationship between the body and the mind. It can be affected by various dimensions of health, including spiritual health. In this study, we aimed to assess sexual function and its relationship with spiritual health and religious attitude in Iranian women.

Methods: The present descriptive, analytical research was carried out on 514 women in reproductive age, who had referred to the health centers of Shiraz, Iran, from February to September 2015. The participants were required to complete the Religious Attitude Scale, Spirituality Well-being Scale, and Female Sexual Function Index. The psychometric properties of these questionnaires were assessed in Iran. SPSS version 22 was used to analyze the collected data, and a P-value lower than 0.05 was regarded as statistically significant.

Results: The mean score of spiritual health was significantly higher in women with a healthy sexual function compared to those with sexual dysfunction (P=0.03). Also, we found a significant relationship between spiritual health and sexual desire (P=0.007) and sexual satisfaction(P=0.03). A significant relationship was also observed between religious health and sexual satisfaction(P=0.03). Besides, the results indicated a significant association between existential health and sexual desire(P=0.002), sexual arousal(P=0.003), and pain(P=0.03). A significant relationship was observed between religious attitude and sexual function(P<0.001).

Conclusion: Given that sexual function is one of the basic components of women's health in reproductive age that needs special attention. It seems that for improving it, taking effective measures such as paying attention to women's spiritual health can have positive effects on their sexual function.

Please cite this article as: Yazdanpanahi Z, Beygi Z, Sajadian SZ, Saheb Karam Z, Hajifoghaha M. Investigation of Sexual Function and Its Relationship with Spiritual Health and Religious Attitude in Iranian Women: A Descriptive Study. J Health Sci Surveillance Sys. 2024;12(4):426-433.

Keywords: Religion, Sexual dysfunction, Spirituality, Female, Iran

Introduction

Sexual function is the result of neuromuscular interactions and hormonal mediators, which is affected by biological characteristics, personal relationships, and cultural, traditional, and social factors.[1, 2] Spiritual health is an important factor that needs to be considered in sexual function.[3]

Spiritual health is the most recently recognized dimension of health, which has been classified alongside other health dimensions.[4] Evidence suggests that without spiritual health, other dimensions of health cannot be fully realized, and a high quality of life cannot be reached.[5] Spiritual health refers to

a person's attitude toward themselves, others, and a higher power/God. It helps an individual develop feelings of identity, satisfaction, inner tranquility, harmony, and purposefulness in life. It generally comprises of existential and religious well-being. Existential well-being is defined as purpose and satisfaction in life, along with an accepting mindset toward death and suffering.[6, 7]

Some studies have demonstrated the positive influence of spiritual health on sexual function.[8, 9] Religious well-being is a component of religion, which represents one's relationship with a supreme power.[10, 11] In this respect, researchers revealed that women with higher scores of religious health, knowledge, and attitude had a better sexual function than others.[12] Conversely, a study reported that many religious people did not have a healthy sexual function due to misconceptions or lack of knowledge about religious concepts related to sexual function.[13] There is also a study which did not indicate any relationship between religion and sexual function.[14] Nevertheless, some researchers believe that religious beliefs and values can affect marital life and that people with higher levels of religiosity have a healthier sexual function compared to those with lower levels of religiosity.[12, 15]

A systematic review (2014) indicated that sexual satisfaction was associated with demographic characteristics, social, physical, and mental health, social support, family relations, and cultural/ideological factors, including religion.[16] In a previous study, Muslim women with high levels of sexual shame reported lower levels of sexual satisfaction.[17] Nevertheless, no research has yet investigated the correlation of spiritual health and religious attitude with sexual function in women of reproductive age in Iran; however, health providers are required to pay attention to these factors.[18] Considering the religious background of Iran and the importance of sexual function in marital life, the present study aimed to assess sexual function and its relationship with spiritual health and religious attitude in Iranian women.

Methods

The Ethics Committee of Nursing and Midwifery Faculty of Shiraz University of Medical Sciences, Shiraz, Iran approved the study (93-01-85-8837).

Study Design

The present descriptive, analytical study was an attempt to assess the association of sexual function with religious attitude and spiritual health in women in reproductive age, who were referred to healthcare centers in Shiraz, Iran in 2015.

Sample Size

According to a study,[19] considering d=0.04, q=69%, P=31%, and z=1.96, a sample size of 514 was estimated for this study.

Setting

First, ten healthcare centers were selected among healthcare centers in the north, south, east, and west of Shiraz, Iran. In this study, there was an attempt to select the centers that are close to each other in terms of social and economic levels. Next, eligible participants were selected based on the number of individuals referred to each center.

Study Population

In this study, married women, aged 15-45 years, who were living in Shiraz, Iran, for at least one year were recruited. On the other hand, we excluded the breastfeeding women who had given birth to their children in the past eight weeks, women with obvious sexual dysfunction, menopausal women, pregnant women, and women who had not lived with their partner in the past six months from the study. All the participants gave their written informed consent forms. The participants were explained that they could withdraw from the study whenever they wished.

Data Sources

Data were collected through a self-report method, using a demographic information form, Female Sexual Function Index (FSFI), Spiritual Well-Being Scale (SWBS), and Religious Attitude Scale. The data collected were analyzed in SPSS version 22. The instruments used in the study were as follows:

1. FSFI

The FSFI contains 19 questions, scored using a six-point Likert scale, to assess women's sexual function in dimensions of sexual desire, sexual arousal, lubrication, orgasm, satisfaction, and pain in the past four weeks. Each item was scored from zero to five, with the final score ranging from zero to 95. In a previous study, scores below 28 represented sexual dysfunction.[20] In Iran, the psychometric properties of this questionnaire was assessed which indicated a Cronbach's alpha coefficient of 0.70 for the total score.[21] Moreover, Iranian researchers reported a Cronbach's alpha coefficient of 0.95 for the total score of sexual function;[22] overall, these studies contributed to the framework of the current study.

2. SWBS

The SWBS contains 20 items, with even items evaluating existential well-being and odd items assessing religious well-being. The existential well-being subscale examines an individual's relationship with the world and his/her purpose and satisfaction in life, while the religious well-being subscale assesses their relationship with God.[23] The items are

scored using a six-point Likert scale, ranging from "completely agree" (1) to "completely disagree" (6). The scores of each subscale range from 10 to 60, with the total score ranging from 20 to 120. Scores of 20-40, 41-99, and 100-120 represent low, moderate, and high spiritual well-being, respectively.

The SWBS was previously translated into Persian, and its content validity was confirmed; the Cronbach's alpha coefficient was estimated to be 0.82.[24] Another study also reported Cronbach's alpha coefficients of 0.91, 0.91, and 0.93 for the religious well-being, existential well-being, and spiritual health subscales, respectively.[11] Moreover, another study estimated the Cronbach's alpha coefficient of 0.89;[25] these studies contributed to the framework of the present study.

3. Religious Attitude Scale

The Religious Attitude Scale consists of 25 items and six domains, including worship (pray), morals and values, impact of religion on life and behavior (praying/fasting), social issues, ideologies and beliefs, and science and religion. The items are rated on a five-point Likert scale, ranging from "completely disagree" (1) to "completely agree" (5); the final score ranges from 25 to 125. Scores above 100 represent high levels of religious thoughts, scores of 51-99 indicate moderate levels, and scores below 50 denote low levels of religious thoughts. The Cronbach's alpha coefficient was 0.954 for this scale in a study carried out in Iran,[26] which contributed to the framework of the present research.

Statistical Methods

SPSS version 22 was used to analyze the collected data. To investigate the relationship between the study variables, we used *t*-test and Fisher's exact test. A P-value less than 0.05 was considered statistically significant.

Results

This study was conducted on 514 women, with a mean age of 30.90±5.8 years. Most of the participants were housewives. Also, most of the subjects and their spouses had high school diplomas or academic degrees. The demographic features of the subjects are presented in Table 1.

Based on the results, almost two-thirds of the participants had a sexual dysfunction. Dysfunctions in sexual desire and arousal were the most prevalent problems, while lubrication problems were the least prevalent ones. The results of independent *t*-test revealed a significant relationship between age at marriage and sexual function (P=0.02); in other words, women with a longer marital life had higher sexual function scores.

According to the results presented in Table 2, spiritual health was significantly related to sexual desire and satisfaction (P<0.05). Besides, a significant relationship was observed between existential well-being and sexual desire, sexual arousal, and pain. We also found a significant relationship between religious well-being and satisfaction (P<0.05).

As shown in Table 3, there was a significantly higher mean score of existential well-being in the group of women without sexual problems (P<0.05). The mean score of religious well-being was also higher in women with a healthy sexual function as compared to those with sexual dysfunction. The results of *t*-test demonstrated that sexual function was significantly associated with spiritual health and existential well-being (P<0.05). Based on the results, the mean score of spiritual health was significantly higher in the participants with a healthy sexual function as compared to those with a sexual dysfunction (P<0.05).

According to the results presented in Table 4, there was a significant relationship between religious attitude and female sexual function. All participants with a poor religious attitude experienced a sexual dysfunction. Sexual dysfunction was also detected in 52.7% of women with a highly religious attitude.

Table 1: Demographic characteristics and sexual function

Demographic Characteristics		With Sexual Dysfunction Score<28		Without Sexual Dysfunction Score≥28		P value
Age (Mean/SD)		31.01	5.40	30.90	5.75	0.73*
Education (No/%)	Under diploma	111	30	16	18.1	0.009**
	Diploma	153	41.2	55	38.5	
	Academic degree	107	28.8	62	43.4	
Job (No/%)	Housewife	322	86.8	113	79	0.02***
	Employed	49	13.2	30	21	
Job of husband (No/%)	Freelance	237	63.9	89	62.2	0.38**
	Government	217	34.2	54	37.8	
	Unemployed	7	1.9	0	0.0	
Education of husband (No/%)	Under diploma	134	36.1	39	27.6	0.04***
	Diploma and academic degree	237	63.9	104	72.4	
Age of marriage (Mean/SD)		21.20	4.30	22.10	4.30	0.02*
Duration of marriage (Mean/SD)		9.9	6.41	8.50	5.40	0.17*

*t-test; **Fisher's exact test; ***Chi-squared test

Table 2: The relationships between the subscales of female sexual function and spiritual health

Variables	Variable score	Spiritual health	Existential health	Religious health
Desire	>3.3	83.85±20.47	43.04±11.71	47.69±10.61
	≥3.3	72.90±20.47	38.47±11.79	45.38±11.02
	P-value*	0.007	0.002	0.09
Arousal	>3.4	96.68±20.68	42.99±11. 60	46.97±10.59
	≥3.4	84.99±19.56	38.50±11.97	46.50±11.20
	P-value*	05. 0	0.003	0.73
Lubrication	>3.4	89.03±21.06	41.99±12.27	47.04±11.12
	≥3.4	85.12±17.96	39.07±10.64	46.04±9.86
	P-value*	0.17	0.08	0.52
Orgasm	>3.4	88.97±20.91	42.07±12.16	46.90±10.78
	≥3.4	85.32±18.54	38.87±10.95	46.46±10.97
	P-value*	0.2	0.06	0.80
Satisfaction	>3.8	89.8±20.08	42.08±11.61	47.71±10.30
	≥3.8	83.64±20.52	39.18±12.53	44.46±11.74
	P-value*	0.03	0.07	0.03
Pain	>3.8	89.65±21.06	42.40±11.38	47.24±10.29
	≥3.8	84.78±22.04	38.93±12.72	45.85±11.80
	P-value*	0.07	0.03	0.30

*t-test

Table 3: The relationships between sexual function and spiritual health

Health dimensions	Mean±SD		P value*
	With sexual dysfunction	Without sexual dysfunction	
Spiritual health	86.37±20.26	92.03±20.12	0.03
Existential health	40.07±12.16	44.31±10.81	0.009
Religious health	46.31±10.99	48.01±10.30	0.25

*t-test

Table 4: The relationship between religious attitude and female sexual function

Sexual function	Category	With sexual dysfunction	Without sexual dysfunction	P value*
Religious attitude	(Low) 50	4 (100%)	0 (0%)	≤0.001
	(Intermediate) 51-99	113 (85.6%)	19 (14.4%)	
	(High) ≥100	39 (52.7%)	35 (47.3%)	

*Fisher's exact test

Discussion

In the present study, we aimed to assess the female sexual function and its relationship with spiritual health and religious attitude in Iran. The results indicated a significant difference between the groups of with and without sexual dysfunction as to the level of education; this is consistent with the findings of other relevant studies.[27-29] Generally, a higher education level can change a person's attitude toward social, cultural, and psychological issues and affect their sexual function in various ways. Higher levels of education and knowledge of sexual problems may also be the reason for seeking principled approaches, receiving healthcare services, and looking for appropriate treatments for sexual dysfunction. The results of another study revealed that individuals with higher education levels had higher levels of sexual desire,[30] which might be because this study was performed on women with sexual dysfunctions. Conversely, the findings of a study revealed no significant association between education level and sexual function.[31]

In the current study, the rise in the duration of marital life was accompanied by a drop in the score of sexual function. In other words, women with a longer marital life showed a higher level of sexual dysfunction. We found no significant difference between the groups of with and without sexual dysfunction regarding age at marriage. In contrast, the results of a study revealed that sexual function was significantly correlated with the age of marriage.[32]

In several studies, emotional factors, interpersonal relationships, and psychological factors, like self-confidence and mental body image, were influential in the relationship between age and women's sexual function.[1, 33] In the current study, there was no significant relationship between age and sexual dysfunction with the participants' young age. Various studies have found advanced age to be one of the important factors that can be involved in sexual dysfunction by causing a decrease in an individual's abilities, physical health, or hormonal activity.[1,

[33] However, a study reported advanced age as one important factor in the reduction of sexual desire among couples in the middle and old age.[34]

On the other hand, the current findings indicated no significant relationship between occupation and sexual dysfunction; this is in the same line with the results of a previous study.[35] Based on the present study results, the frequency of sexual disorders was higher among housewives; as housewives spend more time at home and take care of children, their sexual issues may be marginalized. Moreover, these results showed a significant relationship between spiritual health and sexual desire and satisfaction. In other words, the participants who were spiritually healthy showed higher levels of sexual desire and satisfaction. The results also revealed a significant positive relationship between sexual function and existential and religious well-being. Existential well-being was significantly related with sexual desire, arousal, and pain, while religious well-being was significantly associated with sexual satisfaction.

A significant relationship was observed between religious health and religious attitude with sexual function in our results. According to a previous systematic review, sexual satisfaction was associated with religion.[16] It seems that spiritual beliefs can improve mental health and promote people's satisfaction with themselves and their families. Spiritual beliefs also give meaning to life and increase one's peace of mind. Generally, Islamic principles encourage individuals toward kindness and forgiveness, which can be influential in improving existential well-being. Besides, one's relationship with God, charity, and prayers can strengthen religious well-being.[9] The findings of a previous study in Malaysia demonstrated that spiritual health was positively associated with marital satisfaction,[36] which is, to some extent, close to the present study results.

In the present study, most of the participants had experienced a sexual dysfunction. In previous research, some statistics have been reported on women's sexual function in Iran. According to a meta-analysis, 52% of Iranian women in reproductive age suffered from sexual dysfunctions.[37] On the other hand, a study reported that 83% of Iranian women experienced a sexual dysfunction.[21] Another study showed that the prevalence of sexual dysfunction was 77.6% among women.[38] Overall, sexual dysfunctions may be associated with the cultural and religious context of a society, along with a lack of physician visits to manage sexual problems due to common feelings of shame. It seems that training women is a prerequisite for appropriate sexual functioning; nevertheless, taboos, beliefs, and traditions might prevent access to sufficient and accurate information on sexual health. In spite of the fat that sexual health education has been emphasized for all members of the society, no formal comprehensive educational program has been established for Iranians.[8, 38-40]

In this study, dysfunctions in sexual desire and arousal were the most prevalent problems, while lubrication problems were the least prevalent ones. However, a study carried out in China showed that the most and the least prevalent disorders were associated with sexual arousal and orgasm, respectively.[41] This discrepancy might be attributed to the age groups assessed in these two studies; as the Chinese study was carried out on menopausal women, while the present study included women of reproductive age. Differences in sample size, besides racial, religious, and cultural factors, might be also influential.

Based on the results of the present study, the mean scores of spiritual health and religious well-being were significantly higher in individuals with a healthy sexual function compared to the subjects with sexual dysfunction. Additionally, the score of religious attitudes was significantly different in the groups with and without sexual dysfunction. In this regard, a study revealed a significant association between religion and different dimensions of sexual function, except for sexual arousal.[8] Another study in Iran indicated that women with a healthy sexual function had higher scores of religious health.[42] Besides, in a study, religious attitude and sexual satisfaction had significant negative relationships with tendency for divorce.[43]

Evidence suggests that couples' religious beliefs are directly related to their marital satisfaction and happiness, especially in older women. Besides, some studies concluded that religious practice led to an increase in happiness, as well as a significant improvement in the marital satisfaction.[15, 44] Overall, it is suggested that professionals should become familiar with the role of religiosity in different aspects of sexuality;[45] it is recommended that healthcare professionals should provide religious guidance to their clients.[46, 47]

Given the important role of women in family and social health, the present findings can help health policymakers to make appropriate plans for female empowerment and promote their health status. Depending on the cultural background of the society, sexual skill training is essential before marriage to help people identify desirable sexual behaviors in accordance with their religious beliefs. Besides, practical strategies need to be emphasized for preventing or reducing the incidence of sexual disorders, alongside training through journals, books, media (TV and radio), and consultation with healthcare providers. As to sexual behaviors in marital life, it is important to consider the factors associated with a healthy sexual relationship, sexual etiquette, healthy sexual behaviors in marital life, and unreasonable sexual beliefs.

The present study has some strengths; it is the first research in Iran that has assessed relationship between sexual function with spiritual health and religious attitude in females. The results of this research have important implications. Considering that sexual function is one of the basic components of women's health in reproductive age, it seems that improving women's spiritual health and religious attitude can have positive effects on their sexual function. Therefore, health policymakers, planners and care providers should pay special attention to their spiritual health and religious attitudes when educating and managing women with sexual dysfunction.

In this study, there was a limitation related to sampling from different centers, and the selection of homogeneous centers in terms of economic and social levels is one of the factors to overcome this limitation. Also, because there was a limitation of resources, time, place and extent of distribution of married women, this study could not cover large groups of married women in different urban and suburban areas, which limits the generalizability of the study to other areas. Besides, the respondents completed self-report questionnaires and might not have completed them truthfully; we tried to reduce this limitation as much as possible by ensuring data confidentiality. It is recommended that future studies should be conducted with a larger sample size in different cultures and religions in both males and females of different age groups.

Conclusion

The results of the present study revealed a significant relationship between sexual dysfunction and spiritual health and religious attitude. Given the complexity of sexual function, the use of new educational and therapeutic methods in the management of sexual dysfunctions and programs such as education and promotion of spiritual health and religious attitude can increase the sexual function in women of reproductive age.

It is recommended that specialists of reproductive health consider spiritual health and religious attitude to progress and improve the level of sexual function of women. Sexual dysfunctions can be minimized by timely diagnosis and improvement of women's spiritual health via training and provision of accurate information by reliable and informed professionals.

Authors' Contribution

All authors contributed to the design of the study, data collection, data analysis, and drafting and revision of the article.

Acknowledgments

The authors would like to thank the Research Vice-chancellor of Shiraz University of Medical Sciences and Infertility Research Center of Shiraz University of Medical Sciences for financially supporting the research. They would also like to appreciate Ms. A. Keivanshekouh at the Research Consultation Center (RCC) of Shiraz University of Medical Sciences, Iran for her invaluable assistance in editing the manuscript.

Ethical Consideration

The present study was approved by the Ethics Committee of Nursing and Midwifery Faculty of Shiraz University of Medical Sciences, Shiraz, Iran (93-01-85-8837). The objectives and methods of the study were explained to the participants, and they were assured of their right to withdraw from the study at any time; they were also ensured that their information would remain confidential. All participants signed a written informed consent form in this study.

Conflict of Interest: None declared.

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