ORIGINAL ARTICLE

The Relationship between the Job Type and Women's Sexual Function and Satisfaction in Ahwaz

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Abstract

Background: Overall, women make up a third of the world's workforce. With the heavy increase in the number of working women, marital dissatisfaction will also increase. While the strength of the marital relationship without having satisfactory sex is in jeopardy, paying attention to sexual satisfaction is an essential part of healthcare standards; it is also part of sexual health in women. The present study aimed to determine the relationship between the of job and sexual function and satisfaction in Ahwaz city.

Methods: The is a descriptive-analytic cross-sectional study. The sampling was done through random-convenience method on 685 women who referred to the health centers and hospital in Ahwaz (137 housewives and 548 employees in educational, health, medical, and administrative and service sectors) and had the inclusion criteria. A three-part questionnaire was used which included questions on a) personal characteristics including age, occupation type, years past from marriage, the number of children, age of youngest child, age of spouse and preventing pregnancy, b) Female Sexual Function Index (FSFI), and c) Larson Sexual Satisfaction Questionnaire.

Results: There was a significant relationship between the type of job with lubrication, satisfaction, intercourse pain, total sexual function, and sexual satisfaction scores.

Conclusion: According to the results of the study, it seems that there is an relationship between the type of job with lubrication, satisfaction, intercourse pain, total sexual function and sexual satisfaction scores (P=0.4); due to increase in the number of employed women, the detecting and solving of sexual dysfunctions have a significant effect on improving the quality of marital relationships, which is an important step in order to prevent family disputes and its consequences.

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Introduction

Family is one of the main components of society, and obtaining a healthy society depends on the family health; also, the realization of a healthy family depends on their mental health and good relationships with each other.[1]

With the start of the Industrial Revolution, the traditional roles of women changed to some extent, so that instead of mere house, much of their life was spent on activities outside home.[2] Women make up a third of the world's labor force, which is higher in developing countries (about 40%), and in other parts of the world less than a

third.[3] Overall, women's labor force participation in the world remained stable between 1990 and 2010. In 2010, the labor force participation rate was less than 30% in North Africa and West Asia.[4] The participation of women as labor force in Iran was 9.1% according to the statistics in 1996, whereas the recent Iran census shows that the share of women in the official labor force is 11% and currently 2.1 million women work in Iran.[5, 6] In France in 1962-1972, 66% of administrative and office jobs and 38% of industrial jobs were allocated to women.[7] In 1986, nearly 90% of the employees in England were women.[5] In 1996, about 46% of women were in the service sector and 34.5% in the industry sector in Iran. According to the UN report in 2005, in some developed countries, the share of employed women in the management sector is about 50%, whereas in Iran women account for about 5% of managerial positions in the governmental agencies.[8] According to an analysis by the Pew Research Center on labor force statistics from 114 countries in 2018, women make up at least 40% of the workforce in more than 80 countries.[9] Matthews (2010) concluded that with increase in the role of employed women's participation, marital dissatisfaction increased as well.[10] It is estimated that 80% of conflicts and disagreements among married couples are due to loss of sexual satisfaction between the spouses.[11] In expressing biological needs, sexual instinct is deeply mixed with psychological needs, so that the effect of this desire can be seen in many aspects of life. This instinct has an undeniable impact on married life and its cohesion and sustainability. Additionally, this instinct has a constructive and fundamental role in the development of mental health and balance, and it is in the wake of these significant characteristics that sexual desire diverges from other biological needs and becomes a psychological need.[12] Sexual dysfunction is the main source of communication conflicts that can increase the couples' concern about the sustainability of communication and cause divorce and separation of the spouses.[13] The statistics show that 20-30% of American men and 15% of American women turn to relationships beyond the conjugal life because of sexual dissatisfaction.[14] According to the studies in Iran, 40% of divorces have been due to infidelity, and secret relationships in Iranian spouses are due to loss of sexual satisfaction of one of the spouses.[15] Sexual satisfaction is influenced by several factors, including occupational stress, couples' dispute, education and culture, economic problems, moral and sexual harmony, physical and mental problems, and illnesses.[16] Studies have indicated that the rate of sexual desire is an effective factor in the development of sexual dysfunction, so any disorder that causesinconsistency and, therefore, a lack of satisfaction with sex, can lead to sexual dysfunction.[17] The family is the core of each society and the focus of mental health, and sexual satisfaction is one of the factors affecting family survival, and its satisfaction and health; given the increase in the number of employed women and midwives' awareness of sexual issues and factors affecting sexual satisfaction, especially the occupation and continuous contact with the society that can act as family professional counselors, we decided to examine the relationship between the type of occupation with women's sexual satisfaction and performance in Ahwaz.

Methods

This is a descriptive-analytic cross-sectional study that was performed on 685 women who referred to health centers and hospitals in Ahwaz in 2015 and had the inclusion criteria; of them, 137 were housewives and 548 were working in educational, health care, service and administration occupational groups. The sampling method was as follows: out of 32 health centers in Ahvaz, 6 centers (3 centers from the west and 3 centers from the east) and from 7 hospitals affiliated to Ahvaz University of Medical Sciences, 4 hospitals (2 large hospitals, 1 medium hospital and 1 small hospital) were selected by lot. Sampling during the week was random with 2 days of referral to large hospitals, 1 day of medium hospital, 1 day of small hospital, and 2 days of referral to health centers. Sampling method was available in both employed and housewife groups. Sampling with this method was continued until the samples were completed. The inclusion criteria were married women living with their husbands, women aged 18-45, literacy , single spouse, and passage of at least one year from their marriage. The exclusion criteria were any known medical and psychological illnesses, any critical accidents in the past 6 months, pregnancy, experience of abusive or sexual abuse before marriage, drug and alcohol abuse in women and men, the history of abuse of sedative drugs among women and men, and infertility. The participants were selected using convenient random sampling. A three-part questionnaire was used which included a) personal characteristics including age, occupation type, years past from marriage, the number of children, age of youngest child, age of spouse and preventing pregnancy, b) Female Sexual Function Index (FSFI), and Larson Sexual Satisfaction Questionnaire. Content validity was used to provide scientific validity of the demographic information questionnaire. Thus, after studying the latest books and papers, giving them to 10 faculty members in the nursing and midwifery school of Ahwaz and after making the necessary corrections according to their opinion, the final version was prepared. Job classification was done at the start. Some job classes were selected according to the parliamentary resolution and the opinion poll from the scientific board of the occupational health department, considering that many of these occupational categories were in close proximity. Thus, the women in educational fields were in group one, health care (nurses and midwives) in the second group, services were in the third group, and administrative in the fourth group. The final version was developed after making necessary modifications according to their opinion. FSFI has 19 questions that evaluate the women's sexual function

in 6 independent domains of sexual desire, sexual stimulation, vaginal moisture, orgasm, satisfaction, and sexual pain. Regarding scoring, according to the questionnaire designer, the scores of each domain is obtained through sum of the scores of questions in each field and its multiplication by the factor numbers (as in this questionnaire, the number of questions in the domains are not equal, first, to weigh-in the domains with each other, the scores from the questions of each domain were added up and then multiplied by the factor number). The scores considered for questions were 1) sexual desire (1-5), 2) sexual stimulation, 3) vaginal moisture, 4) orgasm, 5) pain (0-5) and 6) sexual satisfaction (1-5 or 0). Zero shows that the person has not had sex during the last 4 weeks. By adding up the scores of the six domains, the score of total domains is obtained. Thus, in scoring, the higher score shows better sexual functioning. Accordingly, weighing-in the domains, the maximum score for each domain is equal to 6, and for the whole scale it is 36. The minimum score for sexual desire is 1.2, sexual stimulation, vaginal moisture, orgasm and pain zero, satisfaction 0.8, and the total score of the minimum score is 2. The overall score less than or equal to 26.55 is considered as sexual dysfunction.[18] In Iran, the reliability and validity of the Persian version of this questionnaire were once approved by Mohammadi in 2004 and then by Fakhri et al. in 2012. The reliability of the whole scale and the sub-scales was obtained by calculating the Cronbach's alpha coefficient. The index of principal components analysis (PCA) constructs was used through varimax rotation and confirmatory factor analysis (CFA) to evaluate the validity of the tool. Detection of the validity was done by inter-group analysis of variance. The overall test-retest reliability coefficient for each domain of the questionnaire was high (0.73-0.86) and the internal consistency was within the acceptable range (0.72-0.90). The study showed that this questionnaire was a reliable and valid tool with good psychometric properties that could be used for early, fast, and accurate screening of women's unknown sexual health in clinics and sex counseling centers.[19, 20] FSFI has 25 questions with 5 options in response to each question based on the Likert scale (never, rarely, sometimes, most often and always). Each question has a score from 1 to 5. Hence, in questions 1, 2, 3, 10, 12, 13, 16, 17, 19, 21, 22, 23, the option "never" scores 1, "rarely" 2, "sometimes" 3, "most of the time" 4, and "always" scores 5. However, in the remaining questions, "always" scores 1, "most of the times" 2, "sometimes" 3, "rarely" 4, and "never" 5. The scale considered for data analysis is between 25 and 125. According to the scores obtained from the classification of the dependent variables, the level of sexual dissatisfaction score is less than 50, low satisfaction 50-75, moderate satisfaction 75-100, and high satisfaction greater than 100.[21, 22] The Hudson Sex Satisfaction Questionnaire was developed in 1981 by Hudson, Harrison, and Croscope to assess the couples' satisfaction levels.[23] The internal consistency of this scale was calculated by the designers and Cronbach's alpha was 0.91. The validity of the scale was calculated by one-week retesting method which was equal to 0.93. The validity of the scale was calculated through discriminant validity, which showed that the scale had the ability to identify the couples with and without sexual problems. For a more accurate analysis, the validity obtained from the method of halving the test was 0.88. The calculated Guttman coefficient was 0.80. In the present study, Cronbach's alpha method was used to determine the reliability of the sexual satisfaction questionnaire, which was equal to 0.93 for the whole questionnaire.[24] Job classification was done at the start. Some job classes were selected according to the parliamentary resolution and the opinion poll from the scientific board of the occupational health department, considering that many of these occupational categories were in close proximity. Thus, the women in educational fields were in group one, health care (nurses and midwives) in the second group, services in the third, and administrative services in the fourth group. For sampling, the employed and housewives admitted to health centers and hospitals affiliated to Ahwaz University of Medical Sciences were selected from the selected sample. The questionnaires were completed by coordinating with the relevant authorities and obtaining oral and written consent from the subjects in the private environment. For the confidentiality of the information, the names of the individuals were not mentioned in the questionnaires. The subjects were allowed to exit the study at any time during the study if they wished. The researcher attended the place, and responded the probable questions of the research samples about the questionnaire questions. Data were collected and analyzed through SPSS 22, using descriptive statistics, Chi – Square and Oneway ANOVA test.

Results

The results in Table 1 show that there was a significant difference between occupational groups in terms of age, marriage age, duration of marriage, number of children, age of youngest child, age of spouse, and income (P<0.001). The occupational education group had a higher age, duration of marriage and age of spouse than other occupational groups. The occupational health care group had a higher marriage age and income than other occupational groups, and housewives had a higher number of children and the youngest child age than other occupational groups. The statistical findings of this Table show the existence of a significant relationship between education and occupational groups (P<0.001). The highest percentage of university education was among health, education, and administrative staff. The results also show a significant relationship between contraceptive methods used and occupational groups (P<0.001). The highest frequency was related to the use of ampoules for contraception in the housewife group.

The results presented in Table 2 showed a significant

Table 1: Demographic characteristics of research units in different occupational groups

Demographic characteristics	Occupational groups					P value
	Health care N=137	Educational N=137	Administrative N=137	Service N=137	Housewife N=137	
Mean±standard deviation						
Age	5.65±33.05	5.14±36.40	4.95±34.74	5.38±33.42	6.64±32.29	<0.001
Marriage age	3.48±24.40	4.02±24.18	4.31±24.24	6.75±10.49	7.98±11.05	<0.001
The number of years after marriage	5.58±8.73	6.13±12.11	6.04±10.46	6.75±10.49	7.98±11.05	<0.001
The number of children	0.93±1.15	0.84±1.67	0.82±1.35	0.98±1.78	1.31±1.97	<0.001
The age of youngest child	4.26±4.02	4.74±6.70	4.76±5.61	4.18±5.54	5.65±5.95	<0.001
The age of spouse	6.74±36.72	5.95±41.03	6.32±38.82	6.66±39.67	8.20±37.04	<0.001
Income	2633.897±57.4	2243.79±711.85	2466.42±871.55	1656.71±619.89	1448.17±0.99	<0.001
Frequency (percent)						
Education						<0.001
Literacy	0	0	0	1 (0.7)	11 (8)	
High school	0	0	0	36 (26.3)	27 (19.7)	
Diploma	0	0	2 (1.5)	59 (43.1)	55 (40.1)	
University	137 (100)	137 (100)	135 (98.5)	41 (29.9)	44 (32.1)	
Contraception						<0.001
OCP	23 (12.4)	36 (19.4)	31 (16.7)	51 (27.4)	45 (24.2)	
Ampoule	1 (8.3)	4 (33.3)	0	2 (16.7)	5 (41.7)	
IUD	15 (18.3)	16 (19.5)	12 (14.6)	17 (20.7)	22 (26.8)	
Condom	65 (24)	60 (22.1)	65 (24)	43 (15.9)	38 (14)	
No Contraception	29 (41.4)	4 (5.7)	11 (15.7)	14 (20)	12 (17.1)	
TL	4 (6.3)	17 (26.6)	18 (28.1)	10 (15.6)	15 (23.4)	

Table 2: Relationship between occupational groups and aspects of sexual function

Aspects of sexual function	Occupational groups					P value
	Health care N=137	Educational N=137	Administrative N=137	Service N=137	Housewife N=137	
Mean±standard deviation						
Sexual desire	3.68±0.86	3.65±0.86	3.49±0.91	3.65±0.92	3.74±1.15	0.27
Excitement	4.02±1.09	3.92±1.15	3.78±1.31	3.64±1.21	3.86±1.33	0.11
Lubrication	4.56±0.92	4.18±0.98	4.33±1.31	3.95±1.25	4.11±1.25	<0.001
Orgasm	4.69±1.23	4.47±1.20	4.44±1.39	4.24±1.46	4.19±1.40	0.17
Satisfaction	4.87±1.24	4.70±1.20	4.64±1.33	4.23±1.47	4.22±1.59	<0.001
Pain during intercourse	4.71±1.22	4.67±1.18	4.73±1.36	4.01±1.18	4.60±1.11	<0.001
Total sexual function	26.56±5.2	26.56±5.31	25.43±6.58	23.74±6.70	24.82±6.93	0.04
Frequency (percent)						
Desirable sexual performance	75 (35.3)	54 (18.2)	65 (22)	48 (16.2)	54 (18.2)	0.008
Undesirable sexual performance	62 (15.9)	83 (21.3)	72 (18.5)	89 (22.9)	83 (21.3)	

Table 3: Relationship between occupational groups and sexual satisfaction

The variable studied	Occupational groups					P value
	Health care N=137	Educational N=137	Administrative N=137	Service N=137	Housewife N=137	
Sexual satisfaction	97.29±14.29	96.49±14.53	96.54±13.89	91.86±15.01	92.89±16.58	0.005

relationship between all domains of sexual function other than desire, stimulation and orgasm (P<0.05). The healthcare group had the highest score in terms of lubrication, satisfaction and total sexual function, and the administrative career group had the highest pain score during intercourse. The statistical results from this Table showed a significant relationship between the type of sexual function and the type of occupation (P<0.001), and the highest frequency percentage was in the group with a good sexual function in health care workers.

A glance at the results of Table 3 shows a significant relationship between sexual satisfaction and type of occupation (P<0.05), which was the highest sexual satisfaction in health care workers.

Discussion

In the results of this study, it was found that occupational groups had a statistically significant difference in terms of age (P<0.05). Borghi et al. also reported that the prevalence of sexual dysfunction increased with age.[25]

Burke and colleagues reported in 2018 that sexual desire and intercourse gradually decreased with age.[26] Also, according to the information in this Table, there was a statistically significant difference between occupational groups in terms of the age at marriage and previous years of marriage (P<0.05). Halford et al. (2016) concluded that sexual satisfaction decreased over time in most couples.[27] According to the rsults, there was a statistically significant difference between occupational groups in terms of the number of children and age of the youngest child (P<0.05). Khalesi et al. reported that sexual satisfaction is higher in those who had two children than the participants who had three or more children.[28] In the study of Mohammadian et al. (2019), the number of pregnancies had a significant relationship with sexual function.[29] Based on the information obtained from this Table, occupational groups had a statistically significant difference in terms of the spouse age (P<0.05). Banaei et al. in 2019 showed that the lack of age difference between the couples could be one of the effective factors in creating sexual satisfaction.[30] Li et al. (2019) concluded that large age differences between couples caused mismatch of sexual needs and, as a result, sexual dysfunction.[31] The results also showed that there was a statistically significant difference between the household income of occupational groups (P<0.05). McNulty et al. (2019) reported that higher income was associated with lower sexual satisfaction.[32] Also,there was a significant relationship between education and occupational groups (P<0.05). Oyanedel et al. (2021) reported that higher education was associated with greater sexual satisfaction in women.[33] There was a statistically significant difference between occupational groups in terms of contraception (P<0.05). In Sanchez-Sanchez's (2021) research, condom use was the only contraceptive method effective in increasing sexual satisfaction.[34] In Jafarzadeh Esfehan et al.'s (2016) study, there was a significant relationship between sexual function and the use of contraceptive methods.[35] The results of this study showed that the type of job had an effect on lubrication score, satisfaction, intercourse pain, and overall sexual function (P<0.05). They had the highest pain score. It was further found that there was a significant relationship between the type of sexual function and type of job; the highest frequency in the group with desirable sexual function was in the healthcare workers. Singh et al. (2014) in their study stated that health care personnel had disorders in all aspects of sexual function.[36] The results of this study are not in the same line with those of this study. It seems that this discrepancy is due to differences in the type of study because Singh's research was a descriptive study in which only one occupational group was studied, but the present study is a descriptive-analytic cross-sectional research in which different occupational groups were examined. The results of this study also showed that there was a significant relationship between sexual satisfaction and type of job (P<0.05). It was also observed that health workers with an average score of 97.29 had the highest sexual satisfaction, and women working in the service unit with an average score of 91.86 had the lowest sexual satisfaction. A 2012 study conducted by Lee et al. reported that nurses were less sexually satisfied than other hospital staff.[37] The results of this study are not consistent with those of the present study. It seems that this discrepancy is due to differences in sampling method. In Lee's study, only two occupational groups (nurses and other hospital staff) were examined, but in the present study, five occupational groups were researched.

Conclusion

According to the findings of this study and considering the limitations , it seems that the relationship between the occupation type with lubricating, satisfaction, intercourse pain, total sexual function, and sexual satisfaction scores; also, the relationship between the sexual satisfaction and function with the occupation type of women in Iran has not been examined and the studies done in other countries have examined sexual function and satisfaction separately in just a few occupational categories. The number of employed women has increased and women have a greater role in family affairs and psychological stresses in their work environment can affect their physical and mental health leading to the development of individual conflicts in family and community dimensions; therefore, the detection and elimination of sexual dysfunctions has an important effect on improving the quality of marital affairs, which is an important step in preventing family disputes and the consequences of it.

This study had several limitations. First, this study was cross-sectional and could not determine the causal relationship, so if prospective studies are conducted in this regard, we will achieve more accurate results. Another is that individual characteristics and differences, mental and psychological characteristics and life, cultural, social and shame differences of the studied samples can affect the way they answer the questions, so it will affect the results of the research; however, controlling these factors has been the responsibility of an outside researcher.

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