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The Relationship of Social Participation with Sexual Function and Satisfaction among Women of Reproductive Age

Zahra Kamyabinia (MSc)[1], Sedighe Azhari (MSc)[2]*, Seyyed Reza Mazloom (PhD)[3,4], Negar Asghari Pour (PhD)[4]

[1] MSc in Midwifery, Department of Midwifery, Faculty of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran
[2] Lecturer, Department of Midwifery, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran
[3] Lecturer, Department of Medical Surgical Nursing, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran
[4] Evidence-Based Care Research Center, Mashhad University of Medical Sciences, Mashhad, Iran
[5] Assistant Professor of Psychiatry, Mashhad University of Medical Sciences, Mashhad, Iran

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ABSTRACT

Background & aim: Sexual satisfaction is one of the most important aspects of sexual function, and it plays an essential role in marital satisfaction. This study was conducted to evaluate the relationship of social participation with female sexual function and satisfaction at reproductive age.

Methods: In this comparative descriptive study, the data was obtained from a total of 284 married Iranian women who were divided into two groups of women with and without sexual dysfunction (n=142 in each group). The participants were selected via multi-cluster sampling method from public health centers in Mashhad, Iran, in 2015. The data collection tools included a socio-demographic form, Female Sexual Function Index (FSFI), and Keyes Social Health (Participation) Questionnaire. To analyze the data, descriptive statistics, Chi-square test, Mann-Whitney U test, Spearman's rank correlation coefficient, and multiple regression were used in SPSS, version 20.

Results: The mean age in two groups were 32.5±7.9 (with sexual dysfunction) and 31.1±7.2 (without sexual dysfunction) years, respectively. There was significant differences between the two groups in terms of social participation, sexual function (P<0.001), and FSFI sub-scale scores including sexual desire (P<0.01), arousal (P<0.001), lubrication (P<0.001), orgasm (P<0.001), and satisfaction (P<0.001). However, there were no significant differences in social participation and subscale of pain (P>0.05) between the two groups.

Conclusion: Higher scores in social participation were associated with more favorable female sexual function.

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Introduction

Sexual satisfaction, defined as the emotional response induced by one's evaluation of his or her sexual relationship, is an important indicator of a successful marriage that ensures the survival and health of the family (1, 2). It can be defined as having a pleasurable sexual experience inducing positive feelings and orgasm (3). Individuals with some degrees of sexual satisfaction have considerably better quality of life than those with no sexual satisfaction. Unpleasurable sex life can lead to frustration and feeling of insecurity in couples.

Sexual satisfaction plays an essential role in prevention of risky sexual behaviors, serious mental illnesses, social crimes, and ultimately divorce (4). Moreover, sexual satisfaction has a very important and strong relationship with marital stability and sexual function (5). According to the Psychiatric Disorder book, sexual function is characterized as a four-stage

* *Corresponding author:* Sedighe Azhari, Lecturer, Department of Midwifery, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran Tel: 09153114399; Email: AzhariS@mums.ac.ir

response cycle consisting of sexual desire, arousal, orgasm, and resolution (6).

Any defect and disorder in any level of sexual function may lead to sexual dysfunction (7). The results obtained by Mazinany (2013) showed that prevalence of sexual dysfunction was 31% in the women referred to the health care centers of Tehran, Iran (8). According to Ramezani (2012), prevalence rates of sexual dysfunction and dissatisfaction in a population-based study in Iran were 50% and 20%, respectively (9). Different factors, namely age, graduation, pregnancy, menopause, drugs, breastfeeding, mental health, attitude, and culture, can affect female sexual function (10-12). There is a wide range of psychosocial factors that may affect sexual function. Proper sexual function is an important component of well-being (13). Women's health is one of the priorities of the World Health Organization (WHO) (14). Based on WHO definition, health is an individual's complete physical, psychological, and social welfare, not only lack of disease or disability (15), with the social aspect being the most comprehensive and prominent aspect (16).

Alizadeh et al. (2012) demonstrated that women's participation in social activities is highly effective in their quality of life (17). In another study by Naeinian (2011) on female sexual dysfunction, it was found that somatic, social, and mental measures for individuals with sexual dysfunction (case group) were lower than those of the control group (healthy and without sexual dysfunction (18). Furthermore, Angella et al. (2013) stated that in patients with traumatic brain injuries, social participation can promote sexual function (19). Some former studies revealed that sexual function might be ameliorated with participation in social activities (18, 20, 21).

Resolving problems result in sexual function satisfaction, which in turn, makes a strong contribution to community health and can be considered as a main variable in preventing psycho-social problems. It seems that despite the high rate of sexual problems in women and its negative consequences, a multitude of questions remain unanswered in this regard.

Considering the discrepancies in results and differences in the study populations and applied questionnaires, we aimed to determine the relationship between social participation and sexual function and the effect of social participation on sexual function and satisfaction of women using Female Sexual Function Index (FSFI).

Materials and Methods

In this case-control study, we aimed to consider social participation as an independent and effective factor in female sexual function and satisfaction. Moreover, this study evaluated the relationship between patients' demographics and sexual function. We performed this study on 284 married Iranian women at reproductive age selected through multi-cluster random sampling method from five public health centers (1, 2, 3, Samen, 53742) in Mashhad, northeast of Iran, 2015.

The inclusion criteria comprised of living in Mashhad, being married, having intercourse in the recent month, not having any severe physical disabilities, having unusual sexual desire, not being pregnant and experiencing menopause, not being addicted, having mental health, not suffering from any diseases, not consuming any specific drugs, not having surgery on the breast and pelvis or chronic tiredness, not being a rape victim, being in a polygamous marriage, and completing informed consent form. The exclusion criterion was withdrawal from the study. The estimated standard sample size was 200 based on a pilot study and sample size formula, but considering subject attrition we included 284 participants, who were divided into two groups of 142 (one group with sexual dysfunction and the other without sexual dysfunction).

Sample size formula:

$$\left(r + 1(p)(p\_1)(z_{1_\beta} + z_{\alpha/2})^2\right) \Big/ (p_1 - p_2)^2$$

After obtaining informed consent, first the demographic form, then the social participation questionnaire, and ultimately the Female Sexual Function Index (FSFI) were given to the subjects. All the ethical considerations (such as informed consent, conflicts of interest, plagiarism, misconduct, and co-authorship) were observed.

The demographics form was designed by the researcher to assess the demographic data. This form included four parts: a) individual characteristics such as age, husband' age, income status, educational level, and husband' educational level, b) midwifery and reproductive characteristics, i.e., age of marriage, having a separate bedroom, number of children, and route of delivery, c) acceptance of sexual role like acceptance of maternal role and wife role, and d) domestic violence.

Social participation was characterized as following any special goals and activities that are valuable in the society. Keyes social health (participation) questionnaire was utilized to assess social participation; this scale consists of six questions rated using a five-point Likert scale (0-4). Scores of this scale can indicate lack of participation (0-6), low participation (7-12), moderate participation (13-18), and high participation (19-24) (16, 22). Cronbach's alpha reliability of the questionnaire was calculated 0.76.

FSFI, which consists of 19 questions and 6 subscales (desire, arousal, lubrication, orgasm, satisfaction, and pain), was also applied. Sexual dysfunction and dissatisfaction were denoted as scores lower than 28 and 3.6, respectively (23). The case group was defined as women with sexual dysfunction and control the group without sexual dysfunction. Cronbach's alpha of the questionnaire was calculated at 0.98.

To analyze the data, descriptive statistics, Chi-squared test, Mann-Whitney U test, and multiple regression were run in SPSS, version 20.

Results

The participants consisted of 284 women at the reproductive age with the mean ages of 32.5±7.9 and 31.1±7.2 years in the case and control groups, respectively. Moreover, the husbands' mean ages were 36.9±8.8 and 35.7±8.0 years in the case and control groups, respectively. The difference between the case and control groups in mean age of women and their husbands was not significant (P>0.05). In other words, the two groups were equal in terms of age variable.

Furthermore, 48.6% and 49.6% of the participants had high school degree in the case and control groups, respectively (Table 1). Most of the subjects in the case (85.9%) and control (77.5%) groups were housewives, respectively. Mean sexual function scores in the case and control groups were 22.4±4.0 and 31.2±2.2, respectively.

Data analysis showed that prevalence of sexual dysfunction and satisfaction was 50%.

Table1. Frequency and percentage individual characters at reproductive aged women attending to Public Health Centers

		Case group	N(%)	Control group	N(%)	P value
Female graduation	Reading and writing	2	1.4	1	0.7	0.018[a]
	Elementary	24	16.9	4	2.8	
	guidance	18	12.7	23	16.2	
	high school	69	48.6	70	49.3	
	university	29	20.4	44	31.0	
Husband graduation	Reading and writing	1	0.7	0	0.0	0.001[a]
	Elementary	3	2.1	0	0.0	
	guidance	23	16.2	9	6.3	
	high school	51	35.9	64	45.1	
	university	25	17.6	42	29.6	
Female job	housekeeper	122	85.9	110	77.5	0.041[a]
	Employee	14	9.9	15	10.6	
	free	6	4.2	17	11.9	
Husband job	Unemployed or free	94	66.2	94	66.2	0.136[b]
	Employee	26	18.3	39	27.5	
	Worker or farmer	22	15.5	9	6.3	
	Total	142	100	142	100	

a) Mannwhitney b) Exact chi-square

In the case group, arousal dysfunction was the most prevalent (66.9%) subscale of dysfunction among respondents followed by desire dysfunction (60.6%), lubrication dysfunction (41.5%), orgasm dysfunction (35.2%), and pain during intercourse (17.6%).

Among the participants, 95.1% and 100% had social participation in the case and control groups, respectively. Furthermore, 46.5% in the case group had low participation and 74.6% in the control group had moderate social participation (Table 2).

Table 2. Frequency distribution and percentage of social participation. Based on Mann Whitney Test

Social participation	Case	N(%)	Control	N(%)	P Value
high	4	2.8	20	14.1	
moderate	65	45.8	106	74.6	
low	66	46.5	16	11.3	P=0.001
Lack	7	4.9	0	0.0	
Total	142	100	142	100	

Data showed that the mean scores of sexual function in the case group were lower than those of the control group. In the present study, individuals with and without sexual dysfunction stated that they had 95.1% and 100% social participation, respectively. Mann-Whitney test reflected that sexual function and some of its subscales (e.g., desire, arousal, lubricant, orgasm, and satisfaction) had a direct significant relationship with social participation (P<0.05; Table 3). However, between pain subscale and social participation there was no significant relationship (P>0.05; Table 3).

Table 3. Mean and standard deviation sexual function' subgroups Based on Mann Whitney Test

		Social Participation mean± sd		P Value
Sexual desire	Case group	3.0	0.82	0. 01
	Control group	4.3	0.80	
Sexual arousal	Case group	3.1	0.85	0.001
	Control group	4.9	0.60	
Sexual lubricant	Case group	3.4	1.1	0.001
	Control group	5.4	0.60	
Sexual orgasm	Case group	3.8	1.05	0.001
	Control group	5.5	0.60	
Sexual satisfaction	Case group	3.4	0.73	0.001
	Control group	5.7	0.53	
Sexual pain	Case group	4.9	1.10	0.053
	Control group	5.6	0.73	

Moreover, according to Spearman test, there was a direct significant correlation between social participation and sexual function (r=0.44, P<0.01). In other words, participants who had higher scores of social participation had higher sexual function scores in comparison with those with lower scores of social participation.

Mann-Whitney test showed no relationship between sexual function and the women and their husbands' age. Chi-squared test indicated a direct significant relationship between scores of sexual function and participants' educational level, income, their husbands' educational level, and occupation (P<0.05). According to the findings of the present study, no relationship was noted between women's job and route of delivery (P>0.05).

Multiple regression reflected a significant relationship between social participation as

independent variable and sexual function as dependent variable, other effective variables like; participation' graduation, job, income, their husband' graduation and job, delivery way(p=0.001, R=0.525, F =7.233, df=13). However, a significant association was found between social participation income (P=0.004), women's job (being employed; P=0.007), husband's job (self-employed) (P=0.046), as well as sexual function and satisfaction (P=0.001) (Table 4).

Table 4. Result of multiple regression test at the relationship between social participation and sexual function

variable	B	β	P Value
Husband' job(free)	-1.799	-0.133	0.046
income	-1.900	-0.167	0.004
Social participation	0.612	0.401	0.001
Job(employee)	4.257	0.255	0.007
Delivery way	0.949	0.087	0.120
Graduation(elementary)	0.525	-0.048	0.502
Husband' graduation(high school)	-1.171	-0.085	0.312
Age	-0.052	-0.070	0.552
Husband' age	0.033	0.050	0.676

Discussion

The results of Spearman and Mann-Whitney tests reflected a significant direct relationship between social participation and sexual function. On the other hand, women with higher scores of social participation had less sexual dysfunction and dissatisfaction. Additionally, there was a strong and significant relationship between social participation and sexual arousal, lubrication, orgasm, and satisfaction, while it showed no relationship between pain during sexual intercourse and social participation; this finding can be explained by the fact that pain does not affect social factors in contrast to other sexual function subgroups. The most prevalent sexual problem in the studied subjects was arousal disorder and then desire disorder in the case group. This finding was not consistent with those of previous studies of Ramezani (2010) and Naiebinia (2011) (9, 18). It must be mentioned that this inconsistency, apart from cultural and geographical factors and religious believes in different countries, can be due to insufficient skills of couples at sexual arousal. As mentioned earlier, the first hypothesis of the study on the relationship between social participation and sexual function was confirmed. This study also showed that social participation in people having sexual dysfunction was lower than that inthe control group. This outcome is in line with those of the studies by Agamohammadian (2007), Askari (2011), Fathi (2013), Sander (2013), and Naeinian (2011) (18-21, 24). In their study, the relationship between occupation and social participation for married women was investigated.

In the current study, we used social participation questionnaire, while in other studies a different questionnaire was applied. In studies of Nikobakht (2014), Abdolasis (2013), and Salmani (2011), a negative association between social participation and total sexual function was noted (25-27). In spite of the mentioned studies that were performed in Iran, we should be aware that the sample of this study was only women, which may have a different impact on women's sexual function. To evaluate the second part of the hypothesis, Mann-Whitney test evaluated the relationship between the scores of social participation and sexual satisfaction. It confirmed a significant relationship between social participation and sexual satisfaction. On the other hand, women with higher score of social participation had higher sexual satisfaction.

Few studies have investigated the relationship between social participation and sexual satisfaction. Findings of the present study confirm those of previous studies. However, the results obtained by Sander (2013) were not consistent with those of the present study (19). From the relationship between participation

and total sexual function, a negative impact is induced, which is not in line with the outcomes of Goshtasbi et al. (2008) who studied sexual function in middle-aged and elderly women. They noted high prevalence rate of sexual dysfunction, especially low sexual desire and arousal disorder in elderly women (28). Sexual desire decline with aging in women seems to be affected by physiological factors. The difference between their study and ours is that we performed the study on women of the reproductive age, whereas Goshtasbi et al. recruited women from different age ranges.

Regarding the relationship of sexual function with women's and their husbands' educational level, we found a direct significant association. However, some authors indicated contradictory results such as Namani et al. (2013) (29). This discrepancy is probably due to the differences in study population and study design. Social participation is an important aspect of social health.

Our outcomes indicate the potential to improve sexual functioning by enhancing social participation of women. This finding can help sex therapists and midwives to cure women with sexual dysfunction and dissatisfaction. One limitation of this study was not accounting for women's mental and emotional status while answering the questionnaire, which could influence their perception and comprehension. Furthermore, a limited number of women were referred to health centers on certain days of week and some of the women were not willing to complete the questionnaire.

Conclusion

We can conclude that social participation promotes sexual function and satisfaction. In other words, women with higher scores of social participation had higher sexual function and satisfaction.

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Conflicts of interest

Authors declared no conflicts of interest.

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