

The Comparison of Sex Education with and without Religious Thoughts in Sexual Function of Married Women

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ARTICLE INFO	ABSTRACT
<p><i>Article type:</i> Original article</p>	<p>Background & aim: One of the most important events in human life is marriage. Sexual satisfaction is one of the effective factors in a successful marriage. Accordingly, sexual health education is necessary. Sex education should be in line with the cultural, religious, and social infrastructures of the society. The aim of this study was to compare the effect of sex education with and without religious teachings on sexual performance of married women.</p> <p>Methods: This clinical trial with a pretest-posttest design was performed in four health centers that were selected through multi-stage cluster sampling, in 2013. A total of 64 women were chosen with regard to the inclusion criteria, such as formal marriage and first marriage, age of marriage ≥ 1, married life with husband, monogamous marriage, and participating in training sessions (sexual health education and sexual health based on religious teachings) that were held for six weeks. Female Sexual Function Index (FSFI) and a demographic characteristics form were used to collect the data. Data analysis was performed using descriptive statistics, t-test, and Pearson's correlation coefficient in SPSS, version 16.</p> <p>Results: In the intervention group, the mean score of Female Sexual Function Index was significantly different before and after the training program ($P=0.03$). The subgroups of sexual desire, orgasm, and sexual satisfaction in the intervention group and subgroups of arousal and sexual satisfaction in the control group were significantly different after the intervention ($P<0.05$). Sexual satisfaction in both groups was significantly different in comparison with baseline ($P<0.01$).</p> <p>Conclusion: Considering the religious culture of Iran, sex education based on religious teachings can enhance sexual performance.</p>
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Introduction

Sexual function in women is an important issue, which has attracted insufficient attention (1); this problem is more common in patriarchal countries (2). Sexual response cycle in women in addition to the physical components consists of a combination of social and religious, biological, and psychological factors such as emotional satisfaction and intimacy (1, 3). Besides, some of the beliefs and misinterpretations in relation to cultural and religious affairs and modesty exacerbate the situation (4, 5). Lack of familiarity with the natural process of intercourse and sexual problems could have serious conse-

quences, such as increased rates of sexual dysfunction, marital conflict, divorce, low self-esteem, depression in adults, domestic violence, sexually transmitted diseases and AIDS epidemic, lack of mental and sexual health, and rape (6).

Studies showed that favorable sexual function in women can be a sign of high health status (7) and it has a great influence on family health, as well (8). Various factors affect sexual performance such as age, menstrual function, psychological and cultural factors, and sex education (1). However, in some studies, religious teachings are cited as a barrier to sex

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education. That is why sex education is deemed unsuitable in Iran and some other countries. In India, trainings related to sexual issues were considered as a taboo for many years. In 2002, the International Organization for Controlling AIDS recommended sex education programs to prevent sexually transmitted diseases (9, 10).

In Iran, public and private sex education courses are held for teaching couples before marriage. Studies have shown that these classes are not efficient enough and many of the couples' problems remain unresolved (11). Bolourian and Ganjlo (2007) showed 83.5% of individuals are suffering from sexual problems and sex education did not rectify these problems (12).

Despite the importance of sex education, there are several obstacles, including feeling of shame, and embarrassment, lack of sex education in schools and universities, lack of official and public programs in health centers or other governmental institutes appropriate for age and gender of the clients, physicians' inattention to sex education, as well as insufficient knowledge about methods of proper education in private or the public sectors. Ignorance about sex education leads to many problems such as emotional, physical, and sexual violence in women (13). It might also cause psychological insecurity, resentment, suspicion, cynicism, violence, and hatred of spouse or the family, since the level of intimacy in the family reduces, and subsequently, conflict and divorce rate increase in these families.

In Iran, experts propounded that 50-60% of sexual problems are because of divorce (14). Aganj et al. (2009) concluded that sex education can increase life satisfaction, and in turn, lower the rate of divorce resulting from sexual problems and sexual dissatisfaction (15).

Sex education must be tailored to cultural infrastructure, social attitudes, age, sex, and individuals' needs (16). Islam strongly emphasizes on education to make the couples aware of their role in the family and enhance their self-concept and self-esteem (14). Studies have indicated that religious beliefs can influence sexual relations. Hosseinzadeh (2011) and Shakerian (2012) concluded that people with stronger religious beliefs are more successful in their sexual relationship with their spouse. Nevertheless, due to misunderstandings

and misinterpretations of some issues related to sexual behavior and obscenity of sexual issues, studies have shown that sexual performance was lower in the religious people (4). Ahmady (2006) stated that religious people have lower sexual performance because of not talking about sexual issues (4).

Sex education is hardly provided by families, and many parents avoid talking about these issues with their children (17). Sex education classes in schools and universities are not held or are insufficient. Thus, the majority of sexual information is achieved through friends and the media. When this information is received in at inappropriate age and cultural condition, it leads to misinterpretation and confusion (9, 18). In health centers, sex education or counseling is not held based on various reasons including inadequate training of doctors and other health care providers about sexual issues, shortage of knowledge, experience, and time, differences in age, gender, and language, as well as prejudice (19). The purpose of this study was to determine the effect of sex education based on religious teachings on sexual function of married women.

Materials and Methods

This clinical trial was conducted with a pretest-posttest design in 2013. For this purpose, multi-stage cluster sampling was performed. The complete list of health centers in Mashhad was prepared and then stratified sampling was carried out. We randomly selected four health centers from among five health centers in Mashhad. From the four centers, two were randomly selected for sexual health education based on religious thoughts (intervention group) and two centers for sexual health training (control group). The sample size was calculated using the article by Danesh (5) ($\alpha=0.05$, $\beta=0.2$, $S1=9.46$, $S2=17.88$, $Z_{1-\alpha/2}=1.96$) with 95% confidence level and 80% power. Finally, 64 women ($n=30$ and $n=34$ in the intervention and control groups, respectively) were chosen through non-randomized sampling from the accessible population referred to the centers based on the inclusion and exclusion criteria.

The inclusion criteria were willingness to participate based on informed consent, literacy, Persian language, being Muslim, official marriage, first marriage, age of marriage ≥ 1 , monogamy,

lack of documented sexual education, lack of medical diseases (such as diabetes, thyroid dysfunction, hepatic disease, and renal disease), or disorders affecting sexual intercourse (e.g., diabetes and multiple sclerosis), lack of drug addiction, no unpleasant events during the last six months, no menopause, and not being pregnant or within three months after delivery. Exclusion criteria were unwillingness to continue participation and absence of more than two sessions.

Sex educational content included the importance of sexuality, reproductive system and its performance, sexual cycle stages, disorders associated with each phase, sexually transmitted diseases, sexual health in women and men, the importance of sex education in marital life, its effect on increasing intimacy and marital adjustment, and information about communication skills that affect sexual relationship and emotional intimacy for both couples.

The included religious teachings consisted of the Quran verses and the Islamic authentic traditional books on sexual and marital relationships such as the purpose of starting a family according to religion, duties of men and women in family, religious discussions about sexual cycle stages, religious teachings about sexual health, which were presented in every session as the situation arose. Sex education content was similar in both groups, but the intervention group was provided with sexual education associated with religious teachings extracted from Quran verses and authentic traditional books about sex and sexual affairs.

Sixty-four women were randomly chosen with regard to the inclusion and exclusion criteria. The data collection instruments included a demographic information form and a questionnaire on sexual function of women named Female Sexual Function Index designed by Rosen et al. in 2000 (20). The questionnaire consists of 19 items with six subscales and minimum and maximum possible scores of 2 and 36, respectively. In general, higher scores indicate better sexual performance. In recent studies, cut-off score for differentiating healthy people from those suffering from sexual dysfunction is considered 26.5 (20). The reliability ($\alpha=0.83$) and

validity of the questionnaire were established by Mohammadi (2008) (6).

After selecting the subjects and obtaining informed consent, they were invited to participate in the training sessions. Beforehand, the demographic form and sexual function questionnaire were completed personally by the participants. Then, the training sessions (six sessions) were held through lecture with PowerPoint content. A question and response session was also held by the researcher in all the six weeks (one session per week). In both groups, the duration of the sessions in both groups according to the study content was 60-75 minutes. The difference between educational groups was religious teachings (presented in the final 10-15 minutes of each session) that were presented in the intervention group in addition to training on sexual behavior (being similar in both groups).

In addition to the presented materials in classes, a pamphlet was provided for the participants to be studied during the week. The participants reviewed the practical points and taught the content to their husbands.

Two weeks after the intervention (a total of eight weeks after the first training session), the sexual function questionnaire was completed again by the participants. Based on ethical considerations, the participants were assured of the confidentiality of the data.

Data was entered into SPSS, version 16. To analyze the data, descriptive statistics, such as mean, standard deviation, and frequency, Chi-square test, Mann-Whitney, paired t-test, and independent t-test were used.

Results

Demographic characteristics of the participants are summarized in tables 1 and 2. The results showed that the two groups were not significantly different in age, age of marriage, number of children, occupation, educational level, and household income.

In the intervention group, the mean sexual function index scores before and after the training were 25.86 ± 5.25 and 27.29 ± 5 , respectively ($P=0.03$). In the control group, mean sexual function index scores before and after training were 26.88 ± 3.95 and 28.07 ± 5.29 , respectively ($P=0.08$).

Table 1. Mean demographic characteristics of subjects in the two groups

	Intervention group (n=30)		Control group (n=34)		P-value
	Mean±SD		Mean±SD		
Age	33.96±7.22		33.17±7.68		0.67 ^a
Length of marriage	13.13±6.86		12.61±7.67		0.77 ^a
Number of children	1.9±0.99		1.64±1.41		0.14 ^b

a: t-test ^b: Mann-Whitney**Table 2.** Comparison of the frequency of demographic characteristics between the two groups

	No. (%)	No. (%)	P-value ^a
Participant education			
Secondary school and under	27(90%)	26(76.5%)	0.19
College education	3(10%)	8(23.5%)	
Husband education			
Secondary school and under	27(90%)	24(70.6%)	0.06
College education	3(10%)	10(29.4%)	
Participant job			
Housekeeper	25(83.3%)	24(70.6%)	0.25
Student or employed	5(16.7%)	10(26.4%)	
Husband job			
Governmental jobs	21(70%)	19(55.9%)	0.30
Private jobs	9(30%)	15(44.1%)	
Income			
Minimum income	4(13.3%)	8(23.5%)	0.35
Moderate and High-income	26(86.7%)	26(76.5%)	

^a: Chi-square test**Table 3.** Comparison of Sexual Function Index and its subgroups in both intervention and control groups before and after training

Intervention group	Intervention group			Control group			After study between two group
	(Before)	(After)	P value	(Before)	(After)	P value	P value
	Mean±SD	Mean±SD		Mean±SD	Mean±SD		
Desire	3.72±0.86	4.04±0.84	0.007	3.93±0.95	3.98±0.93	0.46 ^a	0.81 ^c
Arousal	4.15±1.04	4.36±1.04	0.17	4.24±0.96	4.56±1.03	0.04 ^b	0.44 ^c
Lubrication	4.69±1.28	4.48±1.1	0.39	5.11±0.75	5.22±1.08	0.06 ^a	0.01 ^c
Orgasm	4.62±1.23	4.65±1.07	0.87	4.83±0.82	5.09±1.14	0.01 ^a	0.01 ^c
Satisfaction	4.34±1	4.78±0.92	0.01	4.49±1.13	4.84±0.94	<0.001 ^b	0.79 ^d
Pain	4.33±1.41	4.61±0.99	0.19	4.25±0.97	4.36±1.28	0.55 ^b	0.39 ^d
Total scale score range	25.86±5.25	27.29±5	0.03	26.88±3.95	28.07±5.29	0.08	0.04

A: Wilcoxon B: Paired samples t-test C: Mann-Whitney D: Independent samples t-test

Sexual function index increased in both groups after the intervention, but it was statistically significant only in the intervention group (P=0.03). In addition, subgroups of sexual desire (P=0.007), sexual satisfaction (P=0.01), arousal (P=0.04), and lubrication (P=0.06) were significantly different between the two groups. Sexual satisfaction score in both groups was significant after the intervention (P=0.01 and P<0.001 in the intervention and control groups, respectively). Apart from the components of lubrication and orgasm, other components had normal distribution. T-test reflected that the

components of sexual desire, arousal, satisfaction, and pain were not significantly different after training in neither groups. With regard to sexual satisfaction and lubrication, Mann-Whitney test showed that the two groups were significantly different after training (Table 3).

Discussion

The results showed that although demographic and sexual function were not significantly different in the two groups before the study, mean score of female sexual function

significantly increased after the intervention. The increase was noted in the control group, as well; however, it was not statistically significant. This finding is somewhat different from the results of Smerecnik (2010) since through online survey they found that sex education among Muslims is unsuccessful and the respondents believed that religion has previously expressed the main orders. Therefore, Muslims think that it is not necessary to consider sex education (21). The discrepancy between the two findings is that in this study by combination of religious teachings and sex education, misunderstandings and misperceptions regarding religion about sexual relationship were eliminated in our subjects.

Nevertheless, our results confirmed those of Ahmadi et al. (2006) and Danesh and Kermani Mamazndy (2011). Their studies demonstrated that the correlation between religious commitment and sex is low and lack of religious information regarding sex is considered as a reason. They believed that if information in this regard is transferred properly based on cultural norms of the community, sex education can be effective (4, 5). Rostamkhani et al. (2012), Pak Gohar et al. (2005), and Yazdanpanah et al. (2014) also showed that changing the method of sex education can bring about significant results. In addition, counseling sessions in the study by Rostamkhani et al. caused a significant increase in all the sexual function subgroups (11, 22, 23), which is not in line with our findings.

The comparison of pre- and post-intervention showed that in the intervention group, sexual desire and satisfaction subgroups significantly increased. This finding can be due to combination of sex education with religious teachings or the awareness, knowledge, and motivation that are emphasized in Islamic traditions, which encourage sexual relationship as the cause of peace and tranquility in marriage. For example in Islam, being salacious is considered important for women as it helps sustain marital relationship. The Holy Prophet has stated "The best of your women is a modest woman who preserves herself from all men other than her husband and is voluptuous and enticing for her husband" (Bihar, vol 103, p 237) (24).

Kammerer-Doak (2008) stated that sexual desire in women in addition to love for the sexual partner depends on some psychological

and environmental factors, and information about sexual behavior can influence the desire to have sexual relationship (25). These scientific findings were consistent with the educational content presented in these sessions. Finally, content of sexual behavior training, especially religious teachings, encouraged sexual desire in women. Thus, achieving this finding in the present study may be due to the above-mentioned reason.

In the study by Veral and Temel (2009), the level of sexual satisfaction in men and women in the group of sexual theory training before marriage was higher than the control group (24), which is consistent with our result. In this study, sexual satisfaction in the two groups (intervention and control) had a significant increase.

Bosan et al. (2004) demonstrated that women's sexual satisfaction is provided by various factors such as emotional, biological, mental, and sexual responses and women do not experience sexual satisfaction by only sexual activity. The presence of an emotional and lovely relationship is a prerequisite for having a satisfactory sexual relationship for the majority of women (3). This is consistent with the above findings. Content of sexual behavior education, particularly the contents of religious teaching, was effective and improved love, understanding, and satisfaction from intercourse in our participants. Brody and Weiss (2011) in their study on 1570 participants found that sexual satisfaction from vaginal sex is higher for both men and women (26).

By comparing the two groups after two educational sessions, the subgroups of lubrication and orgasm significantly increased in the control group. This result might be because of religious beliefs, Islamic and Iranian traditional culture, educational content in connection with sexual intercourse, which emphasized on vaginal intercourse. Islam and religious authentic traditions books emphasized on the same type of sexual intercourse, which can increase sexual satisfaction in women due to lubrication and orgasm. Tadayon Najaf Abadi et al. in a study performed in Hasarak, Karaj, Iran (2010) showed that the prevalence of not experiencing orgasm in women is high (26.3%). They also noted that religious beliefs, attitudes,

local beliefs, and teaching can affect sexual relations and women's orgasm intensively (27).

The limitations of our study were not controlling the religious beliefs of individuals and personal differences and not participating the husbands. As the results showed, with appropriate training in accordance with culture and religious beliefs, sexual function can be improved in women.

Conclusion

The comparison of the two different methods of sexual behavior teaching showed that sex education in combination with religious teachings is more effective because of its adaption with culture and beliefs of the Iranian people. To obtain more reliable results, it is recommended to carry out this study in the presence of both couples as proper sex education (using religious teachings) for couples can improve sexual function and behaviors.

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Conflicts of interest

None Authors declared no conflicts of interest.

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