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Predictive Role of Sexual Self-concept in Marital Satisfaction and Sexual Function in Reproductive-aged Women

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ABSTRACT

Background & aim: Sexual self-concept is a cognitive perspective of humans towards their sexual aspects, which reflects their thoughts, feelings, and functions about themselves as sexual creatures and could be a predictor of sexual outcomes. This study aimed to investigate the predictive role of sexual self-concept about marital satisfaction and sexual function in reproductive-aged women.

Methods: This correlational study was conducted on 707 married women (aged 15-49 years) in Sari, North of Iran, in 2016. The subjects were selected by systematic sampling. The data were collected using Snell Multidimensional Sexual Self-concept Questionnaire, ENRICH Marital Satisfaction Scale, and Rosen Female Sexual Function Index. Data analysis was performed using Pearson correlation coefficient, independent t-test, ANOVA, and linear regression tests in SPSS software (version 16.0).

Results: The positive domain of sexual self-concept had the maximum mean score (130.38±19.71). In this domain, the maximum score belonged to motivation to avoid risky sex. The negative domain of sexual self-concept (9.10±9.16) had the minimum score, with sexual monitoring having the maximum score. The results of the linear regression model showed that sexual self-concept could predict 43% and 36% variances of marital satisfaction and female sexual function, respectively.

Conclusion: This study facilitates the conceptualization of sexual health issues. Based on the findings, it is recommended to pay attention to the transactional correlation of sexual self-concept with marital satisfaction and sexual function in primary healthcare settings.

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Introduction

In recent years, the world's perspective on sexual issues has been shifted toward comprehensive and holistic sexual health and well-being. Today, researchers and health organizations regard the emotional and mental dimensions of sexual welfare, especially sexual self-concept (SSC), as one of the most crucial dimensions of sexual health (1-3). The SSC is one of the most crucial factors in the prediction of sexual behavior and function (4, 5). In this regard, the evaluation of SSC can be effective in enhancing the mental-sexual health of women (6).

In addition, this concept is a multidimensional, active, and dynamic structure, which is formed by the individual perception of sexual selfhood and helps individuals to gain information and identity and perform the self-evaluation of their sexual life. In other words, SSC is considered a guide to

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sexual behaviors (7-9). Therefore, the evaluation of SSC is an important predictor of sexual behavior that can be effective in improving the mental-sexual health of women (6, 10).

Furthermore, effective and satisfactory sexual function is one of the most important reasons for prosperity in marital relationships. Such a function not only plays an important role in providing the mental health of couples but also leads to the success and stability of the family foundation (11). Sexual dysfunction has a strong relationship with physical-emotional dissatisfaction and low quality of life (12). However, the positive aspects of sexual health, such as sexual satisfaction, sexual pleasure, and sexual self-esteem, lead to the improvement of sexual health, thereby enhancing mental and physical health (11, 12).

Based on the review of the existing literature, there are very limited studies about SCC (with the aid of a culture-based instrument) and its relationship with sexual behavior, especially in developing countries. The limited studies related to SCC in Iranian setting are indicative of a positive correlation between positive SCC and sexual function (1, 13). However, in none of these studies, the relationship between SCC and marital satisfaction was investigated. With regard to the correlation of marital satisfaction and sexual function with each other (4), the examination of the simultaneous correlation of these two variables with SCC in a single study would lead to more reliable results.

It is anticipated that this design promotes our understanding of human sexuality in Iranian context, which may have important implications for sexual self-concept research, as well as contributing to the better conceptualization of human sexuality. Human sexuality is extensively influenced by sociocultural contexts. Regarding this, the present study was conducted to determine the predictive role of SSC about marital satisfaction and sexual function in Iranian reproductive-aged women.

Materials and Methods

The present correlational cross-sectional study was conducted on 15 to 49-year-old women in 2016. At first, three health centers were selected from the 20 centers of Sari, northern Iran, using the random number table. Then, the sample size of each center was calculated proportional to the total sample size. Finally, a list of women referring to each center was prepared, and the subjects were selected by systematic sampling technique. To this end, the number of all potential reproductive-aged married women in 20 healthcare centers in Sari city (n=52,453) were divided by the estimated sample size (n=707), with a sampling interval of about 75.

Following the approval of the Mazandaran University of Medical Sciences and with the assistance of Integrated Health System (known as CIB in Iran), the selected participants were invited to visit the aforementioned healthcare centers over a telephone-based contact to complete self-administrated questionnaires. In case of reluctance or non-response, the next subject was entered into the research by maintaining the sampling interval.

The inclusion criteria were: 1) married status, 2) age range of 15-49 years, 3) writing and reading literacy, 4) monogamy of husband, 5) living with spouse in the four recent weeks, 6) willingness to participate in the study, 7) lack of any diagnosed mental disorders, 8) non-use of antidepressants during the study, 9) no drug and alcohol addiction, 10) non-pregnancy, 11) no infertility, 12) no menopause, 13) lack of premature ejaculation, and 14) lack of erectile dysfunction. No special exclusion criteria were set.

The sample size was determined to be 707 subjects with a 99% confidence level (α=0.01), 90% power (β=0.01), and a Pearson correlation coefficient of 0.23 (between SCC and sexual function) as reported in a study conducted by Jafarpour et al. using G Power software (1).

The data were collected using the Multidimensional Sexual Self-concept Questionnaire by Snell, ENRICH Marital Satisfaction Scale, Female Sexual Function Index (FSFI) by Rosen, and socio-demographic form. The Sexual Self-concept Questionnaire includes 78 items in 3 domains and 18 dimensions. The positive domain consists of 34 items in 10 dimensions, including sexual optimism, sexual self-efficiency, sexual consciousness, motivation to avoid risky sex, sexual self-esteem, sexual satisfaction, sexual problem prevention, sexual problem management, internal sexual control,

and sexual self-blame. The minimum and maximum scores of this domain range between 0 and 136.

The negative domain is comprised of 16 items and 4 dimensions, including sexual anxiety, sexual fear, sexual monitoring, and sexual depression. The minimum and maximum scores of this domain range between 0 and 64. Finally, the situational domain of this tool entails 18 items in 4 dimensions, including sexual preoccupation, sexual assertiveness, sexual motivation, and sexual self-schema. The minimum and maximum scores of this domain range between 0 and 72. Based on a 5-point Likert scale, the score of these three domains varies from 0 to 4, with the higher score showing the better condition of that domain (13). The Farsi version of MSSCQ with 78 items is valuable and reliable to be applied in Iranian population (14, 15).

The ENRICH Marital Satisfaction Scale consists of 35 items scored on a 5-point Likert scale from 1 to 5, with a higher score indicating better marital satisfaction (16). The Cronbach's alpha coefficient and internal consistency of this scale have been reported as 0.86 and 0.90, respectively (17). The scores of this scale have a range of 35-175. The FSFI is a well-known inventory that includes 19 items to measure female sexual function in terms of desire, arousal, lubrication, orgasm, satisfaction, and pain. The score of of instrument also varies from 0 to 4 based on a 5-point Likert scale. The minimum and maximum scores of this scale are 2 and 36, respectively. A higher score is representative of better sexual function (18). This inventory reportedly has a good reliability with a Cronbach's alpha coefficient of 0.82 and internal consistency of 0.89 (19).

The socio-demographic form contained 24 items related age, job, education, number of marriage in each spouse, pregnancy and delivery history, use of some medicines, and some illnesses.

The ethical considerations were observed by describing the purpose of the research to the participants, ensuring the privacy of the data, obtaining written informed consent, and emphasizing on having the right to leave the study at any stage. In this study, women with low sexual faction and marital satisfaction scores were referred to the family physician of each health care center. The present research was also registered in the Deputy of Research of Mazandaran University of Medical Sciences by the ethical code of IR.MAZUMS.95.2346.

The data were analyzed using SPSS software (Statistical Package for the Social Sciences, version 16.0, SPSS Inc., Chicago, Illinois, USA). The normality of data was determined by Kolmogorov-Smirnov test. Subsequently, data analysis was performed using descriptive (e.g., mean, standard deviation, and frequency percentage) and analytical (e.g., Pearson correlation coefficient, independent t-test, ANOVA, and linear regression tests) statistics. In the next stage, a multivariate regression model was administrated with the variables that were associated with SCC (in univariate regression) at a p-value of < 0.2. The significance level was considered to be < 0.05.

Results

The mean age of the subjects was 34.06±6.89 years, and the majority of them were housewives. Table 1 shows the sociodemographic characteristics of the subjects. Based on the results, motivation to avoid risky sex as a positive SSC dimension had the maximum mean score. In negative and situational SSC dimensions, the maximum mean scores were related to sexual monitoring and sexual self-schema, respectively.

Moreover, marital satisfaction and female sexual function scores were higher than half of the maximum score. Table 2 shows the mean scores of different SCC dimensions, marital satisfaction, and female sexual function.

Based on the univariate analysis, both marital satisfaction and sexual function had a reverse correlation with negative SCC ($P<0.001$). However, the two mentioned variables showed a direct correlation with positive SCC and situational SCC ($P<0.001$). Linear regression test showed that SSC could respectively predict 43% and 36% of the variance of marital satisfaction and sexual function in reproductive-aged women, respectively (Table 3). As the results indicated, with a one-score increase in negative SCC, the scores of marital satisfaction and sexual function decreased by 0.48 and 0.31, respectively. On the other hand, a one-score increase in positive SCC led to 0.12 and 0.10

decrease in marital satisfaction and sexual function score, respectively. Finally, the scores of marital satisfaction and sexual function will respectively increase by 0.19 and 0.12 with a one-score increase in situational SCC.

Table 1. Socio demographic characteristics of participants (n=707)

Characteristics	Mean± SD	Number (%)
Age	34.06±6.89	
Marriage age	21.95±4.70	
Duration of marriage	12.09±7.53	
Job		
Housekeeper		527(74.54)
Employed		180(25.46)
Education		
primary		124(17.54)
Secondary		334(47.24)
Higher education		249(35.22)
Number of children		
0		32(4.52)
1		338(47.80)
2		282(39.90)
≥3		55(7.78)
Lactation		
Yes		210(29.70)
No		497(70.30)
The recent contraception		
Withdrawal		400(56.58)
Condom		166(23.48)
Oral contraceptive		60(8.48)
Others		65(9.20)
No method		16(2.26)

Table 2. The mean and standard deviation of sexual self-concept, sexual function, marital satisfaction scores of participants (n=707)

Variables	Mean± SD	Range	95% confidence interval for mean
Negative sexual self-concept	9.10±9.61	0-51	8.43-9.78
Sexual anxiety	2.39±3.81	0-20	2.11-2.67
Sexual monitoring	3.30±2.37	0-12	3.12-3.47
Fear of sex	1.79±2.97	0-18	1.57±2.01
Sexual depression	1.61±2.56	0-12	1.42±1.80
Positive sexual self-concept	130.38±19.71	59-173	128.93-131.84
Sexual self-efficiency	13.14±2.54	6-16	12.95-13.33
Sexual consciousness	15.50±2.90	5-20	15.28-15.71
Motivation to avoid risky sex	18.57±2.20	5-20	18.40-18.73
Sexual optimism	13.15±2.69	3-16	12.95-13.35
Sexual self-blame	7.40±4.06	0-16	7.10-7.70
Sexual problem management	8.20±2.15	2-12	8.04-8.36
Sexual self-esteem	11.31±2.82	0-16	11.10-11.52
Sexual satisfaction	13.83±4.37	0-20	13.50±14.15
Sexual problem prevention	16.72±2.93	4-20	16.52±16.95
internal sexual control	12.51±3.21	3-20	12.27±12.75
Situational sexual self-	42.29±10.05	11-68	41.55-43.03

concept			
Sexual preoccupation	6.46±4.28	0-20	6.17-6.81
Sexual assertiveness	9.45±3.93	0-16	9.16-9.73
Sexual motivation	9.53±3.21	0-16	9.34-9.82
Sexual self-schema	16.75±2.78	7-20	16.55-16.96
Marital satisfaction	120.48±19.90	53-171	119.01-121.95
Sexual function	26.66±6.30	2-36	26.19-27.12

Table 3. Linear regression between sexual self-concept with marital satisfaction and sexual function

	Marital satisfaction*	**Sexual function****
Negative sexual self-concept		
Univariate analysis		
R	-0.61	-0.53
P	<0.001	<0.001
Multivariate analysis		
Beta (lower, upper bound)	-0.48 (-0.55, 0.01)	-0.31 (-0.47, -0.12)
P	<0.001	<0.001
Positive sexual self-concept		
Univariate analysis		
R	0.45	0.41
P	<0.001	<0.001
Multivariate analysis		
Beta (lower, upper bound)	0.12 (0.07, 0.16)	0.10 (0.08, 0.16)
P	<0.001	<0.001
Situational sexual self-concept		
Univariate analysis		
R	0.42	0.45
P	<0.001	<0.001
Multivariate analysis		
Beta (lower, upper bound)	0.19 (0.11, 0.27)	0.22 (0.13, 0.30)
P	<0.001	0.005

R^{2*}=0.43, R^{2**}=0.36

Note: Linear regression was used for data analysis

Discussion

Female sexual function in marital relationships is one of the most effective factors in women health. It not only plays an important role in providing mental health but also leads to the success and stability of the family foundation (11). On the other hand, sexual dysfunction and inability to have a pleasant relationship with the sexual partner result in negative physical, mental, and social outcomes (20). The SSC as an important psychological factor plays a key role in sexual function and relationships to the extent that it can be considered a predictor of sexual function and even general health (21-23).

Although SCC as a dynamic and changeable phenomenon is naturally formed in adolescence months or years before the initiation of any sexual relationship, it can be changed by different sexual, social, and mental events over time (24). One of the strengths of the present study was the adoption of a larger study population, compared to that of a previous similar study (13). Another strengths was the simultaneous assessment of marital satisfaction and sexual function with SCC through regression analysis as a powerful statistical method (which was not reported in previous studies) (1, 13).

The results of the present research regarding the reverse relationship of negative SSC with marital satisfaction and sexual function are in line with those presented by previous studies. Furthermore, in the present study, situational and positive SSC showed a direct relationship with marital satisfaction and sexual function. This finding is consistent with those obtained in some studies, revealing that people with higher positive sexual self-concept had safer sexual

relations (25). In accordance with our results, it is reported that negative sexual self-concept could lead to the reduction of desire, arousal, and sexual satisfaction in women (14), and that reduced sexual self-concept results in poor sexual function (26).

It seems that an increase in positive SSC and a reduction in negative SSC lead to the improvement of the level of emotional relationship and intimacy between couples (21). In this regard, love, intimacy, and attachment are the main cores of SSC. Accordingly, the women who have a negative attitude toward sex describe themselves as a non-romantic person and prohibit romantic sex. Therefore, positive SSC can significantly affect the experience of women thereby increasing intimacy, love, and sustainable commitment (11).

In addition, since positive SSC reflects such characteristics as sexual consciousness, sexual self-efficacy, and sexual problem management, it seems that the enhancement of these characteristics and skills can increase marital satisfaction in women. As mentioned previously, a higher sexual self-efficacy enables the individuals to better solve their sexual-based problems (27). Besides, the reduction of negative SSC, including sexual anxiety and fear, can help to enhance sexual function and satisfaction in women (28).

The evaluation of the patterns of female sexual function shows the role of sexual self-schema in sexual dysfunction. Women with sexual dysfunction have weaker positive SSC and stronger negative SSC, compared to others (4, 13). In contrast, positive SSC has a direct correlation with the positive aspects of sexual function and can enhance sexual function and satisfaction (28-30). However, negative SSC undermines sexual function since it indicates negative feelings related to the past, which can predict sexual satisfaction rate (30-31).

Compatible with a previous study, in the present study, positive SSC dimension showed a maximum mean score (1). Furthermore, with regard to positive sexual self-concept, the maximum mean score belonged to the aspect of motivation to avoid risky sex (15, 20) or the desire to avoid unhealthy patterns of high-risk sexual behaviors (20).

In agreement with the results of other studies (15, 18, 20), the findings of the present study demonstrated that the minimum mean score is for negative SSC, in which the minimum mean score is for the aspect of sexual depression, which means the experience of feelings of sadness, unhappiness, and depression regarding one's sexual life (20). Some limitations limit the interpretation of our findings. Participants were women from health care centers, which were somewhat homogeneous in terms of social and economic status and not representative of all reproductive-aged women. Another limitation was the evaluation of SSC, sexual satisfaction, and sexual function based on the self-reporting of participants that can affect the results of the study due to the cultural sensitivity toward sexual issues in developing countries, although the authors adopted the maximum effort to assure participants towards the confidentiality of the data. Finally, by considering sexual issues are affected by the marital relationship with a sexual partner, the evaluation of SSC, sexual function, and marital satisfaction in couples, simultaneously, is suggested.

Conclusion

In general, as the concept of SCC is a useful and intuitively satisfying perspective to add to self-understanding, highlighting the importance of individual sexuality as a component of overall personality, assessment of this issue can promote of understanding about sexual health. It seems this study would add greatly to our understanding of sexuality and the self-concept in general and in Iranian context in special.

The results of the present research in terms of predictive role of SCC about marital satisfaction and sexual function in reproductive- aged women have important implications for SCC research, as well as better understanding of human sexuality. Therefore, it seems that considering different dimensions and aspects of SSC and paying attention to a health-based program for enhancing positive SSC and modifying negative SSC dimension can improve the sexual function thereby increasing marital satisfaction and providing psychological and emotional well-being of the family and society. Accordingly, sexual health assessment should be a routine part of health

care systems that state a commitment to improving clients' overall health. Providing resources for this assessment should be available for all across the lifespan. Conducting more studies in the future to assess SCC transition in Iranian women is of our suggestion.

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Conflicts of interest

Authors declared no conflicts of interest.

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