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The Relationship between Dysfunctional Sexual Beliefs and Sexual Quality of Life in Married Women

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ABSTRACT

Background & aim: Dysfunctional sexual beliefs are misconceptions about sexual responses that hinder couples from achieving their ideal relationships and often lead to conflicts. Previous research suggests that addressing these beliefs can enhance women's sexual quality of life. However, due to limited evidence, this study aimed to determine the relationship between dysfunctional sexual beliefs and sexual quality of life in married women.

Methods: This descriptive correlational study involved 200 married women aged 18-49 who visited health centers in Mashhad, Iran. Data were collected using a demographic questionnaire, the Sexual Dysfunctional Beliefs Questionnaire for Women (SDBQ), and the Sexual Quality of Life-Female (SQOL-F) questionnaire. A multi-stage cluster sampling method was employed, which included listing the five health districts of Mashhad and selecting 10 centers (two from each district) based on proportional sampling. One working day per month was randomly assigned to each center for participant selection. Data were analyzed using SPSS version 25 statistical software and the Pearson tests.

Results: The average age of married women was 34.3±6.4 years. The total score of dysfunctional sexual beliefs in women was 84.5±13.5, and the total score of sexual quality of life in the studied women was 65.0±5.8. The Pearson correlation coefficient between dysfunctional sexual beliefs and sexual quality of life in the studied women was negative and significant (P<0.001, r=-0.248).

Conclusion: Dysfunctional sexual beliefs significantly negatively impact the sexual quality of life in married women. The counseling approach for women with low sexual quality in identifying and correcting dysfunctional sexual beliefs is recommended.

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Introduction

Sexual quality of life is a vital aspect of sexual and reproductive health, serving as a significant contributor to overall quality of life. This term encompasses how individuals perceive their sexual attraction, desire, engagement in sexual activities, and their views on sexual function (1). It reflects an individual's understanding of their sexual experiences, with a low sexual quality of life often indicating broader health and quality of life issues within society (2). Emotional factors such as shame, guilt, anxiety, hopelessness, or anger related to sexual issues are crucial when evaluating the emotional dimension of sexual quality of life. Additionally,

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elements like effective communication and intimacy with a partner are linked to the relational aspects of sexual quality of life (3). Rosen (1998) defines sexual quality of life to encompass sexual function, ability, self-efficacy, satisfaction, relationship contentment, and overall happiness (4). Consequently, sexual function stands out as a critical indicator of sexual quality of life (2). In women, sexual function is characterized by the ability to experience desire, arousal, and orgasm, while dysfunctions can manifest as issues with desire, arousal, orgasm, or pain (5, 6). Undiagnosed sexual dysfunction frequently endures, adversely affecting individuals' quality of life (2). A meta-analysis in Iran estimated the global prevalence of sexual dysfunction in women at 42.9%, with specific figures of 42.7% for sexual desire, 38.5% for arousal, 30.6% for vaginal lubrication, 29.2% for orgasm, 21.3% for sexual satisfaction, and 2.5% for sexual pain, highlighting a significant prevalence of sexual dysfunction (7). Ineffective sexual beliefs are inaccurate perceptions regarding sexual responses that individuals accept as truth despite a lack of supporting evidence (8). These beliefs often develop over time through influences from parents, societal norms, sexual experiences, and prior sexual education. Such rigid beliefs create expectations that can obstruct couples' goals and jeopardize their sexual health, leading to significant disagreements, particularly between partners (9).

For women, ineffective sexual beliefs typically fall into six categories of sexually conservative beliefs: the notion that intercourse is essential for sexual relations (10-11). the idea that oral sex is inappropriate and sinful; the belief that women should adopt a passive and receptive role in sex; the perception that sexual desire and pleasure are sinful; the view that sex is primarily a male activity; and the belief that women should control their arousal and enjoyment, as these are deemed sinful experiences. Additionally, there is a prevalent belief that sexual desire, pleasure, and orgasm diminish with age, especially post-menopause (12-15). Body image beliefs assert that physical appearance significantly influences sexual relationships, while beliefs regarding emotional attachment suggest that emotions, love, and compatibility between partners are not crucial to sexual relationships (16-17). Maternal roles are often viewed as more important than sexual pleasure, with reproduction being perceived as the primary goal of sexual relationships (18).

Sexually conservative beliefs and the perception of sexual desire and pleasure as sinful are linked to sexual dysfunction (19), while age-related beliefs correlate with sexual dysfunction and pain. Beliefs regarding maternal roles and the denial of affection primacy show a weaker association with sexual dysfunction (11).

Research by Nobre et al. (2003) revealed that sexual beliefs differ between individuals with and without sexual problems, highlighting that various cognitive and emotional factors are connected to different clinical manifestations. For instance, sexually conservative beliefs, particularly women's perceived passivity in sexual relationships, are associated with low sexual desire and arousal issues, while orgasm disorders relate to body image beliefs and unconscious thoughts about body image (10). Amanelahi and Rajabi (2017) found that women's ineffective sexual beliefs—including those related to age, body image, the sinfulness of sexual desire and pleasure, the prioritization of maternal roles, and the undervaluation of love in sexual relationships—play a significant role in predicting sexual disorders (11). Furthermore, Mohamadi et al. (2017) demonstrated that improving sexual quality of life through education and modification of sexual beliefs can lead to a lack of correlation with scores of ineffective sexual beliefs (12). Given the significance of ineffective sexual beliefs and their impact on sexuality, along with the limited evidence regarding the relationship between such beliefs and sexual quality of life, this study aims to explore the correlation between dysfunctional sexual beliefs and the quality of life among married women.

Materials and Methods

A cross-sectional study was conducted involving 200 married women aged 18-59 years who met specific criteria and visited comprehensive health centers in Mashhad, Iran, from 2019 to 2020. The sample size was determined based on the research by

Abdolmanafi et al. (2015) (9). Using a correlation coefficient of r=0.2 between ineffective sexual beliefs and sexual quality of life, with α=0.05 and β=0.2, the sample size was calculated using an appropriate formula.

$$n = \frac{\left(Z_{1-\frac{\alpha}{2}} + Z_{1-\beta}\right)^2}{\left[\frac{1}{2}\ln\left(\frac{1+r}{1-r}\right)\right]^2} + 3 = \frac{(1.96+1.64)^2}{\left[\frac{1}{2}\ln\left(\frac{1+0.255}{1-0.255}\right)\right]^2} + 3 = 193.6$$

Based on the study by Mohamadi et al. (2017) (12), the estimated sample size was 194 individuals. However, to account for potential attrition and enhance accuracy, the sample size was increased to 200 participants. Inclusion criteria for the study included: being Iranian and a resident of Mashhad, having at least a primary education, being the sole wife of the husband, living with the spouse, engaging in sexual activity within the past month, not having significant medical conditions affecting sexual performance, not taking medications that affect sexual performance, not having psychological or psychiatric issues, not being addicted to drugs or alcohol, not experiencing severe stress in the past six months, not being pregnant or breastfeeding, and not having any mental or physical disabilities. The only exclusion criterion was unwillingness to participate in the study.

Data collection tools comprised a demographic questionnaire, the Sexual Dysfunctional Beliefs Questionnaire (SDBQ) for women, and the Sexual Quality of Life-Female (SQOL-F) questionnaire. SDBQ, developed by Nobre and Pintoguia, consists of 40 questions in six domains, each of which is scored on a Likert scale from 1 to 5 (strongly disagree to strongly agree), and a higher score indicates more dysfunctional sexual beliefs. Due to cultural issues, one question (No. 27) was deleted in accordance with the opinion of the supervisors and advisors .The SDBQ, across six areas of sexual desire/pleasure as a sin, sexual conservatism, age-related beliefs, body image beliefs, denying affection primacy, and motherhood primacy. The validity and reliability of the Persian version of this questionnaire were established by Abdolmanafi et al. (2015). To assess content and face validity, the questionnaire was reviewed by five professors in nursing and midwifery at Mashhad University of Medical Sciences, resulting in the removal of one item related to masturbation. The tool's reliability was confirmed with a Cronbach's alpha coefficient of 0.88. The SQOL-F is a self-report tool which emphasizes the sexual confidence, affective and communicative beliefs of women and consists of 18 items. The questionnaire constitutes four main sections including psychosexual feelings, sexual and relationship satisfaction, self-worthlessness, and sexual repression. Five items in the first section, five in the second section, four in the third section, and four items in the fourth section, each of which was scored based on a 6-point scale from totally agree to totally disagree in the Likert scale. The responses were scored from 1 to 6, and the final scores ranged from 18 to 108. The higher scores indicated a better quality of sexual life in women. Scored from 18 to 36 signified low sexual life quality, scores from 37 to 72 signified average sexual life quality, and scores from 73 to 108 signified a high quality of sexual life. The validity of this tool was confirmed by Masoumi et al. (2013) (13) through content and face validity assessments, and its reliability was supported by a Cronbach's alpha coefficient of 0.77.

Following ethical approval from the university committee and obtaining an introductory letter from Mashhad University of Medical Sciences, the researcher conducted the sampling. A multi-stage cluster sampling method was used, which involved listing the five health districts of Mashhad (stratification) and the health centers and clinics under their jurisdiction. Ten centers were selected from each health district (two from each), according to proportional sampling based on the sample size (cluster sampling). One working day per month was designated for each center, chosen by random selection. Participants were selected from each center based on the eligibility criteria.

Informed consent was obtained from all research participants, and the purpose of the study was clearly explained, assuring them that their information would remain confidential. Participants who agreed to participate completed the questionnaires in a quiet and private room with the researcher's assistance, including the demographic information, the SQOL-F, and the SDBQ.

Data analysis was performed using SPSS version 24. The Pearson correlation coefficient was utilized to determine the relationships between dysfunctional sexual beliefs and sexual quality of life, as well as their dimensions.

A P-value of less than 0.05 was considered statistically significant.

Results

The average age of married women was 34.3 years with a standard deviation of 6.4 years, while their husbands had an average age of 37.7 years and a standard deviation of 7.1 years. The mean body mass index (BMI) for the women was 22.1 kg/m^2 with a standard deviation of 1.2. A significant portion of the women (64 individuals, or 32%) had completed high school. Most of them were housewives (149 individuals, 74.5%) and lived below the poverty line (also 149 individuals, 74.5%). Regarding living situations, 91 individuals (45.5%) resided in rented accommodations, and 171 individuals (85.5%) indicated that others, aside from family members, lived with them.

Table 1. Frequency distribution of the demographic characteristics of the study participants (N=200)

Variable	N (%)
Educational level	
Elementary	13(6.5)
Middle school	34(17.0)
High school and diploma	64(32.0)
Associate degree (post-diploma)	27(13.5)
Bachelor's degree	44(22.0)
Master's degree	18(9.0)
PhD and above	0(0.0)
Husband's education	
Elementary	7(3.5)
Middle school	31(15.5)
High school and diploma	74(37.0)
Associate degree (post-diploma)	17(8.5)
Bachelor's degree	52(26.0)
Master's degree	18(9.0)
PhD and above	1(0.5)
Occupation	
Housewife	149(74.5)
Student	4(2.0)
Employed	47(23.5)
Husband's job	
Student	4(2.0)
Manual worker	22(11.0)
Employed	65(32.5)
Others	109(54.5)
Income	
Less than enough	149(74.5)
Enough	4(2.0)
More than enough	47(23.5)
Housing situation	
Rental	91(45.5)
Housing of relatives	30(15.0)
Others	3(1.5)
Having a regular menstrual cycle	
Regular	154(77.0)
Irregular	46(23.0)
Emotional relationship with spouse	
Poor	2(1.0)
Medium	37(18.5)
Good	99(49.5)
Excellent	61(30.5)
Having a private bedroom	
Yes	142(71.0)
No	58(29.0)
Method of contraception	
Oral contraceptive pills	19(9.5)
Condom	62(31.0)
Interrupted intercourse	58(29.0)
Three-month ampoule	6(3.0)
One month ampoule	7(3.5)
Tubectomy	10(5.0)
IUD	17(8.5)
No method	21(10.5)
Self-reported level of sexual information	
Very high	11(5.5)
High	47(23.5)
Medium	116(58.0)
Low	20(10.0)
Very low	4(2.0)
Information receiving from the training class	
Yes	57(28.5)
No	140(70.0)
Information receiving from the health care provider	
Yes	57(28.5)
No	140(70.0)
Information receiving from radio and television	
Yes	53(26.5)
No	147(73.5)
Information receiving from books and newspapers	
Yes	33(16.5)
No	167(83.5)
Information receiving from the Internet	
Yes	81(40.5)
No	119(59.5)

The average number of pregnancies and deliveries was 1.8 (±0.8) and 1.9 (±1.1), respectively, with a majority of women (154 individuals, or 77%) reporting regular menstrual cycles. The average age of the youngest child among the participants was 1.3 years (±3.8). The average duration of marriage was 12.8 years (±7.2), with women marrying at an average age of 21.6 years (±4.0) and their husbands at 26.0 years (±19.8) (Table 1).

Almost half of the participants (99 individuals, or 49.5%) reported having good emotional relationships with their spouses. The average frequency of sexual intercourse was 2.1 times per week (±1.1) and 7.6 times per month (±3.3), with condoms being the most commonly reported contraceptive method (62 individuals, or 31%). Additionally, 142 individuals (71%) had private bedrooms. The level of sexual knowledge among the participants was predominantly moderate (116 individuals, or 58%), with the majority acquiring this knowledge through the Internet (40.5%) (Table 2).

Table 2. Mean and standard deviation of dysfunctional sexual beliefs and the quality of sexual life of study participants (N=200)

Variable	Mean ± SD	Maximum	Minimum
Sexual desire/pleasure as a sin	11.7±3.9	21.0	6.0
Sexual conservatism	22.7±3.9	31.0	13.0
Age-related beliefs	14.7±3.5	25.0	5.0
Body image beliefs	9.4±2.7	20.0	4.0
Denying affection primacy	16.3±2.8	24.0	9.0
Motherhood primacy	9.8±2.8	20.0	4.0
Total score of dysfunctional sexual beliefs	84.5±13.5	115.0	54.0
Psychosexual feelings	29.2±4.4	37.0	11.0
Sexual and relationship satisfaction	12.8±4.0	26.0	6.0
Self-worthlessness	12.1±1.8	17.0	3.0
Sexual repression	11.1±2.8	18.0	3.0
The total score of the quality of sexual life	65.0±5.8	83.0	34.0

In terms of dysfunctional sexual beliefs, the total score was 84.5 (±13.5), while the total score for sexual quality of life was 65.0 (±5.8). Among the dimensions of dysfunctional sexual beliefs, the highest mean score was for sexual conservatism, while the lowest was for body image beliefs. For sexual quality of life, the psychosexual feelings dimension had the highest mean score, and the Self-worthlessness dimension had the lowest. A significant negative correlation was found between dysfunctional sexual beliefs and sexual quality of life (P<0.001, r=-0.248), indicating that women with higher scores of dysfunctional beliefs tended to have lower sexual quality of life, and vice versa (Table 3).

Table 3. Pearson's correlation between dysfunctional sexual beliefs and the quality of sexual life of study participants

Variable	Sexual repression	Self-worthlessness	Sexual and relationship satisfaction	Psychosexual feelings	P-Value
Sexual desire/ pleasure as a sin					
Coefficient	-0.286	-0.290	-0.238	0.238-	-0.235
meaningful	0.001	<0.001	<0.001	<0.001	<0.001
Sexual conservatism					
Coefficient	-0.218	-0.230	-0.231	-0.288	-0.172
meaningful	0.002	0.002	0.001	<0.001	0.015

Variable	Sexual repression	Self-worthlessness	Sexual and relationship satisfaction	Psychosexual feelings	P-Value
Age-related beliefs					
Coefficient	-0.322	-0.302	-0.232	-0.312	-0.323
meaningful	<0.001	<0.001	<0.001	0.001	<0.001
Body image beliefs					
Coefficient	-0.286	-0.268	-0.213	-0.261	-0.268
meaningful	<0.001	<0.001	0.002	0.002	<0.001
Denying affection primacy					
Coefficient	0.158	0.095	-0.037	0.102	0.158
meaningful	0.025	0.181	0.606	0.149	0.025
Motherhood primacy					
Coefficient	-0.120	-0.040	-0.055	-0.085	-0.085
meaningful	0.089	0.574	0.442	0.231	0.231
Total score of dysfunctional sexual beliefs					
Coefficient	-0.248	-0.271	-0.003	-0.295	-0.295
meaningful	<0.001	<0.001	<0.001	<0.001	<0.001

Discussion

This study aimed to determine the relationship between dysfunctional sexual beliefs and sexual quality of life among married women visiting health centers in Mashhad. The findings indicated that women with higher scores of dysfunctional sexual beliefs experienced a lower quality of sexual life, and vice versa. A significant negative correlation was found between sexual desire and satisfaction, beliefs about sexual conservatism, age-related beliefs, body image beliefs, and overall sexual quality of life in women.

Dysfunctional beliefs can deeply influence an individual's life, leading to behaviors that are often misaligned with these beliefs. Thus, rather than being a direct product of these beliefs, behaviors may manifest as responses to them (20). Although no identical studies were found, the results align somewhat with the work of Novara and Pinto-Gouveia (2006), who suggested that sexual beliefs significantly contribute to the development of sexual problems (18). Their research showed that women with sexual dysfunction had higher scores for dysfunctional sexual beliefs (P<0.05), with notable differences in the dimensions related to age-related beliefs (P<0.01) and body image beliefs (P<0.01). This finding highlights the importance of these two factors in sexual dysfunction among women. Although the difference in the dimension of sexual desire/pleasure as a sin approached significance (P=0.08), other dimensions such as sexual conservatism (P=0.137), motherhood primacy (P=0.630), and denying affection primacy (P=0.731) showed no significant distinctions, potentially due to group heterogeneity (18).

Silva et al. (2016) found that individuals with sexual dysfunction held significantly more false sexual beliefs compared to those with normal sexual function. Additionally, there is growing evidence that the perceptions couples have of each other and their relationship events significantly affect relationship quality. This study demonstrated that sexual function in both men and women correlates significantly with beliefs about body image (P<0.001, r=0.254) and cognitive disorders related to appearance (P<0.001, r=0.353), suggesting these can predict sexual function in both genders. Cognitive disorders related to appearance may mediate the relationship between beliefs about appearance and sexual function, implying that a strong belief in the importance of body image in relationships can lead to sexual dysfunction due to dysfunctional beliefs surrounding appearance (21).

Moreover, Spencer et al. (1991) highlighted the detrimental effects of unrealistic standards regarding intimate relationships on interaction patterns and spousal satisfaction (22). The current study's findings suggest that such beliefs can positively predict sexual dysfunction, aligning with previous research.

Healthy beliefs and attitudes are crucial for effective marital communication. When couples fail to recognize their irrational beliefs, these

can contribute to marital issues. Increased knowledge about sexual relationships can enhance communication skills. Inadequate sexual knowledge, misconceptions about sexual relationships, and misunderstandings about sexual performance can escalate conflicts and sexual problems among couples (23, 24). Thus, there is a strong link between individuals' beliefs about normal versus abnormal sexual performance and their experiences of sexual dysfunction and pleasure (25). The use of valid and reliable tools was a strength of this study. However, one limitation was the reliance on the accuracy of participants' responses. To promote honesty, detailed explanations about the study's aims were provided. Future research should consider replicating this study with women from diverse cultural and geographical backgrounds.

Conclusion

The results of this study revealed a significant negative relationship between dysfunctional sexual beliefs and sexual quality of life among the participants. Specifically, women with higher scores of dysfunctional sexual beliefs reported lower sexual quality of life and vice versa. Therefore, it is recommended that women with low sexual quality of life receive attention for identifying and rectifying dysfunctional sexual beliefs through effective counseling approaches.

Declarations

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Conflicts of interest

The authors declared no conflicts of interest.

Ethical Considerations

The ethics committee of the Mashhad University of Medical Sciences approved this study. Informed consent was obtained from all research participants after clearly explaining the study's purpose and assuring them of the confidentiality of their information (IR.MUMS.NURSE.REC.1398.017).

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Authors' contribution

M.M supervised the study. M.M, A.N and MA.R contributed to the conceptualization, and methodology. M.MM, A.N and M.M contributed to the data collection. MT.Sh, A.N and M.M contributed to the statistical analyses. M.M, A.N, MT.Sh and MA.R contributed to interpretation of data. A.N, M.M, and M.MM drafted the manuscript. M.M and A.N reviewed and revised the manuscript. All authors read and approved the final manuscript and agreed to be accountable for all aspects of the work.

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