



Association of religiousness and sexual disorders: A cross-sectional study on married women of reproductive age referring to public health centers of Shiraz, South of Iran

Fatemeh Ghodrati¹, Zahra Yazdanpanahi², Zahra Beygi³ and Marzieh Akbarzadeh⁴

¹PHD, Department of Theology, Humanities College, Yasouj University, Yasouj, Iran

²Community Based Psychiatric Care Research Center, Department of Midwifery, School of Nursing and Midwifery, Shiraz University of Medical Sciences, Shiraz, Iran

³Student Research Committee, department of Midwifery, School of Nursing and Midwifery, Shiraz University of Medical Sciences, Shiraz, Iran

⁴Maternal –fetal medicine research center, Department of Midwifery, School of Nursing and Midwifery, Shiraz University of medical sciences. Shiraz, Iran

Corresponding E-mail: akbarzadm@sums.ac.ir

ABSTRACT

Sexual health status of married women in the reproductive age, one of the most important community health issues. Recent research has highlighted the effects of religious beliefs with sexual life and sexual problem may be mediated. This study aimed to investigate the association of religiousness and .through individual differences in spirituality. sexual disorders in a cross-sectional study in women of reproductive . This cross-sectional study was conducted on women aged 15-45 years old referring to Shiraz health centers in 2015 with a sample size of 210. Cluster sampling was done firstly. Then, purposeful sampling was conducted in each center. Data collection was done using Religious Attitude Questionnaire and Female Sexual Dysfunction index. Correlation coefficient and Fisher's test. The mean age of the study population was 30.67±6.60. were performed for data analysis in SPSS software. According to the findings, 74.3% had sexual dysfunction. Furthermore, the rate of impaired sexual desire was 72.9% and 62.4% in sexual arousal. Orgasmic disorder was the highest reported sexual dysfunction. There was a statistically significant correlation between religious thoughts and different dimensions of sexual function such as sexual desire (P= 0.005), psychological stimulation (p= 0.05), lubrication (p= 0.02), orgasm (p=0.013), and satisfaction (p= 0.001). Religious thoughts with dimensions of sexual function (libido, orgasm, etc.) was associated. So, the improvement in families and society's sexual health could result from the increase in the individuals' knowledge about sex related issues and religious thoughts in this regard. Therefore, sexual health education, in accordance with religious values, is one of the priorities in community health system.

Keywords: Religious, Attitude, Sexual Dysfunction, Reproductive

INTRODUCTION

Sexual activity is an important and necessary component in women's life[1] . About 60-80% of women in the world suffer from sexual dysfunction, which can affect many aspects of their lives both directly and indirectly [2] .These disorders can emerge from our daily behaviors as a family and social conflict, and unnecessary anger; moreover, improper treatment of such disorders can also result in chronic symptoms, anxiety, self-oriented trends, and guilt feelings. Lack of attention to this issue leads to social problems such as divorce, crime, offense, drug addiction and various psychological and physical diseases, which threaten the public health [3] . Different studies have reported several conclusions regarding the prevalence of sexual dysfunction. In a study by Fajewonyomi and colleagues in

Nigeria, the prevalence of sexual dysfunction was reported 63.7% in 2007 [4]. According to Elnashra and colleagues in 2007, the prevalence of sexual dysfunction was reported 69% in Egypt [5]. Amidu in his study found that 72.8% of the subjects had one or more sexual problems [6].

Despite the fact that couples may go on their relationship as a social group, their attraction and trust fade. In sum, they start to hurt each other due to the feeling of sadness and despair among them [7]. According to a study, the prevalence of sexual dysfunction was reported 31% in Iran [8]. Evidence also suggests that a high level of marital conflict is in association with the family members' relationship [9]. Studies have shown that if couples can manage their conflicts in a positive way along with problem-solving skills, many conflicts will not be harmful [10]. Due to our society's cultural structure and Islam's emphasis on divorce obscenity and its consequences, especially about families with children, couples are not willing to separate, so finally they may live together for many years despite their unsatisfying life accompanied with mental, physical, and mental agony. Due to the dominant rules in Iran, we do not have any access to the formal statistics of emotional divorce. Despite this restriction, few dissatisfied cases refer to the court to divorce. The ratio of divorces to the number of family records shows that the rate of emotional divorce is several times higher than the actual divorce [11]. Reduction of family religiosity can lead to emotional divorce. In other words, religion can be an incentive for couples to maintain the family life and provide appropriate cultural patterns [11].

Research has shown that the couples' sexual satisfaction and religious differences are of the most effective factors causing this problem (emotional divorce) [11]. On the other hand, the reduction of effective sexual communication and intimacy are of the factors influencing marital conflicts. Understanding women's sexual desire, its effect on sexual health promotion, and reduction of sexual risks and violence have been emphasized in different studies [12-18]. Despite the fact that talking about sexual problems is an obvious taboo due to our culture, we cannot ignore its constructive and inevitable impact on interpersonal relationships. Many couples are not aware of the benefits of satisfying sexual relationship due to our culture restrictions and the dominant unnecessary embarrassment. In addition, they do not refer to the specialists as they face troubles in this regard and finally it leads to a cold relationship. Although sexual health education is considered as a human right and mental health necessity by international organizations [19], it has caused many challenges in different cultures [20]. In Iran, sexual issues have been stated in doubt (as a conservative and religious country). Moreover, modesty tends to inhibit people from stating their problems in this regard [21]. Since research on this issue is scanty in our society, this study aimed to determine the relationship between religious thoughts and sexual dysfunction.

MATERIALS AND METHOD

This cross-sectional study was done on 15-45 year old women referring to Shiraz health centers in 2015 with a sample size of 210. Sample size, According to the results of previous studies and Khalegi's article [22] with a correlation coefficient confidence level 0.23 and 0.95 ($\alpha = 0.05$) and power of 90% ($\beta = 0.1$), 196 people were estimated and with probability of the loss of 10 percent, 214 patients were collected.

$$c_{r=\frac{1}{2}} = \ln \frac{1+r}{1-r}$$

$$n = \frac{(z_{1-\frac{\alpha}{2}} + z_{1-\beta})^2}{c_r^2} + 3$$

Cluster sampling was done primarily and some centers were selected randomly (among centers located in the north, south, west, and east of Shiraz). Then, purposive sampling was done in each center. After written informed consent was obtained, Demographic forums, Religious Attitude Questionnaire, and Female Sexual Dysfunction index were applied for data collection. Most of the questionnaires by the researcher and a few of women due to sensitivity and embarrassment demanded that sexual dysfunction disorder questionnaire were completed by her. Of course, during sampling, the researcher was present at the clinic to explain the possible confusion about questions.

Inclusion criteria were residency in Shiraz at least for one year, Iranian nationality, ability to read and write, and age between 15-45 years. Exclusion criteria included early menopause, unwillingness to participate in the study, and lactating women whose delivery time was less than 8 weeks.

Female Sexual Dysfunction index contains 19 questions and aims to assess the domains of sexual functioning (e.g. sexual desire, arousal, lubrication, orgasm, satisfaction, and pain). Each question is scored between 0-5. The scores below 28 are considered as impaired sexual function [23-24]. According to Sepehriyan's study in Iran, Cronbach's alpha was 0.95 for global sexual functioning. Reliability was determined for each of the domains as follows: 67%, 88%, 89%, 86%, 93%, and 90% for sexual desire, arousal, lubrication, orgasm, satisfaction, and pain, respectively [25]. We relied on his findings for this study. Religious Attitude Scale contains 25 questions and 6 domains in this relation including worship (pray), morals and values, the effect of religion on the life and behavior (praying - fasting), social issues, ideologies and beliefs and finally science and religion. Likert scoring options were completely agree, somewhat agree, neutral, somewhat disagree, and completely disagree. This scale is a 25-Question test based on 5-point Likert scale (totally agree was scored 5, disagree, neither agree nor disagree, agree or total disagree were scored 1). To score these items, the positive attitudes were marked 4, 5. Negative ones were marked 1, 2 and neutral was marked 3. Scores over 100 were interpreted as high levels of religious thoughts and scores 51-99 had moderate religious thoughts while those below 50 had poor or weak level of religious thoughts. The valid correlation coefficient between the global score and each item was 0.0001. Spearman-Brown and Gutmann's methods were applied for estimating the reliability which was 0.948 and 0.933, respectively. Cronbach's alpha was 0.954. It can be used as a valid criterion for determining the religious thoughts in both patients and general population [26]. The data were analyzed using T-test, Chi square and Pearson correlation coefficient. P-values less than 0.05 were considered.

Ethical considerations:

This research project (No: 93-01-85-8837) was approved by the local Ethics Committee of Shiraz University of Medical Sciences and written informed consents were obtained from all the participants.

RESULTS

The mean age of the study population was 30.1 51.5 ± 5.51 . 29% had primary school education, 27% had diploma and 43% had a college degree. The two groups with and without sexual dysfunction were not significantly different in terms of age ($p=0.15$), occupation (0.84), husband's job (0.08), and economic and social situation ($p=0.64$) and they were matched. About 74.3% had sexual dysfunction while the rest had a satisfying level of sexual function. In people with sexual disorders about 72.9% were in the sexual desire part and 62.4% in the arousal part.

. The maximum disorders were related to orgasm dysfunction (75.7%), the minimum ones belonged to sexual satisfaction (59%), and finally 60.6% had pain. (Table 1). According to the correlation coefficient, a relationship existed between religious thoughts and sexual function ($p \leq 0.001$). Among people with sexual dysfunction, about 4 patients (2.6%) had weak religious thoughts, 113 (72.4%) had moderate attitudes, and 39 (25%) had high religious thoughts. Among those without sexual dysfunction, about 19 patients (35.2%) had moderate religious thoughts and 35 (64.8%) had high religious thoughts. The highest percentage of people with moderate religious thoughts belonged to those with sexual dysfunction (Table 2). There was a correlation coefficient and relationship between religious thoughts and sexual desire. The highest percentage belonged to people with good sexual desire and moderate attitudes (73.7%) ($P: 0.005$). There was no significant relationship between sexual arousal and religious thoughts ($p: 0.051$) while it was significant between lubrication and religious thoughts ($p: 0.02$) (Table 3).

DISCUSSION

According to the results of this study, about two thirds of women (74.3%) had sexual dysfunction. Sexual Dysfunction in section of Sexual arousal and lubrication, compared to the rest of the sexual cycle has been more common. Amidu and colleagues conducted a study in 2010 to determine the prevalence of sexual dysfunction. The target population consisted of 400 healthy women aged 58-18 years. According to the results, 72.8% of the subjects had one or more sexual problems. The most prevalence was in sexual dissatisfaction (77.7%), anorgasmia (72.4%), low number of sexual relationship (71.4%), vaginismus (68.1%), sexual aversion (62.5%), no emotion in the relationship (71.5%), and lack of sexual relationship (54.2%) [6]. The result of his study was consistent with ours while they did not match in the disorder type. In our study, sexual arousal, lubrication and orgasmic disorder had a

high prevalence of other disorders, but sexual dissatisfaction and anorgasmia were the most prevalent ones in Amidu's study. In this study, no any case of vaginismus and sexual aversion was reported. Amidu applied GRISS index for data collection while we applied FSFI. The difference of disorder type may root in alcohol consumption (26%) and high level of education (62.1%) in women participating in Amidu's study. Alcohol affects sexual response. Besides, high education makes women looking for more sexual assertiveness and expectation about their sexual partner. Other studies have proved the effect of women's sexual assertiveness on sexual relationship and satisfaction (13-16, 18, 27-29). All women were married in our study while just 28.9% were married in Amidu's study. Marriage is the most important factor for access to an organized communication and strong family base, so the distance between family members and even death cannot deteriorate or destroy it, but can keep it alive.

Some studies have confirmed the effect of this relationship [30-31]. It seems that sexual disorder results from the lack of awareness and training in this regard.

Proper sexual arousal in women requires previous education. However, taboos, beliefs, and traditions may hinder the access to adequate and proper information about sexual health [19]. Although comprehensive sexual health education has been emphasized for all individuals, it has not been performed for Iranians, yet [32-33].

The results of Falah's study on 2449 people showed that about 93.1% of females suffered from sexual disorder in Qazvin, and only 21.5% of women were satisfied with their sexual activity (18), while arousal dysfunction was the most sexual disorder among them. The result of his study is consistent with that of our study because of the similar disorder type despite its higher prevalence. This difference may root in the social and cultural differences, lack of attention to women's sexual problems despite more attention to kids and daily life and finally the shame which prevents them from expressing their problem [34].

In our study, there was a significant relationship between religious thoughts and all aspects of sexual function other than sexual arousal. Kaplan believed in mental health (among various factors); he also stated that a high percentage of women suffer from sexual dysfunction due to the low level of mental health [35]. A study aimed to examine the relationship among religious thoughts, happiness, and mental and physical health. The results showed that there was a significant direct pathway from religious attitude to optimism and from optimism to mental health and finally from mental health to physical health [36].

Some studies have defined religion as an important determining factor in sexual behavior among students.

Other studies have declared that positive religious thoughts and people's commitment to religious faith are among the important factors in marriage stability, marital satisfaction and the decrease in sexual disorders. On the other hand, more religious conflicts lead to more argument among the couples [37]. According to some studies, more religious conflicts lead to higher levels of marital dissatisfaction [38]. This is consistent with the studies done by Bennet[39], Hunler [40], Orathinkal and colleagues [41], Antonsen [42], and Fiese and colleagues [43].

Ahmadi's findings suggest that religious commitment can primarily strengthen and improve the couples' relationships to improve their parenthood roles. Secondly, it helps people to plan for spending their leisure time with family and this commitment moves them toward adaptation with their spouse's different preferences. The last but not the least, it helps them to solve their conflicts, enjoy and feel satisfied [44].

Study limitations

The present study had some limitations. There is a social negative taboo and attitude in regard to the sexual issues in our society, and the findings were based on a convenience sample of female patients. Thus, the results could not be generalized to male patients. Besides, individuals' features and differences, mental and psychological characteristics, and patients' embarrassment to answer can impress the study results; of course, they were out of the researcher's control.

Table 1: frequency of sexual dysfunction and subscale sexual cycle in research society

Variable	score	Frequency(%)	MEAN± SD
sexual function	28 <	54 (25.7%)	22.58 ± 0.08
	≤28	156 (74.3%)	
desire	>3.3	57 (27.1%)	3.45 ± 1.1
	≤3.3	153 (72.9%)	
arousal	>3.4	79 (37.6%)	3.47 ± 1.57
	≤3.4	131 (62.4%)	
lubrication	>3.4	53 (25.2%)	3.79 ± 1.56
	≤3.4	157 (74.8%)	
orgasm	>3.4	51 (24.3%)	3.9 ± 1.67
	≤3.4	159 (75.7%)	
satisfaction	>3.8	86 (41%)	4.04 ± 1.55
	≤3.8	124 (59%)	
pain	>3.8	83 (39.5%)	3.92 ± 1.69
	≤3.8	127 (60.5%)	

Table 2 : The relationship between sexual dysfunction and religious attitude in research society

Level of religious attitude	score	Without sexual dysfunction(%)	With sexual dysfunction(%)	P - value	Correlation	statistical test
religious attitude	Low (≤ 50)	0 (0%)	4 (2.6%)	0.000	0.32	Fisher exact test
	Moderate (51-99)	19 (35.2%)	113 (72.4%)			
	High (100 ≤)	35 (64.8%)	39 (25%)			

Table 3 : relationship between subscale of sexual function and religious attitude in research society

variable	score	Low attitude (%)	Moderate attitude (%)	High attitude (%)	p- value	statistical test
desire	>3.3	3 (5.3%)	42 (73.7%)	57(21.1%)	0.005	Fisher exact test
	≤3.3	1 (0.7%)	90 (58.8%)	62 (40.5%)		
arousal	>3.4	3 (3.8%)	55 (69.6%)	21 (26.6%)	0.051	
	≤3.4	1 (0.8%)	77 (58.8%)	53 (40.5%)		
lubrication	>3.4	1 (1.9%)	41 (77.3%)	11 (20.8%)	0.02	
	≤3.4	3 (1.9%)	91 (58%)	63 (40.1%)		
orgasm	>3.4	3 (5.9%)	36 (70.6%)	12 (23.5%)	0.013	
	≤3.4	1 (0.6%)	96 (60.4%)	62 (39%)		
satisfaction	>3.8	4 (4.7%)	62 (72.1%)	20 (23.3%)	0.001	
	≤3.8	0(0%)	70 (56.5%)	54 (43.5%)		
Pain	>3.8	4 (4.8%)	58 (69.9%)	21 (25.3%)	0.003	
	≤3.8	0 (0%)	74 (58.3%)	53 (41.7%)		

CONCLUSION

The results demonstrated that there was a statistically significant relationship between religious thoughts and impaired sexual functions. Sexual dysfunction affects various aspects of life, including sexual function and the couple's relationship; on the other hand, the inability to establish appropriate sex life leads to an increase in family conflicts. Since dysfunction played an undeniable role on mental health and marital sex life. With regard to our culture, it is recommended that a scheduled educational program should be designed so that we can facilitate the conception of proper sexual behavior along with pattern or modeling of religious thought before marriage. In addition, measures should be taken to provide practical solutions based on religious thoughts to prevent sexual disorders and deviations, along with real examples. Finally, concerns are needed about proper sexual behavior with regard to marital issues, important factors in desirable sex, proper manners, pattern of sexual intercourse, and the desirable effects of sexual behavior on marital relationships

Acknowledgements

This article is a part of Research Project, (No:93-01-85-8837). The researchers would like to appreciate Research and Technology Department of Shiraz University of Medical Sciences and Researchers appreciate Student Research Committee for financially supporting the research. The authors would like to thank Center for Development of Clinical Research of Nemazee Hospital and Dr. Nasrin Shokrpour for editorial assistance.

REFERENCES

- [1] Novak E, Berek JS. Berek & Novak's gynecology. 14th, editor: Lippincott Williams & Wilkins; 2007. 247 p.
- [2] Moor H. Essential of obstetrics and gynecology Translated by Arian Mehr S, Malek Mohammady S, Supervised Ghaemmaghmi F. 2th, editor. Tehran: Tabib publication 2005. pp: 364-5. [Persian] p.
- [3] Allen CT, Swan SC, Raghavan C. Gender symmetry, sexism, and intimate partner violence. *Journal of Interpersonal Violence*. 2009;24(11):1816-34.
- [4] Fajewonyomi BA, Orji EO, Adeyemo AO. Sexual dysfunction among female patients of reproductive age in a hospital setting in Nigeria. *Journal of Health, Population and Nutrition*. 2007:101-6.
- [5] Elnashar A, EL-Dien Ibrahim M, El-Desoky M, Ali O, El-Sayd Mohamed Hassan M. Female sexual dysfunction in Lower Egypt. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2007;114(2):201-6.
- [6] Amidu N, Owiredu WK, Woode E, Addai-Mensah O, Quaye L, Alhassan A, et al. Incidence of sexual dysfunction: a prospective survey in Ghanaian females. *Reproductive Biology and Endocrinology*. 2010;8(1):1.
- [7] Scanzoni L, Scanzoni JH. Men, women, and change: A sociology of marriage and family: McGraw-Hill Companies; 1988.
- [8] Matulonis U, Kornblith A, Lee H, Bryan J, Gibson C, Wells C, et al. Long-term adjustment of early-stage ovarian cancer survivors. *International Journal of Gynecological Cancer*. 2008;18(6):1183-93.
- [9] Lindsey EW, Colwell MJ, Frabutt JM, MacKinnon-Lewis C. Family conflict in divorced and non-divorced families: Potential consequences for boys' friendship status and friendship quality. *Journal of Social and Personal Relationships*. 2006;23(1):45-63.
- [10] Siffert A, Schwarz B. Spouses' demand and withdrawal during marital conflict in relation to their subjective well-being. *Journal of Social and Personal Relationships*. 2011;28(2):262-77.
- [11] Kafashi M sS. The effective social-economic factors of emotional divorce between two groups of housewives and working women of Qom County. *Journal of Contemporary Sociology*. 2014;3(5):125-53.
- [12] Rickert VI, Sanghvi R, Wiemann CM. Is lack of sexual assertiveness among adolescent and young adult women a cause for concern? *Perspectives on sexual and reproductive health*. 2002:178-83.
- [13] Apt C, Hurlbert DF. The female sensation seeker and marital sexuality. *Journal of sex & marital therapy*. 1992;18(4):315-24.
- [14] Hurlbert DF. A comparative study using orgasm consistency training in the treatment of women reporting hypoactive sexual desire. *Journal of Sex & Marital Therapy*. 1993;19(1):41-55.
- [15] Hurlbert DF, Apt C. Female sexual desire, response, and behavior. *Behavior Modification*. 1994;18(4):488-504.
- [16] Basson R. Using a different model for female sexual response to address women's problematic low sexual desire. *Journal of Sex & Marital Therapy*. 2001;27(5):395-403.
- [17] Nazari A. M. BM, Bay F. The effects of group-based sex therapy on sexual assertiveness in educated women. *The Journal of Psychology Tabriz University*. 2010;5(19):162-76.
- [18] KA. The relationships between sexual behavior and the gender role schemas in married students: the comparison of women and men sexual behavior in the family. *The Journal of Family Studies*. 2006;2(8).
- [19] Abedian K, Shahhosseini Z. University students' point of views to facilitators and barriers to sexual and reproductive health services. *International journal of adolescent medicine and health*. 2014;26(3):387-92.
- [20] Amado LE. Sexual and bodily rights as human rights in the Middle East and North Africa. *Reproductive Health Matters*. 2004;12(23):125-8.
- [21] DeJong J, Jawad R, Mortagy I, Shepard B. The sexual and reproductive health of young people in the Arab countries and Iran. *Reproductive health matters*. 2005;13(25):49-59.
- [22] khalegi F DF. Relationship between religious attitude, moral commitment and lifestyle and marital status (divorced / not divorced) women and men in Isfahan. *Ethics*. 2013;2(11):107-32(in persian).
- [23] Rosen RC. Assessment of female sexual dysfunction: review of validated methods. *Fertility and sterility*. 2002;77:89-93.
- [24] Rosen CB, J. Heiman, S. Leiblum, C. Meston, R. Shabsigh, D. Ferguson, R. D'Agostino, R. The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex & Marital Therapy*. 2000;26(2):191-208.
- [25] HL. SF. Female sexual dysfunction and some associate factors in urmia city *The journal of medical urmia* 2011;23(2):148-54.
- [26] Ebrahimi A NdH, kalantari M, molavi H, Asadolahi GH. Factor structure, Reliability and Validity Religious Attitude Scale. *isfehan university*. 2008;10(2):107-16.
- [27] Tolor A, Kelly BR, Stebbins CA. Assertiveness, sex-role stereotyping, and self-concept. *The Journal of Psychology*. 1976;93(1):157-64.

- [28] Southern S, Cade R. Sexuality counseling: A professional specialization comes of age. *The Family Journal*. 2011;1066480711408028.
- [29] Shafei P. The relationships between female married students' sexual assertiveness taiMATT, Iran: Tarbiat Moalem University; 2005.
- [30] Torfy SH. Study the effectiveness of communication skills training in a behavior cognitive manner on increasing intimacy and Reduce marital conflict Couples (dissertation). Ahvaz: Islamic Azad University SR. 2012 [Persian].
- [31] Meystre C, Bourquin C, Despland J-N, Stiefel F, de Roten Y. Working alliance in communication skills training for oncology clinicians: A controlled trial. *Patient education and counseling*. 2013;90(2):233-8.
- [32] Latifnejad Roudsari R, Javadnoori M, Hasanpour M, Hazavehei SMM, Taghipour A. Socio-cultural challenges to sexual health education for female adolescents in Iran. *International Journal of Reproductive BioMedicine*. 2013;11(2):101-10.
- [33] Maasoumi R, Lamyian M, Khalaj Abadi Farahani F, Montazeri A. Women's perception of sexual socialization in Iran: A qualitative study. *Journal of Qualitative Research in Health Sciences*. 2013;2(3):221-33.
- [34] GM. YFL. Prevalence of sexual dysfunction and related factors among married couples in Qazvin. *The Journal of Qazvin University of Medical Sciences* 2009;13(1):49-55.
- [35] Sadock BJ, Sadock VA, Levin Ze. Kaplan and Sadock's study guide and self-examination review in psychiatry: Lippincott Williams & Wilkins; 2007.
- [36] Shahni yalagh Manijeh SH, movahad Ahmad . causal relationship between religious attitudes, optimism, mental health and physical health in university students. *Journal of Education and Psychology*. 1383;11(2):19-34.
- [37] M. GV. Attachment styles and religious orientations as predictors of success and failure of marital relationship. *Journal of Behavioral Sciences researches*. 2009;7(2):143-53. [Persian].
- [38] Call VR, Heaton TB. Religious influence on marital stability. *Journal for the Scientific Study of Religion*. 1997:382-92.
- [39] WJ. B. Effect of Christian Values on Marital Satisfaction in a Literature Review For The Degree Of Master Of Social Science (Counseling). . University Of South of Australia. 2004.
- [40] Hünler OS, Gençöz T. The effect of religiousness on marital satisfaction: Testing the mediator role of marital problem solving between religiousness and marital satisfaction relationship. *Contemporary Family Therapy*. 2005;27(1):123-36.
- [41] Orathinkal J VA. Religiosity and marital satisfaction. *Contemporary Family Therapy* 2006;28:497-504.
- [42] JL. A. God in marital triangle: A phenomenological study of the influence of Christian faith in the marriage relationship. . Trinity Western university. 2003.
- [43] Fiese BH, Tomcho TJ. Finding meaning in religious practices: the relation between religious holiday rituals and marital satisfaction. *Journal of Family Psychology*. 2001;15(4):597.
- [44] Ahmadi KFA, A. Arabnia, AR. Relationship between commitment Religious and marital satisfaction. *Journal of Family searching*. 1996;2(5):55-67.