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Research Paper

Effect of Marital Relationship Enhancement Education Based on the Approach of Religious Teachings on Sexual, Spiritual and Mental Health

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ABSTRACT

Background and Objectives: The aim of this study was to evaluate the effect of marital relationship enhancement education based on the approach of religious teachings on different dimensions of sexual, spiritual, and mental health in married women.

Methods: This interventional study with a control group was carried out from November 2021 to February 2022 in Amol, Iran. A total of 72 married women were included in two groups, including an intervention group and a control group. The subjects of the intervention group received marital relationship enhancement based on religious teachings in six two-hour group sessions once a week. Participants in the two groups completed the female sexual function index (FSFI), spiritual well-being scale (SWB) and general mental health questionnaires (GHQ) before and after the end of the intervention. The Independent and paired t-tests, Chi-square test, and ANCOVA were used for data analysis.

Results: The mean scores of female sexual function, spiritual well-being, and mental health were 25.96±3.69, 95.82±14.31 and 21.17±12.56, respectively. The mean values of sexual function (P<0.001) and also its dimensions, including arousal (P<0.001), lubricant (P<0.001), orgasm (P<0.001), satisfaction (P<0.001) and sexual pain (P=0.044) were different between the two groups. The mean scores of spiritual well-being and its dimensions, including religious well-being and existential well-being were different between the two groups (P<0.001). The mean scores of general mental health and its dimensions, including anxiety and insomnia symptoms, social dysfunction, and depression symptoms were different between the two groups (P<0.001). The mean pre-to-post test scores of female sexual function, spiritual well-being, general mental health, and its domains (except for sexual desire and somatic symptoms) increased significantly in the intervention group (P<0.001). The differences in the control group were not significant in any of the above cases.

Conclusion: Marital relationship enhancement education based on religious teachings is recommended for promoting sexual function, religious well-being, and general mental health among married women.

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Introduction

The family is the main and important institution of society [1]. Establishing a correct relationship between family members is the most important factor in the well-being and stability of the family throughout the life course [1]. According to various studies, an unhealthy family has wide and long-term consequences for its members. Members of such families suffer from significant symptoms of depression, anxiety, and distress, have lower general health, and exhibit more traumatic individual and social behaviors [2].

The presence of religious beliefs has a significant impact on the stability of the family [3]. Nowadays, in most families, religion and family life are deeply intertwined and inseparable. Religious values play an important role in the marital life of couples, and strengthening certain values can have positive outcomes in married life. Religiosity is the most essential factor in the mutual understanding of couples, and religion has important effects on the relationship between couples. Studies have indicated that instructing the educational package of religious-psychological teachings promotes marital satisfaction [3]. Another noteworthy point is that sexual function has been one of the important factors affecting marital satisfaction and sexual intimacy [4]. Sexual skills training has increased sexual satisfaction and reduced sexual violence and marital incompatibility among married women [5]. Therefore, the study and recognition of human sexual desires and behaviors are some of the most significant issues in public health, especially mental health, which has been fully and comprehensively addressed in religious teachings [6]. Research has indicated that spirituality has a positive effect on marital relationships. The success of family life is fostered in the context of spiritual health through learning psychological, instructive, and moral teachings in religion that promote the spiritual health of family members [7]. Therefore, the cornerstone of marriage should be laid in such a way that it leads to the optimal functioning of the family and the promotion of spiritual health among its members [6]. Evidence shows that religion has significant teachings for understanding various mental experiences as well as mental health. The importance and sanctity of marriage and family formation from the religious perspective have also led to the fact that most of the religious teachings are dedicated to identifying stressors between spouses and promoting the mental health of family members, with Islamic teachings offering particular richness in this field. Religious beliefs have a positive effect on mental health. Holding religious beliefs can be considered the biggest factor in mental health [6].

Many educational programs have been developed to improve couples' behavioral, emotional, and social problems based on different approaches; however, the use of comprehensive, original, and reliable teachings of religion has received less attention from families, therapists, and researchers. Considering that religious culture, along with moral, social, and family guidelines, has been deeply rooted in Iranian families over the years, it is essential to focus on religious teachings in the promotion and adaptation of marriage. This includes preparing educational programs in this field and recognizing the need for interventions to improve the relationships between couples. Therefore, the present study was conducted to determine the effect of marital relationship enhancement education based on the approach of religious teachings on different dimensions of sexual, spiritual and mental health of married women in 2022.

Methods

Participants

This interventional study with the control group was carried out from November 2021 to February 2022 in two active health centers in Amol, Iran. The primary objective of this study was to improve sexual function with subsequent promotion of spiritual and mental health. The centers were randomly divided into two equal groups of intervention and control. In this way, the names of the active health centers of Amol, which are similar in terms of demographic, economic, cultural and social characteristics, were written on pieces of paper and placed in a box. After mixing the papers, two centers were randomly selected.

Procedure

A total of 72 married women were divided into two equal groups: An intervention group and a control group. Inclusion criteria included providing informed consent, being a married Iranian woman residing in Amol city, ability to read and write in Persian, practicing the same religion as their spouse, living with their spouse for at least one year, being the sole spouse, having stable sexual activity (at least in the past four weeks), being in a permanent marriage, having no previous training in mental health, sexual health and spirituality, no major medical conditions affecting sexual function, not using medications that disrupt sexual function, no substance abuse, and no sexual disorders being treated in the spouse. The exclusion criteria included not completing the questionnaire, not answering more than 10% of the questionnaire questions, being menopausal, pregnant, or having given

birth in the last three months, and experiencing a stressful event in the last three months (e.g. death or acute illness of close relatives, major changes in living conditions).

The sample size for each group (35 participants) was calculated using a formula comparing two averages in two independent groups. The calculation assumed a confidence level of 95%, 80% study power, 5% error, 2.7 accuracy, and a standard deviation of 3.9, based on previous studies [8, 9]. To account for a 10% loss during the study, a total of 72 eligible women were randomly selected and divided into two equal groups (36 in each group). Of the initial 120 married women, 32 were not willing to participate, and 16 met the exclusion criteria. Thus, 72 married women consented to participate and completed the study. In this study, both the subjects and the researcher were not blinded, although blinding was used to analyze the data. The intervention group received marital relationship enhancement sessions based on religious teachings. These sessions were conducted in six two-hour weekly group meetings and included lectures, question-and-answer sessions, group discussions, an educational package, and CDs. A summary of the group marital relationship enhancement training sessions is shown in Table 1.

Also, a question-and-answer session was held by the therapist on WhatsApp for the participants. Groups of eight to ten people were formed and women were taught by a person who was skilled in both religious and health fields. The educational package was developed based on reliable and authentic sources and articles, which were approved by all members of the research teams. The control group received the usual care. A free educational package was provided to the control group at the end of the 6-week intervention. For monitoring purposes, individuals in the control group were contacted weekly by phone.

Materials

Data collection

The research questionnaires were distributed to participants after explaining the objectives of the research, providing basic training on how to complete the questionnaires, ensuring the confidentiality of the collected data, and obtaining written consent for participation in the study. Participants in both groups completed the Female sexual performance index (FSFI), Spiritual well-being scale (SWB) and general mental health questionnaire (GHQ) before and one week after the end of the intervention.

Data collection instruments

Female sexual function index (FSFI)

This index measures women's sexual performance in six areas with 19 questions: 1) Desire, 2) Arousal, 3) Lubricant, 4) Orgasm, 5) Satisfaction, and 6) Sexual pain. This scale was developed and validated by Rosen et al. It has been used in many studies and has shown a high degree of internal consistency and reliability (92%). Its Persian version is a reliable and valid tool for evaluating women's sexual performance, with a Cronbach's α coefficient of 0.8, indicating good reliability. The minimum score is two and the maximum is 36. A higher score indicates better sexual performance [10, 11].

Spiritual well-being (SWB) scale

The SWB scale was developed by Paloutzian and Ellison (1983). This is a 20-question questionnaire whose answers are based on a six-point Likert scale (from strongly agree to strongly disagree). This scale has two subscales: Religious well-being and existential well-being, each containing 10 statements and scoring between 10 and 60. The total score of spiritual well-being is the sum of the scores of these two subscales (20-120). Biglari Abhari et al. (2018) validated the Persian version of the SWB scale, reporting a Cronbach's α coefficient of 0.85, confirming its reliability [12].

General mental health questionnaire (GHQ)

This scale has 28 questions and four subscales, including physical symptoms, anxiety and insomnia, social dysfunction, and depression. The α coefficient for these scales ranges between 0.70 and 0.93. The total score ranges from 0 to 84, with lower scores indicating better mental health. The Persian version of GHQ-28 was used in this study as the gold standard for diagnosing mental disorders [13].

Data analysis

The collected data were analyzed using SPSS software version 22. The normality of variables was assessed. Demographic variables were analyzed using descriptive statistics. Independent and paired t-tests, chi-square test, and ANCOVA were used for data analysis. ANCOVA was applied to compare endpoint scores between the two groups while accounting for baseline scores as covariates. A significance level of <0.05 was considered for all tests.

Table 1. Summary of group marital relationship enhancement training sessions

Sessions	Educational Content Titles
1	-Familiarization with the objectives, methods, the structure of meetings and the class rules. -Training on the importance and goals of marriage from a religious perspective. -Understanding the significance of religion to the institution of the family and efforts to strengthen it using verses and hadiths. -Training on the duties, rights, and responsibilities of women and men from a religious perspective to maintain peace and intimacy between couples. -Training on the roles and duties of both partners in preserving the dignity of male and female sexuality from a religious perspective. -Providing an educational package. -Answering women's questions.
2	-Review the contents presented in the previous session. -Description of the clients' experiences related to the topics from the previous lesson. -Familiarization with the differences between humans and other creatures, and the use of instincts to achieve perfection. -Understanding the differences between men and women in physiological and anatomical aspects, as well as the principles of difference in religion. -Training on the anatomy and physiology of the female and male reproductive system. -Introduction to the sexual cycle in men and women. -Familiarization with the importance and role of sexual issues in marital relationships and the religious teachings regarding them. -Answering women's questions.
3	-Review of the contents presented in the previous session. -Description of the clients' experiences related to the topics covered in the previous lesson. -Familiarization with sexual health and the perspectives of religious teachings on it. -Training to improve the sexual performance of couples based on religious teachings. -Training in verbal and emotional communication skills for couples from a religious perspective, including correct communication methods. -Familiarization with religious views on love and romantic relationships between couples. -Understanding communication and social skills that form the foundation for more appropriate sexual relations from the perspective of Islam. -Answering women's questions.
4	-Review of the contents presented in the previous session. -Description of the clients' experiences related to the topics from the previous lesson. -Familiarization with mutual respect in the relationship between couples from a religious perspective and its behavioral manifestations. -Understanding forgiveness in the relationship between couples from a religious perspective and its manifestations. -Familiarization with positive thinking and optimism in couples' relationships from a religious perspective. -Training in controlling anger, as well as verbal and physical aggression in couples' relationships, including the correct ways to express these emotions from a religious standpoint and their manifestations. -Familiarization with restraining self-superiority in the relationship between couples from a religious perspective and its manifestations. -Understanding the importance of peace in the family environment and the significant role of women in fostering a relaxing family atmosphere. -Answering women's questions.
5	-Review of the contents presented in the previous session. -Description of the clients' experiences related to the topics from the previous session. -Training on spiritual health and the related religious teachings. -Familiarization with the role of spiritual health in sexual health and marital relations, along with the associated religious teachings. -Discussion and exchange of opinions about women's experiences of sexual and spiritual health. -Answering women's questions.
6	-Review of the contents presented in the previous session. -Description of the clients' experiences related to the topics from the previous session. -Training in mental health and the related religious teachings. -Familiarization with the role of mental health in sexual health and marital relations, along with the associated religious teachings. -Familiarization with the role of mental health in spiritual health and the related religious teachings. -Discussion and exchange of opinions about women's experiences regarding sexual, spiritual and mental health. -Answering women's questions. -Review of the whole program.

Results

The average age of married women was 34.69±7.76 years (range: 18-48 years), and their husbands' average age was 39.96±8.12 years (range:19-57 years). The average duration of marriage was 13.74±7.74 years (range: 2-32 years). Most of the women were housewives, and their husbands were self-employed. The highest frequency of education attainment for both women and men was a diploma. More than a quarter of the women expressed dissatisfaction with their income sufficiency. Most of the women owned their homes and had two children. The individual-family characteristics of married women in two groups are shown in Table 2.

The mean score of married women's sexual performance was 25.96±3.69. In various dimensions of sexual performance, the results were as follows: Libido, 4.45±0.85; arousal, 3.65±0.84; lubrication, 4.38±0.97; orgasm, 4.47±0.4; satisfaction, 4.87±0.40 and sexual pain, 4.46±0.85. The lowest average sexual performance score was observed in the dimension of sexual arousal.

Table 2. Individual-family characteristics of married women in the two groups

Variables		Mean±SD/No. (%)			P
		Intervention Group	Control Group	Total	
Age (years)		35.47±8.29	33.92±7.21	34.69±7.76	0.399
Husband's age (years)		40.04±9.17	39.47±7.02	39.96±8.12	0.615
Marriage duration (years)		14.39±8.44	13.08±7.02	13.74±7.74)	0.478
Occupation	Housewife	31(86.1)	29(80.6)	60(83.3)	0.527
	Employed	5(13.9)	7(19.4)	12(16.7)	
Husband's occupation	Unemployed	0	1(2.8)	1(1.4)	0.165
	Worker	16 (44.4)	8(22.2)	24(33.3)	
	Employee	3(8.3)	6(16.7)	9(12.5)	
	Self-employed	17(47.2)	21(58.3)	38(52.8)	
Education	Primary	7(19.4)	5(13.9)	12(16.7)	0.692
	Secondary	10(27.8)	7(19.4)	17(23.6)	
	Diploma	13(36.1)	16 (44.4)	29(40.3)	
	University	6(16.7)	8(22.2)	14(19.4)	
Husband's education	Primary	9(25.0)	2(5.6)	11(15.3)	0.068
	Secondary	11(30.6)	10(27.8)	21(29.2)	
	Diploma	10(27.8)	11(30.6)	21(29.2)	
	University	6(16.7)	13(36.1)	19(26.4)	
Income level	Satisfied	9(25.0)	8(22.2)	17(23.6)	0.957
	Fairly satisfied	17(47.2)	18(50.0)	35(48.6)	
	Unsatisfied	10(27.8)	10(27.8)	10(27.8)	

Note: Chi-square test and t-test were used to compare differences between the two groups.

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The average spiritual well-being score was 95.82±14.31, with its subdimensions as follows: Religious well-being, 52.06±6.05, and existential well-being, 43.76±10.16. The highest average score of different dimensions of spiritual well-being was related to religious well-being. Before the intervention, the majority of participants had moderate levels of spiritual well-being. The mean mental health score was 21.17±12.56. The scores for the different dimensions of mental health were: Somatic symptoms, 4.53±4.10; anxiety and sleep symptoms, 6.56±4.19; social dysfunction, 5.55±3.77; and depressive symptoms, 4.56±3.44. The lowest mean score of different dimensions of mental health was related to physical symptoms, followed by depressive symptoms.

Findings from the study comparing sexual function and its dimensions between the intervention and control groups showed that the value of F was significant at the level of 0.0001. Specifically, there were significant differences in sexual function and its dimensions, except for sexual desire (F=0.382, P=0.539). Significant differences were observed in the following dimensions: Arousal (F=14.690, P<0.001), lubrication (F=19.613, P<0.001), orgasm (F=20.546, P<0.001), satisfaction (F=14.112, P<0.001) and sexual pain (F=4.197, P=0.044).

The intervention group showed significantly greater improvements in sexual function and its dimensions (except sexual desire) compared to the control. The effect size analysis revealed the following increases at the end of the intervention attributed to the group effect: A 38.4% increase in mean sexual function, a 17.6% increase in mean sexual arousal, a 22.1% increase in mean lubrication, a 22.9% increase in mean orgasm, a 17% increase in mean sexual satisfaction, and a 5.7% improvement in sexual pain (Table 3).

Table 3. ANCOVA results for sexual function and its dimensions at the end of the interventions in the two study groups (n=36)

Variables	Mean±SD*				F	P**	Effect Size
	Intervention Group		Control Group				
	Pre-test	Post-test	Pre-test	Post-test			
Sexual function	25.11±3.68	28.84±3.41	26.80±3.55	26.32±3.79	27.170	0.0001	0.283
Sexual desire	4.27±0.83	4.07±0.82	4.64±0.84	4.24±0.95	0.382	0.539	0.006
Sexual arousal	3.51±0.71	4.46±0.88	3.78±0.95	3.96±0.93	14.690	0.0001	0.176
lubricant	4.26±0.91	4.99±0.78	4.49±1.03	4.32±1.02	19.613	0.0001	0.221
Orgasm	4.36±0.78	5.10±0.87	4.59±0.98	4.45±1.03	20.546	0.0001	0.229
Sexual Satisfaction	4.28±0.71	5.03±0.88	4.65±0.89	4.47±1.10	14.112	0.0001	0.170
Sexual Pain	4.27±0.83	5.19±0.98	4.64±0.84	4.90±0.94	4.197	0.044	0.057
Spiritual Health	94.64±11.94	108.19±10.19	97.00±16.44	98.05±17.65	49.459	0.0001	0.418
Religious well-being	51.11±5.18	57.72±3.24	53.00±6.75	53.58±8.73	34.277	0.0001	.332
Existential well-being	43.53±8.55	50.47±8.62	44.00±11.68	44.47±11.51	31.349	0.0001	0.312
Mental health	21.89±12.66	10.94±8.65	20.44±12.59	20.17±13.98	46.504	0.0001	0.403
Somatic symptoms	4.25±3.86	3.98±3.80	4.81±4.36	5.56±4.83	2.998	0.088	0.042
Anxiety and insomnia	6.55±4.22	3.94±3.45	6.56±4.23	7.17±4.98	27.070	0.0001	0.282
Social dysfunction	6.25±3.90	2.00±1.74	4.81±3.54	3.94±3.39	17.128	0.0001	0.199
Depression	4.83±3.28	1.93±1.22	4.28±3.62	3.92±3.05	23.615	0.0001	0.255

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*The mean post-test scores of sexual function, spiritual well-being, the mental health index, and its dimensions (except for sexual desire and somatic symptoms) showed a significant increase in the intervention group compared to pre-test values (P=0.0001). No significant changes were observed in the control group for sexual function, spiritual well-being, the mental health index, or their dimensions (paired t-test). **ANCOVA.

The mean pre- to post-test scores of the sexual function index and its dimensions (except sexual desire) increased significantly in the intervention group (P=0.0001) (paired t-test) (Table 3).

A comparison of the difference between spiritual well-being and its dimensions (religious and existential well-being) between the two intervention and control groups showed that the value of F was significant at the level of 0.0001. Specifically, there was a significant difference between in the groups in the mean scores of spiritual well-being and its dimensions. The intervention group was significantly superior in increasing spiritual well-being and its dimensions compared to the control (P<0.001). The effect size indicated that 41.8% of the increase in mean spiritual well-being, 33.2% increase in mean religious well-being, and 31.2% increase in mean existential well-being at the end of the intervention was related to group effect. The mean pre- to post-test scores of spiritual well-being and its dimensions significantly increased in the intervention group (P<0.001) (paired t-test) (Table 3).

A comparison of the differences in mental health and its dimensions (somatic symptoms, anxiety, and insomnia symptoms, social dysfunction, and depression symptoms) between the intervention and control groups showed that the value of F was significant at the level of 0.0001. Specifically, significant differences were observed in the mean scores of mental health and its dimensions, excluding somatic symptoms. Improvements were noted in anxiety and insomnia (P<0.001), social dysfunction (P<0.001) and depression symptoms (P<0.001) between the two groups.

The general mental health improvement, along with improvements in its domains (except for somatic symptoms, P=0.088), including anxiety and insomnia symptoms, social dysfunction and depressive symptoms, was significantly greater in the intervention group compared to the control group P<0.001). The effect size indicated that 40.3% of the mean improvement in mental health, 28.2% of the mean improvement in anxiety and insomnia symptoms, 19.9% of the mean improvement in social dysfunction, and 25.5% of the mean improvement in depression symptoms at the end of the intervention were related to the effect of the group. The mean pre to post-test scores of the mental health index and its dimensions (except for somatic symptoms) increased significantly in the intervention groups compared to the control group (P<0.001) (paired t-test) (Table 3).

Discussion

This study was performed to investigate the effect of marital relationship enhancement education based on the approach of religious teachings on different dimensions of sexual, spiritual, and mental health of married women in 2022. According to the results, there was a significant improvement in sexual function and its dimensions (except for libido) in the intervention group compared to the control group. Our findings are in line with other studies [9, 14-16].

Similar studies have shown that religious values play an important role in the married life of couples, and strengthening some values can have positive consequences in married life [3]. Religion can also play a significant and effective role in promoting marital satisfaction [17]. Cognitive education based on spiritual and religious principles has been effective in improving spouses' relationships and consequently, their marital satisfaction [3]. Family-centered psychological programs based on religious frameworks have enhanced couples' abilities to maintain appropriate marital relationships, leading to greater satisfaction [18]. Therefore, considering the importance of sincere relationships in terms of marital satisfaction, along with the religious culture of our country, training in comprehensive, genuine, and reliable teachings of Islam for wives can be very beneficial. This may help explain the possible reasons for the lack of change in sexual desire observed in the present study. It should be noted that sexual desire disorder in women is a common and often annoying problem that has many negative effects on their quality of life. This issue is often multifactorial and requires a multifaceted assessment and treatment approach. On the other hand, the libido stage of the sexual response cycle is a complex stage with various factors and is difficult to treat. Therefore, response to treatment is expected to be more difficult. Supporting this finding, Khorramabadi also asserts that issues related to sexual desire are multifactorial and typically difficult to treat. Also, experiencing the positive aspects of sexual desire after the educational process demands practicing sexual skills, spending more time, or engaging in long-term use of sexual skills, which falls outside the short-term educational intervention of the present study [19].

The present study demonstrated that marital relationship enhancement training improved spiritual well-being and all its dimensions in the intervention group compared to the control group. Our findings are in line with other studies [20, 21]. In this regard, a similar study revealed that implementing religious teachings for men

and women with marital problems, in the form of the Iranian-Religious lifestyle education method, can enhance spiritual well-being and reduce emotional divorce [2].

Researchers have shown that the existence of spirituality and religion in the family system, in addition to providing bonds of unity among family members, can create an emotional bond between members, maintain peace in the family, provide psychological health for the members and generally improve the functioning of the family [22]. Shaykholeslami et al. believe that spirituality and spiritual thoughts guide couples to enjoy the positive points of their lives by deepening their experiences and instilling hope, which plays an important role in a couple's commitment to their marital relationship [23]. As a result, spirituality strengthens the marital bond between couples. Beazari Kari posits that the realization of religious teachings among couples can help avoid uninformed actions, incorrect attitudes, and weak emotional relationships. It also fosters proper habits and behaviors, encourages spouses to understand shared life goals, acknowledges the natural inclinations and instincts of both men and women, clarifies their rights toward one another, and creates a safe environment for questions and discussions. This approach cultivates a positive and optimistic attitude toward spouses, emphasizes efficient and unambiguous behaviors, enhances social skills, and encourages the performance of religious duties and cooperation in the pursuit of closeness to God. Such practices can lead to spiritual well-being and motivate couples to achieve common goals and reach agreements in life. Paying attention to religious teachings is the best approach to mental and spiritual health. Therefore, greater attention should be paid to this important principle to have a dynamic and lively society. Considering the changes in lifestyle in today's world and the proliferation of science and technology, it is necessary to emphasize and plan for strengthening relationships and family structures based on religious strategies in order to promote spirituality [24].

The present study showed that the intervention group was significantly superior in increasing mental health and all aspects of it (except somatic symptoms) compared to the control group. These results are in agreement with other studies [25]. Estrada et al. also indicated that religious education, by increasing awareness about religious beliefs and practices and their effect on couples and the community, had a significant effect on mental health. They also concluded that religious teaching positively influenced connectedness, enhanced self-esteem, improved coping skills, and reduced stress, while also promoting a low-risk lifestyle and overall well-being [26]. A review of the literature showed that religious-spiritual psychotherapy improved stress, anxiety, and depression in individuals, and skills training in religious patterns increased mental health [27]. Another study showed that religious teachings and godliness have a direct relationship with the health of both individuals and society. As long as people maintain strong faith, a corresponding level of individual and social mental health is expected [24]. Religious beliefs and practices are associated with fewer depressive symptoms. Moreover, active religious coping and religious practices had a significant inverse relationship with anxiety so that with increasing positive religious coping, women's anxiety decreased [28]. Essentially, religious ideas serve as a crucial source for meeting spiritual needs and fostering psychological development in humans. Faith and belief in God mitigate the effect of anxiety-inducing factors, heal troubled hearts, calm the restless soul, and instill chastity, optimism, and hope in individuals. This, in turn, promotes social justice, enhances social relations within the community, and provides the necessary security and tranquility to society [29].

Perhaps the reason for the lack of change in the somatic symptom dimension in the present study is that achieving physical health requires more time, which is beyond the short duration of the educational curriculum implemented in this study. Furthermore, these types of somatic symptoms are highly significant in establishing and maintaining mental health within a nurturing family environment and community. It seems that providing other treatment strategies at the appropriate time is necessary, especially in terms of somatic symptoms of chronic problems that could impact physical aspects of mental health.

Conclusion

The results of the present study showed that marital relationship enhancement education based on the approach of religious teachings is effective in improving the sexual, spiritual, and mental health of married women. Teaching religious principles related to marital relations increased the level of sexual health, spiritual well-being, and mental health in all their dimensions. Therefore, counselors, psychologists, and family therapists are advised to use religious teachings based on marital relationships to improve the health of couples in various sexual, spiritual, and mental dimensions. The findings of this study can be used in educational programs and health service policies, as well as in family health initiatives and psychology and counseling clinics.

Limitations

One of the limitations of this protocol is the lack of follow-up and blinding. Although this study was conducted at two active health centers, the results cannot be generalizable to all married women. Another limitation was the lack of access for religious minorities to participate in the research. A key strength of this protocol is its focus on sexual issues, particularly from the perspective of religious teachings, which is often less addressed due to the taboo nature of sex and cultural considerations. To obtain more reliable results, it is recommended to conduct this project with both spouses present and to compare it with other training packages aimed at improving the spiritual and mental health of married women.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Ethics Committee of Qom University of Medical Sciences (Code: IR.MUQ.REC.1400.086). Informed consent was obtained from all subjects before the study.

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Authors' contributions

Conceptualization and supervision: Hajar Pasha and Zohreh Khalajinia; Methodology: Hemmat Gholinia; Data collection: Hajar Pasha, and Hemmat Gholinia; Data analysis: Hemmat Gholinia; Funding acquisition, resources, investigation, writing the original draft, review & editing: All authors.

Conflict of interest

The authors declared no conflict of interest.

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