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Relationship between sexual satisfaction and religious attitudes in pregnant Muslim women: A cross-sectional study in Türkiye

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Abstract

During pregnancy, various factors influence sexual life, and religious attitudes play a significant role. However, studies on sexual satisfaction and religious attitudes in pregnant Muslim women are limited. This cross-sectional study, conducted in Türkiye's Mediterranean region with 230 pregnant volunteers (October 2023–March 2024), found that sexual satisfaction is significantly associated with educational status, frequency of intercourse, perceptions of safety, and feelings of shame or guilt. Despite no restrictions on sexual activity in healthy pregnancies, religious beliefs can negatively impact sexual life. The study highlights the lack of discussion on female sexuality during pregnancy in clinical settings and emphasizes the need for integrating this topic into pregnancy education. While contributing to the limited literature, findings are specific to one region and based on self-reported data, which may introduce bias *(Afr J Reprod Health 2025; 29 [10]: 187-194).*

Keywords: Pregnancy; Sexual Activity; Sexual Satisfaction; Sexual Life During Pregnancy; Religious Attitudes

Résumé

Pendant la grossesse, divers facteurs influencent la vie sexuelle, et les attitudes religieuses jouent un rôle important. Cependant, les études sur la satisfaction sexuelle et les attitudes religieuses chez les femmes musulmanes enceintes restent limitées. Cette étude transversale, menée dans la région méditerranéenne de la Turquie auprès de 230 volontaires enceintes (octobre 2023 – mars 2024), a montré que la satisfaction sexuelle est significativement associée au niveau d'éducation, à la fréquence des rapports sexuels, à la perception de la sécurité ainsi qu'aux sentiments de honte ou de culpabilité. Bien qu'aucune restriction n'existe pour l'activité sexuelle lors de grossesses sans complication, les croyances religieuses peuvent avoir un impact négatif sur la vie sexuelle. L'étude met en évidence l'absence de discussions sur la sexualité féminine pendant la grossesse dans les contextes cliniques et souligne la nécessité d'intégrer ce sujet dans l'éducation prénatale. Tout en contribuant à la littérature limitée, les résultats restent spécifiques à une région donnée et reposent sur des données autodéclarées, ce qui peut introduire un biais *(Afr J Reprod Health 2025; 29 [10]: 187-194).*

Mots-clés: Grossesse; Activité sexuelle; Satisfaction sexuelle; Vie sexuelle pendant la grossesse; Attitudes religieuses

Introduction

Pregnancy is a remarkable life event that impacts quality of sexual life. The physical, psychological, social, and cultural changes experienced during this period can negatively affect the quality of sexual life of couples, specifically women.[1] The changes experienced during pregnancy vary across different trimesters.

In the first trimester, a decrease in libido is observed due to pregnancy-related complaints such as gastric distress, nausea and vomiting, fatigue, drowsiness, general physical discomfort, breast tenderness, and increased vaginal discharge.[2] In the second and third trimesters, additional factors such as abdominal enlargement; breathing difficulties; pelvic ligament pain; frequent urination; reduced mobility; lactation; partial fear of harming the baby; and the perception of sexual intercourse being immoral, sinful, or incompatible with motherhood can lead to negative attitudes toward sexuality in pregnant women.[3,4] Studies have reported a decrease in sexual desire, frequency of sexual intercourse, orgasm, and sexual satisfaction during pregnancy.[1,5,6] Pregnant women and their partners often restrict sexual activities due to the fear of harming the fetus, simultaneously facing the dilemma of remaining sexually active to maintain a healthy marital. However, it is noted that there are no contraindications to continuing sexual activity during pregnancy, except in high-risk cases.[7]

Research on sexual problems has found that numerous sociocultural factors impact women's sexual lives, including the sociodemographic characteristics of the community; cultural structure; conflicts between personal, familial, and religious values; inadequate education or misinformation about sexual matters; traditional views on sexuality; conservative upbringing; and social taboos.[2-4,8] Religious beliefs emerge as an important sociocultural factor influencing individuals' sexual lives. In particular, negative attitudes towards sexual activity during pregnancy are closely tied to the religious values and beliefs embedded within society. In this context, it is crucial to examine what religious attitude means and how it is shaped in order to better understand its impact on sexual life. Religious attitude is the consistent manner in which a person directs their feelings, knowledge, thoughts, and behaviors related to religion.[9] A person's knowledge and beliefs about religion, their interest in the commands and prohibitions of their faith, their adherence to religious obligations, their defense of their beliefs, importance they place on religious activities, alignment of their behaviors with their religion, and their overall religious attitude are all factors that shape their religious attitude.[10] One of the main reasons women may avoid sexual activity during pregnancy maybe due to the belief that sexual activity is sinful and religiously inappropriate.[8]

However, there is a lack of studies in the literature directly examining women's religious attitudes and their sexual behaviors during pregnancy. This study aimed to examine the relationship between sexual satisfaction and religious attitudes of pregnant Muslim women.

Research question

Is there a significant relationship between religious attitudes and sexual satisfaction levels in pregnant Muslim women?

Methods

Study design

The study was conducted as descriptive and cross sectional. The study population comprised pregnant women who visited the Obstetrics and Gynecology outpatient clinic at Tarsus State Hospital from October 2023 to March 2024. Considering a confidence level of 95%, an error margin of 95%, and effect size of 30%, the minimum sample size was determined to be 195 participants using the two-tailed test in G*Power 3.1.9.4 software.[11] Considering the possibility of missing data, the study was completed with a total of 230 participants.

Inclusion and exclusion criteria

Participants were included in the study if they voluntarily agreed to participate and signed the informed consent form, had applied to the Obstetrics and Gynecology outpatient clinic of the hospital where the research was conducted, were 18 years of age or older, had at least a primary school education, and had sufficient proficiency in reading and understanding Turkish.

Participants were excluded from the study if they had a diagnosis of high-risk pregnancy (e.g., preeclampsia, gestational diabetes, placenta previa), had been diagnosed with a psychiatric disorder or were using psychiatric medication, had previously been diagnosed with sexual dysfunction or had undergone sexual therapy, or did not fully complete the study questionnaires and provided incomplete data.

Data collection

Data were collected using the Personal Information Form, the Golombok–Rust Inventory of Sexual Satisfaction (Female Form), and the Ok-Religious Attitude Scale.

Personal information form

The Personal Information Form, developed by the researchers, comprised questions designed to determine certain descriptive characteristics of pregnant women, such as age, duration of marriage, educational level, number of pregnancies, number of births.

Golombok–Rust Inventory of sexual Satisfaction (GRISS)

The GRISS was developed by Rust and Golombock.[12] Turkish standardization, validity, and reliability study was conducted by Tuğrul et al.[13] The scale consists of 28 items and 7 sub-scales and includes two forms prepared for men and women. The sub-scales of the female form include frequency, communication, satisfaction, avoidance, touch, vaginismus, and anorgasmia. Higher scores indicate deterioration in sexual functioning and the quality of the relationship. Cronbach's alpha value was found to be 0.87 in the validity and reliability study of scale for female form.[12] In the present study, the Cronbach's alpha value was found to be 0.85.

Ok-Religious Attitude Scale (RAS)

This scale was developed by Ok[14] to measure the level of religiosity. It comprises eight items and uses a 5-point Likert type scale. Participants rate the extent to which they agree with the statements by assigning a score between 1 and 5. The first two questions in the cognition sub-dimension are reverse coded. The lowest and highest scores that can be obtained from the scale are 8 and 40, respectively. A high score indicates a high level of religious attitude, and a low score reflects a low level of religious attitude. The analyses indicate that the scale has high internal consistency (Cronbach's alpha values 0.81 and 0.91). In the present study, the Cronbach's alpha value was determined to be 0.88.

Data analysis

Data were analyzed using SPSS version 25.0. Demographic and clinical characteristics of the participants were presented as frequencies analysis. Normality of the data was tested using Skewness–Kurtosis values. For data that met parametric conditions, t-test was used for two independent groups, and one-way analysis of variance test was used for more than two independent groups. Pearson correlation was performed in parametric conditions and Spearman correlation was performed in nonparametric conditions.

Ethical considerations

This study was approved (number: 2023/44; date: 22/08/2023) by the Non-invasive Clinical Studies Ethics Committee at the Tarsus University.

Results

The average age of the participants was 29 years, and the average duration of marriage was 7 years. Moreover, 42.2% of the participants had an education level of high school, university, or higher; 67.4% stated that pregnancy reduced the frequency of sexual intercourse; and 52.2% stated that sexual intercourse during pregnancy was unsafe (Table 1).

Mean sexual satisfaction score of the participants was 60.10±11.85, and mean religious attitude score was 37.85±4.76 (Table 2). There was a positive correlation between sexual dissatisfaction and religious attitudes among the pregnant women participating in the study($r=0.130, p<0.05$) (Table 3)

Table 1: Sociodemographic characteristics of participants (n = 230)

Variables		X±SD					
Age (years)		29.51±5.76					
Duration of marriage (years)		7.04±5.80					
Number of pregnancies		2.65±1.39					
Number of childbirths		1.45±1.32					
		GRISS			**RAS**		
	n (%)	X±SD	Test	p	X±SD	Test	p
Education							
Primary school	82 (35.7)	62.60±10.60			39.27±4.12	19.738*	**0.000*******
Middle School	51 (22.2)	60.41±10.48	2.968**	**0.033*******	38.45±2.29		
High school	61 (26.5)	59.89±13.78			37.57±5.98		
University or above	36 (15.7)	55.75±11.91			35.11±5.28		
Pregnancy impact on the frequency of sexual intercourse			3.469****	**0.001*******		-0.958***	0.338
Decreased	155 (67.4)	61.94±10.75			37.77±4.49		
Unchanged	75 (32.6)	56.29±13.13			38.01±5.29		
Is sexual intercourse safe during pregnancy?			-2.616****	**0.009*******			
Safe	110(47.8)	57.99±11.27			37.18±5.76	-1.366***	0.172
Unsafe	120(52.2)	62.03±12.09			38.47±3.50		
Do you experience feelings of guilt or shame during sexual intercourse during pregnancy?					38.77±3.50	-2.712***	**0.007*******
Yes	92 (40)	64.11±10.94	4.349****	**0.000*******			
No	138 (60)	57.43±11.72			37.24±5.36		

* Kruskal-Wallis Test; ** One Way Anova; ***Man Witney U Testi; ****t testi; *****p<0.05

Table 2: Mean and standard deviation values of scales

Variables	Mean	SD	Min.	Max.	Percentiles		
					25	50	75
GRISS	60.100	11.85	19.00	92.00	53.00	60.00	68.00
Infrequency	3.46	1.62	0.00	8.00	2.00	3.00	4.00
Non-communication	6.54	1.25	2.00	9.00	6.00	6.00	7.00
Dissatisfaction	5.85	2.85	0.00	12.00	4.00	6.00	8.00
Avoidance	6.43	4.02	0.00	15.00	3.00	6.00	10.00
Nonsensuality	5.30	2.87	0.00	15.00	4.00	5.00	7.00
Vaginismus	6.69	2.45	0.00	13.00	5.00	7.00	8.00
Anorgasmia	5.50	2.93	0.00	13.00	4.00	6.00	8.00
RAS	37.85	4.76	16.00	63.00	37.00	40.00	40.00

Table 3: Pearson's correlations between variables (n = 230)

Variables	RAS	
	r	p
GRISS	0.130*	0.048
Infrequency	0.021	0.754
Non-communication	0.081	0.223
Dissatisfaction	0.031	0.644
Avoidance	0.183**	0.005
Nonsensuality	0.043	0.515
Vaginismus	0.117	0.076
Anorgasmia	0.070	0.288

*0.05 level (2-tailed); ** 0.01 level (2-tailed).

Discussion

This study was found that as the educational level of the pregnant women participating in the study increased, their sexual satisfaction improved and the quality of their relationships improved. A significant relationship was found between educational level and sexual satisfaction score. Yıldız and Kıvanç[8] found that as educational level increased, sexual satisfaction also increased. Güleroğlu *et al.*[15] conducted a study to determine the factors that negatively affect sexual function during pregnancy and found that lower educational level negatively affected sexual function. Similarly, Eryilmaz *et al.*[16] observed that lower educational level had a significant negative effect on sexuality during pregnancy. This may be attributed to the fact that pregnant women with higher educational levels tend to receive more prenatal care, are aware of resources where they can access information from, and can more easily obtain accurate information by researching topics such as sexuality during pregnancy, where many misconceptions and myths often exist.

Pregnancy can change the frequency of sexual intercourse for numerous reasons. Anatomical and physiological changes during pregnancy, psychological and cultural factors are among these reasons.[17] However, fears and myths such as harming the fetus or the pregnancy during sexual intercourse, the belief that sexual activity during pregnancy is sinful and religiously unacceptable, concerns about causing preterm birth, difficulty finding comfortable positions for sexual intercourse, and an unattractive body image can disrupt sexual activity during pregnancy.[18,19] In a study conducted in Iran, 81.8% of women reported having less sexual intercourse during pregnancy, and 69.7% indicated a decrease in sexual desire due to pain during intercourse.[20] In a study conducted in Türkiye, it was reported that 22% of pregnant women experienced sexual problems, and 50% experienced pain during sexual intercourse.[21] Pregnant women participating in the study were asked about the impact of pregnancy on the frequency of sexual intercourse, and it was found that those with decreased sexual intercourse frequency had lower sexual satisfaction. A lower frequency of sexual intercourse during pregnancy has been associated with lower sexual satisfaction.[19]

It was determined that pregnant women who considered sexual intercourse safe and did not experience feelings of guilt or shame during intercourse had higher levels of sexual satisfaction. Additionally, there were statistically significant differences between the group that considered sexual intercourse safe and the group that did not, and between those who experienced feelings of guilt and shame and those who did not. Furthermore, Yıldız and Kıvanç[8] found that those who were not afraid of sexual intercourse during pregnancy had higher levels of sexual satisfaction. Additionally, Darling and Davidson[22] stated in their study that guilt is a factor that negatively affects sexual satisfaction.

In line with the findings of the present study, previous research highlights that fears and distress related to sexual activity during pregnancy are common and have important implications for sexual well-being. For example, despite medical evidence indicating that sexual activity does not harm the fetus[23], couples—especially pregnant individuals—frequently express anxiety and concern regarding its safety.[24] Such fears have been shown to negatively affect sexual function and contribute to decreased sexual frequency[25] and increased postpartum dyspareunia.[26] In our study, pregnant women who viewed sexual intercourse as safe and did not experience guilt or shame reported higher sexual satisfaction, further supporting these findings.

Moreover, sexual distress, which often stems from fear, has been identified as a key factor associated with lower sexual satisfaction during pregnancy.[27,28] Given that sexual distress is a central component of sexual dysfunction, these results underscore the importance of addressing emotional and cognitive barriers—such as fear of harming the fetus or violating religious norms—as part of prenatal care and sexual counseling. Promoting positive attitudes toward sexuality during pregnancy may not only reduce distress but also enhance relationship satisfaction and overall sexual well-being.[24] It was observed that as the educational level of the pregnant women participating in the study increased, their religious attitudes decreased.

A significant relationship was found between educational level and the average religious attitude scores of the groups. In the study conducted by Kavak *et al*., it was determined that university graduates had the lowest religious attitude scores. In a study conducted with pregnant women[29], Polat *et al.*[30] found that compared to the literate group, those with university and higher education had lower levels of religious attitudes. The findings obtained in the present study are consistent with literature. It was found that pregnant women who felt shame and guilt about sexual intercourse had a significantly higher religious attitude scores.

In Türkiye, sexuality is generally viewed as a taboo due to religious reasons or societal pressure.[21] In the study conducted by Küçükdurmaz *et al.*[31], pregnant women expressed that they considered sexual intercourse during pregnancy to be sinful. Additionally, a review of international literature indicates that, similarly, pregnant women avoid sexual intercourse during pregnancy due to the belief that it is sinful.[32]

It is impossible to find a single definition that perfectly describes human sexuality. Sexuality is the result of many factors in every society, including biological, psychological, sociocultural, ethical, religious, spiritual, and political and legal factors.[33] In societies like Türkiye, where religion overlaps with cultural values, sexuality during pregnancy is heavily influenced by the cultural environment. A positive correlation was found between the average sexual satisfaction scores and average religious attitude scores of the pregnant women participating in the study. However, an increased sexual satisfaction score indicates lower sexual satisfaction and deterioration in the quality of the relationship. Thus, it was determined that pregnant women with high religious attitude scores had lower sexual satisfaction and were those whose relationship quality was deteriorating. A review of the literature reveals that sexuality during pregnancy is Influenced by religious values and attitudes.[33] Not only in Islam but also in Christianity and Judaism, sexuality can conflict with religious taboos.[34]

Conclusion

The study found that religious attitudes impact sexual satisfaction among pregnant Muslim women. However, data on sexual function in pregnant women is limited. Prospective, quantitative studies are needed to establish norms. Given the diversity of global sexual beliefs, further research in different cultures, especially in high-income countries, is essential.

During antenatal care, healthcare providers should assess pregnant women’s sexual activity, particularly in primary care. Identified issues should be addressed, and couples offered joint counseling.

Strengths and limitations

The study was conducted in a specific geographical region (Mediterranean region of Türkiye), which may limit the generalizability of the findings to other populations. This limitation is acknowledged. Since the study deals with sensitive topics like sexual life and religious attitudes, self-reported data may be subject to social desirability bias. Participants may have responded in ways they felt were socially acceptable rather than providing completely accurate information. The study design does not allow for causal inferences regarding the relationship between religious attitudes and sexual satisfaction. This limitation is clearly stated in the manuscript. Other potential factors that may influence sexual satisfaction, such as psychological well-being, partner attitudes, and cultural variations within religious beliefs, were not extensively examined, which could introduce bias into the interpretation of results. The study used validated and reliable instruments (Golombok–Rust Inventory of Sexual Satisfaction and Ok-Religious Attitude Scale) to minimize measurement bias and ensure consistency. The manuscript describes rigorous statistical analyses, including normality tests and correlation analyses, to ensure the robustness of findings.

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Contribution of authors

ÖK conceived and designed the study, curated the data, performed the formal analysis, acquired funding, developed the methodology, administered the project, provided resources and supervision, and prepared the original draft as well as contributed to the review and editing of the manuscript. TS contributed to the conceptualization, funding acquisition, methodology, supervision, and participated in the writing of the original draft and critical review and editing of the manuscript. TI contributed to data curation, funding acquisition, investigation, and participated in the review and editing of the manuscript. All authors read and approved the final version of the manuscript.

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Conflicts of interest

The authors have no conflicts of interest relevant to this article to disclose.

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