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The Association of Lifestyle, Mental Health, and Spiritual Health with the Desire for Childbearing among Couples Preparing For Marriage

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ABSTRACT

Background and Objective: Considering the declining fertility rate in Iran, it is critically important to identify factors that influence the desire for childbearing. The present study was therefore designed to examine the association of lifestyle, mental health, and spiritual health with the desire for childbearing among couples preparing for marriage in Babol, northern Iran.

Methods: This cross-sectional study enrolled 440 premarital individuals (220 males and 220 females) selected through convenience sampling. Data were gathered using standardized instruments, including the Childbearing Desire Questionnaire (score range: 8-40), the BASIS-A Lifestyle Inventory (score range: 62-310), Brief Symptom Inventory-18 (score range: 0-72), and the Spiritual Well-Being Scale (score range: 20-120), and were subsequently analyzed.

Findings: Childbearing desire was found to be significantly and positively associated with lifestyle (B=0.04, p=0.026) and spiritual health (B=0.30, p<0.001), whereas a significant negative association was observed with mental health (B=-0.39, p<0.001). Furthermore, age (B=-0.23, p<0.001) and educational level (B=-1.76, p<0.001) also exhibited significant negative correlations with childbearing desire. In the multivariate regression analysis, spiritual health emerged as a key independent predictor of childbearing desire among couples, with each one-unit increase in spiritual health score corresponding to a 0.5-unit increase in childbearing desire (B=0.52, p<0.001).

Conclusion: The study findings suggest that enhancing spiritual well-being may be regarded as an effective intervention to promote childbearing desire among couples preparing for marriage.

Keywords: *Childbearing Desire, Lifestyle, Mental Health, Spiritual Health, Couples*.

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Introduction

Over recent decades, the desire for childbearing has undergone substantial transformation in numerous countries, particularly in developing regions. Childbearing is recognized not merely as a demographic behavior but also as a phenomenon with profound social and cultural implications that may directly or indirectly influence the general and psychological well-being of families (1, 2). A growing body of empirical evidence indicates that parenthood is associated with reduced mortality, enhanced life satisfaction, and improved mental health outcomes (3, 4). Nevertheless, the sustained decline in Iran's fertility rate, which has now dropped below replacement level, has generated considerable concern regarding the nation's demographic trajectory (5). The accelerating growth of the elderly population, the contraction of the working-age demographic, and the associated socioeconomic ramifications (6) have collectively emphasized the imperative of investigating determinants of childbearing desire.

Fertility behavior and demographic dynamics within any given country are shaped by a complex interplay of economic, social, cultural, and environmental determinants (7). These factors exert a direct influence on reproductive behaviors and the decision-making processes surrounding childbearing. Lifestyle constitutes a particularly significant variable in this context; it encapsulates an individual's habitual patterns, attitudinal frameworks, and daily practices, while also functioning as a mechanism for the construction of personal and social identity (8). In a study by Rafiei Moqaddam et al., modern lifestyle patterns and exposure to foreign media were found to significantly modify individuals' childbearing orientations (9). In addition, a range of other variables—including economic fluctuations, employment status, income level, gender role perceptions, educational attainment, and the degree of economic and social autonomy enjoyed by couples, especially women—have been consistently identified as influential determinants of childbearing decisions, alongside psychological stressors and overall quality of life (10-12).

Spiritual health is a cultural determinant that appears to exert a significant influence on childbearing intentions (13). Defined as a psychological resource that fosters inner cohesion and promotes a profound sense of connectedness with the self, the divine, the community, and the broader environment, spiritual health contributes to emotional stability and resilience in the face of life adversities (14). While some investigations have reported a significant positive correlation between elevated spiritual well-being and reduced childbirth-related fear (15, 16), other studies have suggested that religious affiliation or religiosity may, in certain contexts, be inversely associated with childbearing desire (17-19).

Mental health is also recognized as a salient psychosocial determinant of childbearing decisions. Longitudinal evidence derived from cohort studies in Germany and China indicates that individuals with more favorable mental health profiles tend to express stronger childbearing intentions (20). Conversely, many women postpone childbearing as a result of pregnancy- and delivery-related anxieties, apprehensions regarding the loss of personal autonomy, anticipated disruptions to lifestyle and identity, or a perceived absence of adequate support from their partners (21, 22). The research conducted by Hosseini et al. further corroborates the substantial contribution of psychosocial variables to childbearing desire (23).

A systematic review conducted by Rahnama et al. revealed that the determinants of childbearing desire in Iran are multifactorial and encompass economic, social, psychological, cultural, and religious dimensions (24). Similarly, Modiri et al., in a study focused on men residing in Tehran, reported that economic status, employment, income level, and cultural attitudes significantly influence childbearing intentions (25). Notably, the existing literature has predominantly concentrated on demographic and economic correlates, whereas the roles of psychological factors and lifestyle behaviors have remained comparatively underexplored. Despite the relatively extensive volume of published work in this area, notable gaps remain in the research literature. The concurrent investigation of psychological variables, lifestyle patterns, and

spiritual well-being may offer a more integrated and comprehensive understanding of the reproductive decision-making processes among couples. Given Iran's distinctive cultural, religious, and national characteristics, conducting contextually grounded and locally adapted studies is imperative. Importantly, to date, no investigation has simultaneously examined the combined effects of lifestyle, mental health, and spiritual health on childbearing desire within the specific cultural milieu of Iran, a country currently experiencing a marked decline in fertility rates. This lacuna represents a significant research gap that warrants systematic exploration. The present study was therefore conducted with the aim of examining the association of lifestyle, mental health, and spiritual health with childbearing desire among couples preparing for marriage in Babol. In the first step, univariate relationships between these factors and childbearing desire were examined. Subsequently, in multivariate analysis, the predictive power and contribution of each variable were determined in the presence of other factors.

Methods

This cross-sectional investigation received ethical approval from the Research Ethics Committee of Babol University of Medical Sciences (approval code: IR.MUBABOL.REC.1402.089) and was carried out during the summer of 2024 among couples registered with the Shokouhi Health Center in Amirkola, Babol County. Participants were recruited through convenience sampling. The required sample size was determined based on the study's objectives and the number of predictor variables included in the multivariate regression model. Assuming four predictor variables, with the regression slope serving as the effect size, a 95% confidence interval, and 95% statistical power, G*Power software (version 3) yielded a minimum requirement of 191 couples. To accommodate an anticipated 20% attrition rate, the target sample was adjusted to 230 couples (230 males and 230 females). Following the application of pre-specified exclusion criteria, complete data from 220 couples (220 males and 220 females) were ultimately included in the final analysis.

Inclusion criteria consisted of having a firm decision to marry, having undergone premarital medical examinations, having educational attainment above elementary level for both partners, and providing informed consent to participate in the study. Exclusion criteria included diagnosis of intellectual disability or severe psychiatric disorder in the past year (e.g., bipolar disorder, schizophrenia, or severe depression, based on self-report or health records), being under legal guardianship, and incomplete questionnaire completion by either partner.

The researcher visited the Shokouhi Health Center in Amirkola and invited 430 couples to participate in the study, of whom 254 agreed and completed the research questionnaires. A total of 24 incomplete questionnaires were excluded from the study. Ultimately, 220 couples completed the demographic questionnaire, the Childbearing Desire Questionnaire (score range: 8-40), the Lifestyle Questionnaire (score range: 62–310), the Mental Health Questionnaire (score range: 0-72), and the Spiritual Health Questionnaire (score range: 20-120). The demographic questionnaire included age, sex, education, occupation, and history of illness. All ethical principles in research, including written informed consent, privacy protection, and confidentiality of information, were observed.

Childbearing Desire Questionnaire (Attitudes Toward Fertility and Childbearing Inventory= ATFCI): This is an 8-item self-report instrument employed to evaluate childbearing desire. Responses are recorded on a five-point Likert scale, ranging from strongly disagree to strongly agree. The internal consistency of the scale was established in the present study, with a Cronbach's alpha coefficient of 0.837, indicating satisfactory reliability. Total scores were computed by summing individual item responses,

yielding a possible range of 8 to 40. Based on total scores, participants were categorized into five groups: less than 13 (very low desire), 14-19 (low desire), 20-25 (moderate desire), 26-31 (high desire), and 32 or above (very high desire) (26).

Kern Lifestyle Questionnaire (Basic Adlerian Scales for Interpersonal Success–Adult Form= BASIS-A): The Kern Lifestyle Questionnaire consists of 62 items and comprises five primary subscales (Belonging/Social Interest, Going Along, Taking Charge, Wanting Recognition, and Being Cautious) and five secondary subscales (Harshness, Entitlement, Liked by All, Striving for Perfection, and Softness). Within the Adlerian framework, lifestyle is conceptualized as a relatively enduring personality construct that originates from early childhood experiences and subsequently shapes behavioral patterns in adulthood. Items are rated on a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), yielding a total score between 62 and 310, with higher scores reflecting a more adaptive and healthier lifestyle (27). Psychometric evaluation conducted by Bashiri et al. confirmed the instrument's satisfactory content, face, and criterion validity, and the internal consistency, as measured by Cronbach's alpha, was reported to exceed 0.7 (28).

The Brief Symptom Inventory-18 (BSI-18): The Brief Symptom Inventory, developed by Franke et al., is an 18-item self-report instrument comprising three subscales: depression, anxiety, and somatization. Responses are scored on a four-point Likert scale (ranging from "not at all" to "extremely"). Each subscale yields a score between 0 and 24, and the total score ranges from 0 to 72. The cut-off point for clinically significant symptoms is ≥4 for each subscale and ≥10 for the total score (29). This questionnaire was validated in Iran by Shaeiri. In the Iranian version, the validity was reported as 0.81 and the reliability as 0.90 (30).

The Spiritual Well-Being Scale (SWBS): Developed by Paloutzian and Ellison, this scale consists of 20 items and comprises two subscales: religious well-being and existential well-being. The total spiritual health score is calculated by summing these two subscales, with a possible range of 20 to 120. Responses are scored on a six-point Likert scale (ranging from strongly disagree to strongly agree). Scores are categorized into three levels: low (20-40), moderate (41-99), and high (100-120) (31). The reliability of this scale in an Iranian sample, based on Cronbach's alpha coefficient, was reported as 0.89 for the total scale, and the test-retest reliability coefficient was 0.82, indicating high internal consistency and stability over time (32).

Descriptive statistics for the participant characteristics were summarized using means and standard deviations for continuous variables, and frequencies and percentages for categorical variables. The normality of the data distribution was examined using the Kolmogorov–Smirnov test. To evaluate bivariate linear relationships between quantitative variables, Pearson's correlation coefficient was calculated. Univariate and multivariate linear regression models were then constructed to identify predictors of childbearing desire, with all study variables entered into the models. In the multivariate analyses, adjustments were made for potential confounding variables, including age, sex, and educational level. Unstandardized regression coefficients (B) along with their 95% confidence intervals were reported for each predictor. All statistical procedures were conducted using SPSS software (version 20), and a p-value of <0.05 was considered statistically significant.

Results

A total of 440 premarital or newly married couples (220 males and 220 females) were enrolled in the present study. The overall mean age of participants was 26.13±6.35 years, with male participants having a mean age of 28.55±6.47 years and female participants 23.71±5.22 years. The majority of participants (432

individuals, 98.2%) reported no underlying medical conditions, whereas 8 participants (1.8%) had a history of one of three common illnesses—namely, diabetes mellitus, hypertension, or thyroid disorders (Table 1). The mean total score for childbearing desire was 31.09±5.6, indicating a high level of desire among both men and women. The mean total lifestyle score was 197.58±13.59, reflecting an acceptable and moderate lifestyle status. The mean total mental health score was 5.85±8.91, suggesting good mental health overall. Regarding spiritual health, the mean total score was 98.45±16.92, which falls within the moderate range but is very close to the high category (Table 1).

Table 1. Demographic characteristics and variables of lifestyle, mental health, and spiritual health

Variable	Number(%) or Mean±SD
Age	
Under 25 years	243(55.2)
26 to 35 years	157(35.7)
Over 35 years	40(9.1)
Education	
Elementary and middle school	30(6.8)
High school diploma	106(24.1)
University education	304(69.1)
Occupation	
Unemployed	82(18.6)
Employed	354(81.4)
History of prior illness*	
Yes	8(1.8)
No	432(98.2)
Current illness**	
Ill	11(2.5)
Healthy	429(97.5)
Childbearing desire	31.09±5.62
Lifestyle	
Belonging/Social Interest	26.43±3.32
Going Along	33.13±3.87
Taking Charge	22.49±5.23
Wanting Recognition	25.14±4.18
Being Cautious	12.19±3.03
Harshness	20.50±3.03
Entitlement	16.35±3.7
Liked by All	8.65±2.1
Striving for Perfection	17.98±2.6
Softness	14.21±2.70
Total score	197.58±13.59
Mental health	
Somatization	1.95±2.60
Depression	2.23±3.18
Anxiety	2.31±3.10
Total score	5.85±8.91

Spiritual health	
Religious Well-Being	49.68±8.75
Existential Well-Being	48.78±8.92
Total score	98.45±16.92

[*]Of the 8 patients with a history of illness, 3 had diabetes, 2 had hypertension, and 3 had thyroid disorders. [**]Of the 11 current patients, 6 had diabetes, 3 had hypertension, and 2 had thyroid disorders. Scoring method for the main variables: Lifestyle: total score ranges from 62 to 310, with higher scores indicating a better lifestyle. Childbearing desire: less than 13 (very low or no desire), 14-19 (low desire), 20-25 (moderate desire), 26-31 (high desire), 32 or above (very high desire). Spiritual health: low (20-40), moderate (41-99), high (100-120). Mental health: cut-off for subscales (depression, anxiety, somatization): ≥4; total score cut-off: ≥10.

In univariate analysis, lifestyle components including Belonging/Social Interest (B=0.39, p<0.001), Going Along (B=0.49, p<0.001), Harshness (B=0.25, p<0.001), and Striving for Perfection (B=0.67, p<0.001) demonstrated significant positive associations with childbearing desire, while components such as Being Cautious (B=-0.64, p<0.001), Taking Charge (B=-0.22, p<0.001), and Liked by All (B=-0.34, p=0.007) showed negative associations. In the domain of spiritual health, both Religious Well-Being (B=0.59, p<0.001) and Existential Well-Being (B=0.59, p<0.001) exhibited strong positive associations with childbearing desire. On the other hand, mental health components, including Somatization (B=-0.33, p<0.001), Depression (B=-0.40, p<0.001), and Anxiety (B=-0.36, p<0.001), revealed significant negative associations with childbearing desire (Table 2).

Table 2. Association of lifestyle, mental health, and spiritual health with childbearing desire among couples preparing for marriage

Variable	Univariate analysis		
	B (SE)	95% CI	p-value
Lifestyle			
Belonging/Social Interest	0.39 (0.07)	0.52 – 0.81	0.001
Going Along	0.49 (0.06)	0.36 – 0.62	0.001
Taking Charge	0.10 (0.06)	-0.02 – 0.23	0.104
Wanting Recognition	-0.64 (0.08)	-0.81 – -0.48	0.001
Being Cautious	-0.22 (0.05)	-0.33 – -0.13	0.001
Harshness	0.25 (0.08)	0.30 – 0.63	0.001
Entitlement	0.15 (0.07)	0.08 – 0.36	0.002
Liked by All	-0.34 (0.12)	-0.59 – -0.09	0.007
Striving for Perfection	0.67 (0.09)	0.31 – 0.86	0.001
Softness	0.04 (0.02)	0.16 – 0.31	0.517
Total score	0.04 (0.02)	0.00 – 0.08	0.026
Spiritual health			
Religious Well-Being	0.59 (0.02)	0.33 – 0.43	0.001
Existential Well-Being	0.59 (0.02)	0.32 – 0.41	0.001
Total score	0.30 (0.01)	0.17 – 0.22	0.001
Mental health			
Somatization	-0.33 (0.08)	-0.80 – -0.46	0.001
Depression	-0.40 (0.07)	-0.87 – -0.56	0.001
Anxiety	-0.36 (0.07)	-0.74 – -0.46	0.001
Total score	-0.39 (0.02)	-0.30 – -0.19	0.001

Linear regression test (p<0.05)

In the multivariate regression model, spiritual health (B=0.52, p<0.001), age (B=-0.10, p=0.014), and educational level (B=-0.07, p=0.049) retained their statistically significant associations with childbearing desire. Conversely, lifestyle (B=0.03, p=0.420) and mental health (B=-0.07, p=0.089) did not reach statistical significance in the final model. Notably, for each one-unit increase in spiritual health score, childbearing desire increased by 0.5 units (B=0.5). Sex (B=-0.05, p=0.184) was also not significantly associated with the outcome in the final model (Table 3).

Table 3. Associations of lifestyle, mental health, and spiritual health with childbearing desire among couples preparing for marriage in univariate and multivariate regression analyses

Variable	Univariate analysis			Multivariate analysis		
	B (SE)	95% CI	p-value	B (SE)	95% CI	p-value
Lifestyle	0.04 (0.02)	0.00 – 0.08	0.026	0.03 (0.01)	-0.02 – 0.04	0.420
Spiritual health	0.30 (0.01)	0.17 – 0.22	0.001	0.52 (0.01)	0.14 – 0.20	0.001
Mental health	-0.39 (0.02)	-0.30 – -0.19	0.001	-0.07 (0.02)	-0.10 – 0.01	0.089
Sex (female/male)	-0.14 (0.53)	-1.10 – 0.91	0.793	-0.05 (0.42)	-1.46 – 0.47	0.184
Age	-0.23 (0.04)	-0.29 – -0.13	0.001	-0.10 (0.03)	-0.01 – -0.02	0.014
Education (below diploma/diploma/university)	-1.76 (0.43)	-2.61 – -0.91	0.001	-0.07 (0.36)	-1.54 – -0.10	0.049

Univariate and multivariate linear regression analyses (p<0.05)

Discussion

The results of the current investigation identify spiritual health, age, and level of educational as three principal and statistically significant determinants that independently predict the desire for childbearing among couples preparing for marriage. Among these, spiritual health emerged as the most robust predictor, demonstrating the strongest positive association with childbearing intentions. In contrast, both increasing age and higher educational status were consistently associated with a modest decline in childbearing desire. These observed patterns are corroborated by the broader empirical literature, wherein multiple studies have affirmed that individuals reporting higher levels of spiritual well-being tend to express more favorable attitudes toward childbearing (33, 34). This convergence of evidence is plausibly rooted in the multifaceted functions of spirituality—namely, its capacity to instill a sense of hope and purpose, bolster psychological resilience in the face of life's challenges, and cultivate a state of emotional preparedness that facilitates the acceptance of the responsibilities and demands inherent in parenthood (35, 36).

Beyond these universal mechanisms, the specific cultural and religious landscape of Iran, where spirituality and religious observance occupy a central position in social life, may serve as a contextual amplifier, further accentuating the positive relationship between spiritual health and reproductive intentions. Nonetheless, the empirical picture is not entirely uniform; a subset of studies has yielded divergent or even contradictory findings concerning the influence of religious orientation and religiosity on childbearing desires (17, 18). These discrepancies are likely attributable to a range of methodological factors, including the use of diverse measurement instruments.

An additional noteworthy finding of the present study was the inverse association between both age and educational level and childbearing desire, a pattern that has been consistently documented in prior research (17, 37). Advanced maternal age, apprehension regarding fertility and offspring health, and the pursuit of academic and professional achievements have all been identified as contributing factors to the postponement of childbearing among women (38). Furthermore, lack of personal autonomy, occupational demands,

physical transformations associated with aging, and the challenge of balancing multiple life roles may constitute important determinants of reduced childbearing intentions. In the present study, while lifestyle and mental health demonstrated statistically significant associations with childbearing desire in univariate analyses, these effects were attenuated and failed to reach significance in the multivariate regression model. Within the cultural context of Iran, where religion and spirituality occupy a central and influential position, it is plausible that spiritual health assumes a more dominant role relative to other psychosocial variables, thereby accounting for the non-significance of lifestyle and mental health after adjustment. An alternative explanation is that spiritual health may function as a mediating variable; that is, individuals with greater spiritual well-being may also experience better mental health indirectly, which in turn may enhance their psychological resilience and prepare them more effectively for the challenges of parenthood. Moreover, the absence of a significant effect for sex in the final model may reflect a shift toward more egalitarian decision-making patterns among Iranian couples, suggesting that both partners are increasingly participating equally in reproductive choices.

In alignment with the findings of the present study concerning lifestyle, previous investigations have demonstrated that individual value systems and personality attributes, including social interest, a sense of belonging, and the drive for perfection, exert a positive influence on childbearing intentions (23). Conversely, personality dispositions such as irresponsibility, a tendency toward comfort-seeking, and excessive caution have been associated with the devaluation of childbearing as a life goal (39, 40). Furthermore, evidence indicates that psychological distress—manifesting as anxiety, depression, and chronic stress—may constitute a significant barrier to parenthood (17). Specific concerns, including fear of maternal role obligations, identity conflict, and apprehension regarding both physical and psychological changes accompanying parenthood, are consistently linked to diminished childbearing desire. These effects are further compounded by culturally mediated social pressures that prioritize career advancement and educational achievement prior to transitioning into motherhood (41).

The results of the present study have important implications for the design of educational and counseling interventions targeted at enhancing childbearing desire among young couples. Specifically, interventions that focus on strengthening spiritual well-being—through spirituality-oriented programs, coping skills training, and cognitive restructuring of attitudes toward childbearing—may prove effective in fostering reproductive intentions. Furthermore, given the negative impact of age and education, supportive policies for young couples, such as financial facilities, academic support, and career assistance, could help reduce delays in childbearing. The present study is not without limitations, including the use of convenience sampling, reliance on self-report questionnaires, and the cross-sectional design, which precludes the establishment of causal relationships. Future research should adopt longitudinal designs, employ random sampling strategies, and include larger and more geographically representative samples to enhance the generalizability of findings.

The findings of the present study indicate that spiritual health was the most significant predictor of childbearing desire among couples, whereas advancing age and higher educational attainment were associated with a diminished desire for childbearing. Interventions designed to enhance spiritual well-being, combined with supportive measures for young couples, may hold promise for improving fertility rates.

Conflicts of Interest: The authors declare no conflicts of interest.

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