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Original Article

Nursing Section

The Effect of Group Sexual Counseling Based on Cognitive Behavioural Approach on Sexual Satisfaction of Women

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ABSTRACT

Introduction: Sexual satisfaction is an important factor in the prevention of sexual dysfunction in women. It is an important factor in the healthy emotional and physiological aspects of sexual relationship.

Aim: The aim of this study was to assess the effect of sexual counselling by cognitive behavioural approach on sexual satisfaction of women.

Materials and Methods: This randomised clinical trial was conducted in two groups with pre-test and post-test on 198 women referred to selected health centres of Hamadan, 2016. The centres were randomised and taken as experimental and control group, three centres were selected as a control group and three as experimental group. The participants were selected by simple random sampling. The intervention group received four sessions (two hours) of group sexual counselling. Before and after the intervention, the demographic and sexual satisfaction questionnaires were completed.

Results: After intervention, there were significant difference between two groups regarding sexual satisfaction ($p<0.001$). The mean score of the experimental group significantly decreased ($p<0.001$) and the mean score of sexual dissatisfaction in the control group didn't changed significantly ($p=0.625$).

Conclusion: The research findings showed that group sexual counseling based on CBT had an effect on the sexual satisfaction and increased women's sexual satisfaction.

Keywords: Cognitive therapy, Iran, Sex counselling

INTRODUCTION

Sex is a requirement for every living being and mature creature, and its importance in a relationship is inevitable [1].

Now-a-days 50 percent of marriages failure is due to the lack of sexual satisfaction. Sexual satisfaction is not only physical pleasure but it also includes all feelings remaining after positive and negative aspects of sexual relationships [2]. Sprecher and Cate's definition for sexual satisfaction is: the degree to which an individual is satisfied or happy with the sexual aspect of his or her relationship [3]. General sexual satisfaction is basically a (subjective) assessment of one's sex life independent of sexual activity. Sexual satisfaction have significant relationship with variables such as frequency of orgasms experienced, the number of intercourse per week, duration of sex, age difference between spouses, duration of marriage, addiction, marital commitment, education and relationships such as supporting relationships, empathy and love [2,4,5]. Sexual satisfaction is an important factor in the prevention of sexual dysfunction in women and it is a multidimensional concept that includes emotional and physiological aspects of sexual relationship [6].

Sexual counselling can provide expert advice to create good information about sexual issues that is necessary for couples. Midwives due to their awareness of sexual health issues and constant contact with the community, can play an important role as family counsellors [7].

In contemporary clinical trials, Cognitive Behaviour Therapy (CBT) is the most popular and the most applicable model of psychotherapy because of its effectiveness among different populations [8]. In CBT, individuals learn to fight with negative thoughts about sexual issues by using problem-solving ability. It is also a way to enhance and maintain good physical and psychological feelings between couples [9]. One of the main components of consultation with cognitive behavioural approach is providing sexual information related to sexual response cycle, anatomy and sexual techniques [8]. In CBT, the strengths of the behavioural therapy and cognitive therapy approaches, i.e., the objectivity, assessment and evaluation and the involvement of the role of memory in the reconstruction and interpreting the information, have been prepared [10, 11].

Based on previous studies, it seems that the level of sexual satisfaction and sexual knowledge in Iranian women population is not desirable. The study conducted by Mofarrah S et al., proved that marital counselling increased sexual satisfaction [2] but this research was not based on CBT method.

Researchers believe that couples unsatisfactory sexual relationships can cause feeling denial, frustration, unhappiness and might lead to the divorce of the couples [7].

The findings of a descriptive-correlation study, conducted by Shakerian A et al., showed that the individuals (Divorce asking women) with lower sexual satisfaction, have higher marital problems scores [12]. It seems that being aware of sexual issues avoids sexual disorders and helps individuals to deal with such problems. It can be expected that providing sexual counselling about such issues can decrease the women's sexual problems. Although a limited number of studies have been conducted about the necessity of methodological counselling in sexual issues in Iran, the cause of conducting this study was to prove the necessity of using sexual satisfaction screening tests and cognitive behavioural counseling services for qualified women referring to health centres. One of the important differences of the present study with the previous studies is that, we used extensive training content in a different socio-cultural context and emphasis on reviewing all homework's of CBT at every meeting. In this study, we used group counseling to provide an opportunity for participants to share their experiences, learn perspectives, and experiment with new behaviours in a supportive environment. Also, the cognitive reconstruction helps them for getting information, ideas and skills. Despite the observed positive effect of CBT in the most previous studies, researchers do not refrain from exploring and explicitly working on sexual problems. Also, due to the socio-cultural differences and the different needs that are being created, studies of this kind are needed. Considering the importance of sexuality and its impact on the health of the family and society,

this study was designed to assess the effect of sexual counselling based on cognitive behavioural approach on sexual satisfaction of women referring to health centres in Hamadan city, Iran.

MATERIALS AND METHODS

The present study was carried out as a randomised clinical trial including an intervention group (n=99) and a control group (n=99) with a pre-test and a post-test on qualified women referring to the selected health care centres of Hamadan, between March and June 2016.

The sample size was determined based on the data of previous study [13]. Based on this information, the sample size was determined to be 82 in each group, and the final sample size became 198 due to the given loss of 20%. The study inclusion criteria were literate married women living in Hamadan city with the age range of 15-45 years (reproductive age) with their duration of marriage was at least 6 months, having less than 10 years of age difference between spouses, no background of remarkable physical and psychological diseases such as psychotic disorders like schizophrenia and severe depression that need special medicine or diet. The study exclusion criteria were pregnancy during the study and unwillingness to continue the study.

Six heath centres were randomly assigned to a control group and an intervention group. Three pairs of health centres (each pair consisted of two near centres that were similar in social, economic, cultural and geographical terms) were randomly selected (the social class of the pair centres was assigned; one pair from the uptown, one from the middle, and one from the downtown). Of which, three centres were randomly assigned to the control group and three to the intervention group. The sample size in each centre was chosen to be 28 individuals, and due to the probable loss of 20%, 33 individuals were selected in each centre using simple random sampling and the total sample size became 33×6=198. The participants of each centre were invited through a public invitation of participating in the research (the inclusion criteria were included in the invitation) which was stuck on the clinics' bulletin. All the participants were emphatically informed that participation in the study was completely voluntary and that they were able to quit it at any stage without any restrictions. A week before the beginning of the intervention in each centre, the participants took the pre-test. In the pre-test, the participants of both groups filled out the informed consent form, the demographic information questionnaire, and the ISS (Index of Sexual Satisfaction) or Hudson sexual satisfaction questionnaire. The demographic questionnaire included age, education level and job of the couples, family income, duration of marriage, number of pregnancies, number of children, and addiction background of the couples. ISS is a 25-item (12 positive questions and 13 negative questions) self-report scale measuring the sexual dissatisfaction level. Respondents provided their attitude based on the seven-point likert scale ranging from "none of the time" (1) to "all of the time" (7). Positive questions have reverse scores and the total score is obtained from summation of all normal and reversed score of the questionnaire, which is between 0-100. The higher score shows the greater sexual dissatisfaction. The clinical cut-off scores under 30 indicate no clinically significant problem, more than 30 indicate significant dissatisfaction [14]. Cronbach's alpha for the original version of this questionnaire was 0.91 [14], and 0.89 for the one translated into Persian in previous studies [4]. So, after construct validity questionnaire translations, it was given to 10 professors of medical and midwifery faculties and revised. After the primary assessments, the intervention group was provided with consultation while the control group received no intervention. The target consultation was provided in the form of cognitive behavioural counselling sessions in 4 two-hour sessions for four weeks [15]. Each session involved questions and answers, lecturing, group discussion (in groups of maximum 10 individuals), and presentation of slides. In order to provide the consultation, cognitive behavioural therapy was used. Each session included:

Session 1: Identification of inefficient beliefs and explaining negative thoughts regarding sexual satisfaction.

Psychological training: Investigating the cognitive behavioural model, introducing cognitive distortions (irrational thoughts that influence the client's emotions) affecting sexual satisfaction

Homework: Reviewing cognitive distortions

Session 2: Examining the homework

Psychological training: Examining strategies to fight against cognitive distortion

Homework: Exercising identification of cognitive distortion using thoughts recording sheets

Session 3: Examining the homework

Psychological training: Introducing preventive methods of behaviours and thoughts that lead to the sexual dissatisfaction. For example, cognitive restructuring that is a strategy to recognise negative, inaccurate thoughts and replace them with alternative ones that are more realistic and helpful.

Homework: Cognitive reconstruction (putting thoughts on trial), completing the thought records, practicing coping, self-observation, behavioural exercises, couple communication and preventing inappropriate behaviours and thoughts

Session 4: Examining the homework

Psychological training: Discussion on strategies of preventing sexual dissatisfaction and its treatment.

Homework: Practicing preventive strategies of sexual problems that lead to sexual dissatisfaction (relapse prevention: a good relapse prevention plan will help the clients to recognise when they are at risk, and it will give them several ways to navigate these experiences successfully)

Participants were informed about the date of attending the sessions through phone calls. Moreover, one day before the sessions, the individuals were reminded about the sessions in order to prevent sample loss as much as possible. Consultation was provided by three midwifery MSC graduates who had participated in cognitive behavioural counselling courses held by a clinical psychologist. Moreover, on a methodology for teaching and counselling, the trainers used a uniform teaching method. After the end of sessions, both groups took the post-test in which the data of sexual satisfaction were measured again. For ethical considerations, by the end of the study, sexual counselling to control group was provided. In order to analyse the collected data, baseline characteristics were compared between groups using linear regression when we need adjusting for continuous variables, chi-square tests or fisher's-exact test for independent and Mc-Nemar tests dependent categorical variables. Descriptive analyses used mean±standard deviation and percentage (number), whereas intergroup comparisons were done using chi-square test, Stuart-Maxwell test and covariance analysis or change analysis. No participants were excluded from the study. All of the tests were carried out at a confidence level of 95%.

RESULTS

The results revealed that average age of the women were 35.04±7.91 and 32.58±7.54 years old in intervention and control groups, respectively. There were no significant differences in the two group's husband's age, number of children, addiction of spouses, education level of the couples and sexual satisfaction but in terms of age and income, they were significantly different [Table/Fig-1].

In order to adjust the effects of income, income was merged as more than 10 million Rials (270 dollars) and below 10 million Rials. According to the results of [Table/Fig-2], after counseling intervention in the experimental group sexual satisfaction improved, that is about 13% of women had sexual dissatisfaction and none of the cases had serious problem. Also, [Table/Fig-2] indicates the presence of sexual dissatisfaction in most individuals of both

Demographic variables		Intervention group		Control group		p-value
		Mean	SD	Mean	SD	
Age (year)		35.04	7.91	32.58	7.54	0.02
Husband's age (year)		39.13	8.17	37.23	8.01	0.10
Duration of marriage (year)		8.95	7.67	8.49	6.99	0.66
Number of children		1.74	0.86	1.53	0.96	0.10
		Frequency	(%)	Frequency	(%)	
Educational status of participants	Primary school	8	8/1	11	11.1	0.060
	Secondary school	10	10.1	16	16.2	
	High school	26	26.3	35	35.4	
	Diploma	33	33.3	28	28.3	
	Higher education	22	22.2	9	9.1	
Husband's educational status	Primary school	7	7.1	10	10.1	0.65
	Secondary school	14	14.1	17	17.2	
	High school	19	19.2	27	27.3	
	Diploma	36	36.4	37	37.4	
	Higher education	23	23.2	8	8.1	
History of women addiction	Yes	1	1	1	1	1
	No	98	99	98	99	
Husband's history of addiction	Yes	26	26.3	21	21.2	0.404
	No	73	73.7	78	78.8	
Family income (dollar)	Below 270	40	40.4	46	46.4	p<0.001
	More than 270	59	59.6	53	53.6	

[Table/Fig-1]: Demographic variables of intervention and control groups.

Variables		Status of sexual satisfaction	Intervention group		Control group		p-value
			Frequency	(%)	Frequency	(%)	
Sexual satisfaction	Before	Sexual dissatisfaction	98	98.99	97	88.98	p=0.5
		No problem	1	1.01	2	2.02	
	After	Sexual dissatisfaction	13	13.13	99	100	p<0.001
		No problem	86	86.87	0	0	
			p<0.001		p=0.625		

[Table/Fig-2]: The frequency of sexual satisfaction of the intervention and control groups before and after intervention based of cut-off scores.

groups before the intervention, so that only 3 of the 198 women had sexual satisfaction (score less than 30). [Table/Fig-3] shows the mean and standard deviation of sexual satisfaction score after adjusting the effect of age and income. The results showed that before the intervention, there were no significant differences between both groups regarding sexual satisfaction score, but after counseling intervention, the mean score of the experimental group showed a significant reduction. In other words, the intervention has led to the improved sexual satisfaction score in this group. Also, slight but significant difference was observed in the mean sexual satisfaction of control group (p<0.001). In other words, the control group showed a significant reduction in sexual satisfaction, for example, after the intervention the problem of 11 members of the control group (11 percent) became more severe.

Variables		Intervention group		Control group		p-value
		Mean	SD	Mean	SD	
Sexual satisfaction	Before	66.11	12.16	67.14	12.91	0.56
	After	21.12	10.40	70.13	12.82	p<0.001
	p-value	p<0.001		p<0.001		
	R Squared=0.820 (Adjusted R Squared=0.817)					

[Table/Fig-3]: The mean and standard deviation of sexual satisfaction score after adjusting the effect of age and income by using analysis of covariance.

DISCUSSION

The present study aimed to investigate the effect of the group sexual counseling using cognitive behavioural approach on women's sexual satisfaction. The findings revealed that cognitive behavioural counseling approach lead to increased sexual satisfaction by decreasing patients' negative affect.

In the present study, women's sexual satisfaction score was low before the intervention. But in a descriptive study conducted by Ziaee T et al., among 140 married employed women, the results were different and showed that most of the participants (56.4%) were extremely satisfied and just 0.7% were not satisfied with their sexual relationship. The reasons of this inconsistency can be the self-constructed questionnaire (demographic characteristic and sexual satisfaction scale) and the difference between participants' job. In our study, most of the women were housewife but in the mentioned study, all of the respondent had job [16].

In the present study, after intervention, the sexual satisfaction scores increased significantly and sexual cognitive behavioural counseling was effective in improving sexual satisfaction score. So far in numerous studies the usefulness of using cognitive behavioural counseling on improving marital satisfaction [17], reducing and resolving marital conflicts [18], improving sexual function [15], sexual knowledge [19], reduction of dysfunctional attitudes and anxiety and increasing dependency in relations between spouses [20] and many other problems has been proven.

Regarding the use of this method in improving sexual satisfaction, however there are many studies in Iran but most of them are not based on CBT and have some limitations such as small sample size and have used different questionnaire for gathering their data. Fatehizadeh M et al., in a quasi-experimental study concluded that cognitive behavioural sexual counselling leads to improvement of the women's sexual satisfaction, which is consistent with the results

of the present study [6]. Also, another Persian study conducted by Shams-Mofaraheh Z et al., mentioned that 4 one-hour sessions of sexual counseling can significantly increase the sexual satisfaction in both men and women which is consistent with the findings of the present research [2]. Shams-Mofaraheh Z et al., in a study conducted in 2015 on sexual satisfaction, achieved similar results. In this study, marital counseling for 5 sessions (one hour) was leading to improved sexual satisfaction [21]. These three mentioned studies used the Larson sexual satisfaction questionnaire and the number of each group's participants was fewer than our study's sample size and their methodology was not based on CBT. Another clinical trial done by Pourheidari S et al., also found that training of sexual skills and life skills (10 sessions of 3 hours) is effective on sexual and marital satisfaction and scores of experimental group (18 couples who referred to a consulting centre in Mashhad), compared with pre-test and in comparison with the control group (18 couples) increased significantly. In this study, researchers used Berg-Cross sexual satisfaction questionnaire which is different from our questionnaire [22]. Vizheh M et al., investigated the effect of three sessions counselling including training tips about infertility, communication skills and sexual issues on the sexual satisfaction of infertile women and reported that counselling can enhance sexual and marital satisfaction in the experimental group which is consistent with the findings of the present study [23]. Sasanpour M showed that sexual cognitive reconstruction therapy can reduce sexual problems of couples and increase their sexual satisfaction but in this research, the sample size in each group was just 10 couples and they were selected from clients of a consultation centre. The results of this research can't be generalised to the community [24].

LIMITATION

The large sample sizes and participating of reproductive age women from different social class are the strengths of this research. The limitation of this study that can be noticed is that this study shows the effect of short-term intervention and does not encompass the long-term effects of intervention and follow-up. Limiting the participants just to women was another limitation of this study.

CONCLUSION

The findings of this study highlight the important role of cognitive behavioural counselling and its positive effect on enhancing women's sexual satisfaction through increase of positive and pleasant behaviour, improving communication, problem solving skills and solving the sexual problem and seeking for a way to prevent the sexual dissatisfaction.

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