Effectiveness of Sexual Skills Training Program on Promoting Sexual Intimacy and Satisfaction in Women in Tehran (Iran): A randomized Clinical Trial

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Purpose: The purpose of this study was to evaluate the effectiveness of sexual skills training on intimacy and sexual satisfaction in women.

Materials and Methods: This is a randomized clinical trial study with parallel design. 70 participants (n=35 each) were divided into 2 groups as control and intervention groups. Women were selected in multiple steps. Some requirements for inclusion criteria were: obtaining a standard score of marital satisfaction, women with a record of 6-24 months of marital life, not having a record of abortion, stillborn birth and not being in pregnancy period, not having a child, not suffering from an acute or chronic and serious disease, not having a surgery on pelvic organs, minimum elementary education of the couples and being Iranian. Exclusion criteria were: women's absence in more than 2 training classes, pregnancy during the study. Data collection was conducted through four questionnaires: demographic characteristics, marital satisfaction, sexual satisfaction and sexual intimacy. Validity and reliability of the questionnaires were measured through content validity and Chronbach Alpha, respectively. The data extracted from the questionnaires were analyzed using SPSS software, version 18.0. For data analysis, descriptive statistics, independent *t*-test, paired *t*-test, or non-parametric tests were applied. Significance level of the test was considered $p < 0.05$.

Results: The results showed that sexual skills training leads to promotion of sexual satisfaction ($P < 0.001$) and sexual intimacy ($P < 0.001$) among the women in intervention group and the impact of training was stable two months after completion of intervention.

Conclusion: In total, the training lessons gave positive views to participants towards their sexual issues so that they formed realistic and positive sexual expectations, healthier sexual behaviors and self-expressions and consequently, gained more sexual knowledge that made them able to experience more intimacy and satisfaction in sexual relationships with their spouses.

Keywords: sex education; sexual satisfaction; intimate relationship; Iran

INTRODUCTION

Intimacy in a satisfactory sexual relationship is connected to the quality of marital life. Coordination and satisfying the couples' needs, satisfying emotional needs of each other, having the skills related to mutual understanding and the knowledge on how to love and how to show passion can lead to satisfaction with and survival of marital life[(1)].

Intimacy has been defined as closeness, similarity and passionate or emotional relationship with someone else that requires a deep understanding and knowledge of each other in order to express the thoughts and feelings that are considered as a source of similarity and closeness[(2)].

For an intimate relationship, sexual relationship is very important. Although sexual relationship without intimacy and love is possible, the most pleasant sexual relationship takes place with love and intimacy[(3)]. In the existing literature, perceived sexual conversation

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Table 1. Some Demographic characteristics of both control and intervention groups of women

Variable	Control group	Intervention group	*p*-value
Women's age*	25.97 ± 4.495	26.03 ± 4.712	0.95
Men's age*	29.06 ± 3.262	30.40 ± 4.685	0.16
Monthly household income (Tomans) **	1512857.14	1528571.43	0.73
Duration of marriage (months)*	17.77 ± 7.341	14.14 ± 7.769	0.11
Average number of sexual relationships during one week*	2.57 ± 1.195	2.77 ± 1.140	0.29
Women's education***			
Elementary school	1 (2.9)	0 (0)	0.18
Secondary-high school	5 (14.3)	1 (2.9)	
Diploma	5 (14.3)	8 (22.9)	
Higher education	24 (68.6)	26 (74.3)	
Men's education***			
Elementary school	1 (2.9)	0 (0)	0.19
Secondary-high school	5 (14.3)	2 (5.7)	
Diploma	13 (37.1)	9 (25.7)	
Higher education	16 (45.7)	24 (68.6)	
How they met each other for marriage***			
Friendship before marriage	9 (25.7)	3 (8.6)	0.11
Personal acquaintance	4 (11.4)	4 (11.4)	
Being introduced by family or relatives	21 (60)	22 (62.9)	
Being introduced by fellow workers	0 (0)	4 (11.4)	
Other	1 (2.9)	2 (5.7)	
Duration of menstruation (day)***			
3-6 days	21 (60)	23 (65.7)	0.62
Longer than 6 days	14 (40)	12 (34.3)	
Interval between two menstruations (day)***			
Shorter than 20 days	2 (5.7)	2 (5.7)	0.55
20-35 days	31 (88.6)	33 (94.3)	
Longer than 35 days	2 (5.7)	0 (0)	
Normal contraception***			
LD pills	3 (8.6)	2 (5.7)	0.56
Condoms	12 (34.3)	17 (48.6)	
Intramuscular injections	0 (0)	0 (0)	
Levonorgestrel (emergencies)	0 (0)	0 (0)	
Natural contraception	20 (57.1)	16 (45.7)	
IUD	0 (0)	0 (0)	
Lack of contraception	0 (0)	0 (0)	
Source for collecting information on sexual issues***			
Book	5 (14.3)	4 (11.4)	0.51
Friend	3 (8.6)	0 (0)	
Family/ spouse	4 (11.4)	2 (5.7)	
Midwife/doctor	3 (8.6)	3 (8.6)	
Internet	3 (8.6)	5 (14.3)	
Satellite channels	0 (0)	0 (0)	
Movies/CD	1 (2.9)	0 (0)	
Other	0 (0)	1 (2.9)	
Multiple ways (combined)	16 (45.7)	20 (57.1)	

*mean ± SD ** average *** (%)
The results were obtained from independent t-test, Mann-Whitney, Chi-Square and Fisher's Exact test.

has been mentioned as the most common factor related to sexual satisfaction[4]. Therefore, the couple's skill in communicating about sexual needs and interests is significant in order to retain sexual and a general satisfaction with the relationship[3]. Intimate sexual conversation is an important way for attaining key information on sexual arousal and confidence, intimacy, emotional support and ultimately increasing sexual satisfaction for both sex[5].

counselors realized that most sexual problems result from issues related to the couple's sexual intimacy not physiological problems. Such problems include differences in sexual preferences about number, place, time and manner of sexual activity, presence or duration of foreplay and afterplay, the degree of interest and type of communication style used by each of the partners[3]. According to the results of reports presented in Iran, many couples suffer from lack of sexual satisfaction so that 50- 60% of divorces and 40% of non-marital and secret relationships are due to this problem[6-8]. Abdoly and Pourmosavi found out that about 70% of women in Tehran who referred to the courts to get divorced complained about sexual dissatisfaction[9]. It is remarkable that complaining about sexual dissatisfaction among women was more than among men. Despite occurrence of such unwholesome problems, many couples felt shameful and sinful to outline and talk about their sexual problems. As a result, they reflected their problems in the form of anxiety, depression, sleeping disorders or genital diseases. Moreover, many couples are negligent about the impacts of this sexual dissatisfaction on their marital dissatisfaction[6,10].

One problem faced by today Iranian society is lack of sufficient information regarding sexual issues and ex-

Table 2. A comparison of means of marital satisfaction, sexual intimacy and sexual satisfaction variables before and after training lessons, in control and intervention groups in women

Variable	control group	intervention group	*p*-value*
Marital satisfaction before training	162.06±21.327	158.80±23.725	0.44
Sexual intimacy before training	102.80±11.737	102.77±11.687	1
Sexual satisfaction before training	102.17±11.341	103.46±11.436	0.53
Sexual intimacy after training	102.14±11.758	110.97±9.253	0.001
Sexual satisfaction after training	101.23±12.455	108.40±11.755	0.003

*The results were obtained from Mann-Whitney and Wilcoxon test. Data presented as mean±SD.
Score range of Marital satisfaction questionnaire: 47-235
Score range of sexual intimacy questionnaire: 30-120
Score range of sexual satisfaction questionnaire: 25-125

istence of improper attitudes and beliefs towards this subject. In other words, there is a misconception of sexual affairs[8]. Therefore, it seems that Iranian women's main challenge is their weakness or lack of skills in communicating with spouse and perhaps, sexual relationship begins while sufficient intimacy has not been established between the couple. That's what Young and Schwartz call non-artistic dialogue and believe that it will lead to some problems for sexual relationships [11]. Therefore, true and right training of sexual skills in order to enhance those skills among couples, early prevention from sexual problems and promoting sexual health are proposed as critical strategies in this respect [12,13]. Such learning makes the couples more aware and sensitive in their interpersonal relationships which leads to more intimacy and pleasure in their marital life [14,15]. So, with respect to the emphasis put by World Health Organization on sexual health, i.e. "equality and mutual respect in sexual relationship" and on "talking with the sexual partner to ensure that the sexual relationship occurs as the partner wishes",[16] the training concepts included in this study which emphasize the effective factors on several aspects of sexual intimacy have been less considered and this study aims to examine the effectiveness of sexual skills training programs in enhancement of sexual satisfaction and intimacy in women living in Tehran.

MATERIALS AND METHODS

Sampling

This randomized clinical trial study with parallel design, was conducted in 2015-2016 in which the research community was composed of all volunteer women who referred to healthcare centers at Shahid Beheshti University of Medical Sciences in Tehran metropolitan. By considering sample loss in follow-up, 35 subjects were included in each control and intervention groups and total 70 samples were selected for this study (**Figure 1**). The healthcare centers were selected using a multi-step selection method from healthcare centers covered by Shahid Beheshti University of Medical Sciences which were geographically located on the north-eastern, eastern and south-eastern areas in Tehran. We first prepared a list of healthcare centers covered by that university

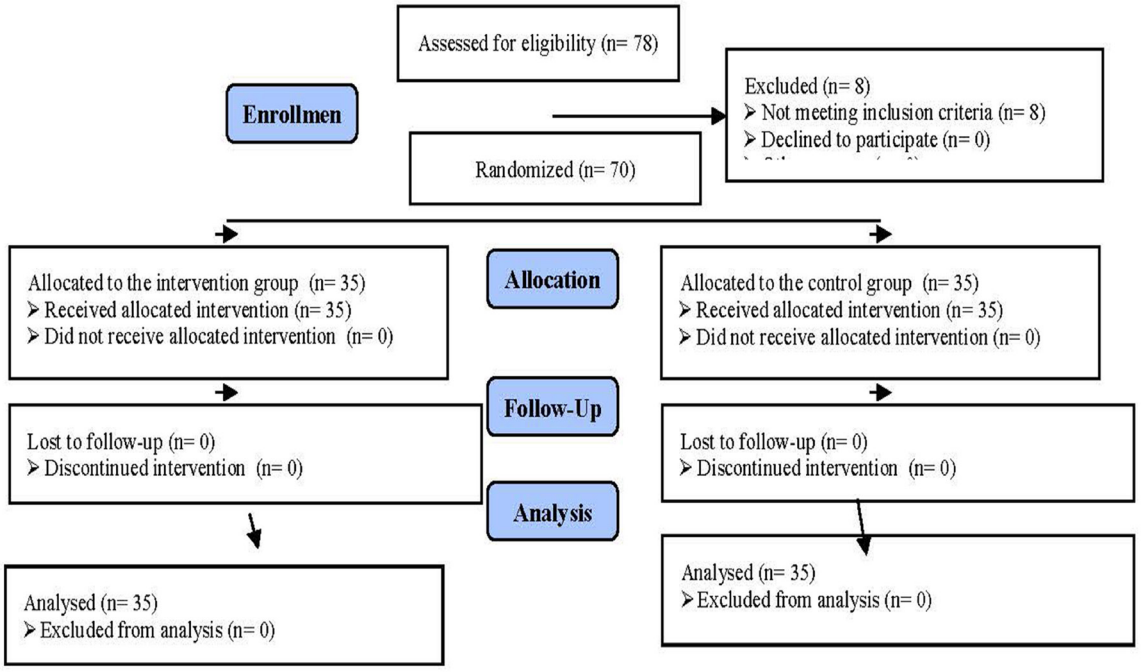

Figure 1. Flow diagram of the study

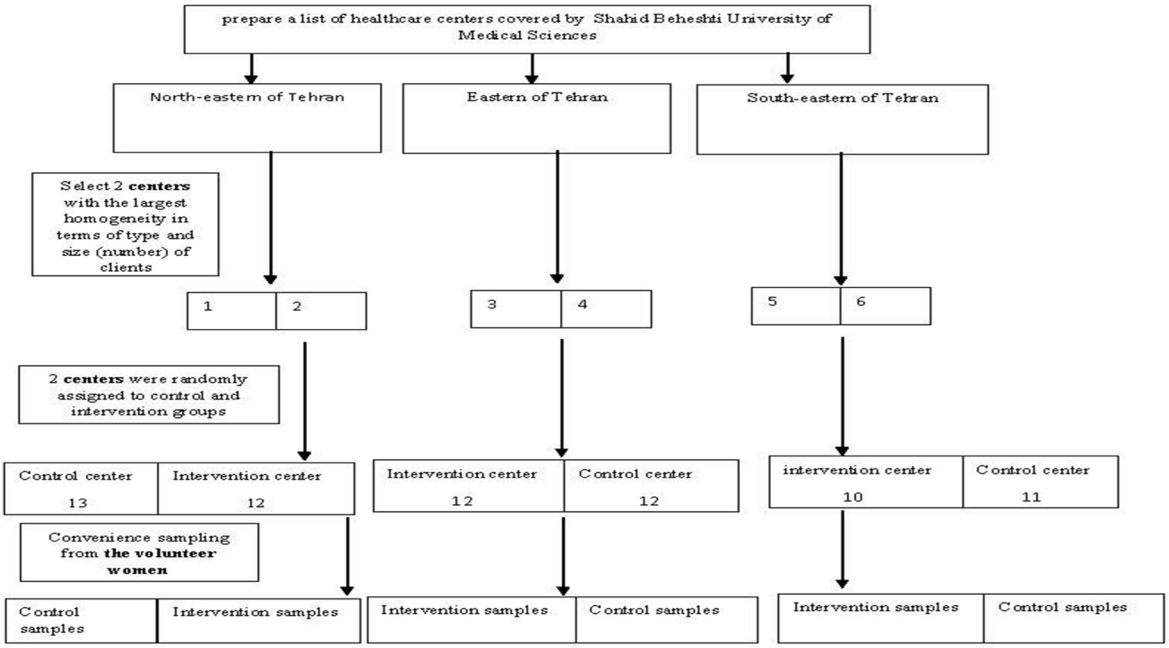

Figure 2. Random allocation of centers

and then 2 centers with the largest homogeneity in terms of type and size (number) of clients were selected from each geographical district (north-east, east and south-east) in Tehran by two-stage cluster sampling method. Finally, these 2 centers were randomly assigned to control and intervention groups through simple randomly assignment method (tossing up a coin), so that the subjects taught to the research units in the intervention group were not accessible for those in the control group. Therefore, in total, 6 healthcare centers, 3 for the intervention group and 3 for the control group, were selected. Convenience sampling from the volunteer women was performed after public notifications across the selected centers (**Figure 2**).

After preliminary interviews with the qualified candidate women and giving the necessary information on how the study was supposed to be conducted, they were asked to take counsel with their husbands if they wished to participate in the study and if their husbands agreed, they could participate. Then the qualified volunteers were evaluated using ENRICH marital satisfaction scale in order to investigate their level of satisfaction with their marriage. The short form of this scale includes 47 items composed of 9 sub-scales (personality issues, marital relationship, conflict resolution, financial management, leisure time activities, marriage and children, relatives and friends, religious bias, sexual relationships). The sum of scores for all 9 sub-scales is indicative of marital satisfaction. Responses to the items were given in Likert-type five-item scale (strongly agree to strongly disagree). The items were scored in 1-5 range. A standard score (t) less than 30 indicated severe dissatisfaction, a standard score (t) from 30 to 40 denoted dissatisfaction, a standard score (t) from 40 to 60 denoted relative and moderate satisfaction, a standard score (t) from 60 to 70 denoted high satisfaction and a standard score (t) higher than 70 indicated extreme satisfaction with marital relationships. The validity of ENRICH marital satisfaction scale has already been evaluated in a study conducted by Soleimanian and colleagues, under the title "Investigation of irrational marital thoughts" and its reliability has been established in several studies[17-20]. The reliability of ENRICH marital satisfaction scale in this study was obtained 0.91 using Chronbach Alpha. Then, women with a standard score of marital satisfaction 30 and higher of ENRICH questionnaire, were eligible to be recruited for the study; it is worthy of mention that those women with a standard score (t) lower than 30 were referred to family consultation clinics.

Patient and Public Involvement

This study was conducted in 2015-2016 in which the research community was composed of all volunteer women who referred to healthcare centers at Shahid Beheshti University of Medical Sciences in Tehran metropolitan. Convenience sampling from the volunteer women was performed after public notifications across the selected centers. After preliminary interviews with the qualified candidate women and giving the necessary information on how the study was supposed to be conducted, they were asked to take counsel with their husbands if they wished to participate in the study and if their husbands agreed, they could participate. Written letters of satisfaction were taken from all interviewees and they were assured that their information would be kept confidentially and their participation is completely voluntary.

Inclusion/exclusion criteria

The requirements for inclusion in this study were: obtaining a standard score of marital satisfaction 30-40 and higher based on ENRICH scale (enriching and nurturing relationship issue, communication and happiness), lack of participation in different sexual training courses by the couples, women with a record of 6-24 months of marital life who were still living with their husband, not having a record of abortion, stillborn birth and not being in pregnancy period, not having a child, not experiencing the death of a loved one over recent 6 months, not

Table 3. A comparison of means of sexual intimacy and sexual satisfaction variables before and after training lessons, in control and intervention groups by together in women

Variable	control group		p-value*	intervention group		*p*-value
	before training	after training		before training	after training	
Sexual satisfaction	102.17 ± 11.341	101.23 ± 12.455	0.07	103.46 ± 11.436	108.40 ± 11.755	0.001
Sexual intimacy	102.80 ± 11.737	102.14 ± 11.758	0.053	102.77 ± 11.687	110.97 ± 9.253	0.001

*The results were obtained from Wilcoxon test. Data presented as mean ± SD.

suffering from an acute or chronic and serious disease or physical disabilities diagnosed by the physician such as depression, diabetes, obsessive-stressful diseases, addiction, Rheumatoid Arthritis in the couples, lack of dependence or addiction to alcohol or ecstatic drugs in the couples, not taking psychiatric and neuropathic medicine prescribed by a doctor over 2 recent years, not having a surgery on pelvic organs (internal or external), minimum elementary education of the couples and being Iranian. Exclusion criteria were: women's absence in more than 2 training classes or pre-test and post-test, pregnancy during the study, occurrence of mishap between pre-test and post-test steps for the research women.

Procedure

After coordination with the women in the intervention group and with the authorities of the clinic, the dates for training courses were set and the women in this group were invited to participate in sexual skills training courses a week after completion of pre-test so that one week before intervention, demographic characteristics of the women were completed by the research units using a researcher-made questionnaire. Similarly, evaluations were performed through Shahsiah's sexual intimacy scale and Larson's sexual satisfaction (in the form of pre-test). Shahsiah's scale included 30 items each with a 4 choice range (always, sometimes, seldom, never) with 1-4 scores. As such, "always" gets 1 score and "never" gets 4 scores. Maximum and minimum scores are 120 and 40, respectively. Higher score indicates more sexual intimacy of the couples. The validity of content of Shahsiah's questionnaire was confirmed in studies by Botlani and colleagues, who were psychologists and consultants at Educational Sciences Department at Isfahan University and its reliability was investigated in a study conducted by Botlani and colleagues, on 70 couples who had referred to Family Cultural Center in Isfahan in 2008 and Chronbach's alpha coefficient was obtained 0.81% [21]. In this study, the internal consistency of Shahsiah sexual intimacy questionnaire was obtained 0.93 using Chronbach's alpha. Larson's sexual satisfaction questionnaire (LSS) contains 25 items and responses are given to 5 choices set according to 5-point Likert's scale with 1-5 scores. In terms of qualitative classification, scores of 25-50 suggest lack of sexual satisfaction, 51-75 indicate low sexual satisfaction, 76-100 conveys moderate sexual satisfaction and 101-125 denotes high sexual satisfaction. Validation of Larson's sexual satisfaction questionnaire was measured and used in several studies[8,22]. In the study conducted by Shams-Mofaraheh and colleagues, the validity of the questionnaire was measured through face validity and content validity. In current work, the reliability of Larson's sexual satisfaction questionnaire was obtained 0.88 using Chronbach's alpha.

Contents of the sexual skills training program

Teaching methods were in the form of self-administered (self-made) educational package including: speeches, presenting PowerPoints, playing educational videos, group discussion and question and answer discussions. The content of self-administered educational package (confirmed by more than 10 respective experts and authorities) was presented in 90 min classes, one day a week, for a total of 5 sessions and in cognitive areas (sexual knowledge and information), emotional (feelings, values and views about sexual issues) and behavioral (sexual behavior) under titles: sexual behavior, factors affecting sexual response and genital anatomy and physiology by an experienced and trained researcher. Meanwhile, the participants were asked to share and practice the skills offered in the educational classrooms with their spouses at home so that their spouses indirectly learn those skills and finally the couple can experience a more intimate sexual relationship. After final data analysis, training lessons, were held where the material taught in the intervention group classes were presented to the control group, too. It is worthy of mention that evaluation of content learning in each lesson was performed through question and answer procedure. Finally women in both groups were again evaluated and followed up using sexual satisfaction and intimacy questionnaire 2 months after the last lesson.

Ethical consideration

After obtaining permission and license from the ethics committee of Shahid Beheshti University of Medical Sciences for conducting this research (SBMU. REC.1393.456), the researcher, holding a written recommendation letter from the authorities of the aforesaid university, referred to the selected healthcare centers of Shahid Beheshti University in Tehran City. Informed consent were taken from all interviewees and they were assured that their information would be kept confidentially and their participation is completely voluntary. This study was registered with a DOI: IRCT201412165667N4 at Iranian Registry of Clinical Trials (IRCT).

Statistical analysis

The data extracted from the questionnaires were analyzed using SPSS software, (Statistical Package for the Social Sciences, version 18.0, SPSS Inc, Chicago, Illinois, USA). For data analysis, descriptive statistics (frequency table, mean, standard deviation and percentage), independent *t*-test, paired *t*-test, or non-parametric tests including Mann-Whitney, Wilcoxon or Chi-Square and Fisher's Exact test were applied. Significance level of the test was considered $p < 0.05$.

RESULTS

In this study, 70 women with 6-24 months of marriage were included in two groups of intervention (35 subjects) and intervention (35 subjects). Personal, social and midwifery records and characteristics of both groups are provided in **Table 1**. The two groups didn't show significant difference with respect to these variables (**Table 1**).

There were no significant statistical differences between the intervention and control groups in terms of marital satisfaction score (ENRICH), sexual intimacy and sexual satisfaction before initiation of this study ($P > 0.05$). Both groups were the same concerning marital satisfaction and sexual intimacy and satisfaction when they entered the study (**Table 2**).

Our findings demonstrated that there was a significant statistical difference between the mean scores of sexual satisfaction after training within a score range of 25-125 in the control group (101.23 ± 12.455) compared to the intervention group (108.40 ± 11.755) and between those of sexual intimacy after training within a score range of 30-120 in the control group (102.14 ± 11.758) compared to the intervention group (110.97 ± 9.253). The results of this study suggest that sexual skills training leads to enhancement of sexual satisfaction ($P < 0.001$) and sexual intimacy ($P < 0.001$) among the women in the intervention group and the training influence has been stable and steady two months after completion of intervention (**Tables 2 and 3**) .

It should be noted that, measuring the score of marital satisfaction has only been one of the inclusion criteria and measuring the score of marital satisfaction after intervention in two groups, has not been evaluated in this study.

DISCUSSION

Our findings indicated that there is a significant statistical difference between the average scores of sexual intimacy and sexual satisfaction among the women in the intervention group after the test. The results of current work suggested that sexual skills training enhanced sexual intimacy and satisfaction in women in the intervention group and the impact of training was steady two months after completion of intervention. The results obtained in current research are consistent with those of the researchers who confirmed the effectiveness of sexual education[14,21-30].

In explaining the results, we may state that in the training lessons, when the participants were able to establish and continue their first non-sexual emotional relationships and then sexual and emotional contacts with their spouses, led to more intimate and close relationships among the spouses. Another issue that enhanced the participants' sexual intimacy with their husbands was teaching how they could have sexual conversation with their spouses. The subjects of study learned to explicit discuss about their sexual needs, interests and priorities with their spouses. When the participants could convey their emotional and sexual issues in an intimate marital context to their spouses and know about their spouses' views on their sexual relationships, conversation about sexual issues caused them to have new views about their sexual relationships and show behaviors that lead to more sexual intimacy.

As a result of training lessons, the participants concluded that they should plan for their sexual relationships to experience more intimate and pleasant sexual relationships with their spouses. Finally, it should be noted that changes in the mean scores of sexual intimacy and satisfaction in the research groups is a result of training the midwifery team who are the front line of treatment of women at healthcare centers in Iran. This suggests that by providing such women with this kind of education at healthcare centers, before they refer to psychologists and sexologists who are not accessible for all Iranian women due to cultural and financial issues, one can significantly help to promote women's sexual health. However, it is worth mentioning that promoting sexual health requires team working with psychologists and respective specialists.

This study had some limitations including: 1- the degree of precision among research units at the time of responding to the questions and their emotional and mental state could affect their manner of responding and in order to remove this limitation and to relatively control it, we attempted to let them complete the questionnaires in a quiet and suitable atmosphere and to provide similar conditions and environments for all the women under study to complete the questionnaires; 2- it was not possible for the researcher to hold simultaneous training courses for both women and men or spouses.

Despite the significant difference between sexual intimacy and sexual satisfaction after training intervention, it was expected that changing capacity of these variables goes further through this intervention. We may increase effectiveness of this intervention through exercising changes in the intervention process such as engaging these women's spouses, simultaneous presence of the couples in the training programs and implementing educational interventions in women with a longer duration of marriage.

CONCLUSIONS

In total, the training lessons gave positive views to participants towards their sexual issues so that they formed realistic and positive sexual expectations, healthier sexual behaviors and self-expressions and consequently, gained more sexual knowledge that made them able to experience more intimacy and satisfaction in sexual relationships with their spouses. Therefore, regarding the impact of sexual satisfaction and intimacy in marital life, sexual skills training is suggested as one of the main strategies for promotion of sexual satisfaction and intimacy and ultimately the couples' marital satisfaction.

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CONFLICT ON INTEREST

The authors report no conflict on interest.

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