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The effect of counselling on the sexual satisfaction of women with hypoactive sexual desire referring to Hamadan health centres, 2017

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A – Study Design, **B** – Data Collection, **C** – Statistical Analysis, **D** – Data Interpretation, **E** – Manuscript Preparation, **F** – Literature Search, **G** – Funds Collection

Summary **Background.** Sexual dysfunctions are among the factors affecting marital satisfaction.
Objectives. The aim of this study was to investigate the effect of counselling on the sexual satisfaction of women with impaired sexual dysfunction referred to Hamadan health centres.
Material and methods. This clinical randomised trial was conducted on 120 low-libido subjects referring to comprehensive health centres in Hamadan city. They were randomly divided into two groups of 60 women. Data collection tools included demographic information forms and social and personal characteristics, the Hudson Sexual Satisfaction Questionnaire and a questionnaire of low-level sexual desire assessment, completed in both groups. The counselling and care programme consisted of 7 sessions, each lasting 90 minutes. Data was analysed using SPSS software version 16 and *t*-test, ANCOVA and chi-squared tests.
Results. Mean scores in the experimental group were significantly higher than the control following the intervention ($p < 0.001$).
Conclusions. The results indicate the success of counselling on the sexual satisfaction of the research subjects and suggest that midwifery counselling in this area has increased sexual satisfaction and improved libido.
Key words: counseling, orgasm, women, sexual dysfunctions, psychological.

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Background

Various factors affect the strength and stability of a family, among which mention can be made of couple satisfaction. What seems more important than marriage itself and family formation is the durability of marriage, intimacy and marital satisfaction [1–3]. Investigating the facilitators in the relationship between husband and wife and the factors influential in the continuity of this relationship, as well as marital satisfaction, has always been taken into consideration. Marital satisfaction is a multi-dimensional concept covering various factors, such as personality traits, financial issues, parenting styles in childhood and sexual relations. Marital satisfaction is in fact the positive attitude and emotion of the husband and wife [4]. The best definition of marital satisfaction is provided by Tikdarinejad, who recognises it as a sense of happiness, satisfaction and pleasure by the husband and wife when they consider all aspects of marriage, including their sexual satisfaction [5]. Sexual satisfaction is a multi-dimensional sexual concept embracing both the emotional and physiological aspects of a sexual relationship [6]. One of the leading factors of divorce and the problems associated with the relationship between husband and wife is behaviours related to sexual function [7]. Iran ranks fouth in the world [8] in terms of divorce rates, the most common cause of which is sexual dysfunction [9], which is a very common disorder among men and women [10].

Sexual dysfunction may occur in each of the three main components of sexual desires: hypoactive sexual desire, difficulty in provocation and lack of or delay in orgasm. Approximately 40–45% of women have at least one form of sexual dysfunction [11]. One of the most common disorders is low sexual desire or sexual frigidity, which is more common among women; according to other studies, most women's sexual complaints are related to hypoactive sexual desire or so-called sexual frigidity. In general, studies suggest that more than a third of adult women suffer from hypoactive sexual desire [12]. Recent studies have shown that in the United States, 22% of women and 5% of men experience problems associated with reduced libido during their lives, and that one in every ten women suffers from low sexual desire disorder [13]. According to Qian's et al. study, hypoactive sexual desire is relatively common; however, the problem is usually not diagnosed, and in the US, it affects the lives of nearly 8.9% of women aged 18–44, 12.3% of women aged 45–64 and 7.4% of women aged 65 years and more [14]. The prevalence of hypoactive sexual desire in Iranian women is 58.3%, and thus one of the most common sexual disorders [14, 15]. Decreased libido is seen in women with cancer, after delivery, those suffering from chronic kidney disease or depres-

sion, as well as in women who experienced sexual abuse in their childhood [16, 17]. Recent research suggests that hormonal and therapeutic treatments for sexual dysfunction, including low sexual desire disorder, are associated with side effects such as appearance of masculine symptoms, breast cancer and cardiovascular diseases [18]. Considering the side effects of drugs, it is important to consider other methods such as counselling regarding female sexual dysfunction. Counselling is done in a variety of ways, one of which is solution-focused group counselling (SFT), a form of brief therapy that relies on the referrals' references. The purpose of the treatment is merely to help the referrals begin to change their words by changing from talking about the problem to talking about solutions. Therapeutic intervention is performed via a three-step process: the therapist 1) actively strives to raise the problem in a more positive and efficient way and praises the tactfulness and persistence of the referral, 2) helps identify the trap of captivity the referral has woven around herself, and 3) links a pseudo-hypnosis guideline with an obvious sign of advancement in the behaviour of the referral [19]. This method has also been welcomed by the referrals, as the treatment sessions are limited [20]. Consultation is a process that takes steps to strengthen the skills and empower individuals in order to improve their health, where nurses and midwives play major roles [21]. Given the importance of couple therapy and sexual relations in marital life, their impact on family health, the prevalence of sexual dissatisfaction in women and lack of awareness and counselling in this regard in Iran, the present study was carried out with the aim of conducting solution-focused group counselling so as to promote sexual satisfaction in women with hypoactive sexual desire referring to Hamadan health centres in 2016.

Objectives

The aim of this study was to investigate the effect of counselling on the sexual satisfaction of women with impaired sexual dysfunction referred to Hamadan health centres.

Material and methods

Study design

This was a randomised controlled trial study.

Participants

The present research was conducted on 120 women referred to health centres of Hamadan in 2016, together with a control group, with a pre- and post-test design.

The inclusion criteria were: reading and writing skills, no underlying diseases, a minimum of one year marriage, age range of 18 to pre-menopause age, no psychiatric disorders, no use of psychiatric drugs and contraceptive pills, no sexual dysfunctions with the approval of a clinical psychologist, no pregnancy and breastfeeding, being monogamous and the presence of libido on the basis of a low-libido questionnaire.

Sampling method

All clinics in Hamadan (33 clinics) were placed in three main clusters, namely north, centre and south. Clusters were selected based on their socio-economic status. Two clinics were randomly selected from each cluster (six clinics), and in each cluster, a clinic was assigned to the experimental group, and one was considered as the control group; a total of three clinics were assigned to the intervention group, and three clinics were assigned to the control group, and 20 people were selected in each clinic. The sample size was considered to be 95% based on the confidence level of the test, and the test's power was considered to be 90%. Moreover, the expected difference $(\mu - \mu_2) = 1$ is a unit for the mean of the sexual satisfaction score and variance $\sigma^2 = (1.5^2)$. After replacing the minimum amount of sample size required in each group, 60 samples (120 samples in two groups) were selected. The statistical population of this study was just married women referring to Hamadan clinics due to sexual problems; furthermore, marital conflicts received a DSM-IV-TR diagnosis according to low-libido criteria. 120 subjects were selected, as they met the inclusion and exclusion criteria; the study protocol was explained, and written consent was obtained by the centre's psychiatrist and clinical psychologist; subjects were then divided into two groups of 60 – experimental and control (Figure 1). The selected samples were first provided with explanations about how the sessions were to be held and how the training would be conducted; after that, a questionnaire for the assessment of hypoactive sexual desire was completed, and those receiving 5 or higher according to the libido assessment questionnaire were diagnosed with hypoactive sexual desire and entered the study.

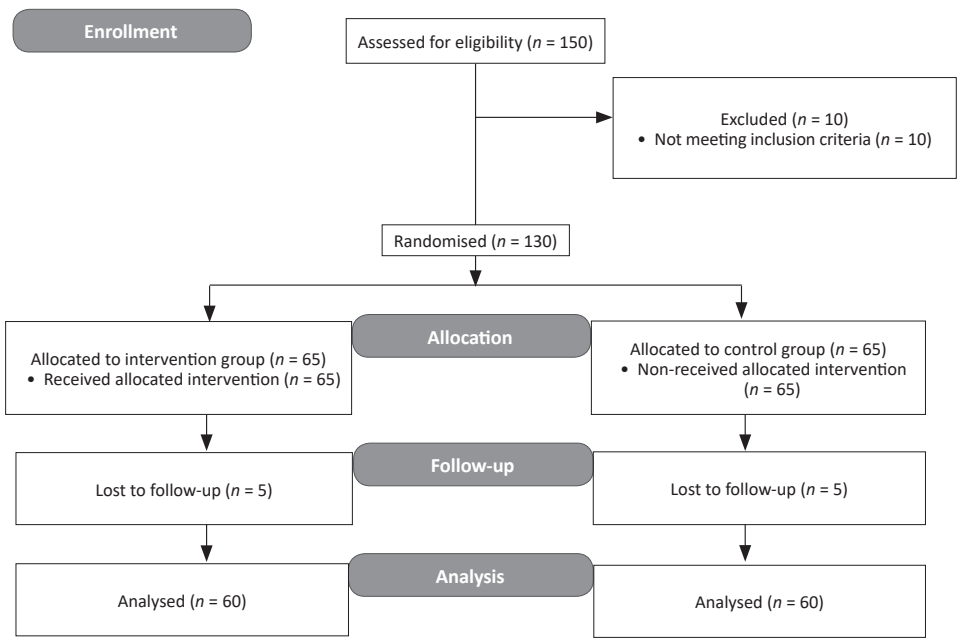

Figure 1. Process of selecting samples

Intervention

For the experimental group, counselling sessions were comprised of 7 sessions, 2 sessions a week for 90 minutes, and were conducted by the researcher in the health centres. The programme of solution-focused group counselling sessions for the experimental group is presented in Table 1. The content of the consultation sessions is as follows:

Session 1. Getting to know the participants, introducing solution-oriented counselling, establishing respect and understanding among team members, expressing the realities of life in the language of the individual for greater understanding and creating a friendly environment.

Session 2. Listing to clients' problems and turning them into positive and practical goals expressed in the clients' own language. For example, a lack of emotional engagement of couples and unwillingness to have sex with one's spouse turned into the statement that one would have more emotional engagement and desire to have sex with one's spouse.

Session 3. Review past exceptions in clients' lives when there were no current problems, and new exceptions that did not exist, with the aim of recalling solutions that brought about change concerning the desire to have sex.

Session 4. Improving relationships, combating formerly defective structures, exploring failed ways and turning them into solutions, modifying and deploying solutions that have improved communication on marital and sexual issues.

Session 5. Changing clients' viewpoints to reduce mistakes and misbehaviour in interpersonal and sexual relationships that have been repeated many times, as well as to satisfy the spouse.

Session 6. Induce changes in clients and provide new solutions and put away past defective thoughts, feelings and behaviours.

Session 7. Examine the changes in clients' problems and provide positive feedback with the aim of admiring them [22].

Six groups of ten subjects were considered. In addition, at the end of each session, the referrals were individually interviewed and the required counselling was conducted. After completing the sessions and after the end of the follow-up period (one month later), both experimental and control groups were given the Hudson Sexual Satisfaction Questionnaire. In order to comply with the ethical principles, a one-session class on solution-focused group counselling was held for the control group at the end of the training sessions (Table 1).

Study instrument

Data collection tools were a demographic questionnaire, the Hudson Sexual Satisfaction Questionnaire and the Decreased Sexual Desire Screener (DSDS). The Hudson Sexual Satisfaction Questionnaire was created in 1981 by Hudson, Harrison and Kruskappa to assess the levels of marital satisfaction. This scale has 25 questions and is considered as a self-reporting questionnaire. Each test item is defined on a scale of 7 degrees between 0 and 6, with scores ranging from 0 to 150, where a high score reflects high sexual satisfaction. Questions 5, 6, 7, 8, 14, 15, 18, 20, 24 and 25 are scored in a reverse order, such that the answer to the first question (*never*) is the highest (6), while for the rest of the questions, the score of *never* is 0. The validity and reliability of the sexual satisfaction questionnaire were confirmed by Nomejko and Dolińska-Zygmunt using the content validity method and Cronbach's alpha coefficient (0.83) [23]. The Decreased Sexual Desire Screener consists of 5 questions answered with yes and no. Patients diagnosed with hypoactive sexual desire disorder (HSDD) are qualified if: they answer yes to questions 1 to 4 and answer no to question 5. The patient may be qualified for a general or acquired HSGD diagnosis. The DSDS questionnaire has 5 questions answered with yes and no, the former receiving a score of 1 and the latter receiving a score of 2; scores are classified into three levels of good (> 5), moderate (5–10) and weak (< 10), and high scores are a sign of hypoactive sexual desire disorder, and thus a score above 5 was included in our study. The validity and reliability of the Decreased Sexual Desire Screener were approved by Clayton et al. [24]. In this study, the reliability was confirmed by calculating the Cronbach's alpha coefficient at 0.79.

Ethical consideration

The protocol of this study was approved by the Ethics Committee of Hamadan University of Medical Sciences (Ref. No: IR.UMSHA.REC.1395.176). The protocol was also registered in the Iranian registry for randomised controlled trials (Ref No: IRCTID: IRCT201607059014N106) and conducted after obtaining permission from the Deputy of Hamadan University of Medical Sciences.

Statistical analysis

Data was analysed using SPSS 16 software. The Kolmogorov–Smirnov test was used to evaluate the distribution of variables. Statistical tables and indexes were used to describe the results of the questionnaires. The tests included was ANOVA, and for inter-group comparison, the chi-square test was used. The level of significance was considered as $p < 0.05$.

Results

Findings related to socio-demographic characteristics

The mean of age was 36.4 ± 7.5 years in the experimental group and 32.1 ± 6.7 years in the control group. Most subjects in the experimental group (50%) had two or three deliveries, and 27% had a natural delivery. In the control group, however, 56% of the individuals had one delivery at most, 23% of whom had a natural delivery. The chi-square test indicated that there was no significant difference considering the number of deliveries and the number of normal and caesarean deliveries between the two groups ($p > 0.05$). According to the results, there was a statistically significant difference between the mean age of the subject and the spouse, the duration of marriage and the mean age at the time of marriage in both groups. The effect of these factors was adjusted by ANOVA testing.

Intervention effect

The majority of subjects had chosen their spouses in full agreement, both on the part of themselves and their families. Except for 5% in the experimental group and 10% in the control group, the rest also had a good relationship with their spouses' family, who supported 53% of the subjects in the experimental group and 71.7% in the control group. 58% of the experimental group did not use a specific prevention method. According to the results, 83.3% of the experimental group and 80% of the control group had good sexual satisfaction prior to the intervention; however, at the end of the study, all subjects in the experimental group reported a better sexual satisfaction level (100%); moreover, after the intervention, the number of poor and moderate cases in terms of sexual satisfaction was zero ($p < 0.001$), while changes in the control group were very limited, and only 75% had a good sexual satisfaction level ($p > 0.05$) (Table 2).

According to the results, the mean and standard deviations of sexual satisfaction score in the experimental and control groups before the intervention were 114.18 ± 18.8 and 114.1 ± 16.7, respectively. Furthermore, after the intervention, the mean of sexual satisfaction score in the control group decreased (112.6 ± 16) but did not result in a statistically significant difference ($p = 0.446$); however, the sexual satisfaction of the subjects in the experimental group increased up to 137.9 ± 7.8 following the intervention, causing a statistically significant difference ($p < 0.001$) (Table 3).

Table 1. Programme of solution-focused group counselling sessions for the experimental group

Session	Goal	Content	Method	Time
First	Introduction and familiarity	Creating communication and the familiarity of the participants with the goals, rules and sessions procedures, creating hope for change in participants.	Lecture and discussion	90 minutes
Second	Promoting awareness regarding finding a solution to low-libido complaints	Purpose: getting familiar with basic principles of solution-based counselling and identifying unrealistic beliefs and expectations. Method: Examining the expectations, beliefs and imaginations of women about marital intimacy and adaptability to marital life – showing the influence of beliefs on attitudes and behaviours.	Lecture and group discussion and PowerPoint	90 minutes
Third	Irrational thoughts and sexual maladaptive cognitions	Explaining cognitive errors – types of irrational thoughts and sexual maladaptive cognitions – familiarisation with all kinds of irrational sexual thoughts – Explaining realistic goals and expectations – understanding mutual expectations and paying attention to the positive attributes of each other.	Lecture and group discussion	90 minutes
Fourth	Cognitive retrofitting training	Making participants committed and encouraged to solve problems – identifying and resolving participants' resistance – eliminating misunderstandings caused by wrong or different interpretations from one another – methods to overcome irrational beliefs, training a contradiction method to improve irrational beliefs.	Lecture and group discussion and PowerPoint	90 minutes
Fifth	Familiarity with sexual physiology and sexual behaviour	Method: Expressing the importance of sexual relation – familiarity with the stages of growth, puberty and sexual growth – familiarity with genital anatomy of women and men – familiarity with the sexual response cycle of women and men – familiarity with sexual disorders of men and women and ways to treat it.	Lecture and group discussion	90 minutes
Sixth	Training how to improve sexual relations – Familiarity with common sexual disorders and ways to treat it	– Preventing factors in the proper sexual relationship, the identifying wrong sexual examples. Eliminating negative sexual beliefs and examples. – Understanding correct and wrong attitudes about sexual issues. – Describing the effects of negative thoughts and attitudes on sexual relations. – Cognitive reconstruction of inappropriate sexual thoughts in couples.	Lecture and group discussion, and PowerPoint	90 minutes
Seventh	Training correct techniques relating to sexual relations	Purpose: How to establish sexual intimacy and training the correct sexual relationships. Method: Teaching how to establish sexual intimacy – training the art of sexual speaking – familiarity with the pre-requisites of sexual behaviour. Examining the sexual cycle and sexual behaviour. Familiarity with the proper techniques of sexual relations and the benefits of using each of these techniques. Familiarity with sexual health. Meeting sessions and conclusion.	Lecture and group discussion, and PowerPoint	90 minutes

Table 2. Comparison of sexual satisfaction level among the subjects in the experimental and control groups

Variable	Variable level	Experimental *n* (%)		Control *n* (%)		*Comparison between the two groups: before intervention	*Comparison between the two groups: after intervention
		before	after	before	after		
Sexual satisfaction	poor	1 (1.7)	0 (0.0)	0 (0.0)	0 (0.0)	$p = 0.627$	$p < 0.001$
	medium	9 (15.0)	0 (0.0)	12 (20.3)	15 (25.0)		
	good	50 (83.3)	60 (100)	48 (80)	45 (75.0)		
*intra-group comparison		$p < 0.001$		$p = 0.446$			

*Chi-square test.

Table 3. Comparison of the mean of sexual satisfaction score among the subjects of the experimental and control group

Variable	Group	Before intervention Mean ± SD	After intervention Mean ± SD	*p
Sexual satisfaction	control	114.1 (16.7)	112.0 (16.6)	$p = 0.446$ $df = 59$ $f = 0.767$
	experimental	114 (18.8)	137.7 (9.8)	$p < 0.001$ $df = 58$ $f = -8.081$
*Intra-group comparison	$f = 0.76$ $p = 0.446$		$f = -8.08$ $p < 0.001$	

*ANOVA test.

Discussion

The present study aimed to investigate the effects of solution-focused group counselling on the sexual satisfaction of women with a low libido. Consistent with studies carried out in this field, the results indicate the success of counselling on the sexual satisfaction of people with hypoactive sexual desire [25], suggesting that midwifery counselling enhances sexual satisfaction and libido. All subjects in the experimental group had a good sexual satisfaction level, and considering the statistically significant difference between the two groups, it can be concluded that counselling is effective on sexual satisfaction. In this regard, Schumm et al. conducted research investigating the effect of marital counselling before marriage on the sexual satisfaction of couples. The results of their study showed that all couples participating in marital counselling before marriage had higher sexual satisfaction [26]. Masoumi also believes that by providing appropriate counselling on sexual issues, the problems in couples' sexual relations are gradually eliminated, and their unawareness turns into perfect knowledge. Moreover, Masoumi et al. examined the effect of sexual therapy on marital satisfaction in pregnant women in 2016; they indicated that counselling increased the score for sexual satisfaction, which is consistent with the present study [27]. In 2017 Parhizgar et al. concluded that sex education or marital counselling plays an important role in family health, reduces sexual violence in the family, prevents sexually transmitted diseases, develops positive attitudes towards sexual relations and sexual pleasure, reduces family incompatibility, helps gain sexual satisfaction experience and results in couples' sexual satisfaction as a result of couples' marital satisfaction [28]. It seems that women's sexual satisfaction is affected by many factors, among which age, education and awareness play major roles [29]. In their study, Yeh et al. revealed the relationship between age, satisfaction degree and sexual relations in women, which is consistent with this study [30]. In the present study, the subjects were at a desired satisfactory level of sexual satisfaction before the intervention, and the number of individuals reporting low sexual satisfaction was very limited. However, at the end of the study, all subjects in the experimental group reported a good sexual satisfaction level. Overall, after the intervention, the number of weak and moderate cases in terms of sexual satisfaction reached zero; however, changes in the control group were very limited, and the number of people with a good level of satisfaction was reduced, which is consistent with the study of Sahraeian et al. (2019) [31]. In a study by Yousefzadeh et al., a comparison was drawn between a sexual enhancement programme and education on marital sexual satisfaction. The analysis showed that spouses who had participated in the sexual enhancement programme had more pleasure in their sexual relations in comparison with the other two groups [32]. Sex education and marital counselling is a long process, through which individuals acquire the knowledge required in sexual issues and form their attitudes, beliefs and values. Marital counselling is a process conducive to healthy sexual growth, marital health, interpersonal relationships, affection, intercourse, body image and gender roles. The focus of such counselling is on biological, cultural, social, psychological and religious dimensions. It is related to the cognitive domain (information and knowledge), affectional domain (emotions, values and attitudes) and behavioural domain (communication skills and decision making). In the present study, marital counselling was effective on the sexual relations of couples through increasing the level of information and knowledge on sex and improving the attitude of women toward sexual issues. Given the major sex-related problems encountered by societies, it is suggested that marital counselling be provided for married couples before and during marriage, which would improve sexual satisfaction and marital life quality. According to the hypothesis of the study, solution-focused counselling is effective on the sexual satisfaction of women with low-libido syndrome. The results of the study show that by providing appropriate sexual therapy, the problems of couples' sexual relations were gradually eliminated, and their obliviousness turned into perfect knowledge, which is consistent with the study of Shirashiani et al. [33] and Tadayon et al. [34]. Another study hypothesis suggests that midwife counselling improves sexual satisfaction in women with a low libido [35, 36]. The results of the current study indicate the success of the intervention in this regard, which is in line with the study of Masoumi et al. as regards the effectiveness of counselling by midwifery personnel [27].

Limitations of the study

The results of this study may not be generalised to other societies, and the presented results are preferably local and should be directed to groups with a similar socio-cultural status. Because of the culture of the community under study, the results may not be generalisable to other countries, including European countries. However, this problem has been a major and important issue in the marital relationship of couples in the country under investigation. Another limitation, due to the cultural conditions of the study population, was that the husbands of women with hypoactive sexual disorders were unwilling to participate in this study. To help women with HSDD and for them to realise that their problem may be that of many other women, we had group counselling sessions with these women to solve this problem. Another limitation of this study was the lack of follow-up of more than one month for women in both groups.

Conclusions

One of the duties of midwives in Iran is to provide advice and counselling for women, men and couples on all matters related to reproductive health and sexual health [36]. The results indicate the success of counselling on the sexual satisfaction of the subjects under study, indicating that midwifery counselling enhances sexual satisfaction and improves libido. Since most women have adequate access to health care centres, it seems that the most appropriate and convenient strategy to improving their quality of life is that health care providers, especially the midwifery personnel, pay attention to marital issues and hold educational and counselling classes in the field of sexual issues with a health-promoting approach.

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