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The effectiveness of sex education on unconsummated marriage: A case study

Zohreh Sepehri Shamloo
Associate Professor, Department of Clinical Psychology, Faculty of Education and Psychology, Ferdowsi University Of Mashhad (FUM)
Corresponding author email: z.s.shamloo@um.ac.ir

Zahra Taherian
Master of counseling Family, Department of psychology, faculty of Education Science and psychology, University of Ferdowsi, Mashhad, Iran
Email: Mahla.taherian@gmail.com

Javad Salehi Fadardi
Professor, Department of Clinical Psychology Faculty of Education and Psychology Ferdowsi University Of Mashhad (FUM)
Email: j.s.fadardi@um.ac.ir

***Abstract*---**The aim of this study was to discuss the effects of training marital skills on unconsummated couples. The current study was conducted using ABA quasi-experimental plan with a single case. For this purpose, one couple with a purposive sampling method was selected and received Sex Education. Patients at the baseline (pretreatment) phase in third, sixth and eighth sessions as well as the 45-day follow-up phase, filled the researcher made questionnaires of the fear of vaginal intercourse, sexual satisfaction scale (ISS), Female Sexual Function Index (FSFI), International index of erectile function (IIEF) and McGill Pain Scale (Mc-gill-pain). For data analysis, two methods of Clinical significance and the percentage of improvement were used. Results showed that training marital skills were effective. Improvement percent for patients, who were receiving sexual treatment in 4 scales of the sexual function was 47%, sexual satisfaction was 64%, fear of vaginal penetration was 98% and pain was92%. Couples with pelvic pain disorders didn't receive adequate sexual skills training. When they received steps of sexual training, then they obtained the necessary health.

***Keywords*---**marital skills, unconsummated couples, case study.

Introduction

Human tendencies and the quality of sexual life are as diverse and complex as the principle of a healthy life. Sexual function is one of the main components of life quality (George, Fluchter, Kirstein and Kunz, 2003; Karaaslan, F., et. al., 2019; Usman, A., et al., 2020), which is considered as an important aspect of life health (Berek, 2007). Sexual desires include several domains in humans such as sexual tendency, orientation, lifestyles, and sexual behaviors (Kaplan-sadock, 2003). The sum of human beings` behaviors shown when facing a sexual partner, is known as sexual behavior (Boluryan and Ganjloo, 2002). The most common form of sexual behavior for women is sexual activity through the vagina. Vaginismus is one of the dysfunctions of sexual behavior in females (Amini, 2009). Vaginismus is defined as the involuntary contraction of the muscles of the vagina in the exterior one-third part that prevents sexual intercourse, associated with dyspareunia, as the most common pain disorder based on DSM-IV-IR in the psychiatric classification system of sexual mental illnesses.

Vaginismus is divided into primary and secondary forms. In the primary form, suffering women have never had painless intercourse due to muscle spasm. In the secondary form of the disease, despite a history of painless, even pleasurable intercourse for women for years, the disorder is progressed due to the emergence of a specific medical condition such as ulcers, strikes, pregnancy and childbirth, surgery, or changes in life. In the primary form of vaginismus, the patient does not experience successful sexual intercourse during her marital life (Semnani, 2003), which is a condition known as unconsummated marriage (UCM) (Ozdmir, 2008). Researches conducted by gynecologists, general practitioners, and specialist clinics for sexual diseases indicated that UCM is not a very uncommon complaint (Bahrami, Eftekhar, Kiamanesh, Sokhandani, 2013). Among the many factors that contribute to the occurrence of sexual dysfunctions in married people, we can consider the taboo of this issue in families.

Many families consider sex education as a taboo, and a large portion of girls have little awareness of their genital anatomy and effective sexual intercourse (Bahrami et al., 2013). Studies indicated a lack of anatomical information, especially among young people. The source of sexual information from childhood to puberty and changes related to puberty for most people is restricted to movies, newspapers, and friends (Dehghani, 2006). Therefore, the patient's lack of awareness toward sexual issues and the provision of false information from the family before marriage leads to fear, panic, and consequent contraction reaction in the body (Semnani, 2003). Sexual education provides the opportunity to learn about sexual matters and prevent problems due to unawareness. Comprehensive sexual education programs are effective in preventing sexual dysfunction, healthy sexual behavior, observance of health, maintaining mental health, establishing family health, and gaining correct gender identity (Berryman, Symth, Taylor, Eamont and Joiner., 2002; Fraken, 2002).

The lack of information and sexual knowledge leads to an increased vulnerability to improper sexual function (Bancroft, 2005, Hatten, 1985). Evaluations showed that formal sexual education programs increase knowledge and awareness toward marital affairs, methods of prevention for disorders and sexual problems. Sexual

education is a process that helps in understanding healthy sexual growth, marital health, interpersonal affairs, emotion, proximity, body image, and sexual roles. Sexual education concerns all aspects of sexuality, such as biological, cultural, social, psychological, and religious aspects. Sex education is related to a number of domains including the cognitive domain (information and knowledge), emotional domain (feelings, values , and attitudes), and behavioral domain (communication skills and decision making) (Breiman et al., 2002). People with higher cognitive ability make better decisions to prevent sexual problems (Atkinson, quoted by Barahani, 2005). Because of this, during 1995 of International Forum on Population and Development, all countries were required to provide proper education to young people about sexual issues (healthy, responsible, and enjoyable). Based on this, health authorities in each country are responsible for providing a brief overview of the community's awareness of sexual issues, then design and provide the necessary trainings (Dehghani, 2006). Regarding the studies, it seems that the lack of sexual education and lack of skill in both partners are among the characteristics seen in UCM couples (Amini, 2009). Therefore, the present study was designed to investigate the effectiveness of marital skills training in improving unconsummated marriage (UCM) disorder.

Type of the research

The present study was applied research in terms of its purpose. During this single subject study, a quasi-experimental design of A-B-A with experimental and control groups was implemented through randomized selection. A-B-A plot of empirical designs in single-subject studies include those whose treatment or intervention is carried out on an individual to determine which treatment or intervention is effective. The A-B-A plot begins with a series of "baseline sizes" (A), followed by the first experimental intervention (B). In the end, the baseline is executed as the follow-up stage (B). In this domain, we deal with certain symbols, A represents the baseline or the step without manipulation; and B represents different treatments or interventions.

The statistical population of this study included all female students of Ferdowsi University of Mashhad during the academic year of 2013-2014, Mashhad health centers and obstetrics and gynecology clinics. The sample of the study was a couple with sexual dysfunction who had the criteria for entering the research. The couple was selected using targeted sampling. The aim of this sampling method was to select those who were consistent with the objectives of the research (Gal et al., 2003).

Criteria for entering the study for the included couple:

- Having an age of 18-40.
- High school degree or above.
- A maximum marriage length of six months.
- Being in the first marriage and with at least one failed attempt of intercourse.
- No diagnosed medical and psychological illness.
- A history of six months attempt and failing to have intercourse.
- Having UCM disorder.

- Having the maximum score in a researcher-made questionnaire "diagnosing the fear from vaginal intercourse"
- Having diagnostic criteria of genito-pelvic pain/ penetration sexual disorder in DSM-5, which was confirmed by semi-structured interviews.
- Exclusion criteria from the study were:
- A couple with a history of poor sexual function (according to the results of the questionnaire for erectile function index).
- A couple who were found not to be in line with the aims of the research during the project.
- A couple with serious communication problems.

Research tools

A researcher-made questionnaire for diagnosing fear from vaginal intercourse

Tangible stress in case of expecting first vaginal intercourse may lead to constriction or tightening of the pelvic floor muscles for women with sexual dysfunction (genito-pelvic pain/ penetration sexual disorder). The symptom of genito-pelvic pain/ penetration sexual disorder is a criterion for detecting this sexual dysfunction.

The researcher-made questionnaire included 30 questions, and the five-point Likert scale was used for answers as rarely (0), sometimes (1), often (2), mostly (3), always (4). The minimum score was zero and the maximum was 120. Lower scores represent lower fear of intercourse. The questionnaire was given to 30 married and educated women. The range of age in subjects was from 25 to 38 years old and their marriage duration was in the range of 2 to 18 years. Cronbach's alpha coefficient for the whole test was 79%. According to a survey by 8 experts and psychologists, this tool had proper content validity.

Index of Sexual Satisfaction (ISS)

Hudson Harrison and Cruscap (1981) introduced this questionnaire to assess the levels of sexual satisfaction between couples. This scale includes 25 questions and is a self-report questionnaire. For instance, "I feel that my sexual life has no quality, or my spouse cannot satisfy me sexually". The response of subjects to each test item is in a range of seven-degree Likert scale between zero and six, and the total score of the subjects is in the range of 0-150. In addition, a number of scale materials have reverse scores. Higher scores on this scale reflect sexual satisfaction. Furthermore, the internal consistency of this scale is calculated by the designers, and Cronbach's alpha is calculated to be 0.91. The reliability of the scale was calculated by one-week revision, which was calculated to be 0.93. In addition, the scale validity was calculated by separation validity, by which it was shown that the scale has the ability to recognize couples with and without sexual disorders (Daniel, Denis & Naveen, 2008). The validity of this scale was also confirmed using the calculation of correlation with the subscale of sexual satisfaction in the Enrich questionnaire, which was 0.41 (Pourakbar, 2010). This questionnaire was conducted by Pourakbar (2010) in a 15-day interval to investigate the normative status of the scale. The results from the test

implementation and its revision were analyzed by correlation test. The results of this test showed that there is a correlation of 0.95 at the significance level of 0.1. In addition, for a more precise calculation of the validity of the method, the test was gone under split-half of 0.88. Guttman's coefficient was also calculated to be 0.80.

Female Sexual Function Index (FSFI)

This questionnaire was developed by Rosen et al. (2000) to measure females' sexual activity and was able to verify sexual arousal disorder in a group of women (Mohammadi et al., 2008). The questionnaire has been used in many studies and has resulted in a high degree of internal consistency and validity. The tool includes 19 questions that measure women's sexual function in six domains (desire, mental stimulation, wetness, orgasm, satisfaction, and sexual pain). Respondents should have at least elementary education, otherwise, the questionnaire must be completed with the help of a married woman or a psychologist of the same sex. In order to evaluate the questionnaire, the scores of the six domains are summed and the total score is obtained. In this way, higher scores represent better sexual performance. Based on weighing the domains, the maximum score for each domain is 6 and 36 for the whole scale. This scale has been normalized in Iran by Mohammadi et al. (2008) and the overall Cronbach's alpha coefficient was calculated to be 0.80.

International Erectile Function Index (IIEF)

This index is used to evaluate men sexual function. 15 questions (IIEF) in five domains (erectile function, orgasmic function, sexual desire, and sexual satisfaction) are used to evaluate overall sexual satisfaction. Higher scores in IIEF indicate better sexual performance in men. IIEF has a proper sensitivity in the evaluation of male sexual dysfunction, and its validity has been confirmed in various languages. For example, the validity, sensitivity, and reliability of the Malay version were 86%, 85% and 75%, respectively. Consequently, the results from the Malay version were very close to these numbers and were, respectively, 79%, 88%, and 82% for validity, sensitivity, and reliability. The domestic research conducted by Mehraban, Shabani, Naderi, and Esfahani (2005) confirmed the credibility of the tool to be 97%.

McGill Pain Scale Questionnaire

The McGill pain Questionnaire consists of 4 main groups and 20 subgroups, which forms a total of 78 words indicating the sensory aspect of pain sensation, ranging from one to ten. The total score of the questionnaire ranges from 0 to 42. The sensory aspect of pain sensation shows the severity of pain from top to bottom in each subgroup, so that the lowest word has the highest score. The patient can select a word for each subgroup. If two words are selected from a group, the lowest word is calculated. If the patient does not find the proper word for his/her pain, he/she can skip that part.

This questionnaire was first used by Melzach (1973) on 297 patients who suffered from different types of pain, which was localized and assessed for reliability by

Khosravi et al. (2012) in Persian. They studied a total of 84 patients, and after 24 hours, the questionnaire was completed again for 30 persons who had maintained a stable condition. Cronbach's alpha coefficient was calculated to be 85% and the reliability coefficient was 80% in all domains (sensory, emotional, assessment, etc.). The stability coefficient of the forming groups maintained a significant relationship during the test.

Research methodology

Among the couples referring to health centers and gynecologists, ten couples who had the criteria for entering the study were examined and selected. Questionnaires for sexual satisfaction and women's performance, pain intensity scale, and international erectile function index were completed. Eventually, according to the interview for differential diagnosis of sexual dysfunction in DSM-IV, the physiological health certificate for genitals, verification of female virginity by a gynecologist, and a high score in the international erectile function index, one couple was entered to the study.

After conducting the interview and completing the questionnaire by the subjects, the conditions of participation in the research and process of treatment sessions were explained for the couple. The martial skills` training protocol was held for eight weekly sessions, however, based on the required time for each assignment to be tried by the couple, the duration of the sessions was variable.

Table 1: Treatment protocol of sexual skills training

Sessions	Training subject	Mutual assignment	Assignment of wife
Session 1	Sexual interview	Training of relaxation and its implementation + Controlling urination in several steps to strengthen penile muscles and gaining self-control ability	Getting naked in front of a mirror for about 30-40 minutes and touching various parts of the body (neck, arm, thigh, lips, etc.) to identify pleasurable areas. When feeling comfortable with this assignment, she starts to touch her genitals and massage the labia of the vagina between two fingers and press and relax. Practicing awareness of body should be done at

			least three times per day. .
Session 2	Examining assignment for previous session / basics of male and female sexual physiology	Having intercourse without touching the genitals, breasts, and penetration, only to take the pleasure of each other's body. Getting acquainted with each other's body in terms of joyful and unjoyful points without verbal harassment. For example when touching the neck, if it is pleasurable saying "I like it", and if touching the arm upsets her saying "it's better to focus on other parts of my body"	First, relax in a relaxing environment such as a bathtub or in the bedroom that feels comfortable, then, inserting a tampon or the small finger (which is clean and free of nails) into the vagina for a few seconds and keep doing this 2-3 times a day.
Session 3	Examining assignment for previous session / Sexual behavior training / Sexual cycles	Previous assignment, and touching the genital area of each other. The wife must be sure that touching her genital area does not have the consequences of the intercourse.	Previous assignment, but if she is ready, uses a larger tampon or the second finger that is slightly larger.
Session 4	Examining assignment for the previous session / The importance of verbal communication during sexual intercourse	Previous assignment	Previous assignment, but if ready, uses a larger tampon or two fingers that are slightly larger.
Session 5	Examining assignment for the previous session / Examining sexual thoughts and learn	Previous assignment and reviewing irrational thoughts and confronting them	If ready, the husband tries to insert a tampon or his small finger into the wife's

	to confront unreasonable sexual thoughts using DTR training		vagina after relaxation. Since she has already inserted a tampon and finger inside, she is prepared to receive a tampon and the second finger, or even two fingers in her vagina
Session 6	Examining assignment for previous session / Training sexual massages + types of hymens	Previous assignment of the fourth session and the husband tries to insert the penis head into the vagina without move-in and move-out action.	Doing relaxation, and if she is ready to enter the penetration step, they get into the position of woman lying on top. Then, wife inserts the penis inside her vagina slowly and with control, and let it be for a while. Then takes the head off and inserts the penis into the vagina.
Session 7	Examining assignment for the previous session / Introducing sexual positions	Performing previous session's assignment, and inserting one-third of the penis into the vagina and moving the penis in and out	Performing the assignment of the previous stage, and moving in and out the action (it is recommended to use positions that are more in favor to the wife and she has more control, then they can try new positions after the healing)
Session 8	Continuing assignments of previous sessions	Performing previous session's assignments. Full penetration of the penis inside the vagina.	Performing previous session's assignments

In addition, the percentage of recovery method was used to analyze the data in the present study, and the recorded changes were considered as the effect of the dependent variable. The formula for the recovery percentage was first presented

by Blanchard and Skuares for analyzing data from single-case experimental designs. In this formula, the difference between the pre-test and post-test scores are divided by the pre-test score. Based on this formula, recovery of 50% or more is considered as significant. In addition, if a person's score be lower than the cut-off point after the intervention, it will be clinically significant. A0 = targeted the problem at the beginning of treatment, A1 = targeted the problem at the end of treatment, A% = recovery level (Barlow and Hersen, 1979).

Findings

Table 2: Investigating the demographic status of the two participants of the study

Participant	Age	Education	Engagement duration	Marriage duration	Previous treatment attempts	Job
A. Communication Illustration Treatment	26	Masters	2 years	8 years	4 sexual counseling sessions	Housekeeper
B. Sexual skills training	23	Bachelors	1 year 5 months	1 year	-	Housekeeper

History of the participant who had received treatment

She was a 23-year-old woman graduated from the Faculty of Psychology and Educational Sciences at Ferdowsi University in Mashhad. She was the third child out of 4, who referred the clinic at the Faculty of Psychology after seeing the advertisement of the project. She was married for one year, and their marriage was in-family marriage. She mentioned that during the engagement, she never thought that she would be afraid of vaginal intercourse, and she only prevented it because of traditional and cultural norms. However, after the first attempt to have intercourse after the marriage, she faced a great deal of stress and showed signs of pelvic contraction. After that, each attempt led to signs of fear and stress, such as cold sweating, pelvic contraction, and rapid breathing. In addition, behavioral signs such as pushing back the husband and preventing complete intercourse were seen.

She acknowledged that she had little sexual information, and had no detailed sexual learning. In addition, she pointed out that her grand sister also had a problem with complete sexual intercourse, and had an operation to remove her virginity. So, her problem was solved, however, she preferred psychological treatments. During the first interview session, the patient described her history of an incident in her childhood, in which when she was five years old, one of the close relatives of her father who was about thirty years old, hugged her when they two were alone and touched her from behind. This incident was repeated every time they were alone at home. Since then, she had guilt and anger feeling until adulthood. Reminding this experience was highly stressful for the patient. So, by doing the assignments at that meeting, and keeping up doing the assignment of the next sessions, she felt better about herself and her past. She also had fine

cooperation with the therapist during the sessions and followed the meetings with proper order.

Table 3: Raw scores and recovery percentage in sexual function scale, sexual satisfaction, vaginal intercourse phobia, and pain index

Therapy session	Patient B. sexual skills training			
	Sexual performance	Sexual satisfaction	Fear of intercourse	Pain index
1st	18	51	51	25
3rd	22	76	49	34
6th	29	121	22	14
8th	33	739	2	4
45 day follow up	34	141	1	2
Recovery rate	47%	64%	98%	92%
Total recovery	75%			

Table 3 shows the scores during the intervention and 45 days after the intervention (follow up). In addition, it shows the percent of recovery in females sexual function questionnaire, sexual satisfaction, fear from vaginal intercourse, and McGill pain scale. Index for recovery percentage after the follow-up session was 47% for sexual function, 64% for sexual satisfaction, 98% for vaginal intercourse phobia, 92% for pain index, and 75% for overall recovery.

As shown in Table 3, scores of the patient in the first session (sexual performance questionnaire) were lower than the cut-off line. In sexual satisfaction level, the patient had the minimum score, and in the scale of vaginal intercourse fear and pain score, she had a maximum score. In addition, the changes occurred during the intervention and follow up period showed an improvement for the patient, and the overall recovery was reported to be 75%. Based on the formula for recovery percentage, a change of 50% or more is considered significant in studies (Dehghani et al., 2010). In addition, in case the score of the patient be less than the cut-off point, this change would be considered clinically significant (Gaal et al., 2003). Therefore, it can be stated that based on the percentage of recovery formula, the improvement in the patient was acceptable (75%).

Discussion and Conclusion

The present study was conducted to evaluate the effectiveness of marital skills training on the improvement of symptoms of unconsummated marriages. In order to achieve this purpose, a couple was selected from the population of women with sexual issues referring to maternity and gynecology clinics in Mashhad. Then, the couple was entered into sex education training sessions. To assess the sexual problems of the referents, a researcher-made questionnaire of vaginal intercourse phobia, the index for sexual satisfaction (ISS), female sexual function index (FSFI), international erectile function index (IEFI), and McGill-pain scale were used. The data from these questionnaires were analyzed using descriptive statistics.

In order to test the effectiveness of marital skills training on the improvement of symptoms in unconsummated marriages, the index of the percentage of recovery was used. As shown in Figure 4-1, the results showed that the patient participating in the training sessions of sexual skills training had a reduce in the symptoms of sexual pain perception, and fear of vaginal intercourse. So, her sexual function was improved, resulting in an increased level of sexual satisfaction. Therefore, the sexual skills and attitude toward sexual intercourse was altered as a result of participating in sexual skill training sessions. In line with the findings of the present research, Gorman and Jacobson (2002), Christensen et al. (2004), Atkins, Berns, Wheeler, Baucom, and Simpson (2004), Saemi (2005), Dehghani et al. (2006), Nazari (2007), Shahsiah, Bahrami, Etemadi, and Mohebbi (2011), Shafienia and Hosseinian (2007), Rahimi, Shafiabadi, and Yunesi (2009), and Faramarzi et al. (2012), reported in their studies the effectiveness and positive impact of marital skills training on reducing the fear of sexual intercourse and vaginal penetration. In addition, regarding the influence and positive effects of martial skills training on improving sexual performance, the findings of the present study were in line with the results of Gormann and Jacobson (2002), Markman et al. (2006), Christensen et al. (2004), Lathilaad et al. (2006), Butler (2006), Forghany (2003), Rafiei Bandri and Nourinipour (2005), Dehghani et al (2006), Shafiinia and Hosseinian (2007), and Faramarzi et al. (2012). Regarding the effect of teaching these techniques on sexual satisfaction, the results of present study were consistent with the findings of Markman et al (2006), Butler (2006), Christensen et al (2004), Shahsiah, Bahrami, Etemadi, and Mohebbi (2011), Shafieinia and Hosseinian (2007), Hamid, Koochaki, and Hayat Bakhsh Malayeri (2012), Rafiee Bandari and Nourianipour (2005), Dehghani et al. (2006) and Faramarzi et al. (2012).

In order to explain the findings of this study, first, the relationship between learning sexual skills techniques and reducing sexual anxiety and stress should be addressed. Various studies and the findings of the present study suggested that the training of sexual skills techniques affects the sexual anxiety and stress, which causes a dysfunction in sexual intercourse and therefore leads to vaginal intercourse phobia. This means that when sexual intercourse is accompanied by stress and feeling of disability, couples experience a huge amount of stress when advancing to the penetration stage, and to avoid this anxiety, they prevent sexual intercourse. This phenomenon is seen in unconsummated marriage syndrome, so that this endeavor may not end well, and does not lead to sexual satisfaction for both spouses. In this case, the person feels humiliated and having sexual intercourse will be a battlefield for her in which she considers herself lost before entering the game. Therefore, not only having sexual intercourse is not pleasurable for the person, but it is also somehow disgusting, which greatly decreases the level of sexual performance and eliminates sexual satisfaction.

During sexual skills training, the participants are taught to avoid confusion when facing anxiety symptoms and negative emotions during intercourse. In this treatment, the participants gain awareness of the structure and nature of the anxiety symptoms and subsequently the perception of pain, and they understand how their own behavior increases the perception of pain. It is pointed out to the participants that if they can manage their anxiety, which is a natural feeling in human, the symptoms of stress will fade after a short time (up to 10 minutes)

because the sympathetic system of the body does not have the ability to stay active for a long time, and the parasympathetic system takes its place shortly after, and the symptoms of stress and anxiety will fade. In fact, participants are taught the process of exposure and prevention of avoidance response. These trainings will reduce the avoidance behavior and consequently the fear of sexual intercourse in the participants because they find that nothing will happen to them in situations where they used to be scared of. When the participants experience sexual intercourse with less stress, more sexual stimulation will happen to her, and therefore she will have more vaginal discharge. This makes it possible to have sex with the least pain experience, and she will feel much less pain. This will encourage the patient to experience more sexual intercourses as a result of sexual stimulation so that her sexual performance will be improved. As the sexual needs are met and sexual performance is improved, sexual satisfaction will improve as well.

Research limitations

The researcher faced a number of limitations during the implementation of the study that may have affected the quality of research. One of these limitations was in the sampling method which was purposeful, and participation of people with high intention had to be treated, hence the generalization of results should be conducted with consideration. On the other hand, regarding the fact that the tests used in this study were self-evaluation type, and the results of these tests were based on self-perception of participants, understanding the individual was related to the self-concept, so that, if the person's self-concept was not consistent with reality, the evaluation of that participant would be accompanied by bias. Another limitation was the small sample size and the lack of other similar studies which used this type of intervention in unautomated marriages, therefore, the generalization of the results may face difficulty.

Suggestions for future researches

According to the findings of this study which showed the significant effects of marital skills training on marital dysfunction (recovery percentage of 75%), on the one hand, and the effective role of sexual satisfaction on marital relationships on the other, it is suggested that the training of martial skills be used to improve sexual quality of conflicting couples who are about to get divorced in future studies. In addition, it seems that the implementation of this training method is also effective in improving sexual function and reducing sexual dysfunctions. Therefore, research on the effects of group training on martial skills on sexual problems can be considered.

References

Amini, Masoomeh (2009). Investigation of consummation time and its related factors in women referred to health centers and hospitals affiliated with the University of Medical Sciences. Shahid Beheshti University of Medical Sciences, Tehran, Iran.

Atkinson, Rital El, Atkinson, Richard C., Smith, Edward E, Bem, Susan Nolen. (2000). Introduction to Psychology by Hilgard, translated by Brahhani,

Mohammad Naghi, Birashk, Behrouz, Beyk, Mehrdad, Zamani, Shahraray, Mehrnaz, Karimi, Yousef, and Mohyeddin, Mehdi. Second Edition, Volume One, Tehran: Roshd.

Bahrami, Hadi; Eftekhar, Mehrdad; Kiamanesh, Alireza; Sokhandani, Firouzeh (2013). Function and self-presenting sexuality in unconsummated couples, Journal of Psychiatry and Clinical Psychology of Iran (Andishe va Raftar), Summer 2013, Volume 19, Number 2 (72): 149-155

Bancroft, J., Carnes, L., Janssen, E., Goodrich, D., & Long, J. S. (2005). Erectile and Ejaculatory Problems in Gay and Heterosexual Men. Archives of Sexual Behavior, 34, 285-297.

Barlow,D.H., & Hersen,M.(1979). Single case experimental designs strategies for studying behavior change. New York: Pergamon Press

Berek, G.; Novak, Gyncology. 14th ed. Piladelphia: Lippinco?? Williams: 2007. P. 269.

Berryman, J. C.; Symth, P.K.; Taylor, A.; Eamont, A. & Joiner, R. (2002). Developmental psychology and your, by BPS black wall, pp 2-257.

Bolourian, Z. & Ganjloo, J. Evaluating sexual Dys function and some related factors in women attending sab?? Health care center. Journal reprod infertile 2007; 8(37): 763-70 (full ?? Persian).

Daniel, N.D. Denis, D.J. and Naveen, L. (2008). “Do Firms Manage Earnings to Dividend Thresholds?”. Journal of Accounting and Economics, 45: 2-26.

Dehghani, Akram (2006). The Effectiveness of sexual skills training on the attitude of couples near marriage. Knowledge and Research in Psychology of Islamic Azad University, Khorashan Branch (Isfahan). No. 30, Winter 2006, pp. 21-38.

Dehghani, Akram (2006). The Effectiveness of sexual skills training on the attitude of couples near marriage. Islamic Azad University of Khorashan Branch (Isfahan).

Fraken, R. E. (2002). Human motivation by wad worth and Thomson learning. Pp 8-296.

George, G., Fluchter, S., Kirstein, M., Kunz, T. (2003). Sex, erectile dysfunction, and the heart: A growing problem. Journal of Herz, 28: 284-290.

Gull Meredith, Walter Borg and Joyce Gull, Quantitative and qualitative research methods in education science and psychology, translated by Ahmad Reza Nasr et al., Tehran, SAMT with the collaboration of Shahid Beheshti University, 2003.

Gurman, A. & Jacobson, N. (2002). Clinical handbook of couple therapy. New York: the Guilford press.

Hatten, K. (1985). Sexual dysfunction. In P.M. Salkovskis, J.Krik, D.M. Clark (Eds.), Cognitive behavior therapy for the problem psychiatry (pp. 370-405). Oxford: Oxford University Press.

Kaplan, Harold, Benjamin, Sadok (2003). Summary of psychology, Behavioral sciences and clinical psychiatry. Volume Two, Translated by Nosratallah Pourafkari, Tabriz, Shahreab.

Karaaslan, F., Dikilitaş, A. (2019). The Association Between Sexual Quality of Life and Periodontal Status in Adult Men. Annals of Dental Specialty, 7(3), 17-25

Khosravi Mahnoush, Seddiqi Senobar, Moradi Alamdari Shaghayegh, Zendehdel Kazem. Persian revision of Mac-Gill pain scale; Translation, validity and reliability in cancer patients: Short Report. Journal of Tehran University of Medical Sciences. 2013; 71 (1): 53-58

Mehraban, D., Shabanini, S., Naderi, G. H., & Esfahani, F. (2006). Farsi International Index of Erectile Dysfunction and Doppler ultrasonography in the evaluation of male impotenc. Iranian Journal of Surgery, 14(1), 25-31. (Persian)

Mohammadi, Khadijeh, Heidari, Masoumeh, and Faghihzadeh, Soghrat (2008). The validity of the Persian version of the female sex function index-definitely as a measure of female sexual function, Journal of Payesh, 3 (27): 269-278.

Ozdmir, O.; Simsek, F.; Ozkardes, S.; Incesuc, Karakoc, B. The unconsummated marriage it frequency and clinical characteristics in a sexual dys function clinic sex marital ?? 2008. 34(3): 368-379.

Pourakbar, S. (2010). Investigating the role of personality traits in explaining the relationship between sexual satisfaction and marital satisfaction. Master thesis, Tarbiat Modarres University.

Semnani, Yousef (2003). A report of successful treatment of an unconsummated marriage after 14 years. Yazd University of Medical Sciences.

Usman, A., Ming, L. C., & Khan, T. M. (2019). Drug-Resistant Sexually Transmitted Infections in Southeast Asia: Regional Challenges to Control. Archives of Pharmacy Practice, 10(1), 1-4.