



Universitat Autònoma de Barcelona

Facultat de Psicologia
Departament de Psicologia Clínica i de la Salut
Programa de Doctorat en Psicologia Clínica i de la Salut

**Study the Effectiveness of Cognitive-Behavioral
Sex Training in Improving Women's Sexual Self-Concept in
Tehran, Iran**

Submitted to the Universitat Autònoma de Barcelona in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical and Health Psychology

Author: Mitra Vahidvaghef

Directors: Dr. Rosa M. Raich Escursell
Dr. Teresa Gutiérrez Rosado

Bellaterra: 2015



Universitat Autònoma de Barcelona

Facultat de Psicologia
Departament de Psicologia Clínica i de la Salut
Programa de Doctorat en Psicologia Clínica i de la Salut

Study the Effectiveness of Cognitive-Behavioral Sex Training in Improving Women's Sexual Self-Concept in Tehran, Iran

Submitted to the Universitat Autònoma de Barcelona in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical and Health Psychology

Author:

Mitra Vahidvaghef

Director:

Rosa M. Raich Escursell

Director:

Teresa Gutiérrez Rosado



Bellaterra: 2015

Abstract

Sexual self-concept has been defined as “cognitive generalizations about sexual aspects of oneself that are derived from past experience, manifest in current experience, influential in the processing of sexually relevant social information, and guide sexual behavior” (Andersen & Cyranowski, 1994, p. 1079)

Cognitive-Behavioral (CBT) is an approach that improves lifestyle by identifying and challenging irrational thoughts as well as reducing and changing problematic behaviors (Epocrates, 2014).

The main hypothesis states that Cognitive-Behavioral Sex Training will be effective in improving the Iranian women’s sexual self-concept.

This research is an experimental study, with a statistical population comprising almost (N: 5000) married women who have used municipality educational facilities in Tehran. The sample group consists of (n: 90) randomly selected women and put into two intervention and control groups

Snell's Multi-dimension Questionnaire (MSSCQ) (1991) was used in pre-, post- test and follow-up stages of two groups. The intervention group received eight sessions of cognitive behavioral sex training that researcher designed and performed it.

The Mix-ANOVA is used to analyze the data. The results of the main hypothesis are $F(1, 79) = 5.148$, $P=0.001$ and partial Eta squared= 0.063 which show that there is a significant difference in means of the experimental and control groups. Thus, Cognitive- Behavioral Sex Training proved to improve sexual self-concept.

Acknowledgment

I would like to express my gratitude and special thanks to my supervisors Dr. Rosa M. Raich Escursell and Dr. Teresa Gutiérrez Rosado for their enthusiasm and kindness. I would also like to thank Cristina the dear secretary of the department who was always caring and kind to me. I would like to tender my many appreciations to Bahram Tashakor who has always been supportive and made me proud of being a woman.

I am so thankful of my dear friends Mina, Mona, Shahrzad, Andreea and Mohsen for helping me to write my thesis.

And my greatest thanks are for my dears Pooyan and Maren, without whom I could not live and finish my Ph.D. in Barcelona.

Contents

1. Introduction	3
1.1. Statement of the problem	3
1.2. Significance of the Research.....	7
1.3. Research Outline	11
2. Literature Review.....	14
2.1. Introduction to sexuality	14
2.1.1. Sex.....	14
2.1.2. Sexuality	14
2.1.3. Gender identity.....	14
2.1.4. Gender role.....	15
2.1.5. Sexual behavior.....	15
2.1.6. Sexual response cycle	15
2.1.7. Sexual disorders	15
2.1.8. Causes of sexual dysfunctions:	17
2.1.9. Sexual anomaly (Paraphilia).....	17
2.1.10. Sexual Health	18
2.1.11. Sexual Rights	18
2.2. Female Sexuality.....	18
2.2.1. Biological Determination.....	19
2.2.2. Social Constructionism	20
2.3. General concept of self in psychology	23
2.4. Sexual self-concept	25
2.5. Sexual satisfaction.....	28
2.6. Sexual self-esteem.....	31
2.7. Historical background of Iran Sex Perspective.....	34
2.7.1. Iran	34
2.7.2. Family and family change in Iran	35
2.7.3. Patriarchy and Iranian Family Control over Children	36

2.7.4. Relationships and sexuality.....	37
2.7.5. Sexuality and Procreation Perceptions of Young Singles.....	38
2.8. A Historical background of Western Sex Perspective	39
2.9. A historical background of Sex Therapy	40
2.9.1. The Origin and Freudian psychoanalysis.....	40
2.9.2. Post-Freudian psychoanalysis.....	41
2.9.3. Post-psychoanalytic contributions / (modern) sex therapy.....	43
2.10. The Effective Approaches in Sexual Cognitive Behavior Therapy.....	43
2.10.1. Behavioral and directive therapies.....	43
2.10.2. Behavioral-analytic sex therapy.....	44
2.10.3. Rational Emotive Therapy	45
2.11. Cognitive behavior sex therapy.....	45
2.12. CBT Therapeutic Techniques	47
2.12.1. The Correction of Misconceptions.....	47
2.12.2. Mutual Responsibility.....	47
2.12.3. Information and Education	47
2.12.4. Attitude Change	48
2.12.5. Eliminating Performance Anxiety	48
2.12.6. Increasing Communication and Effectiveness of Sexual Technique.....	48
2.12.7. Changing Destructive Life-Styles and Sex Roles.....	48
2.12.8. Prescribing Changes in Behaviour.....	49
2.12.9. 49	
2.13. Table of related researches.....	50
3. Objectives and Hypothesis.....	61
3.1. Objectives:	61
3.2. Hypothesis:.....	61
4. Methodology	65
4.1. Participants.....	65
4.2. Procedure	69
4.3. Instruments.....	70
4.4. Statistical analysis	72

5. Data analysis	75
5.1. Descriptive analysis	75
5.1. Inferential analyses	80
6. Discussion	89
6.1. Summary	89
6.2. Discussion of hypothesis.....	91
6.3. Limitations of research.....	96
6.4. Recommendations	97
6.4.1. Research recommendations	97
6.4.2. Practical recommendations	97
References	98
Appendices.....	110
Consent Letter	112
The Extended Multidimensional Sexuality Questionnaire	115
Cognitive-Behavioral Sex Training Sessions	121

List of Tables

Table 1: Related researches	50
Table 2: Design.....	69
Table 3: Procedure.....	70
Table 4: Frequency distributions describing educational status.....	75
Table 5: Statistics describing samples in terms of age	76
Table 6: Descriptive statistics of general mental health.....	76
Table 7: Descriptive statistics of independent sample test.....	77
Table 8: Descriptive statistics of general sexual self-concept.....	78
Table 9: Descriptive statistics of sexual self-esteem.....	79
Table 10: Descriptive statistics of sexual satisfaction.....	79
Table 11: Mauchly's Test of Sphericity of sexual self-concept	81
Table 12: Tests of Within-Subjects Effects of sexual self-concept.....	81
Table 13: Tests of Between-Subjects Effects of sexual self-concept.....	82
Table 14: Mauchly's Test of Sphericity of sexual satisfaction	83

Table 15: Tests of Within-Subjects Effects of sexual satisfaction 83

Table 16: Tests of Between-Subjects Effects of sexual satisfaction 83

Table 17: Mauchly's Test of Sphericity of sexual self-esteem 84

Table 18: Tests of Within-Subjects Effects of sexual self-esteem 84

Table 19: Tests of Between-Subjects Effects of sexual self-esteem 84

Table 20: Correlation between dependent variables 85

Table 21: Correlation between sexual self-concept and mental health 86

List of Figures

Figure 1: Outline of thesis 11

Figure 2: Participant 67

Figure 3: procedure..... 68

Figure 4: Frequency distributions describing educational status 76

Figure 5: Means of mental health subscales 77

Figure 6: Comparing scores of two group in sexual self-concept..... 78

Figure 7: Comparing scores of two group in sexual self-esteem 79

Figure 8: Comparing scores of two group in sexual satisfaction 80

Chapter 1

Introduction

1. Introduction

1.1. Statement of the problem

Through history people with different perceptions and motivations have used sex for a wide variety of purposes. It has always been treated with a mixed sense of fear and respect (Eisler, 1996). Literally, sex means a sexual activity that includes several behaviors. It is an urge or instinct as it manifests itself in behavior. Sex is a normal biological innate desire that every human being has born with and, as the only way of reproduction, it has always been an intrinsic constituent of life.

In a quest for affectionate physical and emotional relationship with other human being, sex is the best choice associated with positive energy and feeling to “mate guard” and to enjoy (Meston & Buss, 2007).

It was until 1966 that sexual situations have always been underestimated. On that era, Masters and Johnson (1966), initiated to change public attitude toward sex by conducting sex counseling to help people deal with their sexual problems. Based upon Diagnostic and Statistical Manual of Mental Disorders [*DSM-IV-TR*], (2000) classification of mental disorders (American Psychiatric Association, 2002), sex therapy falls in the category of behavioral disorders. Disregarding the fact that sex therapy emphasizes performance such as penetrative intercourse and the production of orgasms rather subjective meaning and experience (Teifer, 2004). Sex therapy is not a mere consideration of physiological aspects of “great sex” according to (*DSM-IV-TR* , 2000). During sexual responses and successive orgasm with regard to “great sex” criteria, trivialize the significance of sexual behaviors of those whose intercourse is not emotionally aroused (Kleinplatz, 2001, 2012).

In the past two decades, there seems to be a shift in stressed position researchers from sexual disease and physical disorders to psychological aspects of sexual well-being and positivism. Researchers have extended their research on sexual health which resulted in finding new concepts. Formerly both researchers and health organizations considered it just as a concept referring to disease; however, they have recently realized that sexual health refers to general well-being i.e. Mental, physical, and emotional status of individuals.

According to definition of (World Health Organization [WHO] , 2006), sexual health is “a state of physical, emotional, mental, and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity”.

The definition above signifies the connection among different aspects of sexuality as well as sexual well-being. Sex is an inherent desire that every human is born with. “Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence” (WHO, 2006).

From what has been said so far does one should not conclude that sexual well-being is not only lack of sexual dysfunction or vice versa; sexual satisfaction is the product of desirable feeling or delightful cognitive of sexual behaviors (Oriel, 2005).

From a social perspective, there are many factors that affect sexuality and sexual well-being of society members, namely: gender relations, socio-cultural values, religion, education level, social welfare and so on. Family, as a core of society, plays a major role in breeding individuals’ attitude toward sexuality. Therefore, the sexual life of every individual is largely dependent on the common attitude of her or his family and society toward sexual behaviors.

Providing sexual health necessitates positive attitudes and deep perception about sexuality. The constructive or destructive impact of sexuality, i.e. either sexual well-being or sexual health depends on its associated factors. Sexuality can leave great impacts on the lives of individuals and help to make affirmative sexual basis of society.

What can be inferred from “enriching” sexual health is a society endowed with a deep understanding of sexual attitudes and behaviors in which everyone is entitled to enjoy the sexual right. In such a society sexual health intermingled with individuals’ perception of sexuality and their sexual relationship (Blunt, 2012).

In many societies with traditional culture, people’s attitudes are influenced by predominant sexual taboos resulting from the social costume. Women, in particular, are not supposed to behave sexually. In such circumstances, they have to repress their sexual desires and surrender to the dogmatic belief of their society. An outstanding feature of these societies is always their resistance to change and control their belief. It should not be concluded that women were satisfied with being deprived of their sexual rights and health services; however, they had to

observe culture and religious norms of the society because they had fear of being rejected (WHO, 2006).

Traditional societies were ruled by patriarchal attitudes, so men's needs have always had priority over women's. Having that in mind, women should always be there to fulfill sexual needs of men. A good woman is the one who gives the best pleasure to her man, regardless of her needs and satisfaction (Farahani, 2008). Considering the role that sex plays in human life, whether male or female, there seems necessary to do more research on this field of science to help females improve their understanding and educate themselves to be aware of their needs as men do

Psychologically, sexual self-concept is of utmost significance referring to individual's cognition of sexual behavioral characteristics that one has acquired through life and they are supposed to be reflected in sexual relationships later on. The sexual characteristics acquired in every society, undoubtedly, influence and control sexual behaviors (Andersen & Cyranowski, 1994, 1995, 1999).

The key point is to foster positive attitudes about oneself. To do so, researchers believe that it is important to accept our sexual self as a positive being and be able to handle our sexual behavior, knowing where to express it and how to control it (Rostosky, Dekhtyar, Cupp, & Anderman, 2008)

In societies where women have a positive sexual self-concept, there would be more understanding concerning matters such as using protection, birth control, sexual desires, and sexual needs. Also, they are allowed to freely express their sexuality, and it results in a more sexual satisfaction.

Research findings indicate that Research findings indicate that higher sexual esteem in women will make them to more emphasize their sexual being and experiences, and further talk about their sexual issues such as emotions, satisfaction, and their tendency to participate in risk with their sexual partners (Hensel, Fortenberry, O'Sullivan, & Orr, 2011).

So far, researchers have mostly focused on sexual dysfunctions; however, there is still a large gap between areas concerned psychological aspects of sexual health and how to foster positive sexual self-concept. By employing CBT method, sex therapy aims to alter problematic behaviors in sexual interactions (Freeman, 1989). The prevalent therapeutic method developed

to educate the public is Cognitive-Behavioral Therapy (CBT) approach to sex to manage sexual activity and, i.e. orgasm

The leading researchers in this approach are: Masters and Johnson , LoPiccolo & LoPiccolo (1978), & McCarthy & McCarthy (1984), while should be emphasized in helping couples to reach the greatest pleasure of sex.

Recent researches have come up with the idea that CBT is to identify distorted sexual attitudes and belief with effective remedy of women's self-concept and aid them in treating their sexual problems (Ghorbanshiroudi, Azari, Khalatbari, & Keikhayfarzaneh, 2012; Shafiabadi & Rahimi, 2009; Ter Kuile, Both, & van Lankveld, 2010).

To achieve good sex, researchers, as well as psychologists, are to promote the public knowledge and welfare. In doing so, they are to take therapeutic measures in the areas concerned with not only physical aspects of sexual dysfunction but also the sexual well-being of individuals.

Research community of Iran lacks literature grounded on sexuality so it is officially unknown how much it is important to have sexually educated society, and to promote sexual self-respect, how to encourage women to study about their sexual being and to develop positive self-concepts, and how to find a proper CBT approach to sexuality for this traditional belief system.

To do so, primarily, mental status and sexual attitudes of every individual are to be assessed. Then, using CBT as well as other efficient newfound methods, training sessions are to hold which focus on previously assessed areas. All emotions, desires, and attitudes that people grow within themselves, as well as sexual behaviors, stem from sexual self-esteem. Therefore, to be able to forestall sexual behaviors of individuals under study, it is essential to specifically evaluate sexual self-esteem. Being aware of their way of thought and sexual self-concept that they have raised, more efficiently the researcher would be able to promote their mentality and sexual health.

1.2. Significance of the Research

To protect the family, the couples, in particular, the most noticeable thing that strengthens family bonds is to establish good relationship rested upon agreement and perception. The most important factor that every young couple is worried about is to have a successful marriage and enjoy their marriage. It becomes true when the couples have a mutual agreement and are satisfied with their marriage. Marriage satisfaction is the product of mutual feelings of love and care, understanding, and acceptance of responsibilities as a partner including satisfaction of sexual needs. The characteristics of a successful marriage are sharing ideas in common, feeling of pleasure, being satisfied with relationships, harmony and partnership in every aspect of life, material or intellectual. On the contrary, unsuccessful marriage brings about many social and emotional incompatibilities and distorted relationships grounded on many factors, the most important of which is sexual issues that lead to disordered social relations, leaving a great impact on couples temper and their relationship with other people in the society (Nourani, Sadodin, Joneidi, Shakeri & Mokhber, 2009)

The most crucial matter determining the status of a marital life is sexuality of couples including compatibility with a sexual relationship and tamed sexual orientations.

In a research carried out by Shamloo (2008), it was proved that although sexuality is not the only thing that affects the success of marriage and sense of happiness, but it seems to be so much influential that overshadow other issues in life. Sexual activity, whether consciously or not, is totally connected to couples behaviors, thoughts, and emotions (as cited in Kalantari, Esfahani Asl, Bayat 2012)

In a broader sense, to experience a delightful sex, the relationship should be based upon mutual feeling and love. To put it in other words, when the couples be emotionally aroused, they may experience a satisfactory relationship (Kalantari, Esfahani Asl, Bayat 2012)

Many experts of sexual relationships believe that sexual intercourse can very well reflect the situation of each of the partner that they been through. Less vulnerable are those who have enjoyed their sex; however, social status, disputes, family ties, and failure to adjust influence on thoughts and perceptions of person intended to marry (Goeke-Morey, Cummings, & Papp, 2007).

Family is the most important foundation in all communities, and human sexuality plays a major role in everyone's life. Islam encourages marriage and raising a family, which is the core of society. The parties to the marriage should meet the requirements of marriage, financially and physically. They should be willing to accept responsibility and be able to satisfy each other's needs. In Islam, sexuality is of special significant that should be gratified but only after getting married. Women have a direct influence on it as either wives or mothers; therefore women's marital satisfaction is influential both on the family and men's satisfaction and educational society of children.

While research on the sexual self-concept has expanded in modern societies, in many traditional and religious societies like Iran, sex problems are hidden and ill-treated. Most of the Iranian women never enjoy their sexual life and continue their marriage just for the sake of other factors. The results of a study carried out by (Najafabady, Salmani, & Abedi, (2011) in relation to the prevalence and related factors for anorgasmia among Iranian reproductive-aged women, indicated that many women although enduring different kinds of sexual problem, they have never tried to pose it with sex professionals.

In traditional societies like Iran, there is not education about sexual topics and sexual behaviors are being done by instinct with trial and error. Especially, women's sexual awareness is the worst because they are not expected to have sex before marriage, and they should be virgin. Being sexually ignorant makes them more susceptible to harm since it provide the basis for sexual dysfunction (Hogan, 1978).

(Nouranipur, Besharat, Yousefi, 2007), investigated the relationship between sex awareness and attitudes and marriage satisfaction among a group of young couples. The study indicated that there is a significant direct relationship between the two evaluated criteria.

In recent years, committing adultery is declared as the main cause of divorce (25-50%) among western countries so couples are required to promote their sexual knowledge in order to be able to secure their relationship (Centers for Disease Control and Prevention, 2010).

With the technology development and resource availability such as satellite and the internet, the Iranian's demands and expectations are changing rapidly from the traditional to the modern state. For instance, some individuals think porn movies' tricks are real and expect the same from their partner. Most women, who suffer from a lack of positive sexual awareness and

self-concept, accept all the requests for giving pleasure to their husbands' even if is difficult for them. This is due to holding wrong belief system they have learnt from their mothers. Most of them believe that 'sex is just for men and a woman is just to be a good wife'. Also, there are some women who reject their husband's sex requests in a wrong way by divorce.

According to the Health Center of Iran, the main cause of high divorce rate is sexual dissatisfaction of couples. Studies have shown that most of disputes and divorces of married couples result from inability to gratify sexual needs of partner due to sexual dysfunctions. As far as researchers have noticed, there are remedies to sexual problems in case of being aware of them.

Amirian (2003) concluded that females' willing to divorce is brought about by sexual factors, including: lack of sexual desires (68.1%), post-sex feeling of anger (59.1%), no taste for foreplay (63.9%), and post-sex (orgasm) inattention by the husbands (68.8%). While most of the sexual problems could be solved by having awareness.

In Iran, initiating a sexual relationship has to follow certain costumes, traditions, and behaviors. Young couples are not allowed to experience sex unless they are married. Thus, they should enter into marital life without any sexual experience. Usually, young girls are the victim of such restrictions because they are supposed to be virgin at the time of marriage. So, young girls have to either suppress their sexuality or hide it due to social and religious norms of their society. Based on recent statistics, between 20% to 30% of Iranian young boys and girls have experienced sex before marriage. Being affected by social norms, they feel guilty about what they have done and unfortunately they have limited knowledge of sexual relationships and sexual health that turns out to be problematic later in their life (Baheiraei, Khoori, Foroushani, Ahmadi, & Yarra, 2014). Experiencing sexual relationship under such circumstances, for the first time, leaves adverse effects on their sexual life after marriage.

(Heiman et al., 2011), believed that women are more vulnerable to sexual malfunction. Due to the problem that they are dealing with, women are less willing to have sex while these problems aggravate as they grow older.

Worse than that is the situation of AIDS infection pattern in Iran which is changing from being infected by injection and using infected blood to unprotected sexual intercourses (Nasirian, Haghdoost, 2011).

Generally, women are in urgent need of systematic education to promote their knowledge of sexuality. Everyone in every society is expected to be aware of his or her sexual self to be able to control and find an appropriate solution for sexual problems of the society.

1.3. Research Outline

Following the questions and aim of the research, the author exposed this thesis in six sections.

The first section (Chapter 1) is called Introduction that includes; Statement of the problem, Significance of Research, Definition of Terms and Research Outline.

The second section (Chapter 2) deals with Literature Review that includes a term of main concepts, background.

The third section (Chapter 3) is Objectives and Hypothesis.

The fourth section (Chapter 4) is about the Methodology of research and data preceding includes: Participants, Procedure, Instruments and Statically analysis.

The fifth section (Chapter 5) shows the result of the study.

The sixth section (Chapter 6) is included in discussions and the verification of the hypothesis, explaining limitation and finally, suggestions are given for future researches are in (Chapter 6).

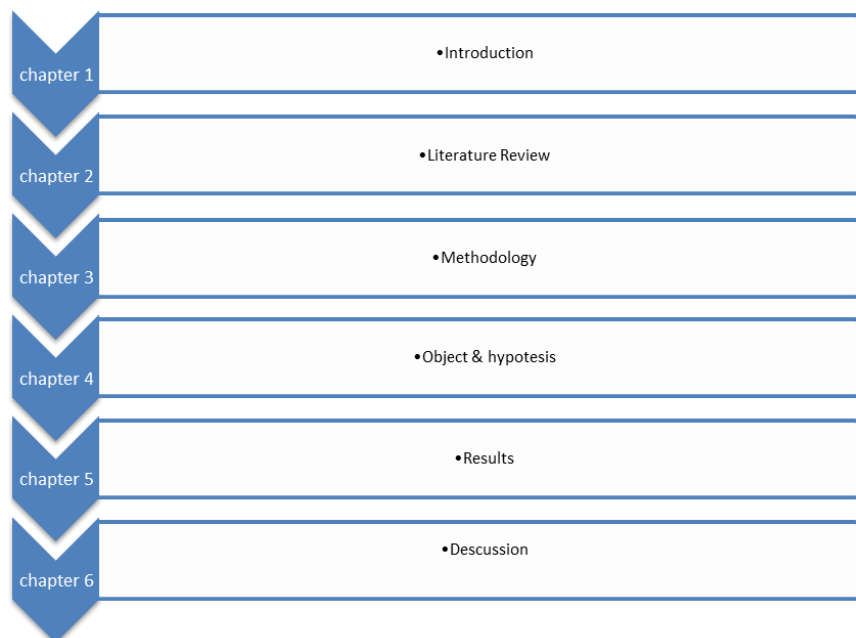


Figure 1: Outline of thesis

Chapter 2

Literature Review

2. Literature Review

This chapter discusses the basis for this research study. It provides an overview of The Historical Background of Iran, An Introduction to Sexuality, General Concept of Sex in Psychology, Female Sexuality, General Concept of Self in Psychology, Sexual Self-Concept, Sexual Self-Esteem, Sexual Satisfaction, Historical Background of Iran, Western Sex Perspective, Sex Therapy, The Effective Approaches in Sexual Cognitive Behavior Therapy, Cognitive Behavior Therapy and Techniques. At the end of this chapter, there is shown a table consisting of some related researches.

2.1. Introduction to sexuality

2.1.1. Sex

The word sex, in biology, refers to genitals organs of the body that accounts for reproduction function and distinguishes males and females; however, there are androgynous individuals who are partly male and partly female. In a broad sense, sex stands for “sexual activity” yet the description above is used by sexual experts and specialists of health and education (WHO, 2006).

2.1.2. Sexuality

Sexuality is one of the essential characteristics of a human being enclosing sexual features and desires of every individual. It may be reflected in every aspect of life, being intellectual or physical, perceptions, dreams, feelings, interaction with others, and social responsibilities. Not every individual may be given an opportunity to experience all aspects of sexuality. It is, either directly or indirectly, influenced by common relationships of people and their role as a part of whole in every community (WHO, 2006).

2.1.3. Gender identity

Gender identity refers to individuals’ attitudes and perceptions that is the production of mental abstractions and determines gender, generally based on the social categorization of individuals, as a male or female. Gender identity directs people toward social groups that they

belong to, although there are mixed genders who are also called bisexual, identified as partly male partly female(Carlson, Buskist, Donald Heth, Schmaltz, 2009)

2.1.4. Gender role

In theory, gender role is a concept that indicates society attitudes toward the nature of responsibilities that are commonly accepted for males and females. According to this idea, being either male or female is associated with certain inborn features that affect the individuals roles based on social and cultural taboos (Fagot, Leinbach, & O'Boyle, 1992).

2.1.5. Sexual behavior

Sexual behavior refers to all activities and relationship between commonly two or more individuals that leads to emotional excitement. Sexuality of every individual may be influenced by genetic patterns that led to maturation of genitals and aimed at procreation, and social patterns and attitudes toward sexual desires to encourage either sexual relationships or more self-control (Sofroniou, 2015).

2.1.6. Sexual response cycle

Sexual response cycle models are proposed to analyze sexual changes during emotional excitement. Among those who proposed these models are: Masters& Johnson (1966), who explain phases of a sexual relationship (plateau, orgasm, and resolution); Kaplan (1974), who proposed a triphasic model of human sexual response articulated sexual desire, arousal, and orgasm as a pattern; and Basson(2001) mentioned other reasons, including a wish for emotional intimacy.

2.1.7. Sexual disorders

Sexual disorder, i.e. annoying problems in any phases of sex, including 1-sexual 2-desire, 3-arousal, 4-orgasm, and 5-sexual pain, which lead to personal distress (Carey & Wincze, 2012). It is usual among women who leave adverse effects on different aspects of their social and individual lives. There are various reasons for sexual disorders. The reasons cover physical and psychological health, intimacy with a sexual partner, sexual background, social status, career, anxiety, and self-perception (Aslan & Fynes, 2008).

In a research, carried out by Hogan (1978), sexual disorders are gender specified. Dysfunction refers to any kind of cognitive, affective, and/or behavioral problems that prevent an individual or couple from engaging in and/or enjoying satisfactory physical, psychological, motor and sensory behavior of an individual and affect one's sexual relationships and satisfaction (Hogan, 1978). Accordingly, the sexual disorder should not be misinterpreted as types of sexuality that are not common to the public (Kaplan, 1974). Kaplan (1974) discovered that discrete female dysfunction may be the result of not reaching to orgasm in their sexual relationships. Therefore, patients with orgasm problems or 'frigid' are usually deprived of this phase of intercourse so in every research related to sexual disorders, they are described by the word 'frigid' (Morokoff, 1978)

One of the situations that make a sexual relationship irritating for females is recognized as dyspareunia which causes pain, mostly among females, in vaginal area while male attempt to penetrate his penis (Masters and Johnson, 1970). Dyspareunia seems to be associated with mental issues that affect the sufferer physical health.

Another example of sexual diseases that is more common is Vaginismus; a disorder that unconsciously causes contraction of vaginal muscles during penetration, long enough to make penetration so painful for women (LoPiccolo & LoPiccolo, 2012)

Nowadays, female *hypoactive sexual desire* disorder (HSDD) and orgasmic disorder are the most frequent dysfunctions among women leading to sexual dissatisfaction. However, females' dissatisfaction seems to have other reasons such as lack of foreplay to making attraction and courtship before penetration. Most of the females are irritated by being used as a means to satisfy males' desires without considering females' need.

During recent decades, many promising improvements have been made in this area leading to more awareness of female sexual problems; the changes occurred as a result of changing social attitudes toward female sexuality, cognitive approach to sexuality, opportunity to express females' problems, physical or mental, and find actual remedies. More commonly, sexual disorders are caused due to an external factor bringing about clinical problems and impair the sexual activity of the affected person; undoubtedly, the result would sexual dissatisfaction (Diagnostic and Statistical Manual of Mental Disorders, [DSM-5], 2014) .

2.1.8. Causes of sexual dysfunctions:

According to Hogan (1978) sexual disorders are brought about by different factors grounded on mental, physical, social or personal aspects.

Mental issues causing sexual disorders may entail stressful situations whether in private or social life, and sexual relationship situations such as sexual desire unawareness, distressed sexual experiences, and sexual self-concepts.

Sexual disorders may occur due to having a physical disease such as cardiovascular disease, glycaemia, disorders of the digestive tract, brain disorder, temporal disorders as secondary effects of a drug or therapy, Hormonal disorders, and anemia or other clinical problems that need to be treated.

Among social and private issues that lead to sexual disorder are being single, failure in making relationship, disturbing experiences, not having a private life, unemployment, religious and ethical issues, and social norms (Barlow, 1986).

Causes of sexual dysfunctions:

2.1.9. Sexual anomaly (Paraphilia)

Paraphilia is a psychological, sexual disease. A person with paraphilia may be characterized by bizarre sexual desires or strange sexual activities. The (DSM-IV-TR, 2000) describes paraphilia as "a recurrent, intense sexually arousing fantasies, sexual urges or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of 6 months" (Criterion A), which "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning".

In (DSM-5 , 2014), paraphilia and paraphilia disorder are distinguished from one another. The paraphilias do not need psychiatric treatment in themselves, and paraphilia disorder is defined as " Currently *Paraphilia* is defined causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others" (Martin, 2011)

2.1.10. Sexual Health

Sexual health or well-being is a condition of having healthy sexual feelings either physically or psychologically without any undesirable symptoms indicating malfunctioned sexuality. To enjoy living in a society with sexual health, positive attitude and concepts toward sexuality and sexual behaviors are to be raised within society so as to everyone experience safe and desirable sex. To stabilize such condition, everyone in society should be entitled to their sexual rights (WHO, 2006).

2.1.11. Sexual Rights

Sexual rights are defined in the universal declaration of human rights as a division of human rights. It is also officially recognized by the union of international law. Sexual rights entail the right of persons that are to be respected without any unfair and unlawful exertion of force.

The proposed criteria of sexual are defined in terms of: availability of sexual services, awareness of sexual behavior, sexual training, emphasis on personal autonomy, freedom of choosing a partner, active or passive sexual freedom, mutual satisfaction of sexual partners, unforced marriage, planned breeding, consistent and joyful sexual life .

The universal declaration of human rights also respects the sexual right of women. “The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences” (The United Nations [UN], 2015).

2.2. Female Sexuality

In today’s world of science, among the most common subject matters of the study, that is under dispute and many researchers have reflected upon it, are sex and sexuality; the issues that surpassed the boundaries of public media and now have their roots in the world of medicine and sociology. Despite all disputes concerning the issue of sexuality, we still have in

hand a lot to learn about women's world of sex and sexual behavior. As far as sexual behavior and disorders are concerned, experts have much to say. Set aside applied accounts of medical experts, sociologists cover perspectives on both sex practice and its impact, within the society, on women sex and sexual pride. What follows is a concise comparative of standpoints between biological and social aspects on this ground.

2.2.1. Biological Determination

The sexual survey may be considered through the windows of biology in theory since this perspective syllogizes every single matter associated with sexuality in the best possible way. As regards, it is biology that determines all the personality entailing physical, sexual and emotional attributes of a human. What is of greater influence in this is heredity (Kelly, 2006). Through an effort, (Kolodny, Johnson, & Masters, 1988) and Kaplan (1974) tried to introduce staged models to further explain sexuality of human based upon biological theories.

The model introduced by Masters et al. (1986) is composed of four steps describing sexual responses of human including excitement, plateau, orgasmic, and resolution. In the first step, excitement occurs as a result of arousal of emotions either physically or mentally which leads to step two characterized by rapid heartbeat and blood circulation resulting in the third step, orgasm, when both men and women experience the highest sexual feeling. Finally, during step four, heartbeat drops and body relaxes its muscles.

According to Kelly (2001), another triphase model is introduced by Kaplan describing sexual responses of human and consisting of desire, arousal, and orgasm. During phase, one body starts to response to sexual stimuli. Phase two is marked with increased blood flow around sexual organs. The final step occurs with an orgasm of the body and decreasing blood pressure. Kaplan, in his model, puts more emphasis on biological aspects, rather than emotional, to explain body reactions during sex.

The problem with adopting the biological attitude toward sexuality is that it only considers the function of sex disregarding how it affects the sexuality in women. Fortunately, according to social constructionism, sexuality is not one-sided and integrates both functional and socio-emotional factors in human sexuality (Epstein, 1991).

2.2.2. Social Constructionism

Kelly (2001) believes that environmental factors, as well as biological ones, may influence human attributes and behavior that is complementary to theories in biology. Social constructionists move a step further than biologists; they assume environment as an underlying factor influencing physical traits of a human. If it is so, it may be possible to attribute different sexual behaviors and differences among men and women to the environment and their relationship in a society.

By putting more stress on cultural differences, the school of social constructionism is to justify differences seen among individuals of different cultures (Baumeister, 2000). As a complex component of every culture, language use and its impact have become an integral part of social constructionism (Baumeister, 2000). Considerably, biological factors are not ignored while cultural and environmental factors are of greater influence on sexuality.

Previous researchers have also questioned how an environment may foster sexuality. They have found that individuals of both are under the influence of their society in learning sexuality (Daugherty and Burger, 1984). They have also noted that females are more impressed by their peers, rather than parents, while male are less impressed than females. However, they do not deny the fact that parents still have a share in breeding sexual behaviors of their children. In another study, Lottes and Kuriloff (1992) studied social influences on sexuality where they discussed that factors like political trends, racial aspects, and religious sects are determining factors in sexuality.

Lottes and Kuriloff, (1994) further noticed that college students are also under the influence of college environment. (Lottes & Kuriloff, 1994)

Ongoing changes in societies' attitudes toward sexuality, the way they view sexuality, consider different sexes, and divide them into different sections of society, affect female individuals, gradually (Jackson & Scott, 2002). It is the society construction that decides the degree at which individuals treat human body sexually. Erotic behaviors, sexuality and orgasm activity, and how females convey their orgasm are all determined by social norms They further describe the procedures of maturation of sexual acts as it passes through all steps to complete a biological cycle and anyone who fails to finish all the steps may have sexual problem. (Jackson and Scott, 2002).

Blackwood (2000), regarding different cultures, suggested that differences in individuals' behavior have roots in their cultural beliefs regarding sex. Attitudes toward sexuality differ from one culture to another; however, all of them have many ideas in common.

Blackwood, in particular, suggests that "the way sexuality is constructed. Sexuality has everything to do with concepts of gender, selfhood, kinship, and marriage, among others" (Blackwood, 2000; p.236). In accordance to this, sexuality obtains its meaning from sociological constructions.

Social constructionism beliefs provide a basis for subjects such as female sex and sexual pride. Since sexual attributes are determined by social constructions of the society, every individual's behavior should be considered within the society. Women's beliefs in themselves and their femininity depend, to a large extent, on society interpretation of the terms like sex, femininity, sexuality, sexual excitement, and other sex related viewpoints. If a woman chooses to hide her sexual desires because she feels her sexual activities are not sufficient according to social measures, sexual concepts arising from the constructions of that society may impede female sexuality.

Researchers believe that women in Western countries have subdued their sexual behaviors (Baumeister & Twenge, 2002); however, there has been a great upheaval, during the past century, to inspire unimpeded statement of female desires. Dramatic changes occurred, in western countries, to sexual thought and behavior of both genders, results from the movements of the 20th century (Kelly, 2001). Regulation of the number of children born through control or prevention of conception by using anovulant and availability of erotic videos and photos are brought about development of science and increased awareness of women and their sexual well-beings (Baird & Glasier, 1999; Kubba, Guillebaud, Anderson, & MacGregor, 2000). Setting aside traditional views, women are no more merely a housewife and they have entered the world of work and business (Rollins, 1996). Alfred Kinsey is known as the founder of research in sexuality who prepared the ground for further researches conducted by Masters and Johnson.

(Daniluk, 1998) is one of the contemporary researchers investigating sexual behaviors among women. Daniluk's prophecy was to cover all aspects of femininity including mental, emotional, and physical aspects of the sexuality of women. According to her sexual behavior of women entails being sexy, thought, nonverbal communication, intercourse, feeling, intimacy,

and self-esteem. She believed that the quality of sexual relationships women experience affects their definition of sexual experience. So, what should be noted here is to let them freely express their feelings about their sexual behavior. Through this research she found out that the meaning each woman attributes to sexual experience depends on how she views that experience, so it seems to be a developing and relative concept; however, all the attributed meanings share something in common. Of course, in interpreting such experience, culture view toward sexuality plays a major role since in western societies it happens within a social context in which language, culture, and behavior have interacted to reinforce the values and beliefs of the dominant culture (Daniluk, 1993).

She also found out in another research that sexual experiences of females were integrated with the dominance of men in a society; the value that gives priority to males need over females. She considered shame and self-blame as two epidemic factors among participants regarding one's account of her sexuality. These elements can prevent and destroy one's emotional and sexual development. (Danilik, 1993).

Significant issues that females had the most struggles with were asserting sexual behaviors, breeding process, the perception of physical appearance, and intercourse. Some researchers recognized the participant selection mechanism in Daniluk (1993) as a potentially affecting factor on the results of the study. The participants in a specific age range may have experience menopause that influence their sexual experience due to some biological changes that occur to females' body (Palacios, Tobar, & Menendez, 2002). To improve the results, they removed the possibility of this factor by changing the age range of the participant to a young group of females.

Other researchers in this area, (Tiefer, 2012), specified that there are sociocultural, political, psychological, social, [and] relationship basis [for] women's sexual problem

Extensive researches conducted on sexuality prove the significance of learning about deterrents and driving factors influencing on women's sexual self-concept by both women and health professionals. Specifically, female's cogitation of sexuality seems to have great effects on various dimensions of heterosexual female life before the age of menopause. How to introduce sexual concept related issues and how to remedy such issues are under the influence of society attitudes toward female sexuality. What is more, identifying factors affecting female confidence

in sexuality may help improving women's situation and their relationship with partners, friends, and themselves.

2.3. General concept of self in psychology

Extensive researches have been conducted in the areas of psychology and sociology to give a conceptual definition for the word 'self'. A pioneering researcher in this area is William James (1890) who defined two types of self; multidimensional self and a unified self in which he integrates active and passive concepts of self (As cited in Leary & Tangney, 2003)

According to James, as an active role, the self is a subject with inborn cognitive capacities to learn and educate the individual. He has provided the ground for others to pose their attitude in this regard and interpret self as an inner psychological entity that is the center or subject of a person's experience (Leary & Tangney, 2003).

James hypothesis is that people in the society need to communicate and share ideas; to work this out; they may decide to unfold their own self to exchange ideas and information. However, there are cases when individuals are aware of their self but refrain from talking about it at all, or to some extent, with anybody else. He is also one of the leading researchers that has posed other concepts like self-image, self-schema, and self-belief, and tried to define them (Leary & Tagney, 2003).

To move the research on the self forward, many critics attempted to analyze definition proposed by James of the word 'self'.

Carl Rogers is one of the potent psychologists who have taken significant steps to help to understand the mental aspects of human. He put a theory of human personality based on *phenomenology*. In this frame, the emphasis is on human respond to the environment (Engler, 2013).

It is assumed that human self is a product of communication with other within an environment in which individual may be influenced by some of other individuals and adopt characteristics that later on may be attributed to him or herself that is shaped over time (Engler, 2013)

Every human being tends to reach perfection Rogers, (1959) a desire that has rooted from thinking about "who I am or a perception of who the individual believes that a person is".

Accordingly, he believes that changes that occur to human results from maturation processing of identity, not a one-night event.

The value that every individual attribute to his or herself is determined gradually through different life experiences to foster self-attitudes (Rogers, 1959). Also, he has proposed a theory called "Client-Centered" approach in which he put "I" above any other thing by discussing that individual perceptions, thoughts, and feelings of him/her-self determine self-value.

Following Rogers' theory, other researchers tried to explore more about human personality to see how an individual gains experience and how experiences are to be. Therefore, it is presumed that experiences and self-knowledge are best understood by the same individual who has developed the character of that self.

Another psychologist, George Kelly, proposed a theory, in 1955, called Personal Construct Theory (PCT). The theory believes that every human being has characteristic that is particular, and every individual sees the world in an incomparable way because of having different thoughts and perception obtained through different life experiences. Kelly resembled human to a scientist and argued that human develop perceptions in the same way as scientist collect data; they both seek for learning more about their surroundings through trial and error procedure (Englar, 1995). Accordingly, everyone experiences different events in the different way leading to different thoughts and perceptions.

Kelly also believed that human has a set of prioritized experiences with different values attributed to them, ranging from the least important to the most important; needless to say that the value attributed to each experience determines its degree of influence on that particular person and also affects one's decision and attitudes (Green, 2005).

Kelly and Roger were provided a basis for further researches grounded on self-concept. The importance of this issue arises from the fact that individuals' thought and perception greatly impact their life and decisions as well as others'. Self-value is what distinguished individuals of a society and makes a unique character for every single one. What "I" think that I am is different from others perception of "me" and that is why, in a same situation, every individual may act differently. Generally, self-concept and self-attitude determine self-value and perceptions about sexual self.

2.4. Sexual self-concept

When it comes to sex and sexuality, most of us think about physical aspects of being sexual; however, the concept of sex covers individuals' mentality as well. The way people think of themselves and others around them, their emotions, thoughts, and tendencies greatly matter in sexual science. Sexual identity as a research area is inspired, during 1970s, which, according to their division, is a quaternion unit composed of: biological sex, gender identity, social sex-role, and sexual orientation (Shively & De Cecco, 1977).

Every human being has a multidimensional identity which entails sexual self, a concept known by Gagnon and Simon (1973) for the first time and is derived from the more general idea of self (Simon & Gagnon, 2011). They believed that sexual self, although born with us, is under the influence of socio-cultural factors.

Sexual self is a constructive component of a human being which actively put acquired perceptions about one's own together to form a unified aspect of being. Therefore, in forming a sexual self, not only individualized perceptions but also social perceptions, such as feelings about sexual relationships and experiences, are influential (Deutsch, 2012).

Definition of sexual self signifies individual self-perceptions and understandings influenced by personal traits and properties with regard to sexuality (Andersen & Cyranowski, 1994; Buzwell & Rosenthal, 1996; Cyranowski & Andersen, 1998; Longmore, 1998; O'Sullivan, Meyer-Bahlburg & McKeague, 2006; Rostosky, Dekhtyar, Cupp & Anderman, 2008; Snell, 1998; Winter, 1988) which is similar to definition of sexual self-concept in being under the impact of feeling and behaviours (O'Sullivan et al., 2006); believe in such a power that enables one to gain control over his/her own and other's sexuality (Johnson, Rew, Fredland, & Bowman, 2010). As regards, by gaining positive or negative perception toward sexuality, individuals may be encouraged or dissuaded to experience being sexual and foster their sexuality (Andersen & Cyranowski, 1994; Andersen, Cyranowski, & Espindle, 1999; Bem, 1993; Birnbaum & Reis, 2006; Hensel, Fortenberry, O'Sullivan, 2012; Markus & Wurf, 1987; Rostosky et al., 2008).

In psychology, schema refers to an internal representation of the world which constructs individuals' perception (Pai, Lee, & Yen, 2012). Sexual self-schemas are the projection of sexual aspects of one's own self that makes the basis of sexuality.

Snell (1995) made huge efforts developing researches on sexuality. He proposed a multidimensional questionnaire to measure 20 dimensions of sexual self of human beings, a questionnaire that also known as Multidimensional Sexual Self-Concept Questionnaire (MSSCQ) (Fisher, Davis, Yarber, & Davis, 2013). The measures are: 1) sexual anxiety 2) sexual self-efficacy 3) sexual consciousness 4) motivation to avoid risky sex 5) chance sexual control 6) sexual preoccupation 7) sexual assertiveness 8) sexual optimism 9) sexual problem self-blame 10) sexual monitoring 11) sexual motivation 12) sexual problem management 13) sexual esteem 14) sexual satisfaction 15) power-other sexual control 16) sexual self-schemata 17) fear of sex 18) sexual problem prevention 19) sexual depression 20) internal sexual control. Individuals' mentalities (scripts) of sexual events may be interpreted as representation dimensions of sexual schemata that every individual has in mind. Whether to project these mentalities or not is the main concerns of individuals referring for sexual consultations. Snell believes that self-attitude toward sexuality is a major factor affecting sexual satisfaction. Complaints of individuals with sexual disorders mostly emanate from one of these sexual angles and because of its multidimensionality they cannot figure its source out (Snell, 1989).

Previous researchers have also proposed another theory called Sexual Self-Schemata as an alternative for Sexual Self-Concept (SSC). The latter theory refers solely to the personal feeling of sexual self, but the former theory is based on a model that mainly measures cognitive projections of sexual self. "Sexual self-schemas (SSS) have been defined as cognitive representations regarding sexual aspects of the self, that are derived from experience, manifest in current sexual cognition, and that influence sexual affect and behavior", which in other words SSS is associated with sexual experiences and may affect those of futures (Barbara L Andersen et al., 1999; Barbara L Andersen & Cyranowski, 1994; Cyranowski & Andersen, 2000).

Sexual self of female individuals is known to have many dimensions entailing both positive and negative ideas (emotional and straightforward feelings vs. anxious and reserved) (Andersen & Cyranowski, 1994). These ideas affect women's attitudes about their sexuality. Those with positive ideas enjoy more of their intercourse and experience higher level of sexual satisfaction, and Cognitively (based on sexual self-schemas model) represent better and more decisive sexual reactions, while women with negative ideas are shy in expression of feelings,

worried about sexual behaviors, enjoy less, and experience lower level of sexual satisfaction (Barbara L Andersen & Cyranowski, 1994; Cyranowski & Andersen, 2000).

Sexual self-schemas suggest a measure that is based on sexual representations of different self-views. These differences may be used as indications to find out the source of sexual problems. An element that has been commonly ignored in sexual researches is self-attitudes, an important indicator that explains the way an individual has scripted his/her sexual world (Vickberg & Deaux, 2005). According to Vickberg & Deaux (2005), other indications may be 1) Reserved Approach, 2) Argentic Sexuality, and 3) Negative Associations.

O'Sullivan, Mckeague, et al., (2006), mentioned other influencing elements in the diagnosis of sexual disorders, namely 1) Sexual arousability 2) Sexual agency and 3) Negative sexual effect. Elements that are reported to have impacts on sexual self-concept are sexual openness, sexual confidence, and sexual embarrassment.

Barlow, (1986) proposed a cognitive-behavioral model that focuses on sexual functions and factors that inhibit arousal and behavioral. Sexual self-schemas play a major role in one's regard. The problems arise according to one's negative expectations, which results in fear and anxiety.

Negative views, such as fear of being rejected, developed by sexual self-schemas and manifested in sexual behaviors is the source of sexual dysfunctions (Cyranowski & Andersen, 2000; Heiman et al., 2011). Sexual dysfunctions as a result of negative sexual schemas are the case witnessed mostly among women (Carey & Wincze, 2012; Heiman et al., 2011; Leiblum & Wiegel, 2002).

A research carried out by Winter (1988) indicated that individuals' sexual self potentially change throughout life. He found that adolescents' self-concepts are related to their choice of contraceptive- and the students with higher sexual self-concept score used more prescription methods in their sexual relationship. He concluded sex education is an essential topic for teenagers and lead to boost adolescent contraceptive.

The proposed cognitive sexual models are proved in researches carried out on females both with sexual dysfunctions and no sexual dysfunction indicating that the first group are less willing to sexual relationships because their negative schemas have surpassed positive ones as

compared to the second group who have experienced joyful relationships and sexual arousal by having more positive schemas (Cyranowski & Andersen, 2000; Kuffel & Heiman, 2006).

Johns on et al., (2010) conducted a research to examine gender differences on homeless male and female teenagers and concluded that sexual self-concept is generally interrelated with social and cognitive changes as well as females with sexual abuse experiences.

A group of female adult, who had experienced sexual abuse in early childhood, were examined to find out the origin of their mental disorders. The study proved the significant impact of sexual schemas on female sexual arousal. It seems that sexual function is directly related to sexual self-schemas, so those who had sexual abuse appeared to experience more sexual disorders and less sexual satisfaction when compared to normal women (Rellini & Meston, 2011a).

Physically handicapped individuals have also been examined concerning sexual self-concept (McCabe & Taleporos, 2003) and to see whether there is a connection between physical function and sexuality common individuals or not.

Ghorbanshiroudi et al, (2012) Studied the Effectiveness of Cognitive-Behavioral Therapy in Developing Sexual Self-Concept in medical facilities in Babol, Iran. The results showed that the intervention proved to boost sexual self-concept.

Özdel, (2013) in his research found sex therapy based on cognitive behavioral methods is effective on sexual problems of women with vaginismus and their spouses.

Ter Kuile, Both, & van Lankveld, (2010) found Cognitive Behavioral Therapy is helpful for Sexual Dysfunctions in Women.

A research on a Christian individuals indicated that accepting sexual self and fostering sexual concepts can positively affect their belief system so as to inflict less harm on themselves and improve their general health (Wagner & Rehfuss, 2008).

2.5. Sexual satisfaction

Life of every human being has always been under the influence of sexual satisfaction that determines the quality of partners' relationships, emotional status, and personal traits as well as social interactions (WHO, 2006).

In other words, sexual satisfaction can be meant as individuals' willing to live a joyful sexual life by experiencing physical pleasure (Snell, 2005; Tolman & Szalacha, 1999; Tolman, 2009). “a

sense of enjoyment or satisfaction with one's sexual life is a highly personal sentiment greatly related to an individual's past sexual experiences, current expectations, and future aspirations” (Davidson, Darling, & Norton, 1995, p. 237). Kontula and Haavio-Mannila (1995) defined emotional, sexual satisfaction as “happiness of the steady relationship” and physical, sexual satisfaction as “pleasurableness of sexual intercourse”. In general, definition of sexual satisfaction depended upon sexual relationship and gratification of sexual needs.

Level of satisfaction may be assessed by different elements among which these are of utmost importance: the amount of pleasure you get from thinking about your sexual experiences, whether you enjoyed your sexual relationships or not, and the way you feel about your physical reactions and behaviors during sex.

Concluding phase of every sexual interaction is orgasm, nevertheless this is only one aspect of sexual pleasure; many elements are determining in arousal of sexual desires and sexual satisfaction (Morokoff, 1978); however, orgasm is still the most available measure. Although everyone can reach orgasm, some of the females never experience it, and many of them have few experiences of orgasm. According to researches carried out in the USA, between 4-10% of female adults have no idea of the feeling of orgasm. Other studies on female experiences of sexual relationships indicate that they reach orgasm not in every sexual relationship but between 40-80% of times. Suppress feeling of orgasm among female individuals is the common complaint of clients referring for sex therapy (Haavio-Mannila & Kontula, 1997).

In the studies of female sexuality, there are many indices known to impact sexual satisfaction including social elements (e.g. age, singularity, matrimony, economic level, sexual background, religion, and belief system, onset of sexual relationship), personal elements (e.g. characteristics, confidence, sexual shame, being sensitive, emotional relationships), sexual attitudes (significance level of sexual concerns, sexual attraction and manifestation in life), sex positions and stimulation techniques (by hands or stimulators), and orgasm frequency (Haavio-Mannila & Kontula, 1997; Schick, Calabrese, Rima, & Zucker, 2010).

Times of sex, type of sex, foreplay, arousal and orgasm are among the elements that influence on the level of sexual satisfaction Times of sex, type of sex, foreplay, arousal and orgasm are among the elements that influence on the level of sexual satisfaction (Sprecher and McKinney, 1993).

WHO (2006), reports that some other factors that proved to be much more influential, namely: being in a sexual relationship with someone, times of intercourse per week, health status, anxiety, and social level.

According to researches of female sexuality, there are five factors that affect sexual satisfaction of female individuals; these factors are: feeling free to express sexual concerns (communicating sexual ideas), having sexual ideas in common with sexual partner (sexual agreement), being satisfied, physically and emotionally, with your partner relationship (pleasure), feeling of stress because of having sexual problems (sexual anxiety), and being worried about impacts of sexual problems in your relationship (relational concerns) (Rellini & Meston, 2011b)

To begin a successful relationship, it is necessary to be skilled at exchanging emotions and thoughts. These skills can help and promote the level of pleasure from the sexual relationship from the beginning to the end (foreplay to orgasm) (Sprecher and McKinney, 1993). Making love or feeling passionate about your partner (Aron & Henkemeyer, 1995; Grote & Frieze, 1998; Yela, 2012), loyalty, and reliability (Sprecher, 2002) can greatly influence the level of sexual satisfaction and lessen the possibility of divorce among spouses (Edwards & Booth, 1999; White & Keith, 1990).

Having single sexual partner results in more sexual pleasure than having relationship with periodic partners or being with more than one partners within a short period of time (Laumann, 1994) since those with long period relationships know their partner needs and desires pretty well. In a study carried out on 868 nurses, it came out that multi-partner women experience less emotional satisfaction (not physical). The explanation is that single partner woman experience orgasm pretty more since her partner cares about her feeling, give her more sexual-esteem, and gratify the female's need first (Davidson & Darling, 1988).

Researches have shown that having one mate for a long period changes physical, sexual attraction to emotional since the couple is more intimate, and their intercourse is accompanied by love making per se.

Partners with more emotional and the consistent relationship seem to experience more sexual pleasure. Individuals with *anorgasmia* cannot experience sexual pleasure well enough because of defected sexual relationships (Hurlbert, 1991). The research also indicated that

women with more sexual confidence have more sexual intercourse resulting in more pleasure and satisfaction because of well gratification of sexual needs and orgasm.

Recently, Higgins et al., (2010) conducted a research to measure physical and mental sexual satisfaction of a group of people in a sexual relationship. They concluded that well quality mental, sexual satisfaction was accompanied by high-level physical satisfaction, as well. The result also suggested that being in a long-term relationship increases the level of mental satisfaction for women, in particular (Higgins, Trussell, Moore, & Davidson, 2010).

In more recent study, among a group of university student who were beginner sexual partner, they measured variables affecting physical and psychological sexual satisfaction (Higgins, Mullinax, Trussell, Davidson, & Moore, 2011). Some of the variables that proved influential include: feel at ease with sex, being mentally prepared for sex, sense of self-respect, having a single partner, the number of intercourse per week, and experience of orgasm.

Galinsky & Sonenstein (2011) conducted a research on a group of male and female to see whether there is a link between reaching maturity (autonomy, self-esteem, and empathy) and measures of sexual pleasure (frequency of orgasm, enjoyment of intercourse enjoyment of giving and receiving oral sex). Females less than males experience orgasm, and reaching maturity in females bring about sexual pleasure as well (Galinsky & Sonenstein, 2011). Therefore, it seems to be a potential link between sexual pleasure and the process of reaching maturity.

Averett, Benson, & Vaillancourt (2008) examined sexual desires of a sample of teenage boys and girls. The results stated that girls more than boys care about intimacy while boys enjoy having intercourse. Outcomes of this research confirms dominance of a belief in the social system of Western countries that females, disregarding of their sexual needs, are to make intimate relationship and should not expect enjoyment of physical sex while male are to enjoy sexual intercourse and women are supposed to gratify their needs.

2.6. Sexual self-esteem

Sexual self-esteem is another facet of sexual self-concept. It is defined as “the value one places on oneself as a sexual being” (Mayers, Heller, & Heller, 2003, p.270). In other words, Snell & Papini, (1989) defined it as “positive regard for and confidence in the capacity to experience one’s sexuality in a satisfying and enjoyable way” (p.256) which may include

physical and psychological sexuality projected in individuals' behavior (Zeanah & Schwarz, 1996).

Sexual self-esteem is the one's sexual self-evaluation that may constantly compare themselves with others, or with their partners (Wiederman & Allgeier, 1993), with regard to sexual traits (Mayers et al., 2003; Rosenthal, Moore, & Flynn, 1991).

Recent progress of psychological research has made it possible to do research on various aspects of sexual self-esteem by using either qualitative or quantitative methods. Mayers et al., (2003) interpret confidence in sexuality as the "the value that one places on oneself as a sexual being, including sexual identity and perceptions of sexual acceptability" (p.207).

Sexual-esteem is defined as "a generalized tendency to positively evaluate one's own capacity to engage in healthy sexual behaviors and to experience one's sexuality in a satisfying and enjoyable way" (Snell, 2002).

Van Bruggen, Runtz, & Kadlec, (2006) found that sexual self-esteem has a significant role on dysfunctional sexual behaviors. Sexual self-esteem and sexual risk-taking relation have been also studied by Breakwell & Millward, (1997a). Squiers, (1998) also found that having a high score of sexual self-esteem influences on using condom among college student. Being aware of the gap in the literature on the sexual self-esteem of heterosexual females, motivated Squiers to carry out this study shed some light on the concept of self-esteem in female sexuality, its impact on female individuals, and how to cope with obstacles to self-esteem. Wiederman (2000) examination of heterosexual women indicated that sexual self-esteem impacts on body image during intercourse.

Sexual self-esteem and sexual health are directly related with regard to different aspects of sexuality (O'Sullivan, Meyer-Bahlburg, & McKeague, 2006; Snell, Fisher, & Walters, 1993; Van Bruggen, Runtz, & Kadlec, 2006) so that better sexual self-esteem status would result in more sexual pleasure and vice versa.

Among partners only with long-term relationships, sexual self-esteem, and risk-taking criteria are positively related (Rosenthal et al., 1991; Seal, Minichiello, & Omodei, 1997). It is interesting to note that sexual self-esteem encourages partners to take fewer risks because they are more confident in their intercourse and care about their sexual health. Women with high sexual self-esteem are more encouraged to use protection (such as condom). Therefore, higher

sexual self-esteem leads to less risky sex by using protection (Buzwell & Rosenthal, 1995; O'Sullivan, Mckeague, et al., 2006; Seal et al., 1997).

It seems that women with more sexual experiences feel more sexual self-esteem and pleasure, during adulthood than beginner females who have no such experiences or single partner during adolescence (Impett & Tolman, 2006).

Through a qualitative approach to sexual perception, Offman and Matheson (2004) studied the impacts of unfavorable relationships, such as sexual abuse, on females. They found that Self-perception is a determining factor in dealing with unfavorable events and effects on how an individual responds to sexual abuse, either mentally or physically (offman and Matheson, 2004). They concluded that females with a firm belief in their sexual beings were less susceptible to injury, facing with physical or mental sex abuse than those females who have negative attitudes toward their sexual self.

Also in another study they found young girls with sexual confidence care much more about their sexuality and are more willing to experience sexual intercourse while taking risk and encourage their partners to be more sexually assertive (Oattes & Offman, 2007).

Females' sexual self-esteem may effect on their views about sexual experiences of their whole life. Since sexual attitudes and individual confidence are interrelated, negative sexual perception may lead to disability and also leave impacts on sexual relationships by constant evaluating of ones' sexual self. Making relationships with favorable outcomes with friends, partner and ones' self to a large extent depends on sexual esteem and confidence of that person, either being positive or negative. Returning from traumatic to normal status also depend on the value that a woman attributes to her sexual self (Mayers et al., 2003, & Offman & Matheson, 2004)

Researchers believe that sexual activity is indirectly influenced by different dimensions of sexual attitude. For instance, further quality of sexual activity of every individual may be determined his/her state of sexual self-esteem (Orr, Wilbrandt, Brack, Rauch, & Ingersoll, 1989; Salazar et al., 2005; Spencer, Zimet, Aalsma, & Orr, 2002); degree of risk taking is depended on individual's mentality (Gerrard, Gibbons, Benthin, & Hessling, 1996); and individual's attitude

toward sexuality greatly impact the one's sexual behaviors. Periodic assessment of different aspects of sexual attitude (Rostosky et al., 2008) suggested that there is a significant correlation between these aspects but no long-term examination has been carried out (Devon J. Hensel, J. Dennis Fortenberry, Lucia F. O'Sullivan & P., 2012).

Mental distress while having sex (due to body image concerns) is another consequence of low sexual self-esteem which justifies differences in sexual attitudes and self-focus (Dove & Wiederman).

In Other researches conducted in studying esteem in sexuality include: Sexual Self-confidence and Body Image of South African Adolescents, Sexual Self-Esteem as a Predictor of Sexual and Psychological activities (Potgieter & Khan, 2005)., there is a correlation between Sexual self-concept and sexual risk-taking (Breakwell & Millward, 1997). Confidence in sexuality and its contribution to sexual perception and the use of protection, such as condom, among college teenagers have been surveyed (Squiers, 1998). Savin-Williams & Diamond, (2000) studied the females' sexual desire, as another influencing factor, is restricted to only heterosexual participants. They uncovered barriers to the sexual self-esteem of premenopausal women.

According to above-mentioned findings, females' sexual self-esteem impacts on their health.

2.7. Historical background of Iran Sex Perspective

2.7.1. Iran

Iran is one of the countries in the Middle East. Although, the Muslim population are in the majority, there are also other religions, such as Zoroastrianism, Judaism, and Christianity, living altogether. Generally, two main sects of Islam are Shia and Sunni but most of the Iranian people are among Shias. The official language of Iran is Farsi, which Iranians inherit, along with their culture, from their predecessors before Islam. However, their religion has changed from Zoroastrian to Islam The advent of Islam in Iran not only affected Iranian culture and civilization, but also it left great impacts on culture, art, and science of Eastern countries and even Europe.

The modernization started in the first half of the 19th century and continued to an omnidirectional westernization of the country during the 1970s. At the beginning of the 20th century, Iran underwent outstanding changes due to the modernization of society influenced by Western culture. The state effort to modernize and promote its economic system was concurrent with the development of a potent and modern army, non-religious education system, and radical nationalism (Lerner, 1987).

Many significant changes occurred in Iran during the second half of 20th century, namely the quick development of the economy, moving toward a modern society, involvement of women in society, and initiating economic activities with other countries. It was along with these changes that women were given voting right, involvement in political activities, and the right to be given high rank within the public officials.

Ratification of new acts and articles, concerning family duties and responsibilities, entitled married women legal rights and helped improving control over procreation, beginning a marital life, and patterns of childbearing, as well. Following these changes, Iran witnessed many improvements in providing the public welfare, in certain populated areas; however, these measures provided the grounds for ethical and regional segregation of the societies of that era. Added to modernization attempts, what sharpened the boundaries among different groups of society was the immense impact of Western culture; a culture that was inconsistent with Islamic criteria. As a consequence of being disappointed with the ruling circumstances of the society set the stage for an Islamic revolution in 1979.

The present situation of families is the outcome of what the Islamic society of Iran has undergone since the ancient times, during the 20th century, after the Islamic Revolution, and the devastating war between in Iran and Iraq (1981-1988), to the present time that every attempt has been made so as to achieve economic progress.

2.7.2. Family and family change in Iran

In Iran, the fundamental unit of the society is family, the product of which is children and this unit as a whole is of the greatest importance for every family member. Being father or brother, mother or sister is associated with certain roles and responsibilities.

An outstanding characterization of families in the past was patriarchy and male gender supremacy. However, nowadays, due to the cultural development of societies, the progress of Islam, and discovering more of the rich pre-Islamic culture of Iranian, this belief system of people has changed (Afkhani 2004).

The process of Modernization, in early 20th century, left great impact on Iranian civilization and, little by little, changed the family relationship of Iranian individuals leading to progress in many aspects of society including industrial, social, education, economy, communication networks, and migration. Following the modification of social rules of law, women were entitled to social and political rights namely, the right to vote. Ratification of the Family Protection Law, in 1967, implicitly influenced family structure and procreation status of Iranian family (Abbasi-Shavazi 2002)

In consequence of the occurred changes to the Iranian culture and society, the young couple obtained more freedom; birth rate went under their control, and they were given an opportunity to choose their partner. However, the past merits of the traditional society still affect family relations and social contacts among the couples and their children (Abbasi-Shavazi 2002).

Despite being single, many young boys and girls have to live with their families in Iran. Statistics indicate that the majority of singles are still living with their parents (73%), while the minority of them are married and living with their spouses (23.2%), and only a trifle portion are young unmarried individuals are living independently (2.5%) (Ebadi 2005).

2.7.3. Patriarchy and Iranian Family Control over Children

In the past, the significant characteristic of Iranian family was obedience to father or husband as a head of the family. The females were to marry and to bear children.

Women's scope of activities was limited to the house to do households and to handle the financial affair. Men were supposed to earn money and supply the needs of their family.

Decisions on marriages were upon the elders of the family who continued their control and interference even after marriage. However, there were also families who tried to be up-to-date and respect their children's idea and gave them an opportunity to choose their spouse; there are still many families who follow the costumes.

The limitation of society, concerning marriage and meeting someone, is usually aimed at girls. According to a traditional belief system, girls are always to behave reasonably well, act and dress ladylike, and they are not supposed to meet anyone before marriage. The most vital issue about an unmarried Iranian girl is to be virgin. In no way, they are allowed to have sex before marriage; however, many of them consider no such limitations for their sons or other boys, except for highly religious families (Nashat 2004).

Many families and even their sons still care so much about the virginity of the girls while it is no shame for a boy to have date and sex despite being single (Abbasi-Shavazi 2002)

2.7.4. Relationships and sexuality

In Islam, sexuality is a natural desire that should be gratified but only after getting married. Single girls of the marriage age, after pubescence, are the main concerns of their family to be married (Mehryar and Tashakkori 1978)

After the second half of the 20th century, little by little, societies began to accept interaction between opposite genders. It was initiated by the appearance of both sexes in public areas, such as parks, cinemas, and restaurants, to spend some times together. Opposite sexual attraction followed by relationship started to happen. Secure and lawful feticide was allowed. Yet, males, even the modern ones, considered virginity as a primary condition for their marriages since they believed in sexual freedom of men and subordination of women.

After the Islamic Revolution of Iran, by resorting to Islam, the public officials tried to turn over the situation. New firmly emphasized rules were approved to control the wave of changes in society and prohibit any sexual relationship out of wedlock by stating that sexual affairs out of wedlock, including infidelity, are constituted as a deadly sin.

For instance, one of the programs run by the government to support the new policies to circumvent some of the problems was the mass public wedding ceremonies afforded by the state. Most of the couples who participated in these ceremonies had an option to date and choose their own spouse that was a kind of breakthrough measure against traditional costumes. It was a novel measure of its kind. Removing the costume of providing marriage settlement on behalf of the bride's family was a step toward their self-determination. Young couples, due to not being able to afford their marriage expenses, were depended on their parents and, as a consequence,

parents allowed themselves to exert their control on every aspect of their life even after marriage (Lerner 1987).

Free and explicit discussions about females' sexuality and desires were under restrictions of moral norms of the society. Females are still required to remain virgin for their husbands from the most families' viewpoint. The intercourse of a single girl before marriage was a disgrace for the family. Therefore, the condition as a whole raised the marriage age and delayed the first sexual experience of females.

2.7.5. Sexuality and Procreation Perceptions of Young Singles

According to different conducted researches, young boys and girls have little to average attraction to sexuality. College students (of Qazvin University- a near capital province of Iran) are proved to have a basic awareness of their genitals (Simbar., Ramezani Tehrani, Hashemi, 2003). A broad survey (Family Planning Association [FPA-Iran], 1998), on 757 teenage boys, aged between 15-19, indicated that the boys had very limited knowledge about pubescence and its associated changes in the body; more than half of them thought of puberty as a sense of shame accompanied by physical as well as mental concerns (+ 69%). Half of the respondent had not any idea of the ways of protection (54%). It was promising to hear that more than three fourth of them were eager to acquire knowledge on this ground. The worst thing was their ignorance about sexual diseases and HIV/AIDS virus. More than 75% of the participants were also unaware of STIs and the ways through which they may be infected (FPA-Iran 1998).

High school girls proved to have more knowledge about sexuality and lady hygiene. They were well aware of the outcomes of marriage at low ages, family responsibilities, protection, and HIV.

Although most of the teenagers (aged 10 to 19) were unaware of STDs ways of protection and infection (Mosleh-uddin, Mirmotahari et al. 2002). Teenage boys (aged 15 to 18), residing in the capital city of Iran (Tehran), were examined in a research in 2002. Their responses were measured on different grounds including reproductive physiology that showed poor knowledge on this ground (0 to +3; mean: 0.97). The participants also had poor knowledge of the ways of protection (mean value of knowledge: 3.14 of 10 methods; SD=2.36) (Mohammadi, 2006). The majority of them were familiar with the word condom, but they rarely knew how to use it.

The average score obtained regarding the condom use, more than 54.8% reported that each condom should not be used only once (index range: 0 – 3, SD=1.20, mean value 1.50), 53% confirmed that condom can prevent pregnancy, 42.4% believed that STDs may be prevented by using condom. Their knowledge about sexual diseases such as STDs and HIV was at an average level. Measurement of their knowledge about the symptom of such diseases was very basic (index range: 0 to +9, mean value: 3.86, SD=2.13)(Mohammadi, 2006).

An investigation on school boys in 2002 (Tavoosi, Zaferani et al. 2004) indicated that they have poor knowledge about the virus of HIV. A number of limited researches carried out in recent years to evaluate the level of sexual awareness among teenagers of different regions.

2.8. A Historical background of Western Sex Perspective

To promote the general view toward sexual concepts in western societies, it seems necessary to look back in the history and gain a better understanding of the way sexuality was defined at that time. Sexual interests known as devil instinct of human being, a desire that has to be suppressed. The western view of sexuality had its root in Greek dualistic world view which places human soul higher than the human body. Human flesh is mundane while our soul is attached to God so its pleasure has to be superior to body pleasures.

Plato believed that , “copulation lowered a man to the frenzied passions characteristic of beasts ” (Bullough & Bullough, 1977, p. 14). Catholicism, under the influence of the Greek's philosophers, propagated the same idea by considering the sexual desires of the human body as the dirty thought that leads to hell (Bullough & Bullough, 2014). It was the ruling atmosphere of that era until the 17th century when a new Protestants' sect emerged; Puritans and Victorians who advocated a discipline to regulate penalties for morally repulsive words.

Later on, between 18th and 19th century, a new attitude has been raised as a result of advancements in medical science. Sexuality was no more a sin, rather a physical problem that ought to be cured.

Bullough and Bullough , (1997) ,argued that, sexuality is no more a sinful act, no more a sickness, yet it is a medical issue that needs to be studied, doctors threatened the public so that to avoid any sexual relationship out of wedlock and disfigured the concept of sex before their eyes.

Thereafter, doctors were regarded as a source of sexual knowledge to define what is right and what is wrong.

Following that century, Freudian approach was established. On that time, the intensity of sexual distortion had been alleviated to nonage sex. Any kind of sexual activity, love making, and homosexuality were regarded immoral. Certain boundaries were superimposed on sexual relationships to keep sexual parties away from the borderlines, warn moralities to them, and remind them the purpose of sex which is procreation. Alfred Kinsey and Masters and Johnson, in the 20th century, came out of western culture with a brand new wave of thought on sexuality. They discussed sexual pleasure as an indispensable part of human being (Bullough & Bullough, 1977).

2.9. A historical background of Sex Therapy

2.9.1. The Origin and Freudian psychoanalysis

Before the emergence of psychological therapy by Sigmund Freud, sexuality within the wedlock was considered as a common means of producing offspring which was a result of the Victorian era (Robinson, 2012). Before Freud, other scholars had also initiated working on sexual grounds, such as Ellis. What Freud did was continuing their way and shedding new lights on sexual issues from a psychological perspective. He believed that sexual matters can greatly influence on psychological mental illnesses of the human. He was the initiator of a new revolution in the field of sexuality. Although not all the Freudians' theories were successful, and even some of them proved to be scientifically distrusted, he managed to change the dominant attitude of that era to sexual issues and make it open to change by considering therapeutic dimensions of sexual relationship (Foucault, 1978). By spreading a new wave of attitude, he made great changes in the treatment of mental and emotional disorders which have to be considered even today.

The theory of psychological therapy of Freud for sexual disorders states that sexual problems occur as a result of mental disorders, experienced by individual in the past, as well as Oedipal Complex Having his mind occupied with sexual depended psychological theories, he attributed most of the nervous diseases of his patient to sexual problems arise from opposition of

feelings between parent and child, and the conflict between id and superego. Therefore, sexual dysfunctions assumed to have originated in one's experience and unconscious sexual conflicts, in other words, he argued that, ignoring such nervous disease and problems lead to both physical and psychological sexual disorders. He also stated that deeply unhealthy sexual attitudes inside one's mind results from problems such as Oedipal Complex, which is a problematic situation between parent and child. (Bocock, 2003)

The therapeutic techniques of this approach are as follows:

The purpose of a long period of psychological sex therapy is to gradually find out the sources of conflicts resulted in sexual problem and are supposed to be within one's mind. In doing so, a psychotherapist is to treat sexual disorders through solving the conflicts of individual's 'mental life' (Atwood & Klucinec, 2007). After solving mental conflicts, sexual disorders are expected to be treated gradually, since they are regarded as the symptoms of hidden psychological problems. Later on, these theories were largely criticized since they were originated from Freudian thoughts which turned out to have a trivial influence on the treatment of sexual problems.

However, Ellis believed Freudian theories were not therapeutic, yet they helped to identify sexual conflicts. He argued that Freudian psychological analysis is barrier to patients' treatment since it lacks explicit instruction for the patient, control assignments, and guidance on how to deal with their negative sexual attitudes. Based on these reasons, Ellis found Freudian theories insufficient for improvement or treatment of sexual problems (Ellis, 1975).

2.9.2. Post-Freudian psychoanalysis

Bieber (1974) believed that sexual disorders originate from deviated thought and attitudes adopted during the early stage of life or imposed upon individuals by parents or society. The attitudes negatively affected individuals' sexual life. What made the situation worse was individuals' ignorance of their sexual problems. Psychotherapists were trying to solve this problem by influencing patients' unconscious mind. In this theory, sexual needs were to either be responded physiologically or make partner with a close relationship.

Accordingly, the most common sexual concerns were how to make love, to start and stay in romantic or sexual relationships, to keep up marriage, or to bear a child. After childbirth,

either of partners may have to deal with some problems such as spousal alienation, lack of sexual interest, having an affair, undesirable feeling to the child or rejection . Long-term psychotherapy sessions aimed at modification of individuals' attitude toward sexuality may treat disorders attributed to mental conflicts (Bieber, 1974)

Psychological treatment is to find out and modify illogical thoughts, and that deviated individual's attitudes toward sexuality. The most common source of these problems comes from parents who raised a child with a wrong belief system and prevented him/her from communicating with others. In psychotherapy session, therapist tries to make intimate relationship with patient in order to be able to influence him/her and reshape patient's mind with regard to some deviated thoughts and encourages the patient to enter into a well-founded relationships with others. Also, there are morally raised patients who are prevented to do sexual practices such as masturbation. By making a close relationship, the therapist makes the patient do what he has always been inhibited from doing. The patient follows the therapist instructions as long as there is a trustful relationship between them (Beiber, 1974).

To do so, the psychotherapist has to establish a well-founded system of thought with no doubt or uncertainty and reduce the feeling of guiltiness with regard to sexual behaviors, in order to be able to influence patients, no misleading information has to be transferred in therapy session. What is more, careful attention should be paid to whatever the patient is trying to express because if any mystified assumption left uncovered, it might be inferred as a taboo that is to be avoided.

While the patient is going through sex therapy session, there are two theories of how to deal with upcoming sexual desires. With regard to psychoanalysis theory and a long period of treatment, it seems irrational to prevent the patient from sexual activity. Therefore, one group believes that patients should be allowed to make sexual relationship when they think they are ready; however, they need to be cautious and avoid doing their previous mistakes. Another group prevents patients from any sexual relationship until the last therapy session so as to protect them from experiencing additional failure (Robinson, 2012)

2.9.3. Post-psychoanalytic contributions / (modern) sex therapy

During the second half of 20th century, sexual movements was going through ups and downs and many were interested to know more about sexuality and how to promote the quality of their sexual relationship.

The first researcher was Kinsey (1948, 1953) who conducted a research to find out a pattern for sexual behaviors of ‘normal’ couples when sexual thought and considerations were no usual. Masters and Johnson (1966, 1970) questioned the nature of ‘normal’ sexual behavior. They studied common people who seemed not have sexual problems. However, detailed examination indicated that there are traces of sexual problems. According to Masters and Johnson, (1960) any abnormal sexual behavior during sex intercourse is regarded as sexual disorder e.g. hypo arousal or aversion to sexual stimuli, and absent, delayed or overly rapid orgasm and ejaculation

Researchers were trying to find solutions for sexual disorders composed of two opposites: psychoanalysts and followers of behavioral strategies of Master and Johnson. The former group focused on underlying sources of sexual disorders originated from internal and mental conflicts while the latter group stressed on treating apparent signs of sexual disorders. Kaplan proposed a mixed theory called ‘new sex therapy’ that is based on both behavioral and psychological symptoms of sexual disorder (1974).

Simultaneously, other sex therapy methods had been proposed such as gestalt therapy, and humanistic theories. Gradually, by combining several specialized branches of sexual disorder diagnosis (e.g. social skills therapy, hypnotherapy, mechanic therapy, pharmacology), sex therapy was developed as an integrated body of knowledge.

2.10. The Effective Approaches in Sexual Cognitive Behavior Therapy

2.10.1. Behavioral and directive therapies

Conceptualization of sexual disorder: having identified detailed elements of ‘normal’ sex as a whole, Masters and Johnson wrote a book in 1970, “Human Sexual Inadequacy”, and brought about a movement in the field of sex therapy. The book proposed new therapeutic method integrated both psychological and behavioral strategies that appeared to work out in a much shorter period of treatment. The book set aside all traditional attitudes toward sexual

disorders stopped relation all the signs to sexual intercourse and did not follow any absurd ideas regarding sexuality. The new method was not only based on physiological or biochemical factors, but also dysfunction could be due to weaknesses in communication, imaginary expectations about sex, lack of sufficient information, negative beliefs, and irrational sexual demands (Foucault, 1978)

Although the method proposed by Masters and Johnson may be considered a behavioral method, it is a leading strategy integrating instructional and behavioral treatment into sex therapy. At first, sex therapy was a brief period of treatment session instructing how to control our nerves and be less anxious to have a better sexual relationship. Masters and Johnson believed that human needs to be educated to know how to deal sexual desires in close relationships with others (Kolodny et al., 1988).

2.10.2. Behavioral-analytic sex therapy

According to Kaplan (1974) a behavioral method that combines plain instructions with sexually oriented problems. In this method, she not only focuses on signs of sexual disorders but also explored non-sexual aspects to see if there has been any other cause of emotional injury. To do so, she tried to find out the way psychological events give rise to signs of sexual disorders. Some of these psychological events may be past trauma, being in a stressful situation, excessive self-concerns, and unstable situations that hinder free expression of feelings. Thus, the new method proposed by Kaplan could both solve sexual disorders and stem out psychological problems.

To give an example, the behavioral method seems to be insufficient in cases where treatment process of a couple is interrupted by a problem of one of them. In such cases, individual with a problem needs to be treated alone in a separate therapy session. There are much more complicated situations when the patient's mind is preoccupied with illogical beliefs. By stressing such beliefs, the therapist tries to discuss and modifies them rather than leaving them uncovered on the back of patient's mind (Kaplan, 1974).

2.10.3. Rational Emotive Therapy

In Rational Emotive Therapy, which is based on the works of Ellis (1975), sexual dysfunction is expressed as a consequence of distorted thinking. Rational psychologists, unlike psychoanalysis, believe that the main factor of the sexual disorder is negative and problematic emotions of sexual experience. The techniques are based on a cognitive restructuring of one's emotions while considering the sexual failure as the most damaging fear to the client. The clients are guided, in a process called “anti-awfulizing”, to feel emotions such as grief, regret, disappointment or in sexual dysfunction context. They are asked to challenge their irrational attitudes and guiltiness, and try to recognize the sexual dysfunction as a disease that any individual might be prone to (Ellis, 1975).

The major roles of a therapist in this method comprise, helping the clients to tackle the embarrass related to negative sexual perspective such as facing negative judgments, avoiding obligatory phrases such as "should" or "must".

Ellis' method of treatment comprises three important issues:

- 1- Providing the client with direct sexual information.
- 2- Designing some activities for the client as homework.
- 3- Clarifying the incorrect cognitive and changing those to positive attitudes.

Also Dengrove (1971) studied a research on human psychology in a social domain and concluded that individuals' thought, feeling, and behaviors are interrelated so that any changes may affect all of them. Accordingly, if one decides to make a change in his/her sexual behavior to get rid of routines, it may lead to favorable changes in sexual attitudes, as well. Surprisingly, a system of thought may be changed without any attempt to do so; simply, it is a secondary result of behavioral modification (as cited in LoPiccolo & LoPiccolo,2012).

2.11. Cognitive behavior sex therapy

Cognitive-Behavior Sex Therapy (CBT) refers to the alteration of a system of thought and belief in order to decrease anxiety and prepare the body for sexual arousal and pleasure. In CBT treatment, the patient has to do homework that encourages the conscious imagination of body to accept it as it is. Masturbation methods are explained to female individuals to experience sexual pleasure. Fantasy and imagery are suggested for increasing

sexual excitement. In order to feel sexy, they are suggested to use stimulants, watch sexually arousing movies and use lubricants and vibrators. To make the female more aware of their sexual organs, they are recommended to do relaxation and Kegel exercises. For those who had not orgasm experience sexual role-play is suggested to overcome their internal inhibitions(Mackay, 1982).

Based on the carried experiments so far, CBT is proved to be more efficient in treating females with orgasmic inhibition. Between 60-90% of females treated with CBT are reported to have successful orgasm experience through masturbating. However, between 33-85% are managed to experience orgasm through sexual relation. In general, it seems that progress made in the sexuality of patients treated, either individually or in the group, with CBT is more persistent.(ter Kuile et al., 2010).

CBT train female to have control of their feelings and undergo less fear and pain. Any painful experience may leave inhibitory effects on females. Therefore, CBT tries to make it a joyful experience without bad feeling and pain by correcting the negative beliefs and practicing sexual activities to lose muscles before penetration and promoting lubricant during penetration(McCarthy, 1986)

Sex therapy sessions are developed to probe patients' mind and behaviors pathologically to see what has caused them going through the unfavorable experience. Through this sessions, therapist makes every attempt to train patients with new methods, reshape their minds, promote promising behaviors, and enable them to express their sexual desires. Therapists' engagement in patients' sexual relationship through CBT therapy works out for many patients (Goodwach, 2005). Studies indicated that CBT is can be influential as much as medical treatment, and, in some cases, even more influential. (Metz & McCarthy, 2007)

CBT sessions are held for a group of patients for about 8 to 10 sessions. During this period the following issues are covered:

education and information about pain in genitals and painful intercourse and how dyspareunia affects desire and arousal, (2) education about different causes and view of pain (3) sexual anatomy education, (4) muscle relaxation (5) abdominal breathing, (6) Kegel exercises, (7) vaginal dilatation, (8) focusing and distraction techniques on body imagery (9

), practice self-expression (10) communication skills (11) social interaction, and challenge of negative attitudes. (12) Structured homework assignments for instance; “stop-start technique,” “sensate focus” (non-demand touching) and permission-giving to normalize desires (McCarthy, 1986)

2.12. CBT Therapeutic Techniques

2.12.1. The Correction of Misconceptions

In some cases of erectile dysfunction or female frigidity giving some straightforward recommendation may help to bring the situation under control. Sometimes patients need someone to show them right and wrong, address their erroneous attitudes and correction irrational beliefs train them with foreplay strategies. It should be remembered not to confuse sexuality and morality (LoPiccolo & oPiccolo, 2012)

2.12.2. Mutual Responsibility

In should be noted that, in case of couples, any sexual disorder is attributed to both of them. Partner of a woman with no orgasm experience is also responsible since he should be trained to know how to grant his partner’ needs. Setting aside the source of sexual disorder, any problematic situation should be fixed in the presence of both parties of a relationship to improve their further intercourse (Freeman, 1989)

2.12.3. Information and Education

It is regrettable to say that patients with the sexual disorder commonly do not have any sexual knowledge. Lack of sexual knowledge results in embarrassment (later on, disorder) during sexual intercourse. Masters and Johnson (1966) reported a case whose reluctance to sex started up since when she thought her clitoris is “disappeared” during stimulation (plateau phase) since she didn’t know that it is a sign of arousal. From that time on, a sense of fear had inhibited her from sexual pleasure. In some other cases, females suffer from severe vaginal pain because their partner is not familiar with females’ genital and put pressure on the wrong location of the vagina (LoPiccolo & oPiccolo, 2012).

2.12.4. Attitude Change

Stress, anxiety, and unwillingness during sexual intercourse are the results of negative social attitude toward sexuality. In some cases, unfavorable experiences or fear of intercourse bring about sexual aversion (Chirstensen & Gregg, 1970, as cited in LoPiccolo & oPiccolo, 2012)

2.12.5. Eliminating Performance Anxiety

Focusing on age, and appreciation of aestheticism to look sexy and to make a competitive sexual atmosphere greatly affect sexual disorders. (Aubrey, 2007) in a research found Television influence on Women's Sexual Self-Concept. To be confident, boost self-esteem and to believe sexual potentials, patients are required to disregard social stressors and do not constantly compare themselves with others during sexual intercourse; they have to be focused on their own relationship to enjoy the sense of pleasure that it gives to them (LoPiccolo & oPiccolo, 2012).

2.12.6. Increasing Communication and Effectiveness of Sexual Technique

Couples with sexual disorder do not have mutual understanding of their sexual preferences which may have its root on different issues including: not being assertive enough to freely express their desires, being over-responsive to bitter disapproval of the partner, lack of interest in new ways of sexual intercourse, and believing that sexual responses are the same in all situations with no difference in the pleasure(Montesi et al., 2013). Thus, straightforward sex therapy sessions promote new sexual strategies and help the couples to promote the quality level of their sexual interaction. For instance, they are invited to share their pleasurable experiences with other couples, watch erotic movies, learn new sexual positions, and be more assertive to discuss their sexual fantasy, strength, and weaknesses (LoPiccolo & oPiccolo, 2012).

2.12.7. Changing Destructive Life-Styles and Sex Roles

In straightforward therapy sessions, therapist plays an active role and do not wait for the patients' feedback. Therapist starts by explaining the situation to clarify the patients' role in life and sexual relationship. For instance, sex for many couples is the last thing to do, after all job, business, cleaning the home, babysitting, and so on. In such cases, there is no energy or attraction to a sexual relationship. The therapist suggests them to give sex a special place in their

life, having a sexual date, set aside all daily stuff to relax and spend some time together (Annon, 1974, as cited in LoPiccolo & Piccolo, 2012).

2.12.8. Prescribing Changes in Behaviour

The significant characteristic of straightforward sex therapy is the therapist suggestions to the couples. They are commonly recommended to gradually change the pattern of their sexual behaviors by, for example, following sensate focus exercises. By doing so, little by little, they can relieve their stress, learn new sexual skills, and be an initiative in their sexual intercourse to make it more enjoyable (Metz & McCarthy, 2007)

2.12.9.

To overcome sexual distress, inhibitory elements, and promote sexual potential, Wolpe (1958) developed a new strategy that also needs a willing partner to be succeeded in. The couple is requested to continue foreplay without intercourse until when they feel overwhelmed with emotions. They are not required to show any responses that make them anxious. The point is; rising wave of positive emotions during arousal inhibits any negative feelings. Gradually, after one or two sessions of love play, negative feelings dies out among outburst of affection (as cited in LoPiccolo & Piccolo, 2012).

2.13. Table of related researches

Table 1: Related researches

Author(s)	Article Title	Method(s)	Results
		Individuals in with long-term relationships were selected to be assessed in terms of sexual satisfaction twice 18 months apart.	It was found that sexual satisfaction and relationship satisfaction were tightly associated one to another.
(Dove & Wiederman, 2000)	Cognitive Distraction And Women's Sexual Functioning	A questionnaire has been completed, concerning cognitive distraction and sexuality, by a sample of young adult women.	More cognitive distraction during sexual activity, came along with lower sexual esteem, higher occurrence of pretending orgasm, less sexual satisfaction, and less consistent orgasm.
(Abdoly & Pourmousavi, 2013)	The Relationship Between Sexual Satisfaction And Education Levels In Women	Sexual satisfaction, sexual function of 270 married women were evaluated by Sexual Satisfaction Scale for women (SSS-W) and Female Sexual Function Index (FSFI).	No lineal relation between sexual satisfaction and formal education level was found in participant women. More sexual dysfunction and lower satisfaction have been found in under-diploma and doctorate groups in comparison to others.
(Ajilchi, Oskoei, & Kargar, 2013) ³	Marital Satisfaction And Mental Health In Multiple Sclerosis Patients' And Healthy Individuals' Accordance To Sex	It is a correlation study of 59 MS patients in Tehran, who were selected by random cluster sampling method and matched with 59 healthy individuals in sex and age. The marital satisfaction questionnaire of Enrich and GHQ were used.	People with MS disease had low level score in their marital satisfaction and the whole of its subscales except the religion and the mental health. Also it is found that the gender has affected the satisfaction elements and personality issues, and healthy men scores in financial management are higher than healthy women.
(Andersen, 1999)	Surviving Cancer: The Importance Of Sexual Self-Concept	Diathesis–stress interaction has been studied. The impact of sexual sex-view of women on sexual morbidity has been widely reviewed and followed by diagnosis and treatment for gynecologic cancer.	Sexual dysfunction could be predicted by sexual self-schemas scale in sexual behavior and responsiveness.
(Aubrey, 2007)	Does Television Exposure Influence College-Aged Women's Sexual Self-Concept?	This study examined whether television exposure shapes female emerging adults' sexual self-concept, were examined by sexual self-concept and spending time self-questioners.	The results show the television influence on Women's Sexual Self-Concept.
(Barbara L Andersen & Cyranowski, 1994)	Women's Sexual Self-Schema.	The Sexual Self Schema Scale's construct was developed to a negative part which is related to embarrassment or conservatism and two positive dimension, passionate–romantic emotions and a behavioral openness to sexual experience.	Generalizations about sexual aspects of oneself that are derived from past experience, manifest in current experience, influential in the processing of sexually relevant social information, and guide sexual behavior.
(Barbara L Andersen et al., 1999)	Men's Sexual Self-Schema	Test-retest and internal consistency reliability and validity together with the factor analysis, internal structure, convergent and discriminant validity,	Men's sexual self-schema scale was developed. Three dimensional construct comprises passionate-loving, powerful-aggressive, and open-minded-liberal traits. Sexual schema is

		process, group difference and change have been widely studied.	derived from past sexual experience, is manifest in current sexual experience, and guides future sexual behavior.
(Blunt, 2012) farziye akhar	"People Aren't Mind Readers": A Study Of Sexual Self-Concept, Partner Communication, And Sexual Satisfaction	Study consists of two different phases using mixture of methods. Thirty face-to-face individual interviews in phase one and the other comprised an online quantitative survey, which assessed sexual self-concept, communication with partners, sexual satisfaction, and condom use.	Sexual self-concept has been found to be important for communication and sexual satisfaction. It has also been concluded that communication significantly affects risk reduction and sexual health promotion.
(Bradford & Meston, 2006)	The Impact Of Anxiety On Sexual Arousal In Women	It studied the effects of three important factors namely state anxiety, trait anxiety, and anxiety sensitivity on physiological and self-report measures of sexual arousal and sexual function.	Authors proposed a curvilinear dependency between state anxiety and physiological sexual arousal. They have also found the correlation between trait anxiety and anxiety sensitivity on one side and sexual arousal on the other. One possibility is to understand the results as impact of sympathetic nervous system on sexual arousal and cognitive interference mechanisms.
(Breakwell & Millward, 1997a)	Sexual Self-Concept And Sexual Risk-Taking	The data has been collected via a postal survey using a 14-item questionnaire about sexual self-concept. The data is analyzed to find the differences between men and women sexual identities.	Sexual and other forms of risk-taking are related and both are likely to impact on health. Results show that males with high score assertiveness use more alcohol, tobacco and having sex without condom. In females, great assertiveness score comes along with less possibility of virginity, having more than one sexual partner and using alcohol. Also it is found dominant social influence on sexual self-concept.
(Byers & Demmons, 1999)	Sexual Satisfaction And Sexual Self-Disclosure Within Dating Relationships.	College men and women in a 3 to 36-month dating relationship have been evaluated by means of a questionnaire in terms of sexual exchange variables, sexual satisfaction, relationship satisfaction, sexual communication satisfaction, and sexual and non-sexual self-disclosure with their partner.	The impact mechanism of the self-disclosure on sexual satisfaction was investigated. Sexual self-disclosure increased sexual rewards, and enhance the sexual satisfaction
(C. Meston & Trapnell, 2005)	Development And Validation Of A Five-Factor Sexual Satisfaction And Distress Scale For Women: The Sexual Satisfaction Scale For Women (Sss-W)	It was a three-phase survey, comprising item selection and interviews with factor analysis, designing and modifications of the questionnaire and further factor analysis, and administration of the final questionnaire to a population of women suffered from sexual dysfunction and controls.	The SSS-W was designed as a 30-item measure of sexual satisfaction and sexual distress. It showed sound psychometric properties with an ability to distinguish clinical and nonclinical samples.

<p>(Cyranowski & Andersen, 2000)</p>	<p>Evidence Of Self-Schematic Cognitive Processing In Women With Differing Sexual Self-Views</p>	<p>The relation between the alterations of sexual self-views and the processing of sexually self-information was studied among women.</p>	<p>It was found that alternating sexual self-views would lead to differences in sexual attitudes and sexual responsiveness among women.</p>
<p>(David Farley Hurlbert & Whittaker, 2015)</p>	<p>The Role Of Masturbation In Marital And Sexual Satisfaction: A Comparative Study Of Female Masturbators And Nonmasturbators.</p>	<p>A non-clinical population of married women was divided into two groups. One with an experience of masturbatory orgasm and the other without that experience. Seven comparative evaluations between the groups were made to assess the effect of masturbation in marital and sexual satisfaction.</p>	<p>It was reported that the group of masturbators experienced more orgasms greater sexual desire, higher self-esteem, and greater marital and sexual satisfaction, and required less time to sexual arousal in comparison with the non- masturbatory group.</p>
<p>(Davison, Bell, LaChina, Holden, & Davis, 2009) health</p>	<p>The Relationship Between Self-Reported Sexual Satisfaction And General Well-Being In Women.</p>	<p>This is community-based cross-sectional research on women who were asked to respond either satisfied or dissatisfied concerning their sexual life.</p>	<p>It is found that the women with lower sexual satisfaction are more prone to lower psychological well-being.</p>
<p>(Devon J. Hensel, , J. Dennis Fortenberry, Lucia F. O’Sullivan & P. Orr, 2012)</p>	<p>The Developmental Association Of Sexual Self-Concept With Sexual Behavior Among Adolescent Women</p>	<p>In a four-year period, the reciprocal developments of sexual self-concept, as well as its relation with the changes in sexual behavior, were studied.</p>	<p>The results show significant impacts of sexual self-concept on behavior. It was noted that sexual self-concept was changed during adolescence in a fashion with less reserve anxiety together with greater personal comfort with sexuality and sexual behavior. Additionally it was found that sexual behavior affects sexual self-concept while sexual self-concept constructs the future behavior.</p>

(Donaghue, 2009)	Body Satisfaction, Sexual Self-Schemas And Subjective Well-Being In Women.	The correlation between the factors such as body satisfaction, sexual self-schemas, and components of subjective well-being in women, have been thoroughly studied in adult women between 18 and 68 years of age.	Body Satisfaction and Sexual Self-Schemas has positive correlation and both of them are influenced by sexual self-schemas
(E Haavio-Mannila & Kontula, 1997)	Correlates Of Increased Sexual Satisfaction	In this study, correlation between factors such as social background, assertiveness, orgasm, sexual practices and ideas, and satisfaction with sexual intercourse were thoroughly investigated, using path analyses.	It was shown that a gratifying sexual intercourse was deeply correlated with the factors such as sexually unreserved and a nonreligious childhood home, early start of sexual life, high education, reciprocal feeling of love, frequent intercourse, and frequent orgasm.
(Farahani, 2008)	Norms, Attitude, And Sexual Conduct Among Female College Students In Tehran; Iran.	A qualitative survey comprises Focus Group Discussions (FGDs) and In-Depth Interviews (IDIs) on a sample of undergraduate female students.	This study described social acceptability of premarital heterosexual relationships in Iran. The results proposed that traditional norms relationships are changing among young people.
(Fard, Reza, Aboeshghi, Kad, & Zadeh, 2014)	Impact Of Sex Education On Family Health Of Students	A quasi-experimental study followed by a post-test study on a single group.	The results prove the efficacy of sex education on preventing sexual disorders, providing more mental health, healthy behavior and gender identity appropriate for different social levels.
(Fariba kalantari, Mariam Esfahani Asl, Mohammad Reza Bayat (2012)health	The Relationship Between Sexual Issues & Marriage Satisfaction Among Married Women	Multiphasic Sex affairs Questionnaire (MSQ) and marriage satisfaction questionnaire were used to evaluate the relationship between sex matters and marriage satisfaction.	There was seen a considerable correlation between sex attitude, sex awareness, sex anxiety, sex depression, outer sex control, sex monitoring, and marriage satisfaction in married women. However, no meaningful relationship between sex-related respect, sex stimulation, and marriage satisfaction was recognized. Additionally, it was proposed that sex monitoring and exterior sex control might predict the marriage satisfaction.
(Goetz, Easton, Lewis, & Buss, 2012)	Sexual Exploitability: Observable Cues And Their Link To Sexual Attraction	A group of men were selected to rate the women's photos in terms of hypothesized cues to exploitability.	It has been suggested by the results that there is relation between sexual attraction to exploitability cues and the exploitative strategies developed by the men.

(Heiman et al., 2011)	Sexual Satisfaction And Relationship Happiness In Midlife And Older Couples In Five Countries	A population of middle-aged and old couples with minimum duration of one year relationship and maximum of 51 years were evaluated to model the relationship happiness and sexual satisfaction.	The longer the duration of a relationship was, a greater happiness and sexual satisfaction for man could be predicted. On the other hand, women reported lower sexual satisfaction in the earlier stages of a relationship and greater one later on.
(Hesary & Zakariaei, 2015)	Comparison Of Sexual Dysfunction And Coping Strategies In Couples Applicants Of Divorce And Normal Couples	The research conducted on a sample of divorce-candidate couples with a minimum education level of the sixth grade elementary. They were administered by questionnaire of Female Sexual Function Index (FSFI), indicator of male sexual function (IIEF) and the coping strategies of Billings and Mouse.	Sexual dysfunction variable was reported as the most considerable difference between divorce-candidate couples and normal ones. Although, there was also another significant difference in terms of rejecting coping strategies, no meaningful contrast between cognitive and behavioral coping strategies was found.
(Larson, Anderson, Holman, & Niemann) (2008).	A Longitudinal Study Of The Effects Of Premarital Communication, Relationship Stability, And Self-Esteem On Sexual Satisfaction In The First Year Of Marriage	A sample of couples was selected to complete the Preparation of Marriage Questionnaire (PREP-M) just few months before marriage. The study was completed by using the Index of Sexual Satisfaction (ISS), one year after the marriage, to evaluate their sexual satisfaction.	The results suggested that the best premarital predictors of man's sexual satisfaction were his wife's self-esteem, open communication, and relationship stability. On the other hand, it proposed the best woman's sexual satisfaction predictors were her husband's empathic communication.
(MacNeil & Byers, n.d.)(1997)	The Relationships Between Sexual Problems, Communication, And Sexual Satisfaction.	A population of men and women in long-term heterosexual relationship has been studied, using questionnaires, to assess the relationship between sexual self-disclosure and sexual satisfaction.	It was found that increasing the number of sexual concerns and problems might result decrease sexual satisfaction. On the other hand, better communication and disclosure of specific sexual likes and dislikes were in relation with increased sexual satisfaction.
(O'Sullivan, Meyer-Bahlburg, et al., 2006)	The Development Of The Sexual Self-Concept Inventory For Early Adolescent Girls	In this study, sexual arousability, sexual agency, and negative sexual affect were shown as different facets of girls' sexual self-concepts using the Sexual Self-Concept Inventory (SSCI).	It was seen that there was a tie between sexual arousability and sexual agency with positive sexual self-esteem, positive future orientation toward sex, intentions to engage in intercourse, and fewer sexual experience. It was also noted that negative sexual affect had relation with stronger abstinence attitudes and lack of intentions or orientation toward sex in the near future.
(Osman Özdel, 2013)	Effects Of Sex Therapy Based On Cognitive Behavioral Methods On Sexual Problems Of Women With Vaginismus And Their	The Golombok Rust Inventory of Sexual Satisfaction was used to a population of married couples suffering from vaginismus. They were assessed before and after receiving cognitive behavioral treatments.	The treatment was shown to be strongly effective on the women with vaginismus.

	Spouses		
(Pai et al., 2012)	The Effect Of Sexual Self-Concept On Sexual Health Behavioural Intentions: A Test Of Moderating Mechanisms In Early Adolescent Girls	The structural equation modelling was used to evaluate the suggested conceptual model. This study aimed at assessing the impact of normative beliefs on the relation between sexual self-concept and sexual health behavioral intentions.	According to the findings, which showed a counter relation between higher sexual self-concept and likeliness one's sexual health protection, researchers proposed that normative beliefs should be regarded by any intervention to help the adolescent girls to clear up their sexual self-concept.
(Ramezani, Ghaemmaghami, Talakar, & Saadat, 2013)	Validity And Reliability Assessment Of Multi-Dimensional Sexual Self-Concept Questionnaire For Iranian Population	The original MSSCQ was translated, retranslated, and tested on a randomly selected population. The reliability and validity of the translation were approved using Cronbach's alpha coefficients, and GHQ-28 and marital satisfaction scale, respectively.	It was concluded that the MSSCQ is a proper tool for the evaluation of the sexual self-concept among Iranian population so it might be recommended as an appropriate tool for sexuality research in Iran.
(Reissing, Binik, Khalifé, Cohen, & Amsel) (2003)	Etiological Correlates Of Vaginismus: Sexual And Physical Abuse, Sexual Knowledge, Sexual Self-Schema, And Relationship Adjustment.	A population of women, who were matched in terms of age, relationship status, and parity, was divided into three different groups of vaginismus, dyspareunia/vulvar vestibulitis syndrome (VVS), and no pain.	The results showed that there were more women with a childhood sexual interference among those with vaginismus. It was also found that the women in VVS group reported lower levels of sexual functioning and a less positive sexual self-schema.
(Reissing, Elke D.; Laliberté, Geneviève M.; Davis, Hannah J.(2005)	Young Woman's Sexual Adjustment: The Role Of Sexual Self-Schema, Sexual Self-Efficacy, Sexual Aversion And Body Attitudes.	A sample of young adult women aged between 18 and 29 has been assessed in terms of sexual self-schema, sexual aversion, sexual self-efficacy, and body attitudes in the sexual adjustment. The results were analyzed with the linear regression path method.	The results showed that more negative body attitude would lead to an increase in sexual aversion, and negative sexual adjustment. According to the results, it was proposed that in order to prevent sexual problems in young women it was efficacious to improve the negative sexual self-schema by increasing sexual self-efficacy.
(Rostosky et al., 2008) (2008)	Sexual Self-Concept And Sexual Self-Efficacy In Adolescents: A Possible Clue To Promoting Sexual Health?	A research on a population including both Caucasian and African American high school students, concerning the relation between sexual self-concept and sexual self-efficacy.	The results noted that women possessed higher sexual self-efficacy and sexual esteem comparing to men. Higher sexual self-esteem alone would predict higher sexual self-efficacy scores. It was also showed that the knowledge of sexual risk and both types of sexual self-efficacy relationship was influenced by sexual self-esteem.
(Steinke, Wright, Chung, & Moser, 2007)	Sexual Self-Concept, Anxiety, And Self-Efficacy Predict Sexual Activity In Heart Failure And Healthy Elders	A mixed population of healthy elders and patients with heart failure has been assessed in terms of sexual activity, psychosexual, and demographical variables.	It was found that individuals with greater sexual self-concept were more likely to be sexually active. The sexual anxiety and sexual self-efficacy showed statistically independent impact on sexual activity.
(Ter Kuile, Both, & van	Cognitive Behavioral	The impact of the CBT treatment method was	Although, there was not any evidence-based CBT treatments

Lankveld, 2010)	Therapy For Sexual Dysfunctions In Women	surveyed by means of 26 studies conducted on women with sexual dysfunction.	for FSAD, directed masturbation or other methods might be alternatively used. In group CBT together with individual biofeedback were useful treatment towards dyspareunia.
(Vencill, 2014) dissertation	Women's Sexual Functioning: The Role Of Self-Objectification, Appearance Anxiety, And Depression	Different models have been assessed using structural equation modeling on a population of adult heterosexual women.	It was found that depression and anxiety can affect the relation between self-objectification and sexual functioning. However more researches should be done in order to ascertain the findings.
(Vickberg & Deaux, 2005)	Measuring The Dimensions Of Women's Sexuality: The Women's Sexual Self-Concept Scale	A study conducted on a sample of 262 women together with a statistical analysis on the obtained results.	A scale comprising 39-item measure is designed to evaluate the women's sexual self-concept. It is well-known as Women's Sexual Self-Concept Scale.
(Wakefield, 2013)	An Archetypal And Inner Cast Of Characters Approach To Sex Therapy With Women Who Have Low Sexual Desire	A treatment approach including techniques of Eros-enhancing awareness, Eros-inhibiting archetypes. This approach also concerned the mechanism should be provided by a practitioner to treat women with low sexual desire. It was an archetypal and inner self system approach towards clients in sex therapy.	It was concluded that the human psyche as a multidimensional whole, comprised different sub-personalities with dynamic interaction. It was also acknowledged that the human sexual experience had different facets.
(Winter, 1998)	The Role Of Sexual Self-Concept In The Use Of Contraceptives	The relation between sexual self-concept and contraceptive behavior has been studied in adolescences.	Sexual self-concept was noted as a significant predictor of contraceptive behavior among adolescences. A scale was also defined to measure the concept. It was proposed to educate teenagers in terms of social and psychological issues of sex to improve their understanding of their own sexuality.
(Zimmer-Gembeck, Ducat, & Boislard-Pepin, 2011)	A Prospective Study Of Young Females' Sexual Subjectivity: Associations With Age, Sexual Behavior, And Dating	It was a study conducted among girls aged 16 to 25, during a year, in order to monitor the changes from adolescence to early adulthood, and to evaluate the relation of sexual self-perceptions with age, sexual behavior, and romantic status.	Girls with more sexual experience and/or steady romantic partners, showed higher sexual subjectivity factors. Sexual body-esteem was the most stable element during the study and showed the least relation with sexual or romantic experiences.

Chapter 3

Objectives and Hypothesis

3. Objectives and Hypothesis

3.1. Objectives:

- (1) The main objective of this research is to investigate the effectiveness of Cognitive Behavioral Sex Training on improving Iranian women's Sexual Self-Concept
- (2) To investigate the Cognitive Behavioral Sex Training on the Improving Iranian women's Sexual Self-Esteem.
- (3) To investigate the Cognitive Behavioral Sex Training on the improving Iranian women's Sexual Self-Satisfaction
- (4) To investigate any correlations between Sexual Self-Concept, Sexual Satisfaction, Sexual Self-Esteem.
- (5) To investigate any correlations between sexual self-concept and mental health.

3.2. Hypothesis:

Hypothesis 1: Cognitive-Behavioral Sex Training will be effective in improving Iranian women's Sexual Self-Concept.

Experimental group "women who received sex training in subject to cognitive-behavioral" will have higher mean of sexual self-concept than control group in post and follow up stages.

Hypothesis 2: Cognitive Behavioral Sex Training will be effective in developing Iranian women's Sexual Satisfaction.

Experimental group "women who received sex training in subject to cognitive-behavioral" will have higher mean of sexual self- satisfaction than control group in post and follow up stages.

Hypothesis 3: Cognitive Behavioral Sex Training will be effective in developing Iranian women's Sexual Self-Esteem.

Experimental group "women who received sex training in subject to cognitive-behavioral" will have higher mean of sexual self- esteem than control group in post and follow up stages.

Hypothesis 4: There are positive correlations between sexual self-concept, sexual satisfaction and sexual self-esteem.

Chapter 4

Methodology

4. Methodology

4.1. Participants

This research went through three phases of data collection. The first phase was sampling and pre-assessment, the second phase was intervention and post assessment, the third phase was follow-up assessment.

The statistical population of the present study consists of all married women who have actively used Municipality educational facilities in Tehran in 2013-14. (N=5000).

The setting of this study is Tehran, the capital of Iran. The capital has been the most important economic pole in the country for the last two decades. The majority of industrial and welfare facilities and resources are centered on Tehran. More than half of the residents have migrated from outside the capital.

In 2011, Tehran had a population of about 8.4 million (United Nations Statistics Division [UNSD], 2014) comprising a mixture of all socio-economic and major ethnic groups.

In this point of view, Tehran represents a cross-section of the whole country. However, young people in a major urban area, such as Tehran, are particularly exposed to new ideas in terms of sexuality and sexual conduct, and thus are likely to be in the vanguard of social and behavioral changes.

Tehran has 22 Municipalities, and each one of them has some branches that are called neighborhood hall, for getting services such as health, sport, hobby and education facilities to neighborhood members. The women who use these facilities are from different levels of economic, education, religion and cultural beliefs that due to having a normal sample of different society's levels.

The first phase of the present study took place between October 2013 and March 2014. The sample group was selected by using random sampling in two stages. Firstly among all town halls in Tehran, four town halls were selected by the random clustering method. The neighborhood halls of these four municipalities helped researcher and gave the information of members for pre-homogeneous of participates. 500 women who were homogenized in terms of marital status, age, education level, and mental health.

In terms of marital status, the married women were selected because premarital sex is prohibited and the girls, who have it, do not have free feeling for speaking about sex. The women were selected in the range of 25 – 45 years old, with the mean of 33 years old, because

according to (Palacios et al., 2002), the participants in a specific age range may have experience menopause that influence their sexual experience due to some biological changes that occur to female's body. The minimum educational level was high-school diploma and the highest academic degree was master of university, since according to Abdoly & Pourmousavi (2013), there is no linear relation between sexual satisfaction and formal education level found in participant women. More sexual dysfunction and lower satisfaction have been found in under-diploma and doctorate groups in comparison to others.

Researcher presented the project to them in the seminar that was done in each one of four municipalities' salon. 433 women of them had the match time and interested for being in this project. Then General Health Questionnaire (GHQ-28), (1997) was used in order to homogenize their General Health. , because according to last researches there are correlation between sexual self-concept and general mental health and having normal score of (GHQ-28) was one of the factors to homogenize the participated (Ajilchi, Oskoei, & Kargar, (2013); Donaghue, (2009); Elsenbruch et al., (2003), Ramezani (2011).

The minimum of (GHQ-28) score is 0 and the maximum is 84. In the current study the cut point is 64 for the participant selection that means some of the participants with high standard deviation were put aside. Finally, 405 persons had all conditions for the second stage of sampling. In the second stage 90 women were selected randomly and were put into two groups, intervention group who received eight sessions Cognitive-Behavior Sex Training and control group.

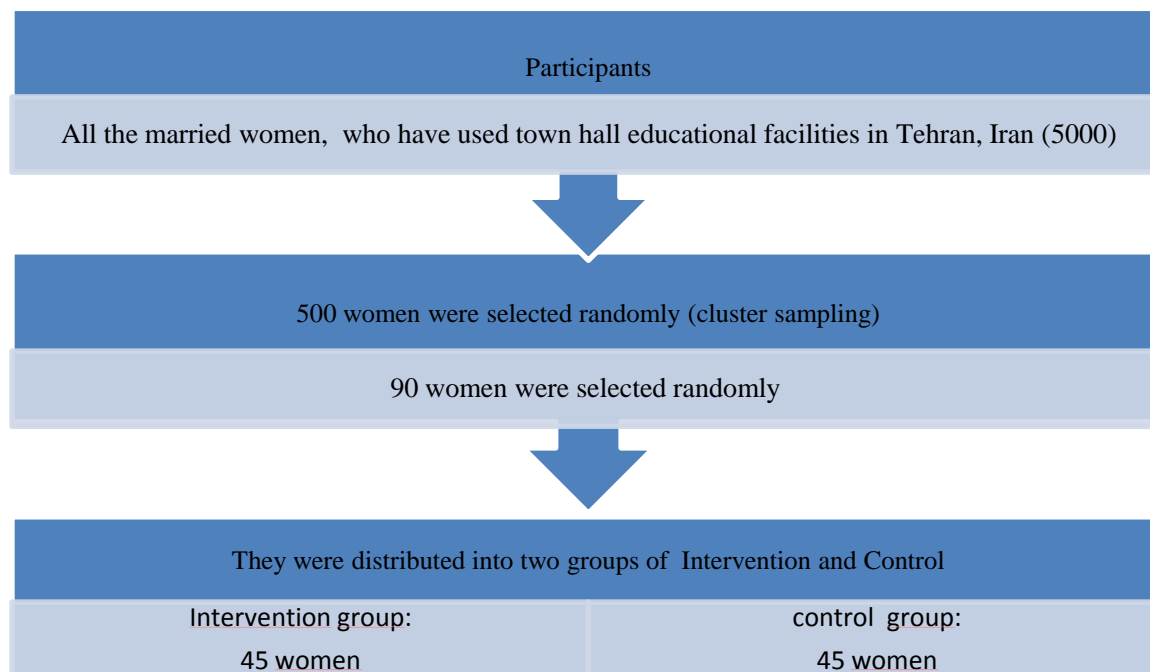


Figure 2: Participant

The second phase began in April and lasted until Jun 2014. We lost three persons of the intervention group, since two of them had more than two sessions absents, and one of them was not interested in being a participant. In the prevent interview with a researcher, she explained her husband did not want her to come to the sexual training. Also, we lost a person of control group because she moved to another city during these two months.

The third phase was in November 2014, six months after post-assessment. Two persons of intervention group found these trainings far away from their religious beliefs and were not interested anymore in participating to the group. Also, three persons of the control group could not be present at the follow-up assessment.

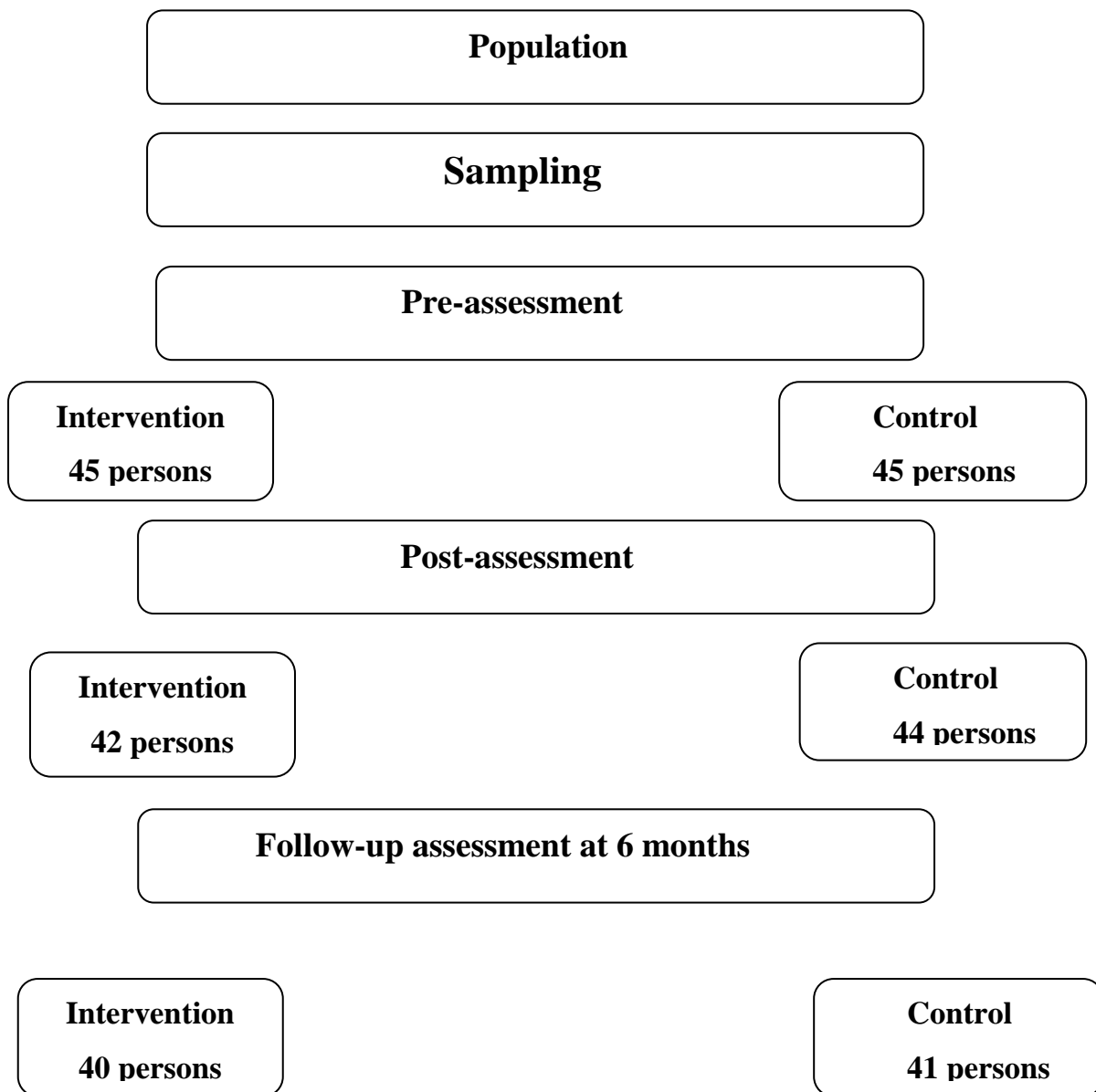


Figure 3: procedure

4.2. Procedure

The research was approved by the Ethics Committee in Human Experimentation and by the research committee of the Universitat Autònoma de Barcelona (UAB).

The design was experimental; Snell's multi-dimension questionnaire (MSSCQ) (1991) was used to evaluate the subjects' self-concept in pre-, post- test, and follow-up (six months later) stages, on two groups, intervention and control.

Table 2: Design

R	T ₁	X	T ₂	T ₃
R	T ₁	--	T ₂	T ₃

The collaboration was requested from all of the Municipalities in Tehran, they accepted to participate in this study. Four of them were selected by cluster sampling. The neighborhood halls of these four municipalities those are responsible for getting services such as health, sport, and hobby and education facilities to neighborhood members, helped researcher and gave the information of members for pre-homogenies of participates. 500 women had the suitable conditions as a sample. Researcher presented the project to them in the seminars those were done in each one of the four municipalities' salon. 433 women had time and were interested in participating in this project. They signed the consent which were required, and answered to (GHQ-28) self-report questionnaires. The time necessary for completing the questionnaire (GHQ-28) was about 15 minutes. During the assessment, researcher was inside the salon to answer possible questions and doubts about items.

In the second stage of sampling, 90 women were selected randomly and were put into two groups, intervention and control. The women in both groups answered (MSSCQ) as a pre-assessment.

The time necessary for completing the questionnaire was approximately one hour. Researcher was in the classroom to answer possible questions about items. Once each participant completed the questionnaire, researcher carefully checked the items to avoid missing data.

The experimental group was trained through Cognitive-Behavior Sex Training, during eight weekly sessions, each of which lasts for 90 minutes. No session was allotted to the control group. Once the intervention sessions were over, the post-assessment was performed on both groups. The follow-up assessment was carried out after six months.

Table 3: Procedure

Activity	Intervention group	Control group
Pre-assessment	(MSSCQ)	(MSSCQ)
Session 1	Introduction	-----
Session 2	Recognition of Incorrect Ideas & Beliefs about Women's Sex	-----
Session 3	Educating about The Anatomy & Improving Sexual Awareness	-----
Session 4	Educating about Relationships Intimacy	-----
Session 5	Recognizing Anxiety And Sensorial Focus	-----
Session 6	Educating And Practicing about Sexual Self-Esteem	-----
Session 7	Educating about Fantasy in Sex	-----
Session 8	Educating Techniques for Improving the Quality of Sex	-----
Post assessment	(MSSCQ)	(MSSCQ)
Follow up at 6 months	(MSSCQ)	(MSSCQ)

4.3. Instruments

The measuring tool in this study are Multidimensional Sexual Self-Concept Questionnaire (MSSCQ) (1991) and 28-item General Health Questionnaire (GHQ-28) (1979).

Multidimensional Sexual Self-Concept Questionnaire (MSSCQ) Snell (1995); Validation in Iran: (Ramezani, 2013).

This questionnaire contains 100 questions and was presented by Snell in 1995. It uses to measure 20 fields of human's libido. The scores in the questionnaire are the criteria for

individual differences in sexual fields assembled into 20 small-scales. The small-scales of this questionnaire included: : 1) sexual-anxiety 2) sexual self-efficacy 3) sexual-consciousness 4) motivation to avoid risky sex 5) chance sexual control 6) sexual-preoccupation 7) sexual-assertiveness 8) sexual-optimism 9) sexual problem self-blame 10) sexual-monitoring 11) sexual-motivation 12) sexual problem management 13) sexual-esteem 14) sexual-satisfaction 15) power-other sexual control 16) sexual self-schemata 17) fear-of-sex 18) sexual problem prevention 19) sexual-depression 20) internal-sexual-control (Snell, 1998).

The small-scales stability level in Snell's study were calculated ranging from %72 to %94 using Cronbach alpha. The reliability is found to be good in (Ramezani, 2013) for MSSCQ $\alpha=0.89$. There are 28 factors in primary questions and 4 factors introduced using factor analysis for subscale analysis. A correlation between GHQ-28 score and MSSCQ ($r=-0.31$, $p=0.008$) and a significant lineal relation between marital satisfaction and MSSCQ ($r=0.3$, $p=0.013$) have been discovered. It is shown that MSSCQ is a proper tool for sexual self-concept assessment in Iran and therefore it is reasonable to be used in researches about human sexuality among Iranian population (Ramezani, et al, 2013).

In the current study Cronbach Alpha was used in order to calculate the reliability of MSSCQ test. The test is almost highly reliable due to the estimated value for Alpha which is 0.87. The Split-halves method is also used to check the reliability of the test. Also, Spearman-Brown coefficient value was 0.95 indicating high reliability of the test.

General Health Questionnaire (GHQ-28) Goldberg & Hillier (1979) Validation in Iran: Noorbala, Bagheri Yazdi, Yasamy & Mohammad,(1999).

The General Health Questionnaire, comprising 28 items (GHQ-28), was used in order to diagnose mental disorders. Goldberg & Hillier (1979) developed the GHQ-28 to screen the "somatic symptoms, anxiety and insomnia, social dysfunction and severe depression" (Noorbala et al., 2004):. Studies have been conducted to assess the validation of the GHQ-28 in different countries around the world, which have shown high validity and reliability to screen the mental disorders in the community of study. GHQ-28 has been translated into Farsi which is the official language of Iran, and have been examined in an independent survey by Noorbala, Bagheri Yazdi, Yasamy & Mohammad (1999) showing high validity and reliability.

The estimated interclass correlation between the test–retest scores was 0.85 (Noorbala *et al*, 1999). To detect psychosis, epilepsy and learning disability ‘mental retardation’, a simple semi-structured clinical interview with its limited validity and reliability was used.

4.4. Statistical analysis

A Mixed-design analysis of variance model (split-plot ANOVA) is used in order to test the differences between two or more independent groups facing participant to repeated trials. In a mixed-design ANOVA model, there are two factors, namely fixed-effects and random-effects factor, which are intersubject and intrasubject variables respectively (Field, 2009).

Therefore, The overall model are Mixed- ANOVA model. Also, Correlation Analysis is used for measuring the relationship between variables.

Chapter 5

Data analysis

5. Data analysis

This chapter mainly includes analyses the gathered data. First of all, descriptive statistics is presented to describe the characteristics of the sample in terms of age, and educational status.. In addition, in order to screen the sample, general health scores were used to exclude the people with pathologically low mental health. As mentioned in the chapter four, the cut point of GHQ-28 is 64 that means some of the participants with high standard deviation were put aside. Finally, among 500 women who were selected randomly by cluster sampling, 405 persons had all conditions for the next stage of sampling. As mentioned earlier, ninety participants were sampled.. They randomly assigned to experiment (N=45) and control (N=45) groups. However, nine respondents refused to participate in post-tests and Follow-up, resulting the final sample of the study consists of 81 participants (N= 41 for experiment group and N=40 for the control group). In the second part of this chapter, the hypotheses are tested via inferential statistical methods. Descriptive and inferential analyses of the study are as follows.

5.1. Descriptive analysis

Frequency table (Table 4) describes the sample in terms of educational status.

Table 4: Frequency distributions describing educational status

Educational degree	Frequency	Percent	Cumulative percent
Below diploma	2	2.46	2.46
Diploma	68	83.95	86.41
Bachelor degree	9	11.11	97.52
Master degree	2	2.46	100
Total	81	100	

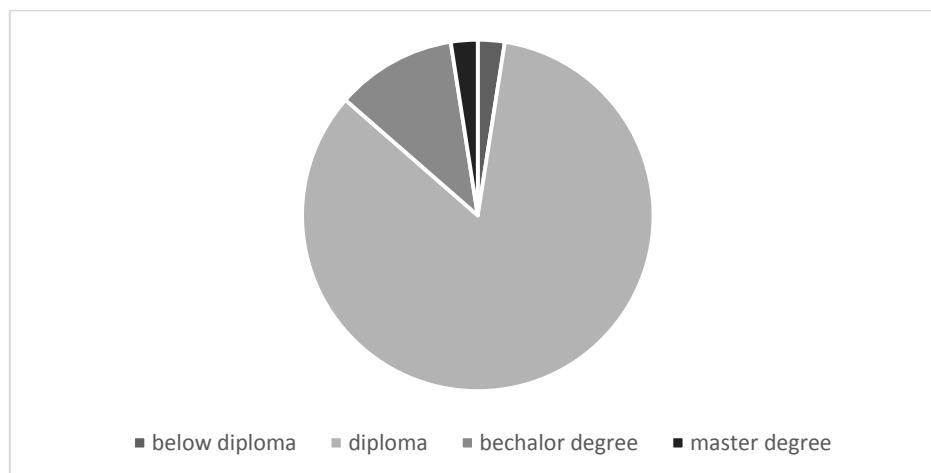


Figure 4: Frequency distributions describing educational status

The descriptive statistics of age is presented in Table 5.

Table 5: Statistics describing samples in terms of age

Mean	Maximum	Minimum	Standard deviation	Variance
35.21	45	25	6.62	43.82

The descriptive statistics of the general mental health questionnaire and its subscales are presented in Table 6.

Table 6: Descriptive statistics of general mental health

	Mean	Maximum	Minimum	Standard deviation	Variance
general mental health	30.31	63	10	19.20	368.64
somatic symptoms	8.87	20	5	6.61	43.69
anxiety and sleep disorder	9.03	21	6	4.26	18.14
social Function	10.98	21	9	7.31	53.43
depression symptoms	8.78	19	4	6.09	37.08

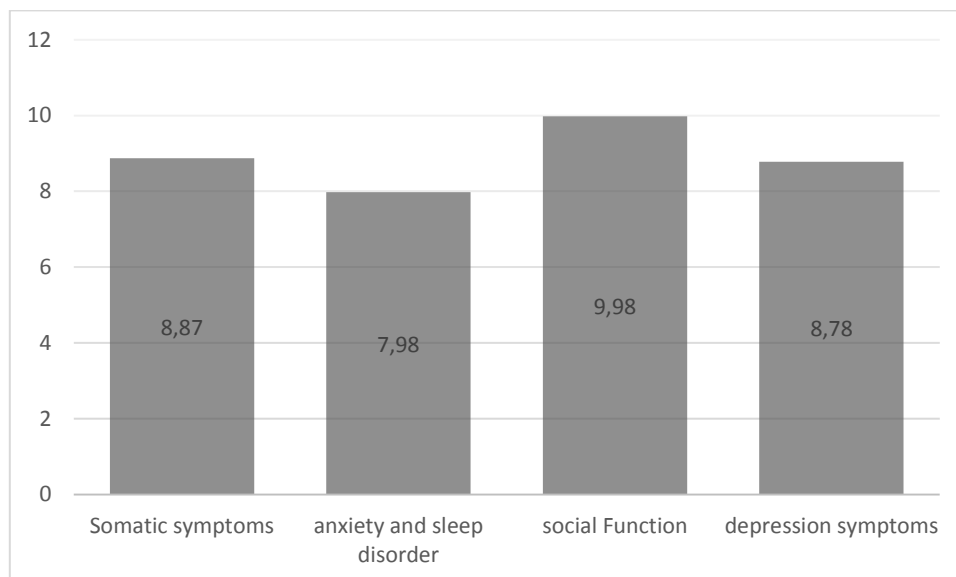


Figure 5: Means of mental health subscales

To understand the equality between the experimental and control group, T-Test was used.

Table 7: Descriptive statistics of independent sample test

Independent sample test	Levene's Test for equality of variances		t-test for Equality of Means						
	F	Sig.	t	df	Sig (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
								Lower	Upper
Pre Sexual Self-Concept	0.677	0.413	0.785	79	0.435	5.693	7.250	-8.739	20.125
Equal variances assumed			0.786	78.88	0.434	5.693	7.245	-8.727	20.114
Pre Self-Esteem	0.712	0.401	1.949	79	0.055	2.144	1.100	-0.045	4.334
Equal variances assumed			0.952	78.34	0.054	2.144	1.098	-0.042	4.331
Pre Satisfaction	3.218	0.077	-0.529	79	0.598	-0.507	0.958	-2.413	1.399
Equal variances assumed			-0.530	76.53	0.597	-0.507	0.955	-2.409	1.396

According to Table 7 the result was (0.78, 1.95, 0.53 and 0.93) that in compare with T-table (1.98) there is no significant difference between experimental and control group in pre-test and both groups are equal. Therefore, mix ANOVA can be used for analysing data.

The descriptive statistics of general sexual self-concept in experiment and control groups are presented in Table 8.

Table 8: Descriptive statistics of general sexual self-concept

		Mean	Maximum	Minimum	Standard deviation	Variance
Experiment group	Pre-test	211.268	275	151	22.634	1131.251
	Post-test	231.829	276	182	24.595	604.945
	Follow-up	219.365	266	136	27.93	780.088
Control group	Pre-test	205.575	255	134	31.556	995.84
	Post-test	207.65	258	139	31.038	963.413
	Follow-up	207.578	260	136	33.189	1101.54

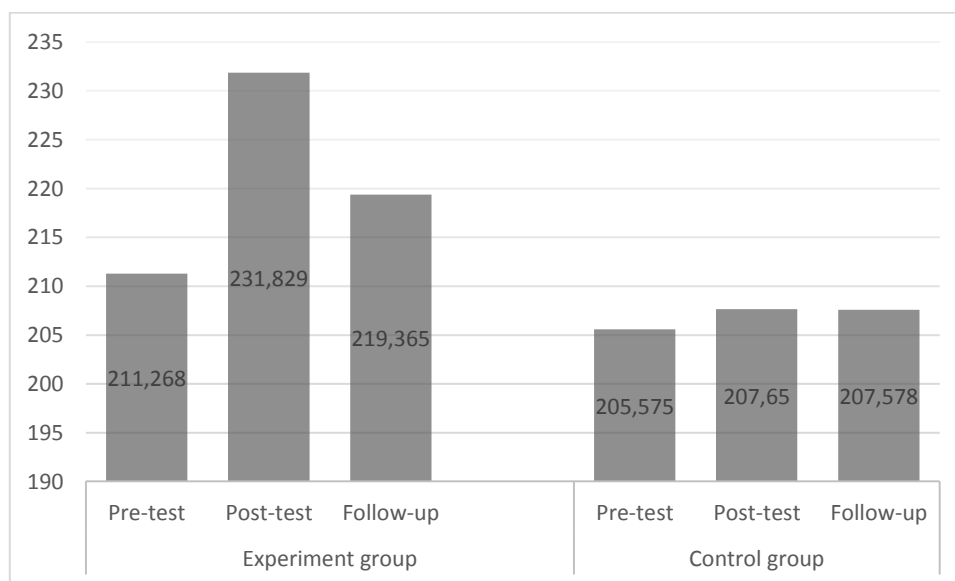


Figure 6: Comparing scores of two group in sexual self-concept

The descriptive statistics of the pre-test, post-test and follow-up of sexual self-esteem in experiment and control groups are presented in Table 9.

Table 9: Descriptive statistics of sexual self-esteem

		Mean	Maximum	Minimum	Standard deviation	Variance
Experiment group	Pre-test	11.22	20	4	5.22	27.3
	Post-test	14.46	20	2	5.04	25.4
	Follow-up	13.07	20	0	5.59	31.25
Control group	Pre-test	9.07	19	3	4.64	21.52
	Post-test	9.12	20	3	4.59	21.06
	Follow-up	8.61	20	3	4.61	21.25

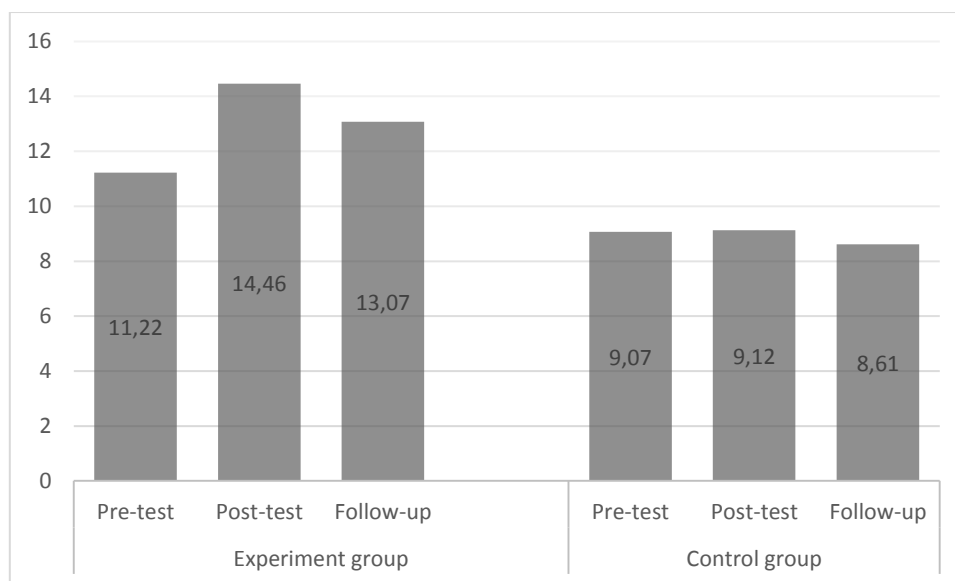


Figure 7: Comparing scores of two group in sexual self-esteem

The descriptive statistics of the pre-test, post-test and follow-up of the sexual satisfaction in experiment and control groups are presented in Table 10

Table 10: Descriptive statistics of sexual satisfaction

		Mean	Maximum	Minimum	Standard deviation	Variance
Experiment group	Pre-test	11.26	19	1	4.72	22.27
	Post-test	15.36	20	4	4.08	16.64
	Follow-up	14.60	20	2	4.71	22.18
Control group	Pre-test	11.77	19	5	3.84	14.75
	Post-test	11.52	19	5	3.78	14.29
	Follow-up	11.52	20	4	3.99	15.92

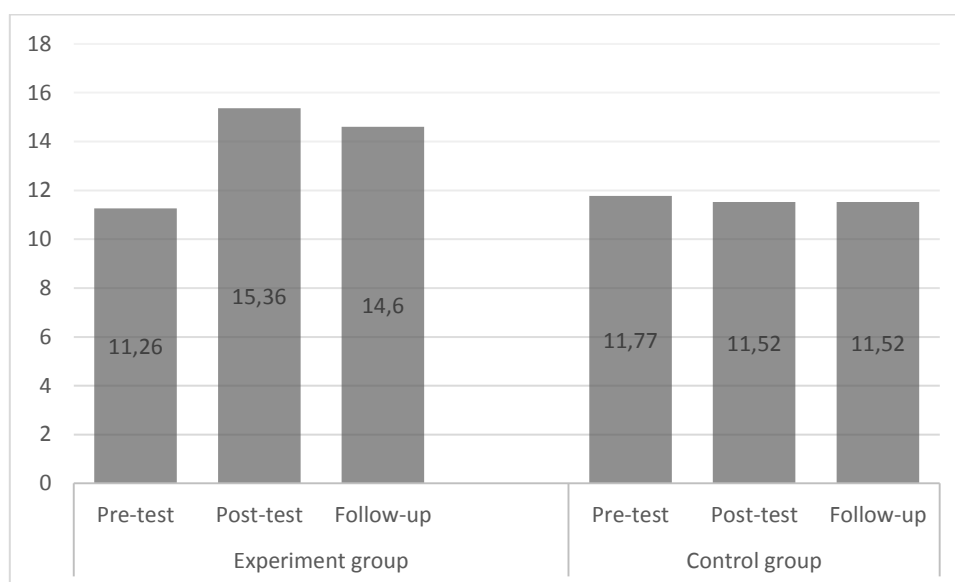


Figure 8: Comparing scores of two group in sexual satisfaction

5.1. Inferential analyses

Hypothesis 1 of the study assumes that Cognitive-Behavioural Sex Training is effective in developing Iranian women's sexual self-concept. In other words, the mean of pre-test, post-test and follow up of sexual self-concept subscale were calculated. Mixed ANOVA (analysis of variances) was used to analyse the gathered data. Since all of the participants completed the same pre-, post- and follow-up tests (within subject variable) and half of them were under treatment (between subject variable), the design of the study was mixed.

Mauchly's test of sphericity was used to test the assumption (Tests the null hypothesis that the error covariance matrix of the orthonormalized transformed dependent variables is

proportional to an identity matrix). Table 11 shows that the assumption was approved (Mauchly's $W=1$, Chi-Square=0).

Table 11: Mauchly's Test of Sphericity of sexual self-concept

Within Subjects Effect	Mauchly's W	Approx. Chi-Square	df	Sig.	Epsilon		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Sexual self-concept	1.00	0.00	2	.	1.00	1.00	1.00

Table 12 and table 13 represent tests of within-subjects and between-subjects effects respectively. According to the highlights in table 13 the main effect of between-subjects is statistically meaningful ($F(1, 79) = 5.148$, $P=0.001$ and partial Eta squared= 0.063).

Table 12: Tests of Within-Subjects Effects of sexual self-concept

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Sexual self-concept	4836.197	2	2418.09	8.44	.0001	.099
sexual self-concept * group	3708.450	2	1854.225	6.475	.002	.078
Error(self-concept)	44100.967	158	286.370			

Table 13: Tests of Between-Subjects Effects of sexual self-concept

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Parti al Eta Squared
Intercept	10819620. 2	1	10819620. 2	4799.95	.000	.98
group	11605.11	1	11605.116	5.148	.026	.063
Error	173566.53 0	79	2254.11			

Finally, the results of mixed ANOVA shows that there is a significant difference between experimental and control group in post-test and follow-up of sexual self-concept scores. Such differences in means are shown only in experimental group but not in control group. Therefore, CBT has meaningful effect on improving sexual self-concept scores.

Hypothesis 2 of the study assumes that Cognitive-Behavioural Sex Training is effective in developing Iranian women's sexual satisfaction. In other words, the mean of pre-test, post-test and follow up of sexual satisfaction subscale were calculated. Mixed ANOVA (analysis of variances) was used to analyse the gathered data. Since all of the participants completed the same pre-, post- and follow-up tests (within subject variable) and half of them were under treatment (between subject variable), the design of the study was mixed.

Mauchly's test of sphericity was used to test the assumption (Tests the null hypothesis that the error covariance matrix of the orthonormalized transformed dependent variables is proportional to an identity matrix). Table 14 shows that the assumption was approved (Mauchly's $W=1$, Chi-Square=0).

Table 14: Mauchly's Test of Sphericity of sexual satisfaction

Within Subjects Effect	Mauchly's W	Approx. Chi-Square	df	Sig.	Epsilon		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Sexual satisfaction	1.00	0.00	2	.	1.00	1.00	1.00

Table 15 and table 16 represent tests of within-subjects and between-subjects effects respectively. According to the highlights in table 16 the main effect of between-subjects is statistically meaningful ($F(1, 79) = 7.26$, $P=0.006$ and partial Eta squared= 0.084).

Table 15: Tests of Within-Subjects Effects of sexual satisfaction

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Sexual satisfaction	169.89	2	84.939	10.946	.0001	.122
sexual satisfaction * group	216.595	2	108.298	13.956	.0001	.150
Error(sexual satisfaction)	1226.063	158	7.760			

Table 16: Tests of Between-Subjects Effects of sexual satisfaction

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	39104.128	1	39104.128	1038.054	.000	.929
group	273.758	1	273.758	7.267	.009	.084
Error	2975.979	79	37.671			

Finally, the results of mixed ANOVA shows that there is a significant difference between experiment and control group in post-test and follow-up of sexual satisfaction scores. Such differences in means are shown only in experiment group but not in control group. Therefore, CBT has meaningful effect on improving sexual satisfaction scores.

Hypothesis 3 of the study states that Cognitive-Behavioural Sex Training is effective in developing Iranian women's self-esteem. In other words, the mean of pre-test, post-test and follow up of sexual self-esteem subscale were calculated. Mixed ANOVA was used to analyse the gathered data.

Table 17 shows that Mauchly's test of sphericity was approved (Mauchly's $W=1$, Chi-Square=0).

Table 17: Mauchly's Test of Sphericity of sexual self-esteem

Within Subjects Effect	Mauchly's W	Approx. Chi-Square	df	Sig.	Epsilon		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Sexual self-esteem	1.00	0.00	2	.	1.00	1.00	1.00

Table 18 and table 19 represent tests of within-subjects and between-subjects effects respectively. According to the highlights in table 19 the main effect of between-subjects is statistically meaningful ($F(1, 79) = 16.86$, $P=0.0001$ and partial Eta squared= 0.17).

Table 18: Tests of Within-Subjects Effects of sexual self-esteem

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Sexual self-esteem	109.991	2	54.996	5.389	.005	.064
Sexual self-esteem * group	104.987	2	52.493	5.144	.007	.061
Error(self-esteem)	1612.346	158	10.205			

Table 19: Tests of Between-Subjects Effects of sexual self-esteem

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Intercept	29337.168	1	29337.168	546.383	.001	.874
group	905.184	1	905.184	16.858	.001	.176
Error	4241.779	79	53.693			

Finally, the results of mixed ANOVA show that there is a significant difference between experiment and control group in post-test and follow-up of sexual self-esteem scores. Such differences in means are shown only in experiment group but not in control group. Therefore, CBT sex training has meaningful effect on improving sexual self-esteem scores.

Hypothesis 4 of the study was there are correlations between sexual self-concept, sexual satisfaction and sexual self-esteem. In order to achieve the objective, Pearson correlations were computed between sexual self-concept, sexual self-esteem and sexual satisfaction. The results are shown in table 20.

Table 20: Correlation between dependent variables

Correlations				
		Pre-Sexual Self-Concept	Pre Sexual Self-Esteem	Pre Sexual Satisfaction
Sexual self-Concept	Pearson Correlation	1	.469**	.675**
	Sig. (2-tailed)		.000	.000
	N	81	81	81
Sexual Self-Esteem	Pearson Correlation		1	.296**
	Sig. (2-tailed)			.007
	N		81	81
Sexual Satisfaction	Pearson Correlation			1
	Sig. (2-tailed)			
	N			81

** . Correlation is significant at the 0.01 level (2-tailed).

As shown in the correlation matrix of table 20 there is a positive relationship between sexual self-esteem and sexual self-concept ($r=0.469$, $P=0.001$). Also a positive relationship was found between sexual satisfaction and sexual self-concept ($r=0.675$, $P=0.000$). Furthermore, the relationship between sexual self-esteem and sexual satisfaction is statistically meaningful ($r=0.296$, $P=0.007$).

Another specific objective of the study was to investigate the correlation between sexual self-concept and mental health. In order to do so, Pearson correlation was computer between total score of general sexual self-concept and mental health scores. The result shows that there is a strong positive relationship between the constructs ($r=0.80$, $P=0.0001$).

Table 21: Correlation between sexual self-concept and mental health

Correlations		
		Mental Health.
Sexual Self-Concept	Pearson Correlation	.80 ^{**}
	Sig. (2-tailed)	.0001
	N	81

Chapter 6

Discussion

6. Discussion

This chapter includes summary and discussions of hypothesis, limitations of research, and recommendations.

6.1. Summary

Although human beings, at all ages, experienced sex throughout their life, it is a unique and personal experience. It varies from one person to another since every individual has his/her own special way of thinking and emotions (Master and Johnson, 1996).

One of the issues that significantly influences married life of individuals is the quality of their sexual relationship. A sexual relationship is a complex process that requires awareness, cooperation, and mutual understanding. Since the physical and mental status of every two persons is different from each other, disagreement in thought and action is totally natural. However, many of these problems can be easily solved by promoting sexual self-concept.

Unlike earlier definitions of the concept of sexual health that only emphasized the lack of sexual dysfunction, recently the concept refers to a situation in which a person enjoys a healthy, proper and normal sexual relationship (WHO, 2006).

Foreign studies suggest that sexual training promotes healthy behaviors through better understating of sexual health. In order to achieve sexual health, the most fundamental way is to promote a public level of sexual awareness through different training methods (O'Sullivan et al, 2006).

The purpose of sexual training is to provide health behavior pattern so as to protect public health, deal with sexual problems and borne diseases. It also plays a significant role in controlling the negative consequences of unintended pregnancy, sexually transmitted diseases, sexual abuse, sexual violence, and sexual frustration. Meanwhile, the spread of sexual disorders, increased rates of diseases transmitted through sexual activity, AIDS, and so on, necessitates sexual training even more.

Disregarding the significant effect of sexual problems in married life which greatly damage the couple's relationship and may lead to nagging, expressing dissatisfaction with life, going in a huff for long time, spying on each other, threatening to break apart, conflicts, and so on (Amirian zade, 2014).

Although Iranian experts believe that 50-60% of divorced occur due to sexual problems and not enough attention has been paid to theoretical and practical training on this ground (Hesary& Zakariaei, 2008).

The reason behind this issue may be the fact that sex is a taboo in traditional and religious cultures; so, Iran, as a religious and traditional country, is not an exception in this regard.

Most of the women, in such societies, think of sex as a one-way relationship. Not only are they unaware of their own feeling and anatomy, but they believe in no right of pleasure and mutual partnership for themselves whereas sexual issues play a significant role in marital satisfaction and mental health.

Cognitive Behavioral Therapy (CBT) is the most common and influential method of sexual dysfunction treatment.

It is also known as one of the most practical methods of couple's therapy. Therefore, “cognition” is the most essential element in learning and changing behavior. Cognition refers to a belief or idea that directly affects human’s relationships, emotions, as well as internal and external processes. If both couples reach to the proper level of cognition and insight about themselves and their sexual issues, they would understand half male-half female rights and responsibilities of a mutual sexual relationship. Thus, they attempt to identify, change and modify their wrong attitudes in order to strengthen their intimate relationship and promote the level of marital satisfaction through expressing their feelings and desires.

After making cognitive changes which occurs as a result of training couples, promoting their level of knowledge and awareness, and modifying wrong attitudes aided by a psychologist, the second element, i.e. change in behavior, has to be considered.

Since married individuals differ in terms of behavior and sexual pattern, it seems necessary to make the couples more compatible by teaching those appropriate behaviors and techniques, strengthening these behaviors, and increasing sexual and marital pleasure.

Preliminary sexual researches are conducted to study behavioral interventions such as communication training, problem-solving, and behavioral agreement. However, since the sexual relationship is a physiologic event, its association with the reconstruction of distorted beliefs hugely affect the behavioral pattern.

Therefore, the current research aims at studying a Cognitive-Behavioral approach (CBT). Among other effective factors that made the researcher select this approach and change it to a cognitive-behavioral sexual training are the ones that have referred to in their studies:

- 1) Researches that proved the effectiveness of CBT in treating sexual problems.
- 2) Advocacy of referees who value promising methods of problem-solving and skill learning.
- 3) Emphasizing on approaches in which there is an active relationship between therapist and patient.

It is also worth noting that, primarily, sex therapy and couple therapy has to be carried out in the presence of both couples but because of sexual taboos in Iran and special condition of Tehran municipality, under whose supervision this research is conducted, it was not possible to hold male training courses so training is carried out on a group of females. In general, training in group is more effective than individual training because individuals of a group come across with people with the same problem and learn from their experience. Not feeling alone in the face of problems alleviates their stress so they can solve their problems with more confidence with the help of others in the group.

The above foregoing items reveal the importance of: 1- sexual health, 2- sexual training in traditional societies, 3- factors affecting sexual health such as sexual self-concept, sexual satisfaction, and sexual self-esteem, and 4- appropriateness of CBT in treating sexual problems. Thus, the researcher made an attempt to design a sexual training course based on CBT for the Iranian married women concerning their mental and cultural needs. The course comprises eight sessions that were 90 minutes each to train 90 females under the supervision of the Tehran municipality. The research results indicated that:

CBT sexual training course carried out on married women living in Iran (Tehran) can significantly promote sexual self-concept, sexual satisfaction, and sexual self-esteem.

In the following, the results of examining research hypothesis are explained in more details.

6.2. Discussion of hypothesis

The first and the main hypothesis of this study was that Cognitive-behavioural sex training will be effective in improving Iranian women's sexual self-concept. Table 13 shows Sig. = (0.026 > 0.001) that means there is a significant difference between experimental and control

group in the post-test and follow-up while there was not a significant difference between experimental and control groups in their pre-test of sexual self-concept scores. Thus hypothesis 1 was approved and the cognitive-behavioural sex training is definitely effective in improving women's sexual self-concept.

This finding is consistent with the ones of previous studies on the similar subject by Andersen et al., 1999; Andersen & Cyranowski, 1994; Bem, 1993; Birnbaum & Reis, 2006; Cyranowski & Andersen, 2000; Dove & Wiederman, 2000; Devon J. Hensel, J. Dennis Fortenberry, Lucia F. O'Sullivan &., 2012; Farahani, 2008; Ghorbanshiroudi et al, 2012; Hassanzadeh & et al, 2005; Jabbari Fard & et al 2014; Khamseh, 2006; Kuffel & Heiman, 2006, Markus & Wurf, 1987; Özdel, 2013; Pai et al., 2012, Pinkerton & Abramson ,1992, Reissing, Binik, Khalifé, Cohen, & Amsel, 2003; Reissing, Elke; Laliberté, Geneviève; Davis & Hannah, 2005; Rostosky et al., 2008; Ter Kuile, Both, & van Lankveld, 2010; Wagner & Rehfuss, 2008; & Winter, 1998, Zimmer, Gembeck, Ducat, & Boislard, Pepin, 2011. Those who believed in significant transactional effects between cognition, behavior and sexual self-concept. Cognitive-behaviour approach emphasizes the crucial role of education and information, for changing the attitudes, expectations, and beliefs.

The base of cognitive-behavioural sex therapy and training comes from Masters and Johnson method as the behavioral techniques. It was the first method to integrate both educative and directive components into behavioral sex therapy. Primarily a short-term behavioural intervention designed to reduce anxiety, increase sensory awareness, reduce self-consciousness and improve sexual communication. This was a fundamental change from the traditional sexual view, which considers sex as the human's natural instinct, to something that must be carefully learned by the people in order to have successful interactions with each other. In the modern approach, it is also considered that most of the sexual problems result from a lack of education or misconceptions about sexuality.

Also, Kaplan would call attention to the client's irrational beliefs, which are identified as the source of the psychopathology (Kaplan, 1974). The therapist challenges these beliefs and unrealistic expectations by bringing them to the forefront rather than allowing them to go unaddressed (Kaplan, 1974).

Clients are seen as needing basic education to counter their maladaptive beliefs and therapeutic tools to engage in the reconstruction of the thoughts and emotions associated with their sexual symptoms (Ellis, 1975).

Schover & Leiblum, 1994 believed in the absence of physiological or biochemical factors, sexual dysfunction exists due to breakdowns in communication, inadequate sex information, negative attitudes, and unrealistic expectations about sex (Schover & Leiblum, 1994).

Markus and Wurf, 1980; Anderson and Cyranowski, 1955; 2000 showed that the previous patterns, mental schema about different matters, and experiences might thoroughly affect the sexual self-concept of individuals. They believe that the sexual self-concept is different among men and women. This is due to the differences in the details of ones' mind; accordingly, their sexual self-concept responds differently to various effective factors. The self-concept is multidimensional. It is composed of self-views or self-schemas, within different fields of social knowledge. The functionalities of sexual self-schemas are to filter, organize, and interpret self-relevant information, and defined as cognitive representations, regarding sexual aspects of the self (Cyranowski & Andersen, 2000; Markus & Wurf, 1987). As regards, by gaining positive or negative perception toward sexuality, individuals may be encouraged or dissuaded to experience being sexual and foster their sexuality.

Farahani (2008), in her research on Norms, Attitude, and Sexual Conduct Among Female College Students in Tehran; Iran found that Low self-efficacy, norms on virginity, age, parents' attitude and poor family relationships were the main factors of sexual contacts.

Differences in sexual behavior between men and women are determined greatly by sexual roles and cultural variables (Khamseh, 2006). Sex education if delivered in time and appropriately can play a role in controlling improper sexual desires, providing healthy sexual behaviors, reducing sex problems and preventing sexually transmitted diseases.

Ghorbanshiroudi et al, (2012) Studied the Effectiveness of Cognitive-Behavioral Therapy in Developing Sexual Self-Concept in medical facilities in Babol, Iran. The results showed that the intervention proved to boost sexual self-concept.

Özdel, (2013) in his research found sex therapy based on cognitive behavioral methods is effective on sexual problems of women with vaginismus and their spouses.

Ter Kuile, Both, & van Lankveld, (2010) found Cognitive Behavioral Therapy is helpful for Sexual Dysfunctions in Women. The results of Jabbari Fard & et al (2014) showed that sex

education has an effect on health behavior. Pinkerton and Abramson (1992) in their study showed that sex education is effective in health behaviors. Hassanzadeh & et al. (2005) have proved the effect of sex education on health behaviours, healthy sexual behaviour, mental health and the prevention of sexual disorders, family health, and gender identity (Hasan Zadeh, 2005).

The second hypothesis of this study was that Cognitive-behavioural sex training will be effective in improving Iranian women's sexual satisfaction. Table 16 shows Sig. = (0.009 > 0.001) that means there is a significant difference between experimental and control group in the post-test and follow-up while there was not a significant difference between experimental and control groups in their pre-test of sexual satisfaction scores. Thus hypothesis 2 was approved and the cognitive-behavioural sex training is definitely effective in improving women's sexual satisfaction. This result is consistent with the results by other researchers such as, Abdoly & Pourmousavi, (2013); Aghamohammadian et al (2006); Blunt; (2012); Byers & Demmons, (1999); Byers,(2005); Chang, and Yang (2005); Davison, Bell, LaChina, Holden, & Davis, (2009); Donaghue, (2009); Elsenbruch et al., (2003); Ghorbanshiroudi et al., (2012); Grief (2001); Haavio-Mannila & Kontula, (1997); Hussaini et al (2004); Kalantari, Esfahani Asl, Bayat (2012); MacNeil & Byers, (1997); Meston & Trapnell, (2005); Tayroudi and Alizada (2006); Teleporos and McCabe (2002).

They found that sexual satisfactions is depended on the factors including, feeling free to express sexual concerns (communicating sexual ideas), having sexual ideas in common with sexual partner (sexual agreement), being satisfied, physically and emotionally, with your partner relationship (pleasure), feeling of stress because of having sexual problems (sexual anxiety), and being worried about impacts of sexual problems on your relationship.

There are three issues which are among the most common factors of sexual intercourse problems, leading to sexual dissatisfaction, namely lack of sufficient education in sexual activities in traditional countries, outdated sexual beliefs, and anxiety. Also, behavioral exercises such as Kegel, relaxation, communication skills and express of requests will effect on improving sexual satisfaction.

The third hypothesis of this study was that the Cognitive-behavioural sex training will be effective in improving Iranian women's sexual self-esteem. The Table 19 shows Sig. = (0.001 \geq 0.001) that means there is a significant difference between experimental and control group in the

post-test and follow-up while there was not a significant difference between experimental and control groups in their pre-test of sexual self-esteem scores. Thus hypothesis 3 was approved and the cognitive-behavioural sex training is definitely effective in improving women's sexual self-esteem. This result is consistent with the results by other researchers such as; Aubrey, (2007) Devon, Hensel, Fortenberry, O'Sullivan & Orr, (2012).; Hurlbert & Whittaker, (2015), Isanc (1972), Larson, Anderson, Holman, & Niemann, (2008), Mayers et al., (2003), Ménard, A. Dana; Offman, Alia, (2009), Offman & Matheson, (2004) (Rostosky et al., 2008) , Wiederman, (2000), (Zimmer-Gembeck, Ducat, & Boislard-Pepin, (2011).

Sexual self-esteem and sexual health are directly related with regard to different aspects of sexuality (O'Sullivan, Meyer-Bahlburg, & McKeague, 2006; Snell, Fisher, & Walters, 1993; Van Bruggen, Runtz, & Kadlec, 2006). Researchers believe that sexual activity is indirectly influenced by different dimensions of sexual attitude. For instance, further quality of sexual activity of every individual may be determined his/her state of sexual self-esteem (Orr, Wilbrandt, Brack, Rauch, & Ingersoll, 1989; Salazar et al., 2005; Spencer, Zimet, Aalsma, & Orr, 2002). Having a high sexual self-esteem is related to physical ability, and those who have better physical abilities enjoy a higher self-confidence (Isanc, 1972). Females' self-consciousness of their body image as a partner during intercourse particularly impacts sexual self-esteem.

Sexual self-esteem led to a comprehensive willingness to positively evaluate personal capacity when participating in healthy sexual activities and pleasant experiences state that women have more encouragement in the sexual relationships. Having a positive view to sexual relationships, can lead to less anxiety and higher self-esteem.

In the present study, sexual self-esteem is improved by correct information and education about anatomy, different stages of sexual responses, changing negative attitudes to positive and believe in be beauty as a healthy human without comparing ones' self with media's model, Learning and practicing communication skills and self-esteem techniques such as, giving positive points to different members of body in front of mirror.

The fourth hypothesis of the study was there are correlations between sexual self-concept, sexual satisfaction, and sexual self-esteem. The results of table 20 the relationship between sexual self-esteem and sexual satisfaction is statistically meaningful. Furthermore, there is a positive relationship between sexual self-esteem and sexual self-concept. Also, a positive

relationship was found between sexual satisfaction and sexual self-concept. This result is consistent with Blunt, (2012); Davison, Bell, LaChina, Holden, & Davis, (2009); Donaghue, (2009); Haavio-Mannila & Kontula, (1997); kalantari, Esfahani Asl & Bayat(2012); Ramezani (2011); (Larson et al.), (2008); Menard & Offman (2009).

Kalantari, Esfahani Asl & Bayat(2012) studied about, The relationship between sexual issues & marriage satisfaction among married women. The results of their research showed that there is a significant relationship between sex attitude, sex awareness, sex anxiety, sex depression, exterior sex control, sex monitoring, and marriage satisfaction among married women. Also Ramezani (2011) found that there is a correlation between marital satisfaction and MSSCQ. The result of Menard & Offman (2009) showed a strong correlation between sexual self-esteem, sexual assertiveness, and sexual self-satisfaction.

Furthermore, Object (6) of study was to investigate any correlations between sexual self-concept and mental health. The results of study showed that there is a strong positive relationship between total score of general sexual self-concept and mental health scores.

This result is consistent with Ajilchi, Oskoei, & Kargar, (2013); Donaghue, (2009); Elsenbruch et al., (2003), Ramezani (2011).

6.3. Limitations of research

As with any study there are limitations. It is worth mentioning that the current research is an experimental study, wherein is not possible for all the variables to intervene, it is likely that the subjects might be influenced by conditions outside of the researcher's control.

The key point is to know that the sexual issues are among the most important problems of the society, and trying to keep them hidden or making denial of their existence has only worsened the condition. It was very difficult to convince women to be an active participant, since the focus of the study was a social taboo, and crossing these red lines in our culture might have caused these women anxiety and tension.

The participants were selected among married women in the range of 25 to 45 years of age. Regarding to different situations between generations and marital and pre-marital sex among Iranian women thus, generalizing the results to a larger society is not feasible.

Sexual issues are something between couples so training for couples can be more effective, but it was not possible to have a mix (male& female) group in Iran.

6.4. Recommendations

6.4.1. Research recommendations

It is recommended that CBT sexual training be studied on women with different ages.

It is recommended that CBT sexual training be studied on the several couples as the private sessions.

Tehran is the capital of Iran and as a capital city has more open-minded citizens; it is recommended that CBT sexual training be studied in different cities.

6.4.2. Practical recommendations

Encouraging the open-minded people in religious fields, and educating experts on sexual matters to solve people's issues are also crucial.

Having some courses at high schools for educating and informing about sexual issues to adolescent and young people.

It is recommended to prepare some information and educational packages for all age groups.

References

- Abdoly, M., & Pourmousavi, L. (2013). The Relationship Between Sexual Satisfaction and Education Levels in Women. *International Journal of Women's Health and Reproduction Sciences*, 1(2), 39–44. doi:10.15296/ijwhr.2013.07
- Ajilchi, B., Oskoei, A. S., & Kargar, F. R. (2013). Marital Satisfaction and Mental Health in Multiple Sclerosis Patients' and Healthy Individuals' Accordance to Sex, 4(11), 845–849.
- Andersen, B. L. (1999). Surviving cancer: the importance of sexual self-concept. *Medical and Pediatric Oncology*, 33(1), 15–23. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10401492>
- Andersen, B. L., & Cyranowski, J. M. (1994). Women's sexual self-schema. *Journal of Personality and Social Psychology*, 67(6), 1079–1100. doi:10.1037/0022-3514.67.6.1079
- Andersen, B. L., Cyranowski, J. M., & Espindle, D. (1999). Men's Sexual Self-Schema, 76(4), 645–661.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text rev.). doi:10.1176/appi.books.9780890423349.
- Amirian zade, M., (2004). Relationship between divorce and sexual problems. *The second conference on family and sexual problems*. Tehran.
- Aron, A., & Henkemeyer, L. (1995). Marital Satisfaction and Passionate Love. *Journal of Social and Personal Relationships*, 12(1), 139–146. doi:10.1177/0265407595121010
- Aslan, E., & Fynes, M. (2008). Female sexual dysfunction. *International Urogynecology Journal and Pelvic Floor Dysfunction*, 19(2), 293–305. doi:10.1007/s00192-007-0436-3
- Atwood, J. D., & Klucinec, E. (2007). Current State of Sexuality Theory and Therapy. *Journal of Couple & Relationship Therapy*, 6(1-2), 57–70. doi:10.1300/J398v06n01_06
- Aubrey, J. S. (2007). Does Television Exposure Influence College-Aged Women's Sexual Self-Concept? *Media Psychology*, 10(2), 157–181. doi:10.1080/15213260701375561
- Averett, P., Benson, M., & Vaillancourt, K. (2008). Young women's struggle for sexual agency: the role of parental messages. *Journal of Gender Studies*, 17(4), 331–344. doi:10.1080/09589230802420003
- Baheiraei, A., Khoori, E., Foroushani, A. R., Ahmadi, F., & Ybarra, M. L. (2014). What sources do adolescents turn to for information about their health concerns? *International Journal of Adolescent Medicine and Health*, 26(1), 61–8. doi:10.1515/ijamh-2012-0112
- Baird, D. T., & Glasier, A. F. (1999). Science, medicine, and the future: Contraception. *BMJ*, 319(7215), 969–972. doi:10.1136/bmj.319.7215.969
- Barlow, D. H. (1986). Causes of sexual dysfunction: The role of anxiety and cognitive interference. *Journal of Consulting and Clinical Psychology*, 52(2), 140–148.
- Basson R. (2001). Using a different model for female sexual response to address women's problematic low sexual desire. *Journal of Sex & Marital Therapy*, 27, 395- 403

- Baumeister, R. F. (2000). Gender differences in erotic plasticity: The female sex drive as socially flexible and responsive. *Psychological Bulletin*, 126(3), 375–379.
- Baumeister, R. F., & Twenge, J. M. (2002). Cultural suppression of female sexuality. *Review of General Psychology*, 6(2), 166–203.
- Bem, S. L. (1993). *The Lenses of Gender: Transforming the Debate on Sexual Inequality*. Yale University Press. Retrieved from <https://books.google.com/books?hl=en&lr=&id=u2a59A74CPcC&pgis=1>
- Bieber, I. (1974). The psychoanalytic treatment of sexual disorders. *Journal of Sex & Marital Therapy*, 1(1), 5–15. doi:10.1080/00926237408405268
- Birnbaum, G. E., & Reis, H. T. (2006). Women's sexual working models: an evolutionary-attachment perspective. *Journal of Sex Research*, 43(4), 328–42. doi:10.1080/00224490609552332
- Blackwood, E. (2000). Culture and Women's Sexualities. *Journal of Social Issues*, 56(2), 223–238. doi:10.1111/0022-4537.00162
- Blunt, H. D. (2012). "People aren't mind readers": A study of sexual self-concept, partner communication, and sexual satisfaction. *ProQuest Dissertations and Theses*, 214. Retrieved from http://ezproxy.net.ucf.edu/login?url=http://search.proquest.com/docview/1036690303?accountid=10003\nhttp://sfx.fcla.edu/ucf?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:dissertation&genre=dissertations+&+theses&sid=ProQ:ProQuest+Dissertations+&+Th
- Bocock, R. (2003). *Sigmund Freud*. Routledge. Retrieved from <https://books.google.com/books?id=LliBAGAAQBAJ&pgis=1>
- Bradford, A., & Meston, C. M. (2006). The impact of anxiety on sexual arousal in women. *Behaviour Research and Therapy*, 44(8), 1067–1077. doi:10.1016/j.brat.2005.08.006
- Breakwell, G. M., & Millward, L. J. (1997a). Sexual self-concept and sexual risk-taking. *Journal of Adolescence*, 20(1), 29–41. doi:10.1006/jado.1996.0062
- Breakwell, G. M., & Millward, L. J. (1997b). Sexual self-concept and sexual risk-taking. *Journal of Adolescence*, 20(1), 29–41. doi:10.1006/jado.1996.0062
- Bullough, V. L., & Bullough, B. (1977). *Sin Sickens & Sanity: A History of Sexual Attitudes*. Garland : New American Library. Retrieved from <https://books.google.com/books?id=IS8bAAAAYAAJ&pgis=1>
- Bullough, V. L., & Bullough, B. (2014). *Human Sexuality: An Encyclopedia*. Routledge. Retrieved from <https://books.google.com/books?id=-cqlAgAAQBAJ&pgis=1>
- Buzwell, S., & Rosenthal, D. (1995). Constructing a Sexual Self: Adolescents' Sexual Self-Perceptions and Sexual Risk-Taking. *Journal of Research on Adolescence*, 6(4), 489–513. Retrieved from <http://eric.ed.gov/?id=EJ534644>
- Byers, E. S., & Demmons, S. (1999). Sexual satisfaction and sexual self- disclosure within dating relationships. *Journal of Sex Research*, 36(2), 180–189. doi:10.1080/00224499909551983

- Carey, M. P., & Wincze, J. P. (2012). *Sexual Dysfunction, Second Edition: A Guide for Assessment and Treatment*. Guilford Press. Retrieved from <https://books.google.com/books?hl=en&lr=&id=WOu2XVaQHeQC&pgis=1>
- Cyranowski, J. M., & Andersen, B. L. (2000). EVIDENCE OF SELF-SCHEMATIC COGNITIVE PROCESSING IN WOMEN WITH DIFFERING SEXUAL SELF-VIEWS. *Journal of Social and Clinical Psychology, 19*(4), 519–543. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3004174&tool=pmcentrez&rendertype=abstract>
- Daniluk, J. C. (1993). THE MEANING AND EXPERIENCE OF FEMALE SEXUALITY A Phenomenological Analysis. *Psychology of Women Quarterly, 17*(1), 53–69. doi:10.1111/j.1471-6402.1993.tb00676.x
- Daniluk, J. C. (1998). *Women's Sexuality Across the Life Span: Challenging Myths, Creating Meanings*. Guilford Press. Retrieved from https://books.google.com/books?hl=en&lr=&id=3_05ZKQQA9YC&pgis=1
- Davidson, J. K., & Darling, C. A. (1988). The sexually experienced woman: Multiple sex partners and sexual satisfaction. *Journal of Sex Research, 24*(1), 141–54. doi:10.1080/00224498809551404
- Davidson, J. K., Darling, C. A., & Norton, L. (1995). Religiosity and the sexuality of women: Sexual behavior and sexual satisfaction revisited. *Journal of Sex Research, 32*(3), 235–243. doi:10.1080/00224499509551794
- Davison, S. L., Bell, R. J., LaChina, M., Holden, S. L., & Davis, S. R. (2009). The relationship between self-reported sexual satisfaction and general well-being in women. *The Journal of Sexual Medicine, 6*(10), 2690–7. doi:10.1111/j.1743-6109.2009.01406.x
- Deutsch, A. R. (2012). A Test of a Conceptual Model of Sexual Self- Concept and its Relation to Other Dimensions of Sexuality.
- Devon J. Hensel, , J. Dennis Fortenberry, Lucia F. O'Sullivan, A., & P., D. (2012). The Developmental Association of Sexual Self-Concept with Sexual Behavior among Adolescent Women. *Adolesc, 29*(4), 997–1003. doi:10.1016/j.biotechadv.2011.08.021.Secreted
- Donaghue, N. (2009). Body satisfaction, sexual self-schemas and subjective well-being in women. *Body Image, 6*(1), 37–42. doi:10.1016/j.bodyim.2008.08.002
- Dove, N., & Wiederman, M. (2000). Cognitive distraction and women's sexual functioning. *Journal of Sex & Marital Therapy, 26*(1), 67–78. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10693117>
- Doyle Zeanah, P., & Schwarz, J. C. (1996). Reliability and Validity of the Sexual Self-Esteem Inventory for Women. *Assessment, 3*(1), 1–15. doi:10.1177/107319119600300101
- Edwards, J. N., & Booth, A. (1999). *Sexuality Across the Life Course*. University of Chicago Press. Retrieved from <https://books.google.com/books?hl=en&lr=&id=C9OGcmFeNaEC&pgis=1>
- Eisler, R. (1996) *Sacred Pleasure: Sex, Myth, and the Politics of the Body-New Paths to Power and Love*. HarperSanFrancisco.
- Elsenbruch, S., Hahn, S., Kowalsky, D., Offner, A. H., Schedlowski, M., Mann, K., & Janssen, O. E. (2003). Quality of life, psychosocial well-being, and sexual satisfaction in women with polycystic ovary syndrome. *The Journal of Clinical Endocrinology and Metabolism, 88*(12), 5801–7. doi:10.1210/jc.2003-030562
- Engler, B. (2013). *Personality Theories*. Cengage Learning. Retrieved from <https://books.google.com/books?hl=en&lr=&id=Ue4WAAAAQBAJ&pgis=1>

- Epstein, S. (1991). Sexuality and identity: The contribution of object relations theory to a constructionist sociology. *Theory and Society*, 20(6), 825–873. doi:10.1007/BF00678098
- Farahani, F. K. A. (2008, May 1). Norms, attitude and sexual conduct among female college students in Tehran; implications for reproductive health policy and research. Retrieved from <http://researchonline.lshtm.ac.uk/682381/1/502693.pdf>
- Fard, F. J., Reza, H., Aboeshghi, S., Kad, S., & Zadeh, K. (2014). Impact of sex education on family health of students, 1(1), 560–569.
- Field, A. (2009). *Discovering statistics using SPSS : (and sex and drugs and rock “n” roll)*. Los Angeles [i.e. Thousand Oaks Calif.] ;London: SAGE Publications.
- Fisher, T. D., Davis, C. M., Yarber, W. L., & Davis, S. L. (2013). *Handbook of Sexuality-Related Measures*. Routledge. Retrieved from <https://books.google.com/books?hl=en&lr=&id=gUnbAAAQBAJ&pgis=1>
- Foucault, M. (1978). The History of Sexuality, Volume 1: An Introduction. *The History of Sexuality An Introduction*, 1, 168. doi:10.2307/1904618
- Freeman, A. M. (1989). *Comprehensive Handbook of Cognitive Therapy*. Springer Science & Business Media. Retrieved from <https://books.google.com/books?id=I95L4S7YhmgC&pgis=1>
- Galinsky, A. M., & Sonenstein, F. L. (2011). The association between developmental assets and sexual enjoyment among emerging adults. *The Journal of Adolescent Health : Official Publication of the Society for Adolescent Medicine*, 48(6), 610–5. doi:10.1016/j.jadohealth.2010.09.008
- Gerrard, M., Gibbons, F. X., Benthin, A. C., & Hessling, R. M. (1996). A longitudinal study of the reciprocal nature of risk behaviors and cognitions in adolescents: What you do shapes what you think, and vice versa. *Health Psychology*, 15(5), 344–354.
- Ghorbanshiroudi, S., Azari, K. N., Khalatbari, J., & Keikhayfarzaneh, M. (2012). Studying the Effectiveness of Cognitive-Behavioral Therapy in Developing Sexual Self-Concept, 2(4), 3378–3381.
- Goeke-Morey, M. C., Cummings, E. M., & Papp, L. M. (2007). Children and marital conflict resolution: implications for emotional security and adjustment. *Journal of Family Psychology : JFP : Journal of the Division of Family Psychology of the American Psychological Association (Division 43)*, 21(4), 744–53. doi:10.1037/0893-3200.21.4.744
- Goetz, C. D., Easton, J. a., Lewis, D. M. G., & Buss, D. M. (2012). Sexual exploitability: Observable cues and their link to sexual attraction. *Evolution and Human Behavior*, 33(4), 417–426. doi:10.1016/j.evolhumbehav.2011.12.004
- Goodwach, R. (2005). Fundamentals of Theory and Practice Revisited: Sex Therapy: Historical Evolution, Current Practice. Part 2. *Australian and New Zealand Journal of Family Therapy*, 26(4), 178–183. doi:10.1002/j.1467-8438.2005.tb00671.x
- Green, D. (2005). Personal Construct Theory and Paediatric Health Care. *Clinical Child Psychology and Psychiatry*, 10(1), 33–41. doi:10.1177/1359104505048789
- Grohol, J. (2013). DSM-5 Released: The Big Changes. *Psych Central*. Retrieved on September 10, 2015, from <http://psychcentral.com/blog/archives/2013/05/18/dsm-5-released-the-big-changes/>

- Grote, N. K., & Frieze, I. H. (1998). 'Remembrance of Things Past': Perceptions of Marital Love from its Beginnings to the Present. *Journal of Social and Personal Relationships*, *15*(1), 91–109. doi:10.1177/0265407598151006
- Haavio-Mannila, E., & Kontula, O. (1997). Correlates of increased sexual satisfaction. *Archives of Sexual Behavior*, *26*(4), 399–419. doi:10.1023/A:1024591318836
- Haavio-Mannila, E., & Kontula, O. (1997). What Increases Sexual Satisfaction? *Archives of Sexual Behavior*, *26*(4), 1–31.
- Handbook of Sex Therapy*. (2012). Springer Science & Business Media. Retrieved from <https://books.google.com/books?id=RprhBwAAQBAJ&pgis=1>
- Health of the university students of Ghazvin (in Farsi) (2014)." *The Journal of Qazvin University of Medical Sciences & Health Services* *28*: 5-13.
- Heiman, J. R., Long, J. S., Smith, S. N., Fisher, W. A., Sand, M. S., & Rosen, R. C. (2011). Sexual Satisfaction and Relationship Happiness in Midlife and Older Couples in Five Countries. *Archives of Sexual Behavior*, *40*(4), 741–753. doi:10.1007/s10508-010-9703-3
- Hensel, D. J., Fortenberry, J. D., O'Sullivan, L. F., & Orr, D. P. (2011). The developmental association of sexual self-concept with sexual behavior among adolescent women. *Journal of Adolescence*, *34*(4), 675–84. doi:10.1016/j.adolescence.2010.09.005
- Hesary, M. S., & Zakariaei, Z. (2015). Comparison of Sexual Dysfunction and Coping Strategies in Couples Applicants of Divorce and Normal Couples, *5*(4), 228–238.
- Higgins, J. A., Mullinax, M., Trussell, J., Davidson, J. K., & Moore, N. B. (2011). Sexual satisfaction and sexual health among university students in the United States. *American Journal of Public Health*, *101*(9), 1643–54. doi:10.2105/AJPH.2011.300154
- Higgins, J. A., Trussell, J., Moore, N. B., & Davidson, J. K. (2010). Virginity lost, satisfaction gained? Physiological and psychological sexual satisfaction at heterosexual debut. *Journal of Sex Research*, *47*(4), 384–94. doi:10.1080/00224491003774792
- Hogan, D. R. (1978). The Effectiveness of Sex Therapy: A Review of the Literature. In *Human Sexuality and Its Problems* (pp. 57–84). Retrieved from https://books.google.es/books/about/Human_Sexuality_and_Its_Problems.html?id=Mgrxw_SZUg8C&pgis=1
- Hurlbert, D. F. (1991). The role of assertiveness in female sexuality: a comparative study between sexually assertive and sexually nonassertive women. *Journal of Sex & Marital Therapy*, *17*(3), 183–90. doi:10.1080/00926239108404342
- Hurlbert, D. F., & Whittaker, K. E. (2015). The Role of Masturbation in Marital and Sexual Satisfaction: A Comparative Study of Female Masturbators and Nonmasturbators. *Journal of Sex Education and Therapy*. Retrieved from <http://www.tandfonline.com/doi/abs/10.1080/01614576.1991.11074029?journalCode=wzjs20#.Vd3Zbvmqk>

- Impett, E. A., & Tolman, D. L. (2006). Late Adolescent Girls' Sexual Experiences and Sexual Satisfaction. *Journal of Adolescent Research, 21*(6), 628–646. doi:10.1177/0743558406293964
- Jackson, S., & Scott, S. (2002). Embodying Orgasm. *Women & Therapy, 24*(1-2), 99–110. doi:10.1300/J015v24n01_13
- Johnson, R. J., Rew, L., Fredland, N., & Bowman, K. (2010). Sexual self-concept in sexually abused homeless adolescents. *Vulnerable Children and Youth Studies, 5*(1), 44–51. doi:10.1080/17450120903335151
- kalantari, Esfahani Asl, R. B. (n.d.). The relationship between sexual issues & marriage satisfaction among married women. Retrieved August 26, 2015, from http://www.irjabs.com/files_site/paperlist/r_573_121228131246.pdf
- Kaplan, H. S. (1974). *The new sex therapy* Brunner. Mazel, New York.
- Kaplan, H. S. (1977). Hypoactive sexual desire. *Journal of sex & marital therapy, 3*, 3–9.
- Kelly, G. F. (2004). *Sexuality today: The human perspective*. McGraw-Hill.
- Kelly, G. F. (2006). *Sexuality Today: The Human Perspective*. McGraw-Hill. Retrieved from <https://books.google.com/books?id=Z8DdPgAACAAJ&pgis=1>
- Kleinplatz, P. ,(2012). *New Directions in Sex Therapy: Innovations and Alternatives*. Second Edition. Kleinplatz (Ed.) New York: Routledge.
- Kolodny, R., Johnson, V. E., & Masters, W. H. (1988). *Masters and Johnson on Sex and Human Loving*. Little, Brown. Retrieved from <https://books.google.es/books?id=w-fetgAACAAJ>
- Kubba, A., Guillebaud, J., Anderson, R. A., & MacGregor, E. A. (2000). Contraception. *Lancet (London, England), 356*(9245), 1913–9. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11130398>
- Kuffel, S. W., & Heiman, J. R. (2006). Effects of depressive symptoms and experimentally adopted schemas on sexual arousal and affect in sexually healthy women. *Archives of Sexual Behavior, 35*(2), 163–77. doi:10.1007/s10508-005-9015-1
- Larson, J. H., Anderson, S. M., Holman, T. B., & Niemann, B. K. (1998). A longitudinal study of the effects of premarital communication, relationship stability, and self-esteem on sexual satisfaction in the first year of marriage. *Journal of Sex & Marital Therapy, 24*(3), 193–206. doi:10.1080/00926239808404933
- Laumann, E. O. (1994). *The Social Organization of Sexuality: Sexual Practices in the United States*. University of Chicago Press. Retrieved from <https://books.google.com/books?hl=en&lr=&id=3RbyuQAYsdMC&pgis=1>
- Leiblum, S. R., & Wiegel, M. (2002). Psychotherapeutic interventions for treating female sexual dysfunction. *World Journal of Urology, 20*(2), 127–36. doi:10.1007/s00345-002-0266-3
- Lerner, G. (1987). *The Creation of Patriarchy*. USA, Oxford University Press.
- Lottes, I. L., & Kuriloff, P. J. (1992). The effects of gender, race, religion, and political orientation on the sex role attitudes of college freshmen. *Adolescence, 27*(107), 675.
- Lottes, I. L., & Kuriloff, P. J. (1994). The impact of college experience on political and social attitudes. *Sex Roles, 31*(1-2), 31–54. doi:10.1007/BF01560276

- Ma, R., Ghaemmaghami, A., Talakar, M., & Sh, S. (2013). Reliability and Validity Assessment of Multi-Dimensional Sexual Self- Concept Questionnaire in Iran, *14*(4).
- Mackay, D. (1982). Cognitive behaviour therapy. *British Journal of Hospital Medicine*, *27*, 242–243, 245, 247.
- MacNeil, S., & Byers, E. S. (n.d.) (1997). The relationships between sexual problems, communication, and sexual satisfaction.
- Markus, H., & Wurf, E. (1987). The Dynamic Self-Concept: A Social Psychological Perspective. *Annual Review of Psychology*, *38*(1), 299–337. doi:10.1146/annurev.ps.38.020187.001503
- Masters, W. & Johnson, V. (1966). *Human Sexual Response*. New York: Bantam Books.
- Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Boston: Little Brown & Co
- Masters, W. H., Johnson, V. E., & Kolodny, R. C. (1986). *Masters and Johnson on sex and human loving*. Little Brown and Company. Meeting on Completing Fertility Transition, New York.
- Mayers, K. S., Heller, D. K., & Heller, J. A. (2003). Damaged Sexual Self-Esteem: A Kind of Disability. *Sexuality and Disability*, *21*(4), 269–282. doi:10.1023/B:SEDI.0000010069.08844.04
- McCabe, M. P., & Taleporos, G. (2003). Sexual Esteem, Sexual Satisfaction, and Sexual Behavior Among People with Physical Disability. *Archives of Sexual Behavior*, *32*(4), 359–369. doi:10.1023/A:1024047100251
- McCarthy, B. W. (1986). A cognitive-behavioral approach to understanding and treating sexual trauma. *Journal of Sex & Marital Therapy*, *12*(4), 322–9. doi:10.1080/00926238608415417
- Meston, C. M., & Buss, D. M. (2007). Why humans have sex. *Archives of Sexual Behavior*, *36*(4), 477–507. doi:10.1007/s10508-007-9175-2
- Meston, C., & Trapnell, P. (2005). Development and validation of a five-factor sexual satisfaction and distress scale for women: the Sexual Satisfaction Scale for Women (SSS-W). *The Journal of Sexual Medicine*, *2*(1), 66–81. doi:10.1111/j.1743-6109.2005.20107.x
- Metz, M. E., & McCarthy, B. W. (2007). The “Good-Enough Sex” model for couple sexual satisfaction. *Sexual and Relationship Therapy*, *22*(3), 351–362. doi:10.1080/14681990601013492
- Mohammadi, M. R., (2006). "Reproductive knowledge, attitude and behaviour of adolescent males in Tehran." *International Family Planning*.
- Montesi, J. L., Conner, B. T., Gordon, E. A., Fauber, R. L., Kim, K. H., & Heimberg, R. G. (2013). On the relationship among social anxiety, intimacy, sexual communication, and sexual satisfaction in young couples. *Archives of Sexual Behavior*, *42*(1), 81–91. doi:10.1007/s10508-012-9929-3
- Morokoff, P. (1978). Determinants of Female Orgasm. In J. LoPiccolo & L. LoPiccolo (Eds.), *Handbook of Sex Therapy* (pp. 147–165). Boston, MA: Springer US. doi:10.1007/978-1-4613-3973-1
- Mosleh-uddin, M. N., M. Mirmotahari, et al. (2002). Adolescent data on reproductive health issues in the I.R. of Iran. IUSSP Semiar, Bangkok, Thailand, United Nation Population Fund.

- Najafabady, M. T., Salmani, Z., & Abedi, P. (2011). Prevalence and related factors for anorgasmia among reproductive aged women in Hesarak, Iran. *Clinics (São Paulo, Brazil)*, 66(1), 83–6. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3044590&tool=pmcentrez&rendertype=abstract>
- Nasirian M, Haghdoost AA. Modeling of new HIV infections based on exposure groups in Iran. Kerman, Iran. Kerman University of Medical Sciences; 2011.
- Neil R. Carlson, William Buskist, C. Donald Heth, Rod Schmaltz: (2009) *The Science of Behaviour* (4th ed.), Toronto, Canada:, pp. 140–141, 9780205702862.
- Noorbala, a. a., Bagheri Yazdi, S. a., Yasamy, M. T., & Mohammad, K. (2004). Mental health survey of the adult population in Iran. *British Journal of Psychiatry*, 184, 70–73. doi:10.1192/bjp.184.1.70
- Nourani Sadodin Sh, Joneidi E, Shakeri MT, Mokhber N. (2009). Comparing sex satisfaction in fertile and infertile women referring to state centers of mashad. *Fertility and in fertility quarterly*. No; 4.
- Nouranipur R, Besharat MA, Yousefi S. (2007). The relationship between knowledge and sexual attitudes and marital satisfaction in couples living in the building of young researchers at Shahid Beheshti University. *Counseling Research & Developments*; 24: 27-39.
- O’Sullivan, L. F., Mckeague, I. W., Dudley, C., Hearn, K. D., Varela, Y., Miller, K., ... Landinez, J. (2006). The development of the sexual self-concept inventory for adolescent girls. *Psychology of Women Quarterly*, 30, 139–149.
- Oattes, M. K., & Offman, A. (2007). Global self-esteem and sexual self-esteem as predictors of sexual communication in intimate relationships. *The Canadian Journal of Human Sexuality*, 16(3/4), 89.
- Oriel, J. (2005). Sexual pleasure as a human right: Harmful or helpful to women in the context of HIV/AIDS? *Women’s Studies International Forum*, 28(5), 392–404. doi:10.1016/j.wsif.2005.05.002
- Orr, D. P., Wilbrandt, M. L., Brack, C. J., Rauch, S. P., & Ingersoll, G. M. (1989). Reported Sexual Behaviors and Self-esteem Among Young Adolescents. *Archives of Pediatrics & Adolescent Medicine*, 143(1), 86. doi:10.1001/archpedi.1989.02150130096023
- Osman Özdel, S. T. N. L. F. Ç. A. N. K. O. (2013). Effects of sex therapy based on cognitive behavioral methods on sexual problems of women with vaginismus and their spouses. *Anatolian Journal of Psychiatry*, 14(2), 129–135. Retrieved from <http://www.scopemed.org/?mno=36933>
- Özdel, Tümkaya, Levent, Ateşci, Oğuzhanoğlu (2013). Effects of sex therapy based on cognitive behavioral methods on sexual problems of women with vaginismus and their spouses. *Anatolian Journal of Psychiatry*, 14(2), 129–135. Retrieved from <http://www.scopemed.org/?mno=36933>
- Pai, H. C., Lee, S., & Yen, W. J. (2012). The effect of sexual self-concept on sexual health behavioural intentions: A test of moderating mechanisms in early adolescent girls. *Journal of Advanced Nursing*, 68, 47–55. doi:10.1111/j.1365-2648.2011.05710.x
- Palacios, S., Tobar, A. ., & Menendez, C. (2002). Sexuality in the climacteric years. *Maturitas*, 43, 69–77. doi:10.1016/S0378-5122(02)00150-0
- Ramezani, M. A., Ghaemmaghami, A., Talakar, M., & Saadat, S. H. (2013). Validity and Reliability Assessment of Multi-Dimensional Sexual Self-Concept Questionnaire for Iranian Population, 14(4), 302–309.

- Reissing, E. D., Binik, Y. M., Khalifé, S., Cohen, D., & Amsel, R. (2003). Etiological correlates of vaginismus: sexual and physical abuse, sexual knowledge, sexual self-schema, and relationship adjustment. *Journal of Sex & Marital Therapy*, 29(1), 47–59. doi:10.1080/713847095
- Rellini, A. H., & Meston, C. M. (2011a). Sexual self-schemas, sexual dysfunction, and the sexual responses of women with a history of childhood sexual abuse. *Archives of Sexual Behavior*, 40, 351–362. doi:10.1007/s10508-010-9694-0
- Rellini, A. H., & Meston, C. M. (2011b). Sexual self-schemas, sexual dysfunction, and the sexual responses of women with a history of childhood sexual abuse. *Archives of Sexual Behavior*, 40(2), 351–62. doi:10.1007/s10508-010-9694-0
- Robinson, L. M. W. and J. W. (2012). Back to the Basics: Origins of Sex Therapy, Sexual Disorder and Therapeutic Techniques. *Reproductive System & Sexual Disorders*, 2012. doi:10.4172/2161-038X.1000109
- Rollins, J. H. (1996). *Women's Minds/women's Bodies: The Psychology of Women in a Biosocial Context*. Retrieved from https://books.google.es/books/about/Women_s_Minds_women_s_Bodies.html?id=kkbaAAAAMAAJ&pgis=1
- Rosenthal, D., Moore, S., & Flynn, I. (1991). Adolescent self-efficacy, self-esteem and sexual risk-taking. *Journal of Community & Applied Social Psychology*, 1(2), 77–88. doi:10.1002/casp.2450010203
- Rostosky, S. S., Dekhtyar, O., Cupp, P. K., & Anderman, E. M. (2008). Sexual self-concept and sexual self-efficacy in adolescents: a possible clue to promoting sexual health? *Journal of Sex Research*, 45(3), 277–86. doi:10.1080/00224490802204480
- Salazar, L. F., Crosby, R. A., DiClemente, R. J., Wingood, G. M., Lescano, C. M., Brown, L. K., ... Davies, S. (2005). Self-esteem and theoretical mediators of safer sex among African American female adolescents: implications for sexual risk reduction interventions. *Health Education & Behavior: The Official Publication of the Society for Public Health Education*, 32(3), 413–27. doi:10.1177/1090198104272335
- Santelli, J. S., Lowry, R., Brener, N. D., & Robin, L. (2000). The association of sexual behaviors with socioeconomic status, family structure, and race/ethnicity among US adolescents. *American journal of public health*, 90(10), 1582.
- Savin-Williams, R. C., & Diamond, L. M. (2000). Sexual Identity Trajectories Among Sexual-Minority Youths: Gender Comparisons. *Archives of Sexual Behavior*, 29(6), 607–627. doi:10.1023/A:1002058505138
- Schick, V. R., Calabrese, S. K., Rima, B. N., & Zucker, A. N. (2010). Genital Appearance Dissatisfaction: Implications for Women's Genital Image Self-Consciousness, Sexual Esteem, Sexual Satisfaction, and Sexual Risk. *Psychology of Women Quarterly*, 34(3), 394–404. doi:10.1111/j.1471-6402.2010.01584.x
- Seal, A., Minichiello, V., & Omodei, M. (1997). Young women's sexual risk taking behaviour: re-visiting the influences of sexual self-efficacy and sexual self-esteem. *International Journal of STD & AIDS*, 8(3), 159–165. doi:10.1258/0956462971919822
- Simon, W., & Gagnon, J. (2011). *Sexual Conduct: The Social Sources of Human Sexuality*. Transaction Publishers. Retrieved from https://books.google.com/books?hl=en&lr=&id=rycoaGg5H_IC&pgis=1
- Snell, W. E. (1998). The multidimensional sexual self-concept questionnaire. *Handbook of sexuality-related measures*, 521-524.

- Snell, W. E., Fisher, T. D., & Walters, A. S. (1993). The multidimensional sexuality questionnaire: An objective self-report measure of psychological tendencies associated with human sexuality. *Annals of Sex Research, 6*(1), 27–55. doi:10.1007/BF00849744
- Snell, W. E., & Papini, D. R. (1989). The sexuality scale: An instrument to measure sexual- esteem, sexual- depression, and sexual- preoccupation. *Journal of Sex Research, 26*(2), 256–263. doi:10.1080/00224498909551510
- Sofroniou, A. (n.d.) (2015). *Therapeutic Psychology*. Retrieved from https://books.google.com/books?id=_MUjCgAAQBAJ&pgis=1
- Spencer, J. M., Zimet, G. D., Aalsma, M. C., & Orr, D. P. (2002). Self-Esteem as a Predictor of Initiation of Coitus in Early Adolescents. *PEDIATRICS, 109*(4), 581–584. doi:10.1542/peds.109.4.581
- Sprecher, S. (2002). Sexual satisfaction in premarital relationships: associations with satisfaction, love, commitment, and stability. *Journal of Sex Research, 39*(3), 190–6. doi:10.1080/00224490209552141
- Steinke, E. E., Wright, D. W., Chung, M. L., & Moser, D. K. Sexual self-concept, anxiety, and self-efficacy predict sexual activity in heart failure and healthy elders. *Heart & Lung : The Journal of Critical Care, 37*(5), 323–33. doi:10.1016/j.hrtlng.2007.09.004
- Tavoosi, A., A. Zaferani, et al. (2004). "Knowledge and attitude towards HIV/AIDS among Iranian students." *BMC Public Health 4*(1): 17.
- Ter Kuile, M. M., Both, S., & van Lankveld, J. J. D. M. (2010). Cognitive behavioral therapy for sexual dysfunctions in women. *The Psychiatric Clinics of North America, 33*(3), 595–610. doi:10.1016/j.psc.2010.04.010
- The Science of Behaviour, Fourth Canadian Edition with MyPsychLab (4th Edition) (9780205702862): Neil R. Carlson, William Buskist, C. Donald Heth, Rod Schmaltz: Books. . Retrieved September 4, 2015, from <http://www.amazon.com/Psychology-Science-Behaviour-Canadian-MyPsychLab/dp/0205702864>.
- The United Nations, Fourth World Conference on Women, Beijing, China - September 1995
- Tiefer, L. (2012). The Medicalization of Sexuality: Conceptual, Normative, and Professional Issues. *Annual Review of Sex Research, 7*(1), 252–282. Retrieved from <http://www.tandfonline.com/doi/abs/10.1080/10532528.1996.10559915#.Vex0q8iqqko>
- Tolman, D. L. (2009). *Dilemmas of Desire: Teenage Girls Talk about Sexuality*. Harvard University Press. Retrieved from <https://books.google.com/books?hl=en&lr=&id=qJQAxWPuCIoC&pgis=1>
- Tolman, D. L., & Szalacha, L. A. (1999). DIMENSIONS OF DESIRE. *Psychology of Women Quarterly, 23*(1), 7–39. doi:10.1111/j.1471-6402.1999.tb00338.x
- Van Bruggen, L. K., Runtz, M. G., & Kadlec, H. (2006). Sexual revictimization: the role of sexual self-esteem and dysfunctional sexual behaviors. *Child Maltreatment, 11*(2), 131–45. doi:10.1177/1077559505285780
- Vencill, J. A. (2014, August 1). Women's sexual functioning: The role of self-objectification, appearance anxiety, and depression. Retrieved from <https://repositories.tdl.org/ttu-ir/handle/2346/58891>
- Vickberg, S. M. J., & Deaux, K. (2005). Measuring the Dimensions of Women's Sexuality: The Women's Sexual Self-Concept Scale. *Sex Roles, 53*(5-6), 361–369. doi:10.1007/s11199-005-6759-y

- Wagner, J., & Rehfuss, M. (2008). Self-injury, Sexual Self-concept, and a Conservative Christian Upbringing: An Exploratory Study of Three Young Women's Perspectives. *Journal of Mental Health Counseling, 30*(2), 173–188. doi:10.17744/mehc.30.2.11u01030x44h307x
- Wakefield, C. (2013). In search of Aphrodite: working with archetypes and an inner cast of characters in women with low sexual desire. *Sexual and Relationship Therapy, 29*(1), 31–41. doi:10.1080/14681994.2013.861594
- White, L., & Keith, B. (1990). The Effect of Shift Work on the Quality and Stability of Marital Relations. *Journal of Marriage and the Family, 52*(2), 453. doi:10.2307/353039
- Wiederman, M. W. (2000). Women's body image self-consciousness during physical intimacy with a partner. *Journal of Sex Research, 37*(1), 60–68. doi:10.1080/00224490009552021
- Wiederman, M. W., & Allgeier, E. R. (1993). The Measurement of Sexual-Esteem: Investigation of Snell and Papini's (1989) Sexuality Scale. *Journal of Research in Personality, 27*(1), 88–102. doi:10.1006/jrpe.1993.1006
- Winter, L. (1988). The role of sexual self-concept in the use of contraceptives. *Family Planning Perspectives, 20*(3), 123–127. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/3417002>
- Yela, C. (2012). Predictors of and factors related to loving and sexual satisfaction for men and women. *Revue Européenne de Psychologie Appliquée, 235–243*. Retrieved from http://www.researchgate.net/publication/232573546_Predictors_of_and_factors_related_to_loving_and_sexual_satisfaction_for_men_and_women
- Zimmer-Gembeck, M. J., Ducat, W. H., & Boislard-Pepin, M.-A. (2011). A prospective study of young females' sexual subjectivity: associations with age, sexual behavior, and dating. *Archives of Sexual Behavior, 40*(5), 927–38. doi:10.1007/s10508-011-9751-3

Appendices

Consent Letter

The aim of the study is how self-concept and marriage satisfaction will be improved by Cognitive-Behavior sex training. In order to complete this research we need to collect data from the Iranian women population by means of some scientific questionnaires. Furthermore, some of the participating women are going to be selected randomly for intervention and control groups. The intervention group is received eight weekly Cognitive-Behavior sex training sessions, each session of 1h/30 minutes (further explanation has mentioned in presentation orally).

You do not have to be in this study. Your participation is completely voluntary. You may choose to stop being in this study at any time without penalty, simply communicating with the researcher, without further explanations.

We do not need your identity. Even you can ask your questions by writing them without name and put them in the box. In order to ensure the character confidentiality of the information provided in these questionnaires, all the answers will be coded numerically for later statistical treatment and in no case shall include the identity of the participants. The data which you provide for us will be used only for research purposes and researchers exclusively have access to them.

There are no expected risks for your participation just Please answer honestly and rigorously carefully to all the questions of the questionnaires. Your answers are really important for accomplishing the objectives of our investigation.

Feedback will be provided at the aggregated level (for all cases under study) at the end of the project for the people interested in it simply asking the researcher at any time about it. Personal feedback will be provided by private sessions or other confidential ways.

If you have questions or concerns about this study you may contact Mitra Vahid Vaghef and/or Dr. Rosa Maria Reich by the following means of contact:

E-mail: vahid.mitra@yahoo.com. Phone: +98-9358917898

E-mail: rosa.raich @ uab.cat Phone: +34-686986785

The researcher Mitra VahidVaghef informed me about this research in the area of Clinical and Health Psychology, UAB. I have read the description of the study I am about to participate in the research. I have heard and understood the presentation orally about session's information. I could ask as many questions as I wanted. I understand that my participation is voluntary. I understand that I may choose to stop being in the study at any time. I also understand that all the information I provide is confidential. I have the ability to request more information if I want.

I have been told that I will receive a signed copy of this consent form to keep.

Signed: _____ Date: _____

Signed (researcher)

The Extended Multidimensional Sexuality Questionnaire

INSTRUCTIONS: The items in this questionnaire refer to people's sexuality. Please read each item carefully and decide to what extent it is characteristic of you. Give each item a rating of how much it applies to you by using the following scale:

- A = Not at all characteristic of me.
 B = Slightly characteristic of me.
 C = Somewhat characteristic of me.
 D = Moderately characteristic of me.
 E = Very characteristic of me.
-

NOTE: **Remember to respond to all items, even if you are not completely sure.**

Your answers will be kept in the strictest confidence.

Also, please be honest in responding to these statements.

1. I feel anxious when I think about the sexual aspects of my life.
2. I have the ability to take care of any sexual needs and desires that I may have.
3. I am very aware of my sexual feelings and needs.
4. I am motivated to avoid engaging in "risky" (i.e., unprotected) sexual behavior.
5. The sexual aspects of my life are determined mostly by chance happenings.
6. I think about sex "all the time."
7. I'm very assertive about the sexual aspects of my life.
8. I expect that the sexual aspects of my life will be positive and rewarding in the future.
9. I would be to blame, if the sexual aspects of my life were not going very well.
10. I notice how others perceive and react to the sexual aspects of my life.
11. I'm motivated to be sexually active.
12. If I were to experience a sexual problem, I myself would in control of whether this improved.
13. I derive a sense of self-pride from the way I handle my own sexual needs and desires.
14. I am satisfied with the way my sexual needs are currently being met.

15. My sexual behaviors are determined largely by other more powerful and influential people.

16. Not only would I be a good sexual partner, but it's quite important to me that I be a good sexual partner.

17. I am afraid of becoming sexual involved with another person.

18. If I am careful, then I will be able to prevent myself from having any sexual problems.

19. I am depressed about the sexual aspects of my life.

20. My sexuality is something that I am largely responsible for.

21. I worry about the sexual aspects of my life.

22. I am competent enough to make sure that my sexual needs are fulfilled.

23. I am very aware of my sexual motivations and desires.

24. I am motivated to keep myself from having any "risky" sexual behavior (e.g., exposure to sexual diseases).

25. Most things that affect the sexual aspects of my life happen to me by accident.

26. I think about sex more than anything else.

27. I'm not very direct about voicing my sexual needs and preferences. (R)

28. I believe that in the future the sexual aspects of my life will be healthy and positive.

29. If the sexual aspects of my life were to go wrong, I would be the person to blame.

30. I'm concerned with how others evaluate my own sexual beliefs and behaviors.

31. I'm motivated to devote time and effort to sex.

32. If I were to experience a sexual problem, my own behavior would determine whether I improved.

33. I am proud of the way I deal with and handle my own sexual desires and needs.

34. I am satisfied with the status of my own sexual fulfillment.

35. My sexual behaviors are largely controlled by people other than myself (e.g., my partner, friends, and family).

36. Not only would I be a skilled sexual partner, but it's very important to me that I be a skilled sexual partner.

37. I have a fear of sexual relationships.

38. I can pretty much prevent myself from developing sexual problems by taking good care of myself.
39. I am disappointed about the quality of my sex life.
40. The sexual aspects of my life are determined in large part by my own behavior.
41. Thinking about the sexual aspects of my life often leaves me with an uneasy feeling.
42. I have the skills and ability to ensure rewarding sexual behaviors for myself.
43. I tend to think about my own sexual beliefs and attitudes.
44. I want to avoid engaging in sex where I might be exposed to sexual diseases.
45. Luck plays a big part in influencing the sexual aspects of my life.
46. I tend to be preoccupied with sex.
47. I am somewhat passive about expressing my own sexual desires. (R)
48. I do not expect to suffer any sexual problems or frustrations in the future.
49. If I were to develop a sexual disorder, then I would be to blame for not taking good care of myself.
50. I am quick to notice other people's reactions to the sexual aspects of my own life.
51. I have a desire to be sexually active.
52. If I were to become sexually maladjusted, I myself would be responsible for making myself better.
53. I am pleased with how I handle my own sexual tendencies and behaviors.
54. The sexual aspects of my life are personally gratifying to me.
55. My sexual behavior is determined by the actions of powerful others (e.g., my partner, friends, family).
56. Not only could I relate well to a sexual partner, but it's important to me that I be able to do so.
57. I am fearful of engaging sexual activity.
58. If just I look out for myself, then I will be able to avoid any sexual problems in the future.
59. I feel discouraged about my sex life.
60. I am in control of and am responsible for the sexual aspects of my life.
61. I worry about the sexual aspects of my life.
62. I am able to cope with and to handle my own sexual needs and wants.

63. I'm very alert to changes in my sexual thoughts, feelings, and desires.
64. I really want to prevent myself from being exposed to sexual diseases.
65. The sexual aspects of my life are largely a matter of (good or bad) fortune.
66. I'm constantly thinking about having sex.
67. I do not hesitate to ask for what I want in a sexual relationship.
68. I will probably experience some sexual problems in the future. (R)
69. If I were to develop a sexual problem, then it would be my own fault for letting it happen.
70. I'm concerned about how the sexual aspects of my life appear to others.
71. It's important to me that I involve myself in sexual activity.
72. If I developed any sexual problems, my recovery would depend in large part on what I myself would do.
73. I have positive feelings about the way I approach my own sexual needs and desires.
74. The sexual aspects of my life are satisfactory, compared to most people.
75. In order to be sexually active, I have to conform to other more powerful individuals.
76. I am able to "connect" well with a sexual partner, and it's important to me that I am able to do so.
77. I don't have much fear about engaging in sex. (R)
78. I will be able to avoid any sexual problems, if I just take good care of myself.
79. I feel unhappy about my sexual experiences.
80. The main thing which affects the sexual aspects of my life is what I myself do.
81. I feel nervous when I think about the sexual aspects of my life.
82. I have the capability to take care of my own sexual needs and desires.
83. I am very aware of the sexual aspects of myself (e.g. habits, thoughts, beliefs).
84. I am really motivated to avoid any sexual activity that might expose me to sexual diseases.
85. The sexual aspects of my life are a matter of fate (destiny).
86. I think about sex the majority of the time.
87. When it comes to sex, I usually ask for what I want.
88. I anticipate that in the future the sexual aspects of my life will be frustrating. (R)
89. If something went wrong with my own sexuality, then it would be my own fault.

90. I'm aware of the public impression created by my own sexual behaviors and attitudes.
91. I strive to keep myself sexually active.
92. If I developed a sexual disorder, my recovery would depend on how I myself dealt with the problem.
93. I feel good about the way I express my own sexual needs and desires.
94. I am satisfied with the sexual aspects of my life.
95. My sexual behavior is mostly determined by people who have influence and control over me.
96. Not only am I be capable of relating to a sexual partner, but it's important to me that I relate very well.
97. I'm not afraid of becoming sexually active. (R)
98. If I just pay careful attention, I'll be able to prevent myself from having any sexual problems.
99. I feel sad when I think about my sexual experiences.
100. My sexuality is something that I myself am in charge of.

Copyright - 1995

101. I responded to the above items based on:
- | | |
|-----|----------------------------------|
| (A) | A current sexual relationship. |
| (B) | A past sexual relationship. |
| (C) | An imagined sexual relationship. |

Cognitive-Behavioral Sex Training Sessions

SESSION 1:

Purpose: Introduction

- Introduce Therapist, members of the group, group rules and regulations
- CBT
- Sexual self-concept
- Sexual satisfaction
- Sexual self-esteem
- Goals of our group therapy

Homework: study the leaflet that is written by the trainer.

SESSION 2:

Purpose: Recognition of incorrect ideas and beliefs about women's sex.

- Discuss about effects of the last session and homework
- Explain cognition and its effects on feeling
- Discuss about usual incorrect ideas and beliefs about women sex
- Related these ideas with the culture, religion, family, personality
- Exposing members' ideas and experiences, and correcting them by the collaboration of other members and trainer

Homework: Think and pay attention to themselves and other's incorrect ideas and Superstitions. Write five of them and try to recognize that.

SESSION 3:

Purpose: Educating about the anatomy and improving sexual awareness.

- Discuss about the effects of the previous session and homework
- Give information about sexual anatomy and genital and sexual dysfunction
- What is Sexual arousal and orgasm in women and men?
- Learning about contraception methods
- Look at some slides and watch some related movies

Homework: improve their awareness by looking at the mirror and touching themselves.

SESSION 4:

Purpose: Recognizing anxiety and sensorial focus.

- Discuss about effects of the previous session and homework
- Explain anxiety and focus
- Discuss about anxiety between members

- Techniques for anxiety reduction
- Discuss about focus between members
- Improving sensorial focus techniques
- Relaxation

Homework: meditation and relaxation

SESSION 5:

Purpose: Improving sexual self-esteem

- Discuss about the effects of the previous session and homework
- Explain self-esteem
- Body image
- Effects of self-esteem in life and sex
- Sexual self-esteem
- Techniques to improve sexual self-esteem

Homework: practice the improving of self-esteem and self-confidence

SESSION 6:

Purpose: Educating about relationships intimacy and communication skills

- Discuss about effect of last session and homework
- Learning variety of voice and look
- Learning about body language
- Effect of Verbal and non-verbal communication
- Expressing own emotional and wants

Homework: try to use these techniques in your life and sex.

SESSION 7:

Purpose: Educating about Fantasy and techniques for improving the quality of sex.

- Design your bedroom
- Playing role during the sex
- What does Fantasy mean?
- How to be open for talking about your Fantasies

Homework: practicing at home

SESSION 8:

Purpose: Questions and answer session

- Summary of sessions
- Emphasizing on specific parts of the sessions depending on the group's needs

-Discussion and conclusion

POST-TEST