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The Impact of Couple Therapy Based on Relationship Enrichment Approach on Couples' Intimacy and Sexual Function

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Abstract

Background: Intimacy is one of the basic and psychological needs of couples and is a motivating factor in their sexual participation.
Objectives: To determine the impact of couple therapy based on the relationship enrichment approach on the intimacy and sexual function of the couples consulting healthcare centers.
Methods: This research was a quasi-experimental study and was performed on 60 couples referring to Comprehensive Health Centers in the southeast of Iran in 2020. The research instruments included a demographic information questionnaire, three standard questionnaires of intimacy and sexual function of men and women. The educational content was implemented only for the intervention group. Data were collected at baseline, 8th week, and 12th week after the intervention. Data were analyzed using descriptive statistics and two-factor repeated measures ANOVA using SPSS (ver. 21) software.
Results: The results showed that the intervention had a significant effect on sexual function and intimacy in the intervention group in three time periods ($P < 0.001$), whereas in the control group, no significant difference was observed in the three time periods ($P > 0.05$).
Conclusions: The results showed that relationship enrichment counseling can increase intimacy and sexual function of couples.

Keywords: Enrichment of Relationships, Sexual Function, Intimacy, Couples

1. Background

Sexual function is a multidimensional phenomenon that can be influenced by various factors, including biological, psychological, and social factors (1). The importance of sexual function is so great that the World Health Organization (WHO) has recognized sexual health as the driving force of human social and intellectual aspects in the path of personality improvement (2). On the other hand, sexual dysfunction can result in personal and interpersonal dissatisfaction, which impacts the individual's health and quality of life and brings about unfavorable mental and physical consequences (3). Lack of sufficient information and education regarding sexual activities, false sexual beliefs, and incompatibility in the relationship, sexual anxieties in each of the parties, disturbed family relationships, culture, lifestyle, and having undesirable sexual experiences in the past are among the factors that might cause such dysfunction (4). Significant evidence indicates how interpersonal relationships such as intimacy and emotional attachment can act as motivating factors for engaging in sexual activities (5). Therefore, intimacy is recognized as an essential emotional need of the couples and the main reason for marital satisfaction (6). In fact, sexual satisfaction and intimacy are very strongly related to each other (7). Psychologists define intimacy as one's ability to communicate with others and express their emotions while maintaining their individuality (8) and characterize it at the level of one's intimacy with their spouse, sharing the common values and ideas, sexual relationship, understanding each other and behaviors such as caressing, satisfying need, and emotional attachment (8, 9). In other words, studies show that couples experiencing lower levels of intimacy in relationship are more likely to experience sexual dissatisfaction (10). Hence, many of the couples referring to consultants, due to their marital intimacy problems, mostly declare sexual dissatisfaction is the main reason for their problems (11), which will ultimately lead to psychological and physical complications in couples (12). Lack of the required skills for developing and maintaining

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an intimate relationship is among the reasons for the decrease in couples' intimacy and the increase in separation and divorce (13). This issue highlights the importance of the need to teach couples the skills of improving their intimacy as one of the ways to increase intimacy. The relationship enrichment approach is among the methods used for improving couples' relationships and increasing their intimacy. This method emphasizes teaching certain skills instead of treatment or problem-solving (14). The aforementioned approach aims to help couples raise awareness of themselves and their spouse, explore their spouse's emotions and thoughts, develop empathy, intimacy, develop effective communication and problem-solving skills (15). In fact, the relationship enrichment approach helps the couples get closer to one another, learn the required skills to maintain the security of their relationship, and acquire the ability to manage the relationship properly (16, 17). Despite the fact that these types of programs are effective, the important point is that since sexual issues are considered taboos in Muslim countries such as Iran and sexual affairs are not discussed with strangers, the implementation and effect of these pieces of training on significant marital-life aspects such as sexual function have not been studied thoroughly (18). As we know, patriarchy prevails in sexual matters in Iranian society, so that men blame women for most of the sexual problems, and they are not interested in obtaining information in this regard (19). On the other hand, discussing such subjects is prohibited from a socio-cultural stance, and families are not willing to discuss their sexual needs and complications in public conversations, especially in parts of the country with traditional and religious populations. Therefore, such consultations with the presence of both husband and wife can be quite impactful. It must also be mentioned that studies in the field of marital life quality and sexual satisfaction have been conducted, but the author has failed to find any studies focused on both marital intimacy and sexual function based on the relationship enrichment consultation in a traditional community.

2. Objectives

The present research aimed to determine the impact of couple therapy with a relationship enrichment approach on the intimacy and sexual function of the couples consulting healthcare centers in Zahedan.

3. Methods

The present research is a quasi-experimental study conducted on couples referring to comprehensive health centers (CHC) of Zahedan city, Iran, from September 2019 to February 2020. The study was approved by the Research Ethics Committee of Zahedan University of Medical Sciences (code number: IR.ZAUMS.REC.1398.204). Based on mean comparisons, sample size was determined to be 30 couples in each group (significance level: 0.05; power: 0.90; attrition: 0.30). The present study employed multi-stage sampling. In the first stage, Zahedan city was divided into four regions (north, south, east, and west). In the second stage, two centers were randomly selected from the north and east regions for intervention. Then, two centers were randomly selected from the west and south as controls. In the third stage, subjects were chosen according to proportional to size of the selected centers for each group using convenience sampling method. Hence, four centers (two intervention centers and two control centers) were randomly selected. Afterward, in the selected centers, the list of all couples eligible for the study was prepared, and in the next step, by convenience sampling, they were invited through phone calls to participate in the study in case of willingness. The volunteer couples then took an intimacy test as one of the admission criteria for entering the study. Couples who got an intimacy score of 132 or lower and had the other admission criteria for entering the study were registered. Randomizer software was used to choose 30 of the registered couples in intervention centers and 30 registered couples in control centers. Data collection was conducted using a questionnaire, including four parts: (1) Demographic Information Questionnaire; (2) Couple's Intimacy Questionnaire; (3) Women's Sexual Function Index Questionnaire; (4) Sexual Function Index of Men Questionnaire. Likert scale was used to score in questionnaires. Regarding the validity and credibility of the tools, it must be mentioned that all questionnaires were standard. The intimacy questionnaire was designed by Schaefer and Olson (20). It has also been confirmed in Iran by Javadivala et al. (21). Women's Sexual Function Questionnaire is also standardized by Rosen (22), which has been approved in Iran by Fakhri et al. (23). Men's sexual function questionnaire was also evaluated by Michael- ton and proved by Javadivala et al. (24). In the present study, for more assurance, reliability was re-evaluated by Cronbach's alpha. For intimacy questionnaire, 0.86, female sexual function questionnaire in different sections between 0.78 - 0.83 and for male sexual function between 0.81 - 0.86. The program was conducted in the selected centers as a seven-session training course. Each session lasted 60 minutes, and two sessions were held per week for the intervention group in the form of lectures, group discussions, and slide shows. At the end of the intervention, intimacy and sexual function questionnaires were completed for eight weeks and then 12 weeks after the intervention in both groups. To analyze the data, the chi-square test, independent *t*-test, repeated measures,

variance analysis, and multiple linear regression were conducted. Data were analyzed in SPSS version 21.

4. Results

Sixty couples (30 interventions and 30 controls) participated in the present study. The results of independent sample *t*-test and chi-square test of the couple's demographic characteristics indicated no significant difference between the two groups (Table 1). Intra-group and inter-group comparisons of couples' intimacy, as well as valuation three stages of time, were performed in between men and women in the control and intervention groups using independent *t*-test and variance analysis with repeated measures. Independent *t*-test indicated that there was no significant difference between the two group's intimacy levels before the intervention ($P > 0.05$). However, results obtained 8 and 12 weeks after the intervention indicated a significant difference between the two group's intimacy levels and two sexes ($P < 0.001$). The mean difference was 36.03 (31.57, 40.48) and 39.33 (34.66, 44) between women's intimacy score at 8 and 12 weeks after intervention in the two groups (intervention and control), respectively; and the mean difference between men's intimacy score was 33.33 (29.12, 37.54) and 40.1 3(35.33, 44.93) in intervention and control groups, respectively. Variance analysis with repeated measures over time (before the intervention, eight weeks, and 12 weeks after the intervention) indicated that time and group variables simultaneously and interactively affected the intimacy score of men and women significantly.

Additionally, results indicated a statistically significant difference between two groups ($P < 0.001$, $\eta^2 = 0.692$) and gender ($P < 0.001$, $\eta^2 = 0.091$), and the mean report results indicated the increase in the intimacy score of couples in the intervention group compared to the control group and a higher increase in intimacy in men over women.. Also, the mean difference was significant in the intervention groups ($P < 0.001$) between intimacy scores of both men and women in the three time stages, while in the control groups of women ($P = 0.67$) and men ($P = 0.90$), was not significant (Table 2). Intragroup and intergroup comparisons of female sexual function in the intervention and control groups in the three time periods before, 8, and 12 weeks after the intervention were evaluated using independent *t*-test and variance analysis with repeated measures. Independent *t*-test indicated that there was no significant difference between the total sexual function score and its domain before the intervention ($P > 0.05$). However, there was a significant difference between mean score women's sexual function 8 and 12 weeks after the intervention across all domains except lubricant ($P = 0.512$ $\eta^2 = 0.016$) and dyspareunia ($P = 0.082$, $\eta^2 = 0.083$). The total mean of women's sexual function score was -0.87 (-3.09, 1.35) before the intervention and 2.29 (0.83, 3.74), and 2.98 (1.57, 4.38) 8 and 12 weeks after the intervention, respectively, which indicates an increase in the difference between the mean scores of the two intervention and control groups. The difference was significant ($P < 0.001$) between the mean score of female sexual function and its areas except in the area of lubricant ($P = 0.056$) over the three-time periods (before, 8 - 12 weeks) in the intervention group (Table 3). Regarding male sexual function, independent *t*-test revealed that there was no significant difference ($P > 0.05$) between the total sexual function score and its domains before the intervention, while a significant difference occurred in all domains, 8 and 12 weeks after intervention ($P < 0.01$). The mean difference in men's sexual function was -2.16 (-5.52, 1.19) before the intervention and 5.13 (2.45, 7.80) and 6.60 (4.04, 9.15) 8 and 12 weeks after the intervention, which indicates an increase in the averages of both intervention and control groups. The difference was significant ($P < 0.001$) in the mean score of male sexual function in the intervention group in the three time periods, while this difference was not significant in the control group ($P > 0.05$) (Table 4). Eventually, multiple linear regression was used to study the impact of intimacy, age, occupation, number of children, educational level, and marriage duration on the sexual function of men and women. Results revealed that the two variables of intimacy ($\beta = 0.440$, $t = 3.78$, $P = 0.001$) and the number of children ($\beta = -0.306$, $t = -2.50$, $P = 0.01$) had a statistically significant impact on sexual function. According to the results, one unit of intimacy increases in women improves their sexual function by an average of 0.44. Also, adding one child to the family decreases women's sexual function by an average of 0.31. However, other independent variables were not statistically significant. Additionally, the results of fitting the multiple linear regression model in men indicated that intimacy was the only variable impacting sexual function ($\beta = 0.616$, $t = 5.12$, $P < 0.001$). In other words, one unit of increase in intimacy score in men improves their sexual function by an average of 0.62. Other variables were not statistically significant.

5. Discussion

Study findings revealed that the average intimacy score in men and women in overtime increased due to consultation, so that women indicated 78% and men indicated 80% difference in the intimacy score compared to the control group after participation in the relationship enrichment program. Besides this, Yoo et al., in their study,

Table 1. Comparison of Demographic Characteristics of the Research Groups [a]

Variables	Control	Intervention	P-value
Age (y)			
Female	29.10 ± 5.61	30.33 ± 6.28	0.43 [b]
Male	31.60 ± 5.42	32.50 ± 5.45	0.52 [b]
Duration of marriage (y)	7.68 ± 4.66	8.47 ± 4.81	0.36 [b]
Number of children	1.83 ± 1.10	2.10 ± 1.25	0.22 [b]
Home area (m^2)	109.17 ± 44.34	115.67 ± 34.90	0.37 [b]
Educational level (female)			0.47 [c]
Elementary and middle school	5 (16.7)	3 (10.0)	
High school	5 (16.7)	4 (13.3)	
Diploma	7 (23.3)	4 (13.3)	
University	13 (43.3)	19 (63.3)	
Educational level (male)			0.58 [c]
Elementary and middle school	6 (20.0)	3 (10.0)	
High school	6 (20.0)	5 (16.7)	
Diploma	4 (13.3)	7 (23.3)	
University	14 (46.7)	15 (50.0)	
Job (female)			0.19 [c]
Housewife	19 (63.3)	16 (53.3)	
Employed	11 (36.7)	14 (46.7)	
Job (male)			0.07 [c]
Unemployed	2 (6.6)	2 (6.6)	
Employed	28 (93.4)	28 (93.4)	
Ethnicity			0.08 [c]
Fars	37 (61.7)	46 (76.7)	
Others	23 (38.3)	14 (23.3)	

[a] Quantitative variables are reported as mean ± standard deviation and qualitative variables are reported as frequency (percent).
[b] Independent *t*-test.
[c] Chi-square test.

concluded that behavioral-communication couple therapy not only increases the feeling of security, support, and creating safe behaviors but also can increase intimacy and build a desirable relationship (25). Khamse et al. have also reported the use of applied intimate relationship skills to be effective in improving marital happiness (26). Masoumi et al. have also reached similar conclusions, indicating the effectiveness of relationship enrichment consultation in sexual intimacy and satisfaction (27). The results of the present study also indicated that intimacy has increased in the intervention group couples compared to control group couples in both temporal stages after the intervention. The results of the present research and similar studies indicate that couples' participation in relationship enrichment programs and improving the relationship through learning effective communicational skills will create better interaction and higher intimacy between the couples, and if both parties of a couple participate in such programs, the created interaction will lead them to better identify their behavioral and communicational challenges and eventually, find it easier to take steps toward solving their problems. Regarding women's sexual function score and its dimension, the results of the present study revealed that mean sexual function was initially 19.06 ± 3.96, which reached its highest value of 22.89 ± 1.54 three months after the intervention. However, Khaleghinezhad et al. reported the average sexual function score of rural women to be 24 ± 5 (28). Sepehrian and Hosseini (29) and Bahrami et al. (30) reported the mean sexual function of fertile women was 21.2 ± 5.6 and 27.4 ± 7.3, respectively. These differences

Table 2. Comparison of the Intimacy in the Two Groups Over Time by Gender Using Two-Factor Repeated Measures ANOVA [a]

Variables	Intervention	Control	MD [b] (95%CI)	P-Value [c]	Effect Size
Women's intimacy					0.78
Baseline	109.23 ± 11.77	113.80 ± 10.40	-4.56 (-10.30, 1.17)	0.12	
Week 8	149.63 ± 6.68	113.60 ± 10.19	36.03 (31.57, 40.48)	< 0.001	
Week 12	154.20 ± 7.97	114.86 ± 9.98	39.33 (34.66, 44.00)	< 0.001	
P-value [d]	< 0.001	0.27			
Men's intimacy					0.81
Baseline	115.46 ± 7.81	119.53 ± 8.92	-4.06 (-8.40, 0.26)	0.07	
Week 8	152.73 ± 7.58	119.40 ± 8.66	33.33 (29.12, 37.54)	< 0.001	
Week 12	158.96 ± 9.50	118.00 ± 9.06	40.13 (35.33, 44.93)	< 0.001	
P-value [d]	< 0.001	0.90			

[a] Descriptive statistics are reported as mean (SD)
[b] MD, mean difference.
[c] *t*-test with Bonferroni corrections.
[d] Two-factor repeated measures ANOVA.

indicate that sexual function is an extremely complicated phenomenon and can be affected by various factors such as living conditions, interpersonal relationships, cultural, economic, and social differences, different populations, and even the different types of questionnaires available in this field. Regarding the dimensions of sexual function, results revealed that the mean score of all dimensions of sexual function, except for vaginal lubrication and dyspareunia, increased significantly compared to before the intervention in the group under counseling. These results are consistent with previous studies (31). Both these studies indicated that sexual consultation had a positive impact on all the dimensions except for dyspareunia. However, the results of the present study were inconsistent with the results of Muhammad-Aliie study conducted in postmenopausal women that indicated dyspareunia score increased significantly after intervention too (32). However, they reported having taught how to use lubricant in their training course, and since one of the causes of dyspareunia in postmenopausal women is vaginal dryness, it might be the reason for this inconsistency. On the other hand, factors such as a variety of infections, vaginismus, and endometriosis may result in dyspareunia in fertile women, which are different from the reasons causing dyspareunia in menopausal women. On the other hand, factors such as a variety of infections, vaginismus, and endometriosis can cause dyspareunia in women of reproductive age that are different from the reasons causing dyspareunia in menopausal women. Additionally, hormonal fluctuations and anxiety can also affect vaginal lubrication (22). Results of the present study revealed that men's sexual function score and its dimensions increased significantly in three time stages in the intervention group compared to the control group. The author found no other study investigating the impact of relationship enrichment training on men's sexual function in Iran; however, there are similar foreign studies focused on men's sexual satisfaction and performance. Nelson and Kenowitz concluded that relationship enrichment interventions and intimacy have a positive impact on sexual function in men with prostate cancer (33). Walker et al. found that intimate relationship training after prostate cancer improves male sexual function, especially during orgasm. Although the effect size was reported to be small to medium, it was suggested that longer interventions might be more impactful (34). Difficulties due to sexual function in men and their intimacy are of great importance that the vast majority of men who experience sexual dysfunction will suffer more if there is a lack of intimacy between them and their partner (35). The aforementioned studies are somehow consistent with the results of the present study and confirm the influence of intimacy on improving men's sexual function even in cases who suffer from an illness. However, side-finding of the study indicated that among the five demographic variables (marriage duration, husband and wife's education, the number of children, ethnicity, and occupation) and intimacy, only intimacy affects men's sexual function, while both intimacy and the number of children affect women's sexual function. According to the results, having more children decreases women's sexual function. This finding was consistent with Afshari's study (36). Several pregnancies and their respective complications, women's unattractiveness after giving birth from their partner's point of view, taking care of the children and their respective responsi-

Table 3. Comparison of the Female Sexual Function in the Two Groups Over Time by Gender Using Two-Factor Repeated Measures ANOVA [a]

Variables	Intervention	Control	MD [b] (95%CI)	P-value [c]	Effect size
Sexual desire					0.04
Baseline	5.73 (1.36)	5.86 (1.40)	-0.13 (-0.84, 0.58)	0.71	
Week 8	7.20 (0.96)	5.76 (1.16)	1.43 (0.88, 1.98)	< 0.001	
Week 12	7.73 (0.69)	5.73 (1.28)	2 (1.46, 2.53)	< 0.001	
P-value [d]	< 0.001	0.71			
Sexual arousal					0.45
Baseline	10.90 (3.62)	12.76 (4.04)	-1.86 (-3.84, 0.11)	0.07	
Week 8	14.20 (1.95)	12.30 (3.34)	1.90 (0.70, 0.48)	0.05	
Week 12	15.23 (1.27)	12.53 (3.37)	2.70 (1.38,4.01)	0.01	
P-value [d]	< 0.001	0.42			
Vaginal lubrication					0.02
Baseline	8.96 (2.68)	10.00 (2.93)	-1.03 (-2.48, 0.42)	0.16	
Week 8	9.60 (1.40)	10.73 (2.28)	-1.13 (-2.11, -0.15)	0.10	
Week 12	10.06 (1.01)	10.56 (2.26)	-0.50 (-1.40, 0.40)	0.81	
P-value [d]	0.05	0.18			
Orgasm					0.20
Baseline	8.33 (2.17)	8.70 (2.29)	-0.36 (-1.52, 0.78)	0.53	
Week 8	9.70 (1.08)	8.70 (1.46)	1 (0.33, 1.66)	0.05	
Week 12	9.80 (1.06)	8.63 (1.62)	1.16 (0.45, 1.87)	0.01	
P-value [d]	< 0.001	0.66			
Sexual satisfaction					0.30
Baseline	10.83 (3.37)	11.20 (3.49)	-0.36 (-2.14, 1.40)	0.68	
Week 8	13.13 (1.77)	10.83 (3.48)	2.33 (0.87, 3.72)	0.02	
Week 12	13.16 (1.64)	11.00 (3.29)	2.16 (0.82, 3.51)	0.01	
P-value [d]	< 0.001	0.10			
Dyspareunia					0.08
Baseline	5 (1.14)	4.06 (1.74)	0.93 (-0.37, 2.24)	0.16	
Week 8	3.76 (1.30)	4.20 (1.56)	-0.43 (-1.17, 0.31)	0.34	
Week 12	3.36 (0.99)	4.23 (1.54)	-0.86 (-1.53, -0.19)	0.51	
P-value [d]	< 0.001	0.65			
Total sexual function					0.39
Baseline	19.06 (3.96)	19.93 (4.62)	-0.87 (-3.09, 1.35)	0.44	
Week 8	22.15 (1.91)	19.86 (3.50)	2.29 (0.83, 3.74)	0.04	
Week 12	22.89 (1.54)	19.91 (3.47)	2.98 (1.57, 4.38)	0.001	
P-value [d]	< 0.001	0.87			

[a] Descriptive statistics are reported as mean (SD).
[b] MD, mean difference.
[c] *t*-test with Bonferroni corrections.
[d] Two-factor repeated measures ANOVA.

Table 4. Comparison of the Male Sexual Function in the Two Groups Over Time by Gender Using Two-Factor Repeated Measures ANOVA [a]

Variables	Intervention	Control	MD [b] (95%CI)	P-Value [c]	Effect Size
Desire					0.10
Baseline	7.66 (1.54)	7.43 (1.92)	0.23 (-0.90, 0.90)	0.57	
Week 8	8.73 (0.86)	7.40 (1.42)	1.33 (0.71, 1.94)	0.002	
Week 12	9 (0.94)	7.63 (1.37)	1.36 (0.75, 1.97)	0.003	
P-value [d]	< 0.001	0.24			
Erection					0.40
Week 8	14.03 (1.40)	12.46 (2.30)	1.56 (0.58, 2.55)	0.02	
Week 12	14.53 (0.77)	12.46 (2.25)	2.06 (1.19, 2.93)	0.001	
P-value [d]	< 0.001	0.89			
Ejaculation					0.12
Baseline	8.93 (1.43)	9.16 (1.31)	-0.23 (-0.94, 0.47)	0.51	
Week 8	9.76 (0.50)	9.06 (1.43)	0.70 (0.14, 1.25)	0.12	
Week 12	9.93 (0.36)	8.96 (1.49)	0.96 (0.40, 1.52)	0.03	
P-value [d]	0.001	0.52			
Problem					0.24
Baseline	12.06 (2.93)	13.30 (2.23)	-1.23 (-2.58, 0.11)	0.07	
Week 8	14.50 (1.13)	13.30 (2.23)	1.20 (0.28, 2.11)	0.03	
Week 12	14.96 (0.18)	13.23 (2.31)	1.73 (0.88, 2.58)	0.001	
P-value [d]	< 0.001	0.73			
Sexual satisfaction					0.10
Baseline	4.13 (0.81)	4.26 (0.86)	-0.13 (-0.56, 0.30)	0.54	
Week 8	4.56 (0.50)	4.23 (0.81)	0.33 (-0.01, 0.68)	0.09	
Week 12	4.73 (0.44)	4.26 (0.90)	1.73 (0.86, 2.59)	0.02	
P-value [d]	< 0.001	0.84			
Total sexual function					0.47
Baseline	44.50 (6.17)	46.66 (6.79)	-2.16 (-5.52, 1.19)	0.20	
Week 8	51.60 (3.13)	46.46 (6.61)	5.13 (2.45, 7.80)	0.01	
Week 12	53.16 (1.80)	46.56 (6.75)	6.60 (4.04, 9.15)	< 0.001	
P-value [d]	< 0.001	0.76			

[a] Descriptive statistics are reported as mean (SD).
[b] MD, mean difference.
[c] *t*-test with Bonferroni corrections.
[d] Two-factor repeated measures ANOVA.

bilities, and being tired from looking after the children might be the reason for this finding. But the important finding of the study revealed that the intimacy variable in both men and women had a positive and significant relationship with improvement in sexual function. Although some studies did not report a significant relationship between intimacy and pain in the sexual function of women, couples with higher intimacy levels reported better sexual function and satisfaction (37). Rubin and Campbell also indicated that increased intimacy is associated with greater sexual satisfaction in non-clinical couples involved in a long-term relationship (38), which is also consistent with the results of the present study. Intimacy is a relationship protector and predictive factor for those suffering from sexual dysfunction since it balances some aspects of sexual function and distress. On the other hand, lower intimacy is associated with higher distress in those suffering from sexual dysfunction (39). The inability to establish

intimacy and a healthy relationship brings about many social, emotional, and physical consequences for couples. Actually, the life of most couples has turned into a static and intimacy-free relationship due to their unawareness of communicational skills and unhealthy communication style (40). Furthermore, women who lack sufficient marital intimacy will experience sexual incompatibility with their husbands and refrain from being in any position leading to sex (41). The interaction between intimacy and sexual function can play a synergetic role in improving the sexual function of the couple, which has a significant part in the continuation of marital life. One of the strengths of this study is the presence of both couples in consultation sessions. One of the limitations of this study was self-report data that cultural issues such as shyness and shame might be influential in responding to sexual issues. Moreover, intimacy is a complicated and dynamic phenomenon and cannot be simply measured and reported using a questionnaire. Development and use of more diverse measures such as conducting deeper qualitative studies might help achieve a more comprehensive image of empathetic responses and disclose further information in this regard.

5.1. Final Conclusion

The results of the present study indicate the positive impact of consultation and training programs on strengthening marital intimacy and the sexual function of couples. Therefore, it is suggested to provide a basis for the implementation of such interventions to enrich relationships, especially for couples living in areas with a certain religious and cultural context who are less supported in this field.

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Footnotes

Authors' Contribution: Study concept and design: N. NM. and S. KH. and A. N.; analysis and interpretation of data: A. P., and N. NM.; drafting of the manuscript: N. NM. and S.KH.; critical revision of the manuscript for important intellectual content: N. NM.; statistical analysis: A. P.

Conflict of Interests: there is no conflict of interest in this study.

Ethical Approval: The study was approved by the Research Ethics Committee of Zahedan University of Medical Sciences, (code number: IR.ZAUMS.REC.1398.204).

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