Original Article

Determination of the Effect of Sexual Assertiveness Training on Sexual Health in Married Women: A Randomized Clinical Trial

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Abstract

Background: Sexual health is a state of physical, mental, and social well-being in relation to sexuality. Sexual assertiveness is a person's ability to meet sexual needs. Considering limited sexual information of women and the taboo nature of talking about sexual needs, the purpose of this study is to evaluate the effectiveness of the sexual assertiveness training on sexual health. **Materials and Methods:** This randomized clinical trial assignment parallel study with a control group was performed in September and October 2016 on 60 married women referred to Imam Reza Health Center in Mashhad. The sample size was estimated to be 30 subjects per group. Instruments included demographic characteristics, sexual assertiveness, and sexual health questionnaire. The pretest was completed in two groups at the beginning of the study and post-test was done for both groups 1 week after educating the experimental group. Descriptive statistic tests included Chi-square, *t*-test, and paired *t*-test, and one-way analysis of variance. A *p* value less than 0.05 was considered to be statistically significant. **Results:** The two intervention and control groups showed no significant difference in terms of sexual health level before starting the study ($t_{58} = 0.854$, $p > 0.05$). After the study, based on the independent *t*-test, the two groups showed significant differences ($t_{58} = -4.077$, $p < 0.001$). **Conclusions:** Sexual assertiveness training can improve women's sexual health. Considering the lack of research in this area and due to the effect of mutual understanding of couples on emotional and sexual issues, further research is necessary for this field.

Keywords: *Assertiveness, Iran, sex education, sexual health*

Introduction

Sexual health includes physical, psychological, and social health related to sexual activity, not merely the absence of disease, dysfunction, or disability.[1] Some measures proposed by the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in 1995 are related to sexuality and gender relations, ensuring the access of women and men to information, education, services needed to achieve adequate sexual health, and benefiting from reproductive rights and relevant responsibilities. The main policy of the World Association of Sexual Health is focusing on sexual rights and its importance in preserving and promoting sexual health.[2,3] In 2004, the World Health Organization (WHO) suggested that sexual health is a subject independent of reproductive health that must be studied separately. The WHO also stated that many diseases and disorders in the world are caused by inattention to the issue of sexual health.[1] In many parts of the world, there is not a proper understanding of sexuality issues. Besides, taboos, misunderstandings, and cultural and social barriers in the way of educating the concepts and positive expressions of sexuality issues have led to the absence or low levels in the quality of sexual health services and related issues.[4] In Iran, many women suffer from a lack of satisfaction in sexual relations and lack of attention to their sexual desires and needs. In this regard, 50% to 60% of divorces and 40% of infidelities and hidden relationships are due to sexual dissatisfaction.[5,6] Based on the results of studies conducted in Iran on the topic of sexual health, factors such as timidity and modesty in the culture of this country are among the main obstacles to a request for advice, information, and help about sexual matters.[6,7]

Sexual assertiveness is as a subtype of sexual relationship and as a person's ability to fulfill

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sexual needs and help the conduct of sexual behavior with the spouse.[8] Despite the sexual revolution of the contemporary era, women are still the weaker gender such that it is believed that men should be the leading ones in sexual relations. Such an attitude causes the women not to able to consciously and freely talk about their mental and physical interests to their spouses and ask them to satisfy their sexual desires and needs.[9] Investigating the role of sexual assertiveness on women's sexual desire, the researchers came to the conclusion that women with a high sexual assertiveness have higher sexual activity, orgasm, sexual desire, sexual satisfaction, and marital satisfaction.[10,11] In several studies in Iran, women reported that their husbands do not understand them emotionally and sexually and do not satisfy their sexual desires.[12] Sexual problems often stem from educational deprivation and misconceptions about sexual desires and sexual relationships.[13] Sexual assertiveness training includes attitudes and practices related to the start of sexual relationship and practices relating to sex refusal and birth control. Few studies have addressed and investigated sexual assertiveness.[14,15] Researchers have examined the effect of sexual assertiveness on self-assertion, self-esteem, and satisfaction with the interpersonal relationship. The results have shown that scores of self-assertion and self-esteem are significantly higher than the satisfaction score on the interpersonal relationship.[14] Despite the impact of the results of this research, in some studies, no significant differences have been seen in sexual assertiveness training. In addition, an intervention study with the aim of sexual assertiveness training on female students showed no differences between the mean scores of the participants in the workshop on sexual assertiveness training and the control group.[16] Although our knowledge about marital sexual relationships is more than the past, we have limited views on how sexual assertiveness affects marital life and on the nature of its interaction with other marital phenomena.[14]

Despite the relatively high level of literacy in Iran, which contributes in easier teaching of the related programs, and despite successful programs such as family planning programs, national programs for youth healthy sexual and reproduction, they have not effectively covered the sexual health issues. Hence, there are some gaps in this regard in the primary health care system and the health and family planning system. Several indoor studies also underlined the urgent and growing need for such programs.[17-20] The most important contributing factors to the necessity of the sexual health education for adolescent girls are classified into five categories: lack of proper sexual knowledge and attitude, lack of education and inappropriate sources of sexual awareness, sociocultural changes, increasing sexual health problems in adolescents, and confirmative religious attitudes.[21] Another study gained significant results regarding the necessity of attitude change and lack of awareness of the women in a sample of Iranian women. Some of these results about sexual issues related are as follows: Couples do not talk about their sexual issues and there are incorrect dominance of husband in sexual relationships; sexual pleasure is all about men satisfaction and women do not have any right about it; wrong belief that there are not any relationships between love and intercourse frequency; acceptance of the wrong idea that sexual relations will become cumbersome and boring with time; and some women suggest that requesting sexual relation is an inappropriate behavior for women.[20] Currently, women have a better understanding of their rights in the sexual matters; however, there is not still enough knowledge and awareness in this area. Although information on sexual issues is not scarce, having low sexual information in relation to women, the taboo nature of talking about sexual needs, and grievances of women in society,[9] as well as the broadening of problems scope in the community and inconsistencies in the results of relevant studies have led us to conduct a study on the effect of sexual assertiveness training on sexual health of married women.

Materials and Methods

This randomized clinical trial assignment parallel study with a control group was performed in September and October 2016 on 60 married women referred to Imam Reza Health Center in Mashhad. The study (IRCT2016062628650N1) was conducted in the Clinical Trial Registration Center of Iran and approved by the Research Council Mashhad University of Medical Sciences. The sample size was estimated as 60 subjects (30 subjects per group). Using the sample size formula – with the reliability coefficient of 95% ($\alpha = 0.05$) and test power of 90% based on the results of Manavipour *et al*.[22] and the formula for comparison of means – 24 subjects per group were assigned ($\alpha = 0.05$, $Z1\text{-}\alpha/2 = 1.96$, $d = 0.6$, $\beta = 0.1$). Considering the fall of 20% per group, 30 subjects per group were estimated. In this study, 32 subjects were included in the intervention group of which two were excluded. The control group also encompassed 31 subjects that one was excluded from the study [Figure 1]. The inclusion criteria were having at least literacy to read and write, being married, not staying away from husband or the husband's bigamy, first marriage of the couples, passing at least 1 year of marriage, having sexual intercourse over the past month, nonpregnancy, no menopause, not the first year after childbirth, drug nonuse of the couple, not having medical and psychological diseases affecting sexual function, not having hormone therapy, the incidence of stressful event during the last 6 months for the couple, and not being under treatment of sexual dysfunction. On the contrary, exclusion criteria among the study were having a regular education about sexual relationships by a consultant or health personnel, having no desire to continue studying, pregnancy during the study, having no sexual relationship during the study, having a stressful event for couples during the study, participating in a course or class and receiving sexual

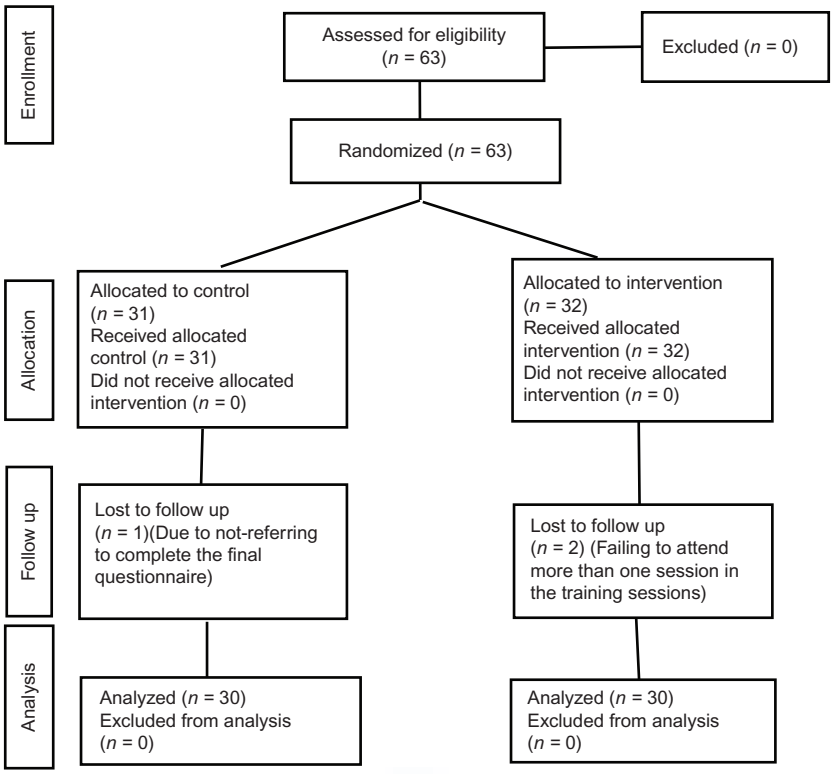

Figure 1: Consort statement

education in another way during the study, missing more than one training session and not attending the post-test.

The sampling was then performed by an available and convenient approach. First, the researcher (not blinded) used random sampling for controlling the exchange of information between the experiment and control groups at the health center. The two groups were selected in the first or last half of the week based on the coin flipping, by which the first 3 days of the week was selected for recruiting control group and the last 3 days of the week for experiment group (random allocation of the study subjects based on the weekdays).[23] At the time of recruiting participants, in both control and experiment groups, the women referring to the center for receiving health services were presented with a description about the research project and how to answer the questions. Moreover, they were assured of the confidentiality of the information. Then, the written consent to participate in the study was signed by subjects and the participant recruiting checklist was completed by the means of the interview and considering the participation criterions. Afterward, the study participants completed demographic characteristics form, the Hulbert sexual assertiveness questionnaire,[24] and sexual health questionnaire.[22] The experiment group was divided into two equal subgroups due to limited teaching space and for better teaching. As a result, 16 participants were taught in every teaching session a day. The training classes were held once a week for 2 consecutive weeks. Researchers studied the effects of developing sexual assertiveness of the high school girls on their sexual sufficiency throughout comparing a 3 h educational program with a 6 h one. They found that 3 h sex education has the same and even slightly higher effects on the girl's sexual sufficiency than 6 h teaching program.[25] The lessons were presented in two 90 min sessions by lecture and PowerPoint presentations. In the first teaching class, the purpose of the training, lesson plans, and learning objectives were explained. Next, questions and answers were done on women's awareness of their general sexual and emotional issues, their sexual rights, and its effect on couples' satisfaction. The content of the first session includes explanation about the necessity of marriage, family peace and comfort, family stability and factors affecting it, family stability from the perspective of the Qur'an, and the traditions of the infallible, the definition of the healthy sexual relationship and its requirements, the benefits of sexual relations for the couples, sexual relation from the Qur'an and infallible traditions' perspective, characteristics of sexual function and sexual reaction cycle in men and women, how to fulfill sexual needs of men and women, couples' rights, consequences of neglecting partner's rights especially women, and divorce and its sexual reasons. A week later, in the second session, the definition of sexual assertiveness, couple's sexual rights, Islamic views on the women's sexual rights, difference of spouses, the effects of women's sexual assertiveness on marital life, and application of sexual assertiveness were presented. This training package was prepared under the supervision of religion and spiritual professor, using related articles and resources, and the views of the experts in the subject. After the second session, the

contents were provided to the experimental group as a booklet for study at home. The control group did not receive any intervention. One week after completing the training, the intervention and control groups were asked to visit the center and complete the Hulbert sexual assertiveness and sexual health questionnaire. Eventually, any question or issue of both groups was answered according to the subject of the study. Hulbert index of sexual assertiveness (HISA) questionnaire includes 25 questions in which the five-item Likert scale is used to choose the options. Scoring of each question given the option of choice is from "Always (0)" to "Never (4)". Questions 3, 4, 5, 7, 12, 15, 16, 17, 18, 21, 22, and 23 are scored in reverse (Always = 4; Never = 0). The test scores range from 0 to 100, with a higher score indicating a high sexual assertiveness. The sexual assertiveness questionnaire has been validated in a study by Hulbert David Farley.[24] In Iran, the questionnaire was validated by Bay to have structured content validity with the internal consistency of 0.91.[26] In conducting the HISA by David Farley Hulbert, the Cronbach's alpha coefficient was obtained as $\alpha = 0.86$. In its implementation by Shafiee, the Cronbach's alpha coefficient was obtained as $\alpha = 0.92$.[27] Reliability of this scale was computed to be $\alpha = 0.84$ in the current study. Sexual Health Questionnaire was prepared by Manavipour *et al*. to measure sexual health.[22] The questionnaire has 33 questions. The scoring of this questionnaire is done by a three-item Likert scale from 1 to 3, referring to answers as follows: "I Disagree":1, "I do not know": 2, and "I Agree": 3. The scope of scores ranges from 33 to 99, where high scores indicate higher levels of sexual health. The results of psychometric analyses conducted on sexual health questionnaire suggest that this questionnaire with 33 questions has internal validity of more than 92%. The reliability of this tool was calculated by Manavipour *et al*. as $\alpha = 0.82$.[22] The reliability of this scale in the current study was $\alpha = 0.81$.

The outcome measure of this study was sexual health and confounding variables that could not be deleted or have little effects on the study results. So, they were considered and monitored in the data collection tool, which includes following quantitative and qualitative variables: (1) quantitative variables including wife age, husband age, duration of marriage, duration of infertility, number of abortions and dead child, number of children, number of deliveries, etc. and (2) qualitative variables including residence and housing status, living with people other than the spouse and children in one place, history of infertility, history of abortion, and giving birth to a dead or defective child, the type of deliveries, type of contraceptive used, watching pornographic films and images, various types of sexual intercourse, the dominant sexual intercourse method, the frequency of intercourse per week, and so on.

The data were analyzed using SPSS software Statistics (SPSS, Version 11.5, and SPSS Inc. Chicago, IL, USA). The descriptive statistics methods including frequency table, mean, and standard deviation were used to evaluate the subjects' characteristics. The Chi-square test was applied to compare groups in terms of qualitative variables, while the independent *t*-test and paired *t*-test were used for quantitative variables. Finally, the one-way analysis of variance (ANOVA) was used to control the effects of confounding variables. The *p* value of less than 0.05 was considered as statistically significant.

Ethical considerations

The sampling was started once the approval for the study was obtained by the disciplinary committee of Mashhad University with Code IR.MUMS.REC.1395.284 on Sunday, August 28, 2016. After reviewing the proposal by the Ethics Committee, the objectives of the study were described to the participants and written consent was given.

Results

The mean (SD) age in the intervention and control groups was 30.65) 7.75) and 30.40 (8.20) years, respectively. There was no statistically significant difference between the two groups in terms of age ($p > 0.05$) and two groups where homological. Also, there were no significant differences between other demographic characteristics of the study subject's two groups [Table 1]. To control the confounding variables, the results of one-way ANOVA showed no significant difference individual between two groups ($p > 0.05$; [Table 2]).

The two intervention and control groups showed no significant difference in terms of sexual health level before starting the study ($t_{58} = 0.854$, $p = 0.39$), and both groups were matched in terms of sexual health at the baseline. After the study, the mean score for sexual health in the intervention group was as 100.00 (8.13) and as 91.25 (8.50) in the control group. Based on the independent *t*-test, the two groups showed significant statistical differences ($t_{58} = -4.077$, $p < 0.001$) [Table 3]. The study findings showed a significant increase in the sexual assertiveness score of the experimental group than the control group. Based on the independent *t*-test, there was a significant difference between pre- and post-teaching sexual assertiveness scores of the experiment group ($t_{58} = -3.90$, $p < 0.001$); however, it was not significant in the control group. The study results revealed that sexual assertiveness teaching led to an increase in the sexual health of the participants [Table 3].

Discussion

This study was conducted to evaluate the impact of sexual assertiveness training on the sexual health of married women. Based on the obtained results, acquiring sexual assertiveness skills is an effective contributing factor with women sexual health. In another study, the effect of sexual assertiveness education was investigated on self-expression,

Table 1: Frequency distribution of some demographic characteristics of the study subjects

Variable	Intervention group *n* (%)	Control group (*n* %)	χ^2	*p*
Educational level				
Primary reading and writing	10 (33.35)	11 (36.70)	2.14	0.571*
Secondary	14 (46.65)	14 (46.65)		
Higher education	6 (20.05)	5 (16.70)		
Spouse educational level				
Primary reading and writing	13 (43.35)	18 (60.00)	2.10	0.536*
Secondary	11 (36.70)	9 (30.00)		
Higher education	6 (20.00)	3 (10.00)		
Household income levels				
Lower-than-enough	13 (43.40)	12 (40.00)	Exact x^2=0.70	1.000*
Enough	16 (53.35)	17 (56.65)		
More than enough	1 (3.25)	1 (3.40)		
Have a separate bedroom				
Yes	20 (66.70)	16 (53.40)	1.11	0.431*
No	10 (33.35)	14 (46.65)		
Occupation				
Housewife	24 (80.00)	22 (73.35)	2.53	0.614*
Employed	6 (20.00)	8 (26.70)		
Husband's occupation				
Unemployed	2 (6.80)	3 (10.00)	Exact x^2=2.36	0.852*
Employee	5 (16.65)	3 (10.00)		
Self-employed	23 (76.65)	24 (80.00)		

*Chi-square test

Table 2: One-way ANOVA to control of some confounding variables

Some confounding variables		Sum of Squares	Mean Square	*F*	df	*p*
Educational level	Between Groups	80.30	26.80	0.80	3	
	Within Groups	1858.60	33.20		56	0.491
	Total	1938.90			59	
Spouse educational level	Between Groups	106.40	35.50	1.08	3	
	Within Groups	1832.50	32.75		56	0.364
	Total	1938.90			59	
Household income levels	Between Groups	24.40	12.20	0.40	2	
	Within Groups	1914.50	33.60		57	0.690
	Total	1938.90			59	
Have a separate bedroom	Between Groups	27.25	57.20	0.80	1	
	Within Groups	1911.70	32.10		58	0.365
	Total	1938.90			59	
Occupation	Between Groups	70.20	23.40	0.70	3	
	Within Groups	1868.70	33.40		56	0.551
	Total	1938.90			59	
Husband's occupation	Between Groups	217.40	54.35	1.73	4	0.157
	Within Groups	1721.50	31.30		55	
	Total	1938.90			59	

self-esteem, and satisfaction with interpersonal relations. They found that acquiring sexual assertiveness skills is an effective contributing factor to women self-expression and self-esteem.[14] Elsewhere, it was found that sexual assertiveness training mediated the association between women's perceived facilitative partner responses and women's sexual function. The perception by the woman that her partner is motivated to find strategies regarding the adaptation of their sexuality to the pain may give rise to a more harmonious and a secure climate for her to discuss

Table 3: The mean and standard deviation of sexual health and sexual assertiveness in intervention and control groups before and after the study

Variable	Group (Mean(SD))		Independent *t*-test		*p*
	Intervention	Control	*t*	df	
Sexual health before the study	74.20 (6.10)	72.90 (5.40)	0.854	58	0.397
Sexual health after the study	100.00 (8.15)	91.25 (8.55)	−4.077	58	<0.001
Paired t-test	*t*=−13.95	*t*=−16.55			
	df=29	df=29			
	p<0.001	*p*<0.001			
Sexual assertiveness before the study	55.15 (15.75)	52.25 (17.65)	−0.70	58	0.50
Sexual assertiveness after the study	64.10 (11.95)	49.50 (16.75)	−3.90	58	<0.001
Paired *t*-test	*t*=-4.80	*t*=2.55			
	df=29	df=29			
	p<0.001	*p*=0.17			

sexual needs. This communication might facilitate the experience of desire and arousal, as two components of sexual function.[28]

In addition, our results showed that sexual assertiveness education affects women sexual health and increases their sexual assertiveness. This result is consistent with results of a study on the effect of education on saying no to reasonable and unreasonable sexual demands without feeling guilty, identifying and requesting sexual intercourse according to their own sexual satisfaction, initiatives in the sexual life, the use of arbitrary sexual words, etc. The results of this study showed that sexual assertiveness education can lead to the tendency of women to have more sexual relations with sexual partners. Moreover, given the key role of sexual relations in marital life, sexual assertiveness education classes can have a significant role in marital and sexual satisfaction.[29] According to our results, sexual assertiveness teaching is a process through which individuals acquire the knowledge and skills necessary for sexual assertiveness form their own attitudes, beliefs, and values and finally have a positive effect on their sexual health. Sexual assertiveness training is related to the cognitive domain (i.e., information and knowledge), emotional domain (i.e., feelings, values, and attitudes), and also behavioral domain (i.e., communication skills and decision-making). In fact, this concept involves attitudes and practices related to the initiation of sexual intercourse and sexual refusal and contraceptive methods. Sexual assertiveness training begins with knowing what sexual behavior is appropriate or not. In addition, it is a complex skill that is mainly achieved through appropriate training and will be developed with more rigorous practice.[6,29] However, a small number of studies have investigated and explored the effects of teaching sexual assertiveness.[8] The findings of the present study were consistent with other works. For instance, in one study, the effectiveness of sexual assertiveness training on decreasing verbal victimization can be explained by the fact that sexual assertiveness approach could improve individuals' knowledge, beliefs, self-esteem, self-efficacy, and assertiveness.[30] Moreover, it can be stated that assertiveness training is appropriate as a treatment approach for people who have difficulties in interpersonal situations. Studies have demonstrated that assertiveness training can enhance social communication of adolescents. An assertive individual can develop close communications with others and release him/her from others' misuse. In comparison, an individual who lacks decisiveness believes that he/she cannot deal with others' misuse.[31]

As mentioned earlier, sexual assertiveness plays a role in the sexual health of the participants of the current study. However, in developing sexual assertiveness program and its effects on the sexual health and fertility, it is necessary to pay attention to the specific cultural and religious aspects as well as the rules and norms and values governing society and family. One important issue in this regard is that women have a set of ways to control their sexual situations and predict their consequences. Of the strengths of this study were the use of sexual assertiveness training in this country, despite cultural taboos and barriers in relation to sexual matters, and also spreading the sexual education topics. Generally, similar studies are one of the factors that can help the researchers to compare their results. However, as this study is new, lack of sufficient background for this comparison is one of its limitations and too, in this study, the sexual health score of the control group increased at the end of the study. This shortcoming can be attributed to limitations for precise control of the study subjects from acquiring insights from other sources and media after completing the pretest and during the study. Another limitation of the study was the taboo of talking about sexual issues, through which, culture, shame, and decency expectations prevent study subjects from normal behavior.

Conclusion

According to the study results, sexual assertiveness training has increased the sexual health of married women. Since the acquisition of such skills can affect women's sexual health, paying attention to sexual assertiveness education

not only affects every person's health but also affects the whole society health. Therefore, we recommended applying sexual assertiveness training as a subset of sex education that affects the sexual issues of the people. Health care manager and policymakers can use these results for providing prerequisites of the sexual assertiveness training in the health care centers in an attempt to improve the sexual health of women.

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Conflicts of interest

Nothing to declare.

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