Sexuality Research and Social Policy
https://doi.org/10.1007/s13178-025-01089-5

Online Sex Education Based on the Good Enough Sex Model on Newlywed Couples: A Protocol for Randomized Controlled Clinical Trial Comparing Male Partner Involvement

Rezvan Zarei[1] · Elnaz Khayer[1] · Marie-Pier Vaillancourt-Morel[2] · Mozhgan Hashemzadeh[1] · Farnaz Farnam[1]

Accepted: 13 January 2025

Abstract

Introduction Despite the importance of male involvement in sex education sessions, mens' participation is often limited. The purpose of this study is to examine the impact of the spouse's presence in online group sex education based on the Good Enough Sex model.

Methods This study randomized controlled clinical trial will be conducted in 2024 on 104 couples who have been married between 1 and 5 years. The participants are randomized to one of two intervention groups. In Group A, women attend all four sessions individually, while in Group B, women participate in two sessions alone and two sessions with their husbands. Both groups receive online group sex education based on the GES model in 4 weekly 90-min sessions.

Results Primary outcomes include sexual satisfaction, function, sexual communication, distress, and frequency of sexual intercourse. Secondary outcomes include pornography use, problematic pornography use, extramarital affairs, and frequency of masturbation. Three months after the intervention, men and women of both groups will complete the questionnaires.

Conclusion Does the presence of men in sex education classes have an effective impact on couples' sexual health.

Policy Implications Suppose the results show that mens' presence in counseling sessions effectively improves couples' sex lives. In that case, strategies should address barriers preventing men from attending counseling and sex education. If the difference between the two groups is not significant, it indicates the impact of womens' participation in sex counseling sessions alone, and appropriate policies should increase women's access to comprehensive sexual health education even in the absence of men.

Trial Registration IRCT20120609009975N11, registered at 2023–12-26.

Keywords Health policy · Sexual health · Sexual satisfaction · Sexual function · Pornography · Iran

Introduction

Sexual health encompasses physical, emotional, mental, and social well-being, which are crucial for relationship satisfaction (World Health Organization, 2006), and is pivotal for individual health, family cohesion, and societal wellness (Flynn et al., 2016). Sexual health entails engaging in safe, consensual sexual activity, free from shame or coercion, and emphasizing pleasure, fulfillment, and satisfaction (Edwards & Coleman, 2004).

Satisfaction of sexual life can be influenced by personal, interpersonal, and sociocultural factors (del Mar Sánchez-Fuentes et al., 2014). One of the important sociocultural factors is having sufficient sexual awareness (Noruzi et al., 2019). This knowledge not only includes the sexual response cycle and sexual differences in men and women but also

✉ Farnaz Farnam
Fz.farnam@gmail.com; f-farnam@sina.tums.ac.ir

Rezvan Zarei
Zareirezvan794@gmail.com

Elnaz Khayer
elnazkhayer@gmail.com

Marie-Pier Vaillancourt-Morel
Marie-Pier.Vaillancourt-Morel@uqtr.ca

Mozhgan Hashemzadeh
hashemzade.mozhgan@gmail.com

[1] Department of Reproductive Health & Midwifery, Tehran University of Medical Sciences, Tehran, Iran

[2] Psychology Department, Université du Québec À Trois-Rivières, Québec, Canada

Published online: 29 January 2025

should emphasize healthy sexual behaviors, intimacy, and sexual communication (Farnam et al., 2008).

Despite the importance of sexual awareness, in Iran, like many other Asian and Muslim countries, sex education is not formally included in the curricula of schools and universities, mainly due to the prohibition of premarital sex (Alavi-Arjas et al., 2018; Farahi et al., 2024). Based on religion and law, the first sexual intercourse must occur after marriage. Even for couples on the verge of marriage, the only formal sex education is a 1-h course for obtaining a marriage license, which is certainly not enough to address the issues young people face in today's complex sex life (Alavi-Arjas et al., 2018; Farnam et al., 2008). Meanwhile, success in the first sexual relations for many newlyweds is associated with a lot of stress and fear, which is caused by many misconceptions in this field. This pressure may lead couples to engage in sexual relations as a duty rather than enjoy which can cause sexual distress, dysfunction, and dissatisfaction in couples (Mohammadzadeh et al., 2022). Meanwhile, with internet penetration, western sexual scripts which are advertised vastly on social media have found a crucial role in forming the sexual behaviors of Iranian youth. In this situation, a dearth of official programs may lead the couple to seek sexual information from online sources such as pornography (Pouralijan et al., 2024), which in the absence of pornography literacy could lead to unrealistic expectations and an inability to differentiate between fact and fiction (Dawson et al., 2020). It seems that without awareness of the strengths and limitations of sexual online sources, couple conflict and problematic behaviors such as extramarital affairs can arise (Webster, 2022), especially in a conservative context. In Iran, in 2021, there were 32.9 divorces for every 100 registered marriages (Iranopendata, 2021). Despite tremendous research in the sexuality field, we have not conducted a national study about the prevalence of sexual dissatisfaction. The results of a systematic review in 2016 with a wide range of dissatisfaction between 2.4 and 78.5% can be evidence of this claim (Nasehi et al., 2017). According to the results of a systematic review in Iran, in all of the reviewed articles, sexual problems and dissatisfaction were among the effective factors in the occurrence or request of a formal divorce or an emotional divorce (Daneshfar & Keramat, 2023). So providing sex programs in the early years of marriage—when couples may face various challenges due to a lack of experience and knowledge—can be effective in promoting their sexual health, since early sexual experiences significantly impact future sexual and overall relationships (Bokaie et al., 2021).

One of the effective sex education models is the Good Enough Sex (GES) developed by McCarthy and Metz in 2007 (Metz & McCarthy, 2007) (Table 1). This model focuses on sexual communication and intimacy and emphasizes that sexual satisfaction and "good enough" sex are more important than achieving perfection, aiming to counter the unrealistic standards often propagated by the media (McCarthy & Wald, 2015). The GES model can be particularly relevant in Iranian society where cultural norms frequently prioritize male desires, leading women to feel they are not entitled to sexual fulfillment, while open discussions about sexuality are limited (Mohammadzadeh et al., 2023). Additionally, this model can help create more balanced sexual expectations and overcome media-driven sexual perfectionism. This model has been implemented in previous studies in Iran in women with breast cancer (Barjasteh et al., 2024) and sexual desire disorders (Farahi et al., 2024). However, the efficacy of the model in healthy couples remain unclear.

Despite the importance of sex life for youth, studies show that men often participate less in sex education due to factors such as long working hours, feelings of shame,

Table 1 Dimensions of the "Good Enough Sex" model

1	Sex is a good element in life, an invaluable part of an individual's and couple's long-term comfort, intimacy, pleasure, and confidence
2	Relationship and sexual satisfaction are the ultimate developmental focus and are essentially intertwined. The couple is an "intimate team"
3	Realistic, age-appropriate sexual expectations are essential for sexual satisfaction
4	Good physical health and healthy behavioral habits are vital for sexual health. Individuals value their and their partner's sexual body
5	Relaxation is the foundation for pleasure and function
6	Pleasure is as important as function
7	Valuing variable, flexible sexual experiences (the "85 percent approach") and abandoning the "need" for perfect performance inoculates the couple against sexual dysfunction by overcoming performance pressure, fears of failure, and rejection
8	The five purposes for sex are integrated into the couple's sexual relationship
9	Integrate and flexibly use the three sexual arousal styles
10	Gender differences are respectfully valued and similarities are mutually accepted
11	Sex is integrated into real life and real life is integrated into sex. Sexuality is developing, growing, and evolving throughout life
12	Sexuality is personalized: Sex can be playful, spiritual, "special"

McCarthy BW, Metz ME. The "good−enough sex" model: A case illustration. Sexual and Relationship Therapy (2008); 23(3):227–34. https://doi.org/10.1080/14681990802165919

and skepticism about the effectiveness of treatment (Hirst & Watson, 1997). This lack of involvement can lead to disappointment for women seeking help alone, compounded by the fact that many counselors may not prioritize treatment for women, doubting its effectiveness. In conservative societies like Iran, the lack of male participation may be exacerbated by prevailing cultural norms. These norms often discourage open dialogue about sexuality, leading to a reluctance among men to engage in such topics (Farahi et al., 2024).

Given the significance of sexual life for young people, the necessity of sex education during the early years of marriage, and the positive outcomes associated with the GES model in prior researches, this study aims to assess the model's impact on the general population. By evaluating the impact of men's participation, this study seeks to guide policymakers and planners in developing effective sex counseling strategies tailored to the needs of couples.

Aims

Primary Objectives The primary objective of this study is to compare the effect of the online sex education program on sexual satisfaction, function, distress, communication, and intercourse frequency according to the presence or absence of the male partner between the two groups.

Secondary Objectives The secondary objectives include pornography use, problematic pornography use, extramarital affairs, and frequency of masturbation according to the presence or absence of the male partner between the two groups.

Outcome Measurements

In addition to demographic and sexual information, this study evaluates 5 primary and 4 secondary variables.

Demographic and Sexual Information

The questionnaire consists of 8 items, divided into demographic and sexual information sections. Demographic items cover age; marriage duration; years of education; employment status (unemployed, full-time, or part-time); economic status (pleasant, middle range, or unpleasant); and number of children. Sexual information includes the history of sexual abuse in childhood or adulthood causing significant distress (none, yes under 14 years old, yes over 14 years old), and concerns regarding fertility or pregnancy during sex (yes, no).

Primary Outcome Measurements

Sexual Satisfaction Sexual satisfaction will be assessed using the Global Measure of Sexual Satisfaction (GMSEX), a 5-item tool on a 7-point Likert scale. The total score will range from 5 to 35, with higher scores indicating greater satisfaction (Lawrance et al., 1998). Validity and reliability have been confirmed in diverse studies, including the Iranian version (Alidoost et al., 2022).

Sexual Function The 5-item Arizona Sexual Experience Scale will be utilized to evaluate sexual function issues in both women and men. This scale measures sexual desire, excitement, erection or lubrication, ability to achieve orgasm, and orgasm satisfaction. Responses are recorded on a 6-point Likert scale, ranging from 1 (extremely easily) to 6 (never each). Scores on the scale range from 5 to 30, with higher scores indicating greater sexual problems, and scores above 18 suggesting sexual dysfunction. The scale has demonstrated validity and reliability in previous studies (McGahuey et al., 2000) including validation in the Iranian population (Pezeshki & Bayrami, 2005). Additionally, female participants will be assessed for pain during sexual intercourse using a single question: "Do you have pain during intercourse?" with responses on a 5-point Likert scale, ranging from 1 (never) to 5 (always). Higher scores indicate more significant sexual pain.

Sexual Distress Sexual distress will be evaluated using a 3-item version of the Female Sexual Distress Scale (FSDS), adapted for use in both women and men (Derogatis et al., 2002). Each item will be rated on a 5-point Likert scale (0 to 4), resulting in a total score ranging from 0 to 12, with higher scores indicating greater distress. Validity and reliability ($\alpha = 0.88$ for women and $\alpha = 0.87$ for men) have been established, with confirmation in the Iranian sample (Azimi Nekoo et al., 2014).

Sexual Communication The Dyadic Sexual Communication Scale (DSCS) will gauge participants' perceptions of sexual communication within their relationships. This 13-item scale is rated on a 6-point Likert-type scale (1 = strongly disagree, 6 = strongly agree) for each item, with a total score ranging from 13 to 78. Higher scores indicate a higher quality of sexual relationship (Catania, 2013). The reliability of the Persian version of the DSCS was found to be adequate ($\alpha = 0.90$) (Alizadeh et al., 2020).

Sexual Intercourse Frequency Sexual behaviors extend beyond intercourse, but as it is commonly perceived as a key aspect, we will include it. Sexual intercourse frequency will be evaluated with a single question: "In the last months,

how often have you engaged in intercourse (vaginal, oral, or anal)?".

Secondary Outcome Measurements, Pornography Use The study defines pornography as "viewing sexual content that elicits sexual arousal and thoughts, including explicit depictions of genital-related activities like vaginal, anal, oral intercourse, and masturbation." To assess pornography usage, a single item was created: "In the last 3 months, have you watched any pornography content?" Response options include yes/no/I prefer not to answer. If answered Yes, additional questions will gauge the frequency of pornography use.

Problematic Pornography Use (PPU) Participants who answered "yes" to the pornography use question will be assessed for PPU. Using a single item, participants will be asked: "Do you feel that you are dependent and addicted to watching pornography and feel the need to watch more and more porn to be satisfied?" Responses will be rated on a seven-point Likert scale, ranging from 1 (never) to 7 (always).

Extramarital Affair Extramarital sexual relationships will be evaluated using a single question: "During the last 3 months, have you engaged in sexual activity with someone other than your spouse/partner? (Yes/no/I prefer not to answer)." If the response is yes, participants will be asked to specify the number of individuals involved.

Masturbation Frequency While masturbation is deemed normal in the realm of sexuality, it faces religious prohibition within Iranian culture. Masturbation, or self-pleasure, involves engaging in sexual activity alone for personal gratification. Masturbation frequency will be gauged with a single question: "Have you engaged in masturbation (self-pleasure) in the past month? (Yes/no/I prefer not to answer)." If the response is affirmative, participants will be asked to specify the frequency.

Methods

Design

A multicenter randomized controlled trial with 1:1 group allocation and blinding of the data analyst will take place in Tehran, Iran, from 2024 to 2025. The study adheres to the Declaration of Helsinki and has received ethical approval from the Ethics Committee of Tehtan University of Medical Sciences (approval number IR.TUMS.FNM.REC.1402.182).

Sampling

The research will take place in Tehran, specifically in health centers affiliated with Tehran University of Medical Sciences, totaling 92 centers serving a population of over 2 million. These centers are part of a National Integrated Health System, recording health information for the covered population. Four centers will be selected for sampling, each serving an equal population.

Procedure

Healthcare centers will be categorized into four geographical zones, with one center randomly selected from each zone. Thus, four centers will be chosen from the total of 92. Within each center, systematic random sampling will be employed. Initially, couples married for 1 to 5 years will be identified from the NIH database. A random number between 1 and 10 will be selected via lottery to choose the first participant, followed by sampling at regular intervals (e.g., every Kth couple) until the desired sample size is reached. This process will yield 26 couples from each center, totaling 104 couples. Participants will be contacted by phone, informed about the study objectives, and assured of data confidentiality. Those meeting the inclusion criteria will be provided with an informed consent form and online questionnaires via a secure web-based server named "Porse Line." Questionnaires will take approximately 10–15 min to complete. While only women in group A will undergo intervention, both partners will be assessed before and 3 months after the intervention.

Participants, Inclusion Criteria Being married for 1–5 years, with the husband present at home for at least 2 weeks per month. Participants must be capable of using smart devices, aged 18–49, and not pregnant or breastfeeding. Additionally, they should not have received sexual education in the last 6 months, be free from medications impacting sexual activity, and report no sexual or chronic illnesses affecting sexual function. Emotional stability, absence of drug addiction, ongoing emotional crises, and willingness of men to participate in meetings are also required. We will be asking these questions during the sampling of couples, and the information will be self-reported. For assessing emotional stability, we will ask: "Have you seriously considered or filed for divorce in the past year?" To evaluate the absence of drug addiction, we will inquire: "Have you used any drugs or stimulants in the past year?" For identifying ongoing emotional crises, we will ask: "Have you experienced any major problems, such as the loss of a child or serious emotional issues, in the past 6 months?

Exclusion Criteria Missing more than one session or withdrawing from participation, as well as becoming pregnant during the intervention or follow-up period.

Randomization

RZ, a member of the research team, will compile a list of 104 eligible couples. FF, the research supervisor, will allocate subjects to intervention groups A (women only) and B (couples) using computerized randomization via https://www.sealedenvelope.com. The assignment will be sealed and handed over to RZ. RZ will then divide the participants into their respective groups. Interventions for both groups will be administered uniformly by FF and RZ. Data analysis will be conducted by an individual external to the research team, ensuring blinding during this phase of the study.

Sample Size

The sample of this study was based on (Farahi et al., 2024) RCT which assessed the sexual satisfaction of participants after intervention based on the GES model. To avoid inflation, type 1 error, we use the Bonferroni adjusted test. According to research five primary dependent variables, we set the significant level at 0.01 Using the following formula and considering the 80% power and 10% dropout possibility, the sample size was 52 couples in each group and a total of 104 couples (Farahi et al., 2024).

Intervention

After the pre-test, both groups will receive training based on the concepts of the GES model (Table 1) will be provided by the corresponding author, a professor at Tehran University of Medical Sciences, an expert in the sexual health field. The educational content for the intervention is organized into four sessions: the first meeting covers reproductive anatomy, fertility, and reproductive health; the second session focuses on the sexual response cycle, sexual satisfaction, communication, and gender differences; the third part addresses managing differences and realistic expectations; and the fourth session explores topics of sexual desire and orgasm. This curriculum has been previously validated and utilized in the Iranian population (Farahi et al., 2024) (Table 2). Although the pre-and post-tests will be obtained from both men and women in two groups, the intervention for Group A will involve only women ($n=52$ women) in all four sessions. In contrast, in Group B, two sessions are present for women and two will include both men and women ($n=52$ couples). The sessions last 90 min and are presented weekly via online education in a web-based platform titled "Sky Room." Participants remain anonymous during the training sessions as they enter the platform only with their code and without any identifiable information. All meetings will be camera-free to ensure privacy, allowing for open discussions of sensitive sexual issues. At the end of each session, practical exercises will be provided, and participants will receive feedback via

Table 2 Content of training sessions

First session	The goals of consultation and familiarization with the GES model, an introduction to the anatomy and physiology of the female and male reproductive system, an explanation of men and women, an explanation of the first three dimensions of the GES model, teaching communication skills and creating and maintaining intimacy (dialogue training, empathetic listening and sharing feelings with each other), emphasizing on maintaining intimacy in the non-sexual aspect of life, correcting misconceptions and superstitions about sex, emphasizing having realistic expectations in accordance with the conditions in sex, defining sexual identity and how to achieve it, exercises of the first session (mirror technique)/noting wrong ideas and thoughts on paper
Second session	An overview of the first session, explanation of the four, five, and six dimensions of the GES model, explanation of a healthy lifestyle (proper nutrition/exercise/sufficient sleep, etc.), the method of institutionalizing it and its role in sexual life, the definition of sexual self-disclosure and How to achieve it, the definition of sexual desire and the factors affecting it, the importance of the role of peace and relaxation in sexual relations and the way to achieve it, the exercises of the second session (preparing a list of interests, desires and red lines in sexual relations and (sharing it with a partner)/practicing sensate focus/preparing a conversation in the presence of respect in order to express a difference or sexual preference/advising to do yoga, listening to silent music, mental imagery, doing a favorite hobby) in a week to relax
Third session	Explanation of the seven/eight/nine/ten dimensions of the GES model, counseling to overcome sexual fears and concerns, training to have flexible sexual experiences, avoiding idealism in sexual relations, setting goals in sexual relations, and familiarity with sexual stimulation styles, training to enjoy each other (sensual training, benefiting from sexual fantasies and fantasies), emphasizing the importance of diversity in the environment of having sex (variety of clothes, bedding, bedroom, etc.) Identifying the five principles in sexual relations (producing like, reducing sexual anxiety and tension, sexual pleasure, self-confidence and self-esteem, intimacy, and relationship satisfaction), the exercises of the third session (designing a sexual relationship based on desires and preferences) sex/acting out sexual fantasy if possible/schedule technique
Fourth session	Brief review of the first three sessions, explanation of the eleventh, twelve, and thirteenth dimensions of the GES model (cycle of sexuality and its differences and similarities in men and women, personalization of sexuality). Giving a special nature to sex, such as petting or giving nicknames to irritating parts of the body

(Farahi Z, Hashem Zadeh M, Farnam F. Sexual counselling for female sexual interest/arousal disorders: a randomized controlled trial based on the "Good Enough Sex" model. J Sex Med.2024)

WhatsApp. Weekly follow-ups will be conducted via telephone, with additional support available through WhatsApp for any questions or concerns.

Statistical Methods

The analysis will entail comparing results within the entire sample pre- and post-intervention, as well as between intervention groups A and B. SPSS 26 will be used for data analysis, employing descriptive statistics such as mean, standard deviation, frequency, and percentage for data depiction. The Independent *t*-test will be utilized to compare quantitative variables between groups, while the Paired *t*-test will assess changes in quantitative variables pre- and post-intervention. Chi-square analysis will be employed for qualitative variables such as demographics, pornography use, and extramarital affairs. Additionally, repeated measure ANOVA will examine the effects of time (pre = 0, post = 1; intragroup variable), group (0 = group 1, 1 = group 2; intergroup variable), and their interaction on all continuous primary and secondary scales.

Policy Implications

If the results show that mens' participation in counseling sessions is effective in improving couples' sex lives, then strategies should be developed to address the barriers preventing men from participating in counseling and sex education sessions. If the difference between the two groups is not significant, it suggests that womens' participation in sex counseling sessions is effective on its own, and appropriate policies should be implemented to increase womens' access to comprehensive sexual health education, even in the absence of men.

Understanding the effectiveness of individual participation in sex education has important policy implications for promoting comprehensive sexual health education, especially for women, even when men are not involved. By ensuring adequate resources and supporting women's participation in sex education programs, policymakers can foster inclusive approaches that address the diverse needs of individuals and couples. This inclusiveness is critical for the development and implementation of effective policies that promote well-being and sexual satisfaction.

In contexts where formal sexuality education in schools and universities is limited or absent—such as in traditional Asian or Islamic societies with cultural taboos surrounding premarital sex—providing women with comprehensive sexuality education becomes even more essential. By empowering women with knowledge and skills related to sexual health, policymakers can help reduce the sexual knowledge gap and improve sexual awareness among couples. Additionally, addressing the reliance on pornography for sexual information, especially among young people, is another important policy consideration. By providing rigorous, evidence-based sexuality education, policymakers can mitigate the potential negative effects of problematic pornography use and promote healthier sexual behaviors.

Limitations

Some limitations should be considered for this study. The results may not be generalizable to women who do not have a partner at that time. Additionally, a longer follow-up period may yield different results. Due to the online nature of the sessions, there will be a possibility that a partner might attend in a group designed specifically for women. To mitigate this limitation, we will schedule the sessions for weekday mornings when the likelihood of a partner being at home will be lower. Due to our religious beliefs, asking questions about certain issues, such as pornography and masturbation, may lead to underestimated results.

Author Contribution Conception, design and final approval of the completed article: RZ, EK, MV, MH & FF. [Plan for future] Acquisition of data: RZ. Analysis and interpretation of data: RZ, EK, MV, MH & FF. Final approval of the completed Article: RZ, EK, MV, MH & FF.

Funding This survey was supported by the Tehran University of Medical Sciences under grant Number 1402–4-100–69433.

Data Availability The datasets generated during the current study are not publicly available due to sensitivity of subject in our country, but are available from the corresponding author on reasonable request.

Declarations

Ethics Approval This study will be performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of Tehran University of Medical Sciences under ethical code IR.TUMS.FNM.REC.1402.182.

Consent to Participate Informed consent will be obtained from all individual participants included in the study.

Consent for Publication The authors confirm that human research participants will provide informed consent for publication. Comprehensible information about the research is provided to the participants in writing to ensure that they understand the purpose and method of the research and are fully satisfied with the study. Participants can talk to the researchers if they have any unclear questions. Written consent forms are kept until the end of the study.

Conflict of Interest The authors declare no competing interests.

References

Alavi-Arjas, F., Farnam, F., Granmayeh, M., & Haghani, H. (2018). The effect of sexual and reproductive health education on

knowledge and self-efficacy of school counselors. *Journal of Adolescent Health, 63*(5), 615–620.

Alidoost, F., Khakbazan, Z., Bothe, B., GharibZade, F., & Farnam, F. (2022). Frequency, pattern and related factors of pornography use and exploring Iranian marrieds view on pornography: A mixed method study. In *PhD thesis in Reproductive Health Department. Tehran University of Medical Sciences*.

Alizadeh, S., Ebadi, A., Kariman, N., & Ozgoli, G. (2020). Dyadic sexual communication scale: Psychometrics properties and translation of the Persian version. *Sexual and Relationship Therapy, 35*(1), 103–114.

Azimi Nekoo, E., Burri, A., Ashrafti, F., Fridlund, B., Koenig, H. G., Derogatis, L. R., & Pakpour, A. H. (2014). Psychometric properties of the Iranian version of the female sexual distress scale-revised in women. *The Journal of Sexual Medicine, 11*(4), 995–1004.

Barjasteh, S., Lopez, V., & Farnam, F. (2024). Group sex counseling based on a modified "Good Enough Sex" model: A randomized trial on sexual health variables among breast cancer survivors in Iran. *Journal of Sex & Marital Therapy, 50*(6), 741–756.

Bokaie, M., Behzadpour, F., & Farajkhoda, T. (2021). The effectiveness of sexual health group counseling based on cognitive behavioral therapy on sexual satisfaction of newly married women. *Journal of Education and Health Promotion, 10*(1), 384.

Catania, J. A. (2013). Dyadic sexual communication scale. In T. D. Fisher, C. M. Davis, W. L. Yarber, & S. L. Davis (Eds.), *Handbook of sexuality-related measures* (pp. 152–164). Routledge.

Daneshfar, F., & Keramat, A. (2023). Sexual dysfunction and divorce in Iran: A systematic review. *Journal of Family Medicine and Primary Care, 12*(3), 430–439.

Dawson, K., Nic Gabhainn, S., & MacNeela, P. (2020). Toward a model of porn literacy: Core concepts, rationales, and approaches. *The Journal of Sex Research, 57*(1), 1–15.

del Mar Sánchez-Fuentes, M., Santos-Iglesias, P., & Sierra, J. C. (2014). A systematic review of sexual satisfaction. *International Journal of Clinical and Health Psychology, 14*(1), 67–75.

Derogatis, L. R., Rosen, R., Leiblum, S., Burnett, A., & Heiman, J. (2002). The Female Sexual Distress Scale (FSDS): Initial validation of a standardized scale for assessment of sexually related personal distress in women. *Journal of Sex & Marital Therapy, 28*(4), 317–330.

Edwards, W. M., & Coleman, E. (2004). Defining sexual health: A descriptive overview. *Archives of Sexual Behavior, 33*, 189–195.

Farahi, Z., HashemZadeh, M., & Farnam, F. (2024). Sexual counseling for female sexual interest/arousal disorders: A randomized controlled trial based on the "Good Enough Sex" model. *The Journal of Sexual Medicine, 21*(2), 153–162.

Farnam, F., Pakgohar, M., Mirmohamadali, M., & Mahmoodi, M. (2008). Effect of sexual education on sexual health in Iran. *Sex Education, 8*(2), 159–168.

Flynn, K. E., Lin, L., Bruner, D. W., Cyranowski, J. M., Hahn, E. A., & Jeffery, D. D. (2016). Sexual satisfaction and the importance of sexual health to quality of life throughout the life course of US adults. *The Journal of Sexual Medicine, 13*(11), 1642–1650.

Hirst, J., & Watson, J. (1997). Therapy for sexual and relationship problems: The effects on outcome of attending as an individual or as a couple. *Sexual and Marital Therapy, 12*(4), 321–337.

Iranopendata. (2021). The drastic increase of divorce rates in Iran: Nearly one in three marriages lead to divorce. Retrieved 25 Oct 2023, from https://Iranopendata.org

Lawrance, K.-A., Byers, E. S., & Cohen, J. N. (1998). Interpersonal exchange model of sexual satisfaction questionnaire. *Sexuality Related Measures: A Compendium, 2*, 514–519.

McCarthy, B., & Wald, L. M. (2015). Mindfulness and good enough sex. In M. M. Read (Ed.), *Mindfulness in sexual and relationship therapy* (pp. 38–46). Routledge.

McGahuey, A., Gelenberg, C., Laukes, F., Moreno, P., Delgado, K., & McKnight, R. (2000). The Arizona Sexual Experience Scale (ASEX): Reliability and validity. *Journal of Sex & Marital Therapy, 26*(1), 25–40.

Metz, M. E., & McCarthy, B. W. (2007). The "good-enough sex" model for couple sexual satisfaction. *Sexual and Relationship Therapy, 22*(3), 351–362.

Mohammadzadeh, Z., Khakbazan, Z., Rad, M., & Farnam, F. (2022). Sexual health and intimacy in women with and without dyspareunia. *Sexuality & Culture, 26*(6), 2057–2069.

Mohammadzadeh, Z., Khakbazan, Z., Rad, M., & Farnam, F. (2023). Comparison of pain catastrophizing and anxiety in patients with dyspareunia and healthy women: A cross-sectional study. *Journal of Medicine and Life, 16*(2), 220.

Nasehi, A. A., Raisi, F., Ghaeli, P., Amini, M., Yahyavi, S. T., & Arabkheradmand, J. (2017). Prevalence of sexual dysfunction among general population of Iran: A systematic review. *Iranian Journal of Psychiatry and Behavioral Sciences*, *11*(4), e7643.

Noruzi, S., Maarefvand, M., Khankeh, H., & Eghlima, M. (2019). Sexual satisfaction studies in Iran, a systematic review. *Women's Health Bulletin, 6*(4), 1–7.

Pezeshki, M. Z., & Bayrami, R. (2005). Reliability and construct validity of Arizona Sexual Experiences Scale (ASEX) among pregnant women referred to Tabriz urban health centers, 2004. In *Proceedings of 2nd national congress on family and sexual problems* pp. 25–26.

Pouralijan, Z., Bőthe, B., & Farnam, F. (2024). Pornography use, demographic and sexual health characteristics among university students: A gender-based comparative study of non-users, non-problematic users, and problematic users. *Reproductive Health, 21*(1), 103.

Webster, K. A. (2022). Pornography use and its effect on marital quality. *Liberty University,* 34. https://digitalcommons.liberty.edu/viewcontent.cgi?article=4925&context=doctoral

World Health Organization. (2006). Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002. https://www.who.int