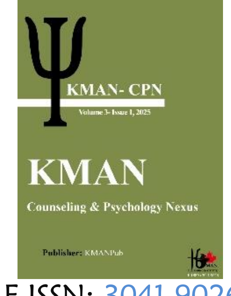
Journal Website

Article history:
Received 17 August 2024
Revised 04 November 2024
Accepted 15 November 2024
Published online 01 January 2025

KMAN Counseling & Psychology Nexus

Volume 3, pp 1-10



E-ISSN: 3041-9026

Comparing the Effectiveness of Sexual Cognitive-Behavioral Education and Sexual Well-Being Education on Sexual Satisfaction and Sexual Self-Efficacy of Couples with Low Sexual Well-Being

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Article Info

Article type:
Original Research

Section:
Family and Couple Therapy

How to cite this article:
Salak, N., & Atashpour, S. H. (2025). Comparing the Effectiveness of Sexual Cognitive-Behavioral Education and Sexual Well-Being Education on Sexual Satisfaction and Sexual Self-Efficacy of Couples with Low Sexual Well-Being. *KMAN Conseling and Psychology Nexus, 3*, 1-10.
http://doi.org/10.61838/kman.fct.psynexus.3.2

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A B S T R A C T

The present study aimed to compare the effectiveness of sexual cognitive-behavioral education and sexual well-being education on sexual satisfaction and sexual self-efficacy of couples with low sexual well-being. This study employed a quasi-experimental design with a pre-test, post-test, and follow-up, including experimental and control groups. The statistical sample consisted of 90 participants, comprising 45 couples, selected using a systematic random sampling method and assigned to three groups. The research instruments included the Sexual Well-Being Questionnaire, the Sexual Satisfaction Questionnaire, and the Sexual Self-Efficacy Questionnaire. Repeated measures analysis of variance (ANOVA) was used for statistical analysis. The results indicated that the implemented interventions were effective in improving sexual satisfaction and sexual self-efficacy in couples with low sexual well-being, with significant differences observed between the groups in the post-test and follow-up stages ($p < .05$, $p < .01$). The findings of this study indicate that both cognitive-behavioral sexual education and sexual well-being education effectively enhance sexual satisfaction and sexual self-efficacy among couples with low sexual well-being. However, sexual well-being education demonstrated greater effectiveness in improving sexual attitude and quality of sexual life.

Keywords: *Sexual well-being, sexual cognitive-behavioral education, sexual self-efficacy.*

1. Introduction

A satisfactory sexual relationship holds a special significance in the lives of couples. Studies in this field have shown that a satisfying sexual relationship that fulfills the needs of both partners plays a crucial role in family stability. Couples who do not have a desirable sexual relationship experience various sexual and marital problems (Moore, 2024; Salehi et al., 2024).

Sexual well-being of couples has recently attracted attention, as it refers to an individual's subjective evaluation of a broad range of physical, cognitive, emotional, and social

aspects of their relationships with themselves and others. It encompasses sexual satisfaction, sexual knowledge, thoughts, feelings, personal experiences, and an individual's approach to sexual desires (WHO, 2020). Sexual well-being is important as it is intertwined with optimizing sexual function and ensuring equal sexual rights (Benchamas et al., 2024; Hajipoor Bagheri, 2024). Couples with poor sexual well-being often suffer from distressing sexual problems, such as anxiety in non-sexual situations, negative sexual schemas, low sexual satisfaction, low self-esteem, and reduced sexual activity (Foster & Byers, 2014). However, research data on couples with low sexual well-being are scarce.

Sexual satisfaction, as a key component of sexual health and an outcome of sexual well-being, plays an essential role in establishing and maintaining a happy marital relationship and mutual satisfaction (Brezsnyak & Whisman, 2004). It refers to an individual's judgment about their sexual behavior and their perception of pleasure (Modarres et al., 2013; Young et al., 2000). Studies indicate that a significant portion of marital conflicts and incompatibilities—such as resentment, deprivation, jealousy, competition, feelings of revenge, humiliation, lack of self-confidence, frustration, failure, and insecurity—stem from a lack of sexual satisfaction, which can gradually deepen the gap between spouses (Fani Sobhani et al., 2018; Farhadi Cheshmeh Morvari et al., 2020; Fisher et al., 2015; Gholamrezaei et al., 2017; Haroon Rashidi & Kiyaniyan Mehr, 2019; Refaee & Fereydooni, 2022; Sánchez-Fuentes et al., 2014; Shahvary et al., 2009; Taravati et al., 2018; Tavakolizadeh & Hajivosogh, 2013; Zegeye et al., 2020).

Lack of proper sexual knowledge and attitudes, weak communication and sexual skills, and unrealistic expectations in marital relationships play a significant role in disagreements and reduced sexual satisfaction (Zegeye et al., 2020).

Sexual self-efficacy (SSE) is a broad concept that includes multiple constructs. It involves the ability to engage in sexual activity when desired, experience pleasurable and satisfying sexual interactions, and use contraception effectively (Ha et al., 2023; Karimpoor et al., 2023; Samakoush, 2023). SSE encompasses individuals' beliefs about their ability to perform effectively in sexual activities, satisfy their partners, and evaluate their sexual abilities (Sadock et al., 2009). Kafaei Atrian et al. (2019) emphasized the impact of SSE on sexual performance (Kafaei Atrian et al., 2019).

Sexual education for couples is crucial, as those equipped with adequate information to enjoy their sexual lives are more likely to experience higher satisfaction (Wylie, 2010). Conversely, mismatched sexual expectations between partners can pose a risk to marital stability (Hull, 2008). The lack of proper sexual information or misinformation increases the risk of various sexual disorders, risky behaviors, sexually transmitted diseases, decreased sexual pleasure, unintended pregnancies, and marital issues (Beaber & Werner, 2009; Gibson & Mitchell, 1997; Pinkerton & Abramson, 1992; Roscoe & krugger, 1990). Therefore, intervention and improvement in this area are essential and unavoidable.

One of the educational approaches that has gained attention in recent years is positive psychology-based therapy. Positive psychotherapy can improve couples' relationships, marital quality, sexual and marital satisfaction, happiness, intimacy, and optimism while reducing behavioral weaknesses (Bahjat et al., 2020; Haroon Rashidi & Kiyaniyan Mehr, 2019; Heydari & Saedi, 2020; Najarpourian et al., 2021). Sexual well-being education, as a positive psychology-based intervention, is linked to well-being therapy (WBT) (Fava, 2016; Fava et al., 2016; Fava et al., 1998). WHO also suggests that promoting individuals' sexual knowledge should focus on enhancing their sexual well-being (Seifen et al., 2022).

Well-being therapy (WBT) is a structured and short-term psychotherapy approach emphasizing self-monitoring of well-being experiences through a structured diary (which differs from traditional cognitive therapy diaries focused on distress), homework assignments, and interactions between patients and therapists (Fava, 2016; Fava et al., 2016; Rotterman & Wright, 2019).

During therapy, individuals are encouraged to identify well-being moments, recognize interruptions in these experiences (interfering thoughts and/or behaviors), apply cognitive-behavioral techniques to address these interruptions, and pursue optimal experiences (Guidi & Fava, 2021).

Several studies have sought to explain the role of sexual well-being in maintaining romantic relationships and couple satisfaction (Byers, 2005; Fisher et al., 2015; Sánchez-Fuentes et al., 2014; Sanchez et al., 2011). Couples with higher sexual well-being report greater life satisfaction, happiness, well-being, quality of life, marital stability, and mental health (Diamond & Huebner, 2012; Killingsworth & Gilbert, 2010; Kobau et al., 2011; Sánchez-Fuentes et al., 2014; Seligman, 2000; Stephenson & Meston, 2013).

E-ISSN: 3041-9026

Another educational approach used in restoring couples' sexual relationships is cognitive-behavioral therapy (CBT). CBT combines cognitive and behavioral approaches and is based on the assumption that thoughts, emotions, physical sensations, and behaviors are interconnected. This approach helps individuals identify their distorted attitudes and dysfunctional behaviors (Chand et al., 2021). According to this premise, although individuals cannot change their emotions about events, group therapy sessions teach them how to imagine the worst-case scenarios and replace negative feelings with positive ones (Ledley et al., 2013). CBT generally aims to enhance positive exchanges, teach necessary marital life skills, provide relevant sexual knowledge, and change irrational and dysfunctional beliefs (Goldenberg & Goldenberg, 2011).

Numerous studies have examined the effectiveness of cognitive-behavioral therapy in improving sexual satisfaction (Amini et al., 2021; Erfanifar et al., 2022; Fani Sobhani et al., 2018; Farhadi Cheshmeh Morvari et al., 2020; Gholamrezaei et al., 2017; Hummel et al., 2017; Metz et al., 2018; Nezamnia et al., 2020; Safar Mohammadlou et al., 2021; Taravati et al., 2018; Tavakolizadeh & Hajivosogh, 2013).

Given the importance of sexual satisfaction and self-efficacy in couples' sexual behaviors, this study aims to evaluate the effectiveness of two sexual education approaches in improving these two components. The concept of sexual well-being in teaching sexual skills and enhancing satisfaction and self-efficacy is a novel approach, and no research has been conducted in this area in Iran. This study attempts to compare the effectiveness of sexual well-being education with cognitive-behavioral sexual education in improving sexual satisfaction and self-efficacy in couples. Therefore, the research question is whether there is a significant difference between the effectiveness of cognitive-behavioral sexual education and sexual well-being education in couples with low sexual well-being.

2. Methods and Materials

2.1. Study Design and Participants

The research employed a quasi-experimental design with a pre-test, post-test, and a three-month follow-up, including an experimental and a control group.

Inclusion criteria included obtaining a score one standard deviation below the mean on the Sexual Well-Being Questionnaire, no history of psychological or sexual disorders, no history of hospitalization based on clinical interviews and examination of participants' medical records, and providing informed consent.

Exclusion criteria for the experimental group were: absence from more than two intervention sessions, undergoing concurrent psychological or psychiatric treatment, divorce, pregnancy, or lack of willingness to continue participation throughout the educational period.

The statistical population comprised couples who attended marital counseling centers in Isfahan in 2022. The sample size was calculated using G*Power software with a confidence level of 0.05, a power of 0.95, and an effect size of 0.25, resulting in a required sample size of 87 participants. Accordingly, 90 individuals were selected as the final sample, with 30 participants in each of the three groups: sexual well-being education, cognitive-behavioral sexual education, and the control group, totaling 45 couples.

The sampling process involved first selecting a list of counseling centers in Isfahan, from which 8 centers were randomly chosen. After contacting these centers, 5 agreed to participate in the study. Information on couples seeking marital therapy services from these centers was collected. Participants completed the Sexual Well-Being Questionnaire as an entry requirement. Couples with low scores who met the inclusion criteria were selected. Those unwilling to participate were excluded, and replacements were randomly selected until the target sample of 90 participants was reached.

The sampling method was systematic random sampling. Ethical considerations were observed by obtaining written informed consent from all participants and ensuring the confidentiality of all collected data.

After selecting the sample and randomly assigning participants to the experimental and control groups, the experimental groups underwent 8 sessions of 90-minute training sessions based on sexual well-being therapy and cognitive-behavioral sexual education. The cognitive-behavioral sexual education package was designed based on Metz et al.'s (2001) cognitive-behavioral sexual therapy model. The sexual well-being education package was developed based on qualitative analysis and validated using deductive qualitative analysis.

Six experts reviewed and approved the content of the educational packages. Both experimental groups were assessed during the pre-test phase using research instruments. They participated in the respective educational programs and were reassessed in the post-test phase at the end of the training and again three months later during the follow-up phase. To adhere to ethical considerations,

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participants in the control group who wished to receive the training were invited to join the therapy sessions after the post-test.

2.2. *Measures*

2.2.1. *Sexual Satisfaction*

Developed by Larson (1988), this questionnaire consists of 25 items measuring four components: sexual desire, sexual attitude, sexual quality of life, and sexual compatibility, assessed using a five-point Likert scale. Bahrami et al. (2012) reported a Cronbach's alpha reliability of 0.93 for this instrument in their study on women's sexual satisfaction (Bahrami et al., 2012).

2.2.2. *Sexual Self-Efficacy*

Based on Schwarzer's General Self-Efficacy Scale, this questionnaire was developed by Vaziri and Lotfi Kashani (2013). It includes 10 items rated on a four-point continuum from 0 (not at all true) to 3 (completely true). Initial studies reported a Cronbach's alpha reliability of 0.86 (Vaziri & Lotfi Kashani, 2013).

2.2.3. *Sexual Well-Being*

A researcher-developed instrument validated with a sample of 479 Iranian individuals aged 20 to 65 years. Exploratory factor analysis (EFA) identified 25 items across four factors: sexual satisfaction, sexual self-efficacy, sexual desire, and sexual assertiveness. The Cronbach's alpha coefficients for these factors were 0.93, 0.92, 0.91, and 0.82, respectively.

2.3. *Interventions*

2.3.1. *Cognitive-Behavioral Sexual Education*

The cognitive-behavioral sexual education intervention consists of eight structured sessions aimed at improving sexual satisfaction and self-efficacy in couples. In the first session, participants are introduced to the program, treatment alliance is established, and the objectives of cognitive-behavioral therapy (CBT) are outlined, emphasizing the impact of sexual education on marital quality, followed by the administration of a pre-test. The second session focuses on behavioral analysis skills, identifying irrational thoughts related to sexual issues and their impact, and teaching communication skills, including verbal and non-verbal interactions in sexual relationships. In the third session, participants learn about the sexual response cycle in men and women, explore erogenous zones, and address misconceptions about sexual relationships, including techniques such as arousal mapping, intimacy, and orgasm. The fourth session introduces cognitive distortions and cognitive restructuring techniques, discussing the psychological factors influencing sexual functioning and how to reframe maladaptive thoughts. The fifth session addresses common sexual dysfunctions and strategies to enhance sexual intimacy, incorporating exercises such as sensate focus phases one and two. In the sixth session, cognitive skills such as relaxation techniques based on Masters and Johnson's approach and Kegel exercises are introduced to promote physical and psychological readiness for sexual activity. The seventh session covers problem-solving skills, emotional expression techniques, and active listening to foster healthy sexual communication. Finally, the eighth session involves summarizing the intervention, conducting the post-test, and providing an open forum for participant questions and feedback.

2.3.2. *Sexual Well-Being Education Intervention*

The sexual well-being education intervention comprises eight sessions designed to enhance couples' understanding of sexual well-being and foster positive experiences. The first session introduces the program, establishes treatment alliance, explains the goals of the sessions, familiarizes participants with the multi-dimensional model of psychological well-being by Ryff, and initiates the structured sexual well-being journal. In the second session, participants learn behavioral analysis skills and the connection between thoughts, behaviors, and emotions (cognitive triangle), explore the importance of verbal and non-verbal communication in sexual relationships, and are encouraged to share past experiences of well-being and moments of sexual euphoria. The third session covers the anatomy and physiology of sexual behavior, the sexual response cycle, common sexual dysfunctions, and techniques for sexual intimacy, including arousal mapping and orgasm, alongside reviewing journal entries and identifying optimal experiences. The fourth session focuses on recognizing cognitive distortions and irrational beliefs related to sexual relationships and replacing them with adaptive thoughts, encouraging participants to challenge premature interpretations of their sexual well-being. In the fifth session, participants are taught techniques to enhance sexual intimacy, including active listening, sensate focus

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phases one and two, emotional expression skills, and reviewing and addressing challenges in their well-being journals while reinforcing positive behaviors. The sixth session delves into understanding sexual preferences, expectations, and desires, promoting self-awareness, mindfulness, and assertiveness in sexual relationships while identifying and addressing disruptions to well-being in the journal. The seventh session introduces emotional regulation strategies, cognitive techniques such as relaxation based on Masters and Johnson's methods, sexual fantasies, guided imagery, and Kegel exercises, while discussing journal insights and feedback on well-being experiences. The final session involves summarizing the intervention, conducting the post-test, and inviting participants for further discussion and feedback.

2.4. *Data Analysis*

Data analysis was conducted at descriptive and inferential levels. Descriptive statistics, including mean and standard deviation, were used, while repeated measures analysis of variance (ANOVA) was applied for inferential analysis. Data analyses were performed using SPSS software version 26.

3. Findings and Results

As shown in Table 1, the mean scores of sexual satisfaction dimensions and sexual self-efficacy in the sexual well-being training and cognitive-behavioral therapy (CBT) training groups increased more significantly in the post-test and follow-up stages compared to the pre-test and the control group.

Table 1

Descriptive Indices of the Research Variables, Separated into Two Groups and Three Phases of the Research

Variable	Components	Groups	Pre-test (M±SD)	Post-test (M±SD)	Follow-up (M±SD)
Sexual satisfaction	Sexual compatibility	Sexual well-being training	11.03±2.64	18.07±2.7	23.47±2.5
		CBT training	11.83±2.36	17.17±2.7	21.57±2.8
		Control	10.50±2.39	11.87±2.6	13.40±3.0
	Quality of sex life	Sexual well-being training	15.10±3.60	21.60±3.3	28.27±3.3
		CBT training	14.27±3.30	19.17±3.01	24.50±3.2
		Control	14.60±3.70	15.90±3.8	17.73±3.7
	Sexual attitude	Sexual well-being training	11.80±2.40	18.40±2.6	24.40±1.9
		CBT training	12.07±2.30	16.40±2.6	20.50±2.1
		Control	11.13±2.40	12.47±2.7	14.27±2.7
	Desire to have sexual relations	Sexual well-being training	9.30±1.40	15.67±1.8	21.17±1.7
		CBT training	10.43±1.70	14.37±1.9	19.33±2.4
		Control	9.23±1.90	10.40±2.1	11.53±2.3
Sexual Self-efficacy		Sexual well-being training	19.17±3.02	25.67±2.7	31.17±2.7
		CBT training	19.57±2.80	24.93±2.7	29.30±3.1
		Control	18.67±3.10	19.57±3.1	20.87±3.4

The results of M Box's test, which examines the assumption of homogeneity of covariance matrices, indicated that the assumption was met for sexual satisfaction dimensions (Box's M = 227.5, F = 1.1, p = .101) and sexual self-efficacy (Box's M = 227.5, F = 1.1, p = .31). Therefore, the assumption of covariance equality was confirmed.

The Kolmogorov-Smirnov (KS) test was used to assess the normality of score distribution. The analysis confirmed the assumption of normality in the pre-test, post-test, and follow-up stages for both experimental groups ($p > .05$).

To examine the assumption of homogeneity of variances, Levene's test was conducted. The results showed that the assumption of equal variances was met for sexual satisfaction dimensions and sexual self-efficacy across the three stages ($p > .05$).

The results of between-subject and within-subject comparisons of the research variables are presented in Table 2.

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Table 2

Effects of Time and Group on Sexual Satisfaction and Self-Efficacy Variables

Effects	Source	Variables	SS	df	MS	F	Sig.	Eta	Observed Power
Within-Subjects	Time	Sexual compatibility	3153.3	1.84	1712.9	1472.9	.000	.944	1.00
		Quality of sex life	3530.9	1.83	1932.05	1852.05	.000	.955	1.00
		Sexual attitude	2928.4	1.94	1505.6	1358.04	.000	.940	1.00
		Desire to have sex	2660.4	1.86	1429.7	1931.99	.000	.960	1.00
		Sexual self-efficacy	2868.3	1.76	1630.7	1850.3	.000	.955	1.00
Time * Group		Sexual compatibility	732.58	3.68	199.1	171.21	.000	.800	1.00
		Quality of sex life	803.18	3.65	219.7	210.64	.000	.830	1.00
		Sexual attitude	682.68	3.89	175.5	158.3	.000	.780	1.00
		Desire to have sex	728.48	3.72	195.75	264.5	.000	.860	1.00
		Sexual self-efficacy	796.18	3.5	226.32	256.8	.000	.855	1.00

Based on the findings in Table 2, the between-subjects analysis revealed a significant difference in the mean scores of sexual satisfaction dimensions, including sexual compatibility, quality of sexual life, sexual attitude, and desire for sexual relations, as well as sexual self-efficacy, between the experimental groups (sexual well-being training and cognitive-behavioral sexual education) and the control group ($p < .001$).

The results indicated that 50.6%, 32.6%, 51.8%, 60.7%, and 44% of the variance in sexual compatibility, quality of sexual life, sexual attitude, desire for sexual relations, and sexual self-efficacy, respectively, were attributed to differences between the groups.

The within-subjects analysis indicated significant differences in all variables across time and group interactions ($p < .001$), suggesting changes in sexual satisfaction dimensions and self-efficacy varied between the research stages among the groups.

Post-hoc Bonferroni tests indicated significant differences between the sexual well-being and cognitive-behavioral groups for sexual attitude and quality of sexual life in post-test and follow-up stages ($p < .05$), but not for sexual compatibility, desire for sex, and self-efficacy ($p > .05$). Both experimental groups showed significant improvements compared to the control group ($p < .05$, $p < .01$).

4. Discussion and Conclusion

The aim of this study was to compare the effectiveness of cognitive-behavioral sexual education and sexual well-being education on sexual satisfaction and sexual self-efficacy among couples with low sexual well-being in Isfahan. The dependent variables in this study included sexual satisfaction with its four components—sexual compatibility, quality of sexual life, sexual attitude, and desire to have sexual relations—as well as sexual self-efficacy. The results indicated a significant difference between the two educational approaches in the sexual satisfaction components of sexual attitude and quality of sexual life. However, no significant difference was found between the two approaches in the components of sexual compatibility, desire for sexual relations, and sexual self-efficacy. The findings suggest that both sexual well-being education and cognitive-behavioral sexual education interventions were effective in improving dimensions of sexual satisfaction and self-efficacy.

These findings align with previous studies which demonstrated the effectiveness of sexual skills training in enhancing marital satisfaction (Refaee & Fereydooni, 2022), as well as studies which confirmed the efficacy of cognitive-behavioral therapy in improving sexual satisfaction (Fani Sobhani et al., 2018; Farhadi Cheshmeh Morvari et al., 2020; Gholamrezaee et al., 2017; Taravati et al., 2018; Tavakolizadeh & Hajivosogh, 2013). Additionally, the findings are consistent with research which highlighted the effectiveness of cognitive-behavioral therapy in enhancing sexual self-efficacy (Erfanifar et al., 2022; Nezamnia et al., 2020; Safar Mohammadlou et al., 2021).

To explain the effectiveness of both sexual well-being education and cognitive-behavioral sexual education on sexual satisfaction and self-efficacy, it can be stated that both interventions aim to improve the quality of sexual life and marital relationships. The training provided in both educational packages covered topics such as anatomy and physiology of sexual behavior, the sexual response cycle in men and women, sexual dysfunctions, intercourse techniques, arousal mapping, intimacy, and orgasm. It appears that awareness of sexual physiology and response cycles enhances individuals' self-awareness and knowledge, allowing them to enter sexual relationships more

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consciously, analyze their own sexual cycles, and behave more intentionally during intimacy. This learning opportunity contributes to greater sexual satisfaction and self-efficacy.

Furthermore, the training of intercourse techniques introduces variety into relationships and positively impacts sexual self-efficacy, as individuals receive different feedback from various sexual techniques and can explore new and better ways to enhance their sexual experiences, ultimately leading to increased satisfaction. The findings also support the notion that addressing and challenging cognitive distortions and irrational beliefs enable couples to adjust their perceptions and interpretations of their own and their partner's sexual behaviors, responding more appropriately to sexual needs while experiencing less anxiety and negative emotions.

Sexual intimacy, communication skills, fostering positive interactions, and active listening during sexual activity help couples develop mutual positive feelings and utilize positive emotions to improve their relationship. Techniques such as relaxation based on Masters and Johnson’s approach, sexual fantasy training, and Kegel exercises for pelvic floor strengthening also enhance physical and mental readiness, aligning sexual needs with fantasies, distinguishing between sexual imagination and reality, and fostering mutual understanding of each other's fantasies. These factors help maintain excitement in the relationship and contribute to achieving shared sexual aspirations.

In the sexual well-being education package, mindfulness training, self-awareness, and assertive expression of emotions, thoughts, and feedback play a crucial role in enhancing sexual experiences with greater understanding and awareness. This training also helps couples gain better self-knowledge and awareness of each other, enabling them to express their desires and expectations assertively without expressing anger. As noted by Levitt, Lefkowitz, and Waterman (2019), mindfulness training enhances sexual self-esteem and satisfaction, particularly among women, leading to greater sexual fulfillment. Creating an environment for better understanding and expression of sexual behaviors fosters more satisfying experiences and greater self-efficacy (Leavitt et al., 2019).

The conceptualization of sexual well-being is rooted in subjective psychological well-being theories and research. Scholars investigating subjective well-being tend to adopt one of two approaches (Ryff, 1989; Ryff & Keyes, 1995). The first approach focuses on the balance of positive and negative affect, positing that individuals with high sexual well-being experience a favorable balance of emotions related to their sexual lives. The second, cognitive approach views well-being in terms of overall life satisfaction, comparing one’s current state with their ideal expectations (McDowell, 2010; Ryff & Keyes, 1995). From this perspective, sexual well-being is defined as an individual's evaluation of their current sexual life in comparison to their ideal sexual experiences. Accordingly, both cognitive and emotional factors were considered in the sexual well-being education sessions.

Based on the significant differences in sexual attitude and quality of sexual life between the two intervention groups, it can be concluded that since psychological well-being focuses on the positive aspects of mental health, sexual well-being education emphasized activities that promote well-being and positive experiences. Monitoring the well-being training process allowed couples to recognize specific vulnerabilities or excessive sexual well-being levels, identify moments of well-being, and enhance their sexual compatibility and relationship quality. Identifying and addressing intrusive thoughts and beliefs that lead to premature interpretation of sexual well-being could effectively improve sexual attitude and quality of sexual life.

Moreover, group training provided an opportunity for participants to share their sexual experiences with others, fostering a sense of normalcy and problem-solving skills without excessive disclosure. Participants learned that their sexual challenges were not unique and explored effective strategies to address them.

Based on the study findings, both sexual well-being education and cognitive-behavioral sexual education significantly improved sexual satisfaction and self-efficacy among couples with low sexual well-being. Therefore, it can be concluded that sexual well-being education, as a novel therapeutic approach, can serve as an effective strategy for sexual education in couples, similar to the widely established cognitive-behavioral sexual education.

Throughout the sexual well-being training sessions, couples were guided to recognize their sexual needs, capabilities, and strengths; maintain their physical and mental health; develop positive attitudes and beliefs about sexual relationships; and strive for mutual sexual satisfaction. The structured journal of sexual well-being experiences helped couples focus on optimal experiences rather than negative emotions or deficiencies, becoming aware of interruptions in their well-being (intrusive thoughts and behaviors), applying cognitive-behavioral techniques to address them, and pursuing optimal experiences.

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Since both educational packages effectively enhanced sexual satisfaction and self-efficacy among couples with low sexual well-being, but sexual well-being education demonstrated greater effectiveness in improving sexual satisfaction, it can be considered a validated and effective therapeutic approach for researchers and practitioners working to improve sexual life quality. Future research should:

1. Investigate the effectiveness of these interventions on sexual dysfunctions and disorders.
2. Examine the impact of these educational packages on a broader range of variables.
3. Compare the effectiveness of these two approaches with other therapeutic interventions.

Authors' Contributions

Authors contributed equally to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Acknowledgments

We would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

According to the authors, this article has no financial support.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. The present study was registered in the National Ethics System under the ethics code IR.IAU.KHUISF.REC.1402.096.

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