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The Effect of Individual and Group Sexual Skills Training on Sexual Satisfaction and Sexual Self-Esteem in Women: A Quasi-Experimental Study on the Effectiveness of Individual Sexual Skills Training on Sexual Satisfaction

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A B S T R A C T

Objective: The aim of this study was to compare the effects of individual and group training in sexual skills on sexual satisfaction and sexual self-esteem among women attending comprehensive health centers in Sanandaj.

Methods: This quasi-experimental study was conducted on 60 women attending comprehensive health centers in Sanandaj, who were randomly assigned to three groups: individual training, group training, and control. Data collection tools included a demographic and obstetric questionnaire, the Hudson Sexual Satisfaction Questionnaire, and the Sexual Self-Esteem Inventory–Short Form (SSEI-W-SF). Data were collected according to the objectives of the study and analyzed using STATA version 12. The significance level was set at 0.05.

Findings: Based on the results, all three study groups were homogeneous in terms of demographic and clinical characteristics. Four weeks after the intervention, the mean and standard deviation of sexual satisfaction in the individual training group showed a statistically significant difference ($p < 0.05$; $p = 0.00$). However, the mean satisfaction scores in the group training and control groups did not show a statistically significant difference. In all three groups, the mean and standard deviation of sexual self-esteem scores four weeks after training did not show a significant difference.

Conclusion: The results of this study demonstrated that individual-based training leads to an increase in sexual satisfaction. Utilizing this educational approach in comprehensive health centers can enhance women's sexual health and improve the dysfunctional cycle of family clinical relationships.

Keywords: *Individual training, group training, sexual skills, sexual satisfaction, sexual self-esteem*

1. Introduction

Sexual satisfaction refers to physical pleasure, beliefs, emotions, and both positive and negative feelings surrounding sexual relationships (Banaei et al., 2025; Finzi-Dottan et al., 2025). This construct encompasses feelings about one's own body and that of the sexual partner, interest in sexual activities, the need for connection with the sexual partner, and achieving satisfaction from sexual activity (Moore, 2024; Nazari, 2024).

According to Nicolosi and colleagues, 39 percent of women suffer from at least one sexual dysfunction (Nicolosi et al., 2004). Based on reports from various epidemiological studies conducted in Iran, 31 percent of Iranian women experience a range of sexual problems (Null et al., 2018). A decline in sexual satisfaction is associated with increased anxiety and worry, reduced self-esteem, and diminished well-being, and it negatively affects future sexual relationships (Rausch & Rettenberger, 2021). Women who report higher levels of marital dissatisfaction tend to report lower levels of sexual self-esteem (Ziaei et al., 2018).

Sexual self-esteem is a fundamental component of an individual's understanding of their sexuality and plays a significant role in various aspects of life, such as sexual satisfaction, relationship quality, and overall well-being (Bennett-Brown & Denes, 2023). Sexual self-esteem involves confidence in engaging in healthy sexual behaviors and experiencing pleasurable sexual encounters, and it plays a critical role in how individuals perceive their ability to engage in healthy sexual behavior and enjoy sexual experiences (Guyon et al., 2023; Pathmendra et al., 2023). This concept includes a positive view of one's capacity to participate in satisfying sexual experiences and a sense of sexual worthiness (Werner et al., 2023). Research has shown that sexual self-esteem influences sexual behavior, emotional responses to sexual thoughts and feelings, and perceptions of sexual acceptability and identity (Kelley et al., 2019).

Effective sexual communication within marital life can have a reciprocal impact on marital relationships and sexual self-esteem (Movahed & Azizi, 2011; Rahimi et al., 2009). One of the essential components of a successful sexual relationship is sexual knowledge and awareness, and training in sexual skills can enhance the quality of marital relationships (Khayatan, 2017; Khodakarami & Aligholi, 2011). Sexual skills training is a process that contributes to healthy sexual development, marital health, interpersonal relationships, emotions, intimacy, body image, and gender roles. By improving sexual satisfaction and sexual self-esteem in couples, it can play a significant role in family health, reduction of marital conflicts, and enhancement of pleasurable sexual experiences (Dashtestannejad et al., 2015; Khayatan, 2017).

Training based on models can be implemented in various ways (Ghavam-Nasiri et al., 2012). Currently, individual and group training are among the most common and widely recognized structured educational methods (Rhodes & Carlson, 2001). Given the taboo nature of sexual issues in our country, couples often possess limited, incomplete, and sometimes incorrect information about sexual matters, and the available training is very limited and insufficient. Considering that few studies in the country have examined the effects of sexual education, the present study aimed to compare the effect of individual and group sexual skills training on sexual satisfaction and sexual self-esteem in women attending comprehensive health centers in the city of Sanandaj.

2. Methods and Materials

2.1. Study Design and Participants

This quasi-experimental study was conducted in 2019 on 60 women who met the inclusion criteria and were referred to comprehensive health centers in Sanandaj. Inclusion criteria included literacy (reading and writing), willingness to participate in the training sessions, being married for at least one year, not being pregnant, no participation in any sexual education-focused classes, no history of specific physical or mental illness, no use of medications affecting sexual function such as phenothiazines, antidepressants, hypnotics, sedatives, cardiovascular drugs, or antihypertensive medications, not being in the process of divorce.

Exclusion criteria included becoming pregnant during the training period, incomplete responses to the questionnaire, irregular attendance in training sessions, emergence of marital conflicts during the intervention, and lack of willingness to continue participation in the study. Sampling was carried out from mid-April 2019 to the end of September 2019. Based on the results of the study by Grafer et al., and considering a 95% confidence level and 90% test power, the sample size was determined to be 20 participants per group. Participants were selected through convenience sampling and were then randomly assigned to three groups: individual training, group training, and control.

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In the group training arm, considering the possibility of dropout during the intervention, 25 participants were initially selected and divided into two subgroups of 13 and 12 participants. Ultimately, with the withdrawal of 5 participants from the study, no disruption occurred in the intervention process, and the group training was conducted with 20 participants divided into two subgroups of 10.

To collect data, the researcher visited the centers every morning and, after providing the necessary explanations, obtained informed consent from all eligible women. Then, in the presence of the researcher, participants completed the demographic and obstetric questionnaire, the sexual satisfaction questionnaire, and the sexual self-esteem questionnaire. The body mass index (BMI) of all participants was recorded by measuring their height and weight and entered into the questionnaire.

The individual training group received six instructional sessions in a step-by-step manner, with two sessions per week. Each 90-minute session consisted of 60 minutes of face-to-face instruction followed by 30 minutes of discussion. Participants assigned to the group training arm were initially divided into two groups of 10. They then attended 90-minute sessions held twice a week, with the first 60 minutes conducted as a lecture and question session, and the final 30 minutes dedicated to group discussion. Both the individual and group training sessions utilized a projector and whiteboard. The educational content was identical for both intervention groups. The control group received no educational intervention.

Four weeks after the completion of the intervention (training), the sexual satisfaction and sexual self-esteem questionnaires were re-administered in the presence of the researcher for all three groups. To adhere to ethical standards, one educational session was held for the control group after the conclusion of the study.

2.2. Measures

2.2.1. Self-Esteem

The Sexual Self-Esteem Inventory–Short Form for Women (SSEI-W-SF) was developed by Zeanah and Schwarz in 1996 to assess women's sexual self-esteem as a multidimensional construct encompassing feelings of sexual adequacy, body image, and comfort with sexual intimacy. This standardized instrument contains 35 items divided into five subscales: skill and experience, attractiveness, control, moral judgment, and adaptiveness. Each item is rated on a 5-point Likert scale ranging from "not at all like me" to "very much like me," with higher scores indicating greater levels of sexual self-esteem. The tool has demonstrated strong internal consistency and test-retest reliability in various populations, and its validity has been supported through correlations with related constructs such as self-worth and relationship satisfaction. Numerous studies in both clinical and non-clinical contexts have confirmed its psychometric properties, making it a widely accepted measure for evaluating sexual self-esteem in women.

2.2.2. Sexual Satisfaction

The Hudson Sexual Satisfaction Questionnaire was developed by Hudson, Harrison, and Crosscup in 1981 as a brief and reliable instrument for measuring sexual satisfaction within intimate relationships. The questionnaire consists of 25 items covering emotional and physical aspects of sexual interaction, such as desire, pleasure, communication, and fulfillment. Each item is rated on a 5-point Likert scale ranging from "never" to "always," with higher total scores reflecting greater sexual satisfaction. The tool does not include distinct subscales but is designed to yield a single composite score that represents overall sexual satisfaction. Its high internal consistency and construct validity have been confirmed in multiple studies across diverse demographic groups, and it is frequently used in clinical assessments and research evaluating the outcomes of sexual health interventions.

2.3. Intervention

The intervention was delivered over six structured sessions, each lasting 90 minutes, with content designed to enhance sexual knowledge, attitudes, and communication skills. The first session focused on establishing rapport with participants, clarifying the goals of the training, and emphasizing the importance of marital intimacy. The second session provided an overview of the physiology, anatomy, and sexual behaviors of both men and women to build foundational knowledge. In the third session, participants were guided in identifying and correcting common misconceptions about sexual matters. The fourth session centered on fostering sexual intimacy and teaching skills for emotionally connected communication. The fifth session introduced proper sexual techniques and methods for enhancing mutual satisfaction during intercourse. Finally, the sixth session familiarized participants with common sexual dysfunctions, aiming to reduce stigma and promote help-seeking behavior. Throughout the program, educational

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materials and interactive discussions were employed to facilitate engagement and learning.

2.4. Data Analysis

Data were analyzed using STATA statistical software (version 12) through Chi-square tests and one-way analysis of variance (ANOVA) followed by Tukey's post-hoc test.

3. Findings and Results

The results showed that the three groups were homogeneous in terms of demographic and obstetric characteristics. The demographic and obstetric characteristics of the study participants are presented below:

Table 1

Demographic Characteristics of the Study Groups

Characteristic	Individual Training (Mean ± SD / n (%))	Group Training (Mean ± SD / n (%))	Control (Mean ± SD / n (%))	Significance Level (p)
Age (years)	29.95 ± 5.53	31.30 ± 5.50	34.05 ± 7.97	0.391 (Kruskal-Wallis)*
Husband's age (years)	34.05 ± 5.45	36.60 ± 6.10	38.70 ± 7.71	0.173 (Kruskal-Wallis)*
Age at marriage (years)	21.50 ± 2.92	19.85 ± 3.04	23.30 ± 4.92	0.191 (ANOVA)****
Husband's age at marriage	26.15 ± 2.60	25.20 ± 3.03	28.25 ± 4.24	0.182 (ANOVA)****
Body Mass Index (BMI)	25.15 ± 4.03	34.60 ± 3.62	24.74 ± 3.23	0.150 (Kruskal-Wallis)*
Education level				0.624 (Fisher's Exact Test)**
– Primary	3 (15%)	2 (10%)	2 (10%)	
– Guidance school	2 (10%)	4 (20%)	1 (5%)	
– Secondary school	1 (5%)	1 (5%)	4 (20%)	
– Diploma	4 (20%)	7 (35%)	5 (25%)	
– University	10 (50%)	6 (30%)	8 (40%)	
Husband's education level				0.315 (Fisher's Exact Test)**
– Primary	2 (10%)	3 (15%)	1 (5%)	
– Guidance school	1 (5%)	2 (10%)	3 (15%)	
– Secondary school	2 (10%)	3 (15%)	1 (5%)	
– Diploma	3 (15%)	8 (40%)	5 (25%)	
– University	12 (60%)	4 (20%)	10 (50%)	
Employment status				0.116 (Pearson test)***
– Housewife	13 (65%)	17 (85%)	11 (55%)	
– Employed	7 (35%)	3 (15%)	9 (45%)	
Husband's employment				0.268 (Fisher's Exact Test)**
– Worker	3 (15%)	3 (15%)	4 (20%)	
– Employee	6 (30%)	4 (20%)	10 (50%)	
– Self-employed	11 (55%)	13 (65%)	6 (30%)	

* Kruskal-Wallis Test ** Fisher's Exact Test *** Pearson Test **** One-Way ANOVA

Table 2

Obstetric Characteristics of the Study Groups

Characteristic	Individual Training (Mean ± SD / n (%))	Group Training (Mean ± SD / n (%))	Control (Mean ± SD / n (%))	Significance Level (p)
Number of pregnancies	1.05 ± 1.09	1.95 ± 1.31	1.40 ± 1.09	0.073 (Kruskal-Wallis)*
Number of abortions	0.10 ± 0.30	0.55 ± 0.05	0.35 ± 0.58	0.200 (Kruskal-Wallis)*
Number of deliveries	0.95 ± 0.99	1.45 ± 1.09	1.05 ± 0.88	0.326 (Kruskal-Wallis)*
Number of live children	0.95 ± 0.99	1.35 ± 0.74	1.15 ± 0.87	0.342 (Kruskal-Wallis)*
Type of last delivery				0.160 (Fisher's Exact Test)**
– Vaginal delivery	8 (40%)	11 (55%)	9 (45%)	

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– Cesarean section	3 (15%)	7 (35%)	7 (35%)	
– No delivery	9 (45%)	2 (10%)	4 (20%)	
Contraceptive method				0.874 (Fisher's Exact Test)**
– None	2 (10%)	1 (5%)	3 (15%)	
– Natural	7 (35%)	8 (40%)	7 (35%)	
– Condom	4 (20%)	2 (10%)	5 (25%)	
– Pill	3 (15%)	2 (10%)	1 (5%)	
– Injection	1 (5%)	0 (0%)	1 (5%)	
– IUD	3 (15%)	7 (35%)	3 (15%)	

* Kruskal-Wallis Test ** Fisher's Exact Test

According to the Kruskal-Wallis test, the mean sexual satisfaction score in the individual training group increased from 62.7 ± 7.02 before the intervention to 70.2 ± 5.77 four weeks after the intervention, and this difference was statistically significant ($p < 0.05$) (Table 4).

Table 3

Mean Sexual Satisfaction Scores Before and After the Intervention Among Study Groups

Group	Before Intervention (Mean ± SD)	After Intervention (Mean ± SD)	Intra-group Test Result (p)**	Inter-group Test Result (p)*
Individual Training	62.7 ± 7.02	70.2 ± 5.77	0.000	0.000
Group Training	73.95 ± 11.88	73.75 ± 11.75	0.937	
Control	74.15 ± 9.47	72.6 ± 7.86	0.171	0.435

* Kruskal-Wallis Test ** Chi-square Test

Before the intervention, the sexual satisfaction scores showed a statistically significant difference among the three groups ($p < 0.05$). However, following the intervention, no significant difference was observed in sexual satisfaction between the groups ($p > 0.05$).

Table 4

Mean Sexual Self-Esteem Scores Before and After the Intervention Among Study Groups

Group	Before Intervention (Mean ± SD)	After Intervention (Mean ± SD)	Intra-group Test Result (p)**	Inter-group Test Result (p)*
Individual Training	105.40 ± 10.84	109.10 ± 8.77	0.068	0.366
Group Training	108.65 ± 10.72	105.40 ± 9.27	0.085	
Control	104.40 ± 7.58	104.05 ± 7.61	0.439	0.165

* Kruskal-Wallis Test ** Wilcoxon Test

According to the Kruskal-Wallis test, the mean sexual self-esteem scores did not differ significantly between the three groups before the intervention ($p > 0.05$). Similarly, post-intervention differences in mean sexual self-esteem were not statistically significant among the groups ($p > 0.05$). Intra-group analysis using the Wilcoxon test confirmed that none of the groups showed significant changes in sexual self-esteem scores.

4. Discussion and Conclusion

This study, which examined the effect of individual and group sexual skills training on sexual satisfaction and sexual self-esteem, revealed that sexual satisfaction significantly increased four weeks after individual training. However, no significant changes were observed in the group training and control groups. This suggests a possible relationship between individual sexual skills training and enhanced sexual satisfaction.

In the present study, the mean sexual satisfaction score before the intervention differed significantly between the individual training group and the other two groups. A similar result was reported by Hezbiiyan et al. (2016), who investigated the effect of counseling on postpartum sexual functioning in women attending health centers in Hamedan, where significant differences between groups were observed before the intervention (Hezbiiyan et al., 2016). In their

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study, some demographic variables differed significantly among participants. However, in the current study, given the homogeneity of demographic and obstetric characteristics across all three groups, the observed differences may be attributed to sample attrition in the individual training group, difficulties in replacing participants, lack of cooperation, or the small sample size.

Conversely, the findings of this study contradict those of Kargar et al. (2021), who compared individual and group training on sexual satisfaction in women with different body mass indexes. In their study, group training had a more significant effect than individual training (Kargar et al., 2021). Similarly, the results of Abedi et al. (2017), which examined the impact of individual versus group training on sexual satisfaction in postmenopausal women, also contradict the current findings, as group training was found to be more effective in improving sexual satisfaction (Abedi et al., 2017). Studies (Hakimi et al., 2019; Hezbiiyan et al., 2016) also reported that group training had a significant effect on sexual satisfaction. In contrast, our study found no statistically significant difference before and after the intervention in the group training group. This inconsistency might be explained by cultural differences among participants. Another possible explanation could be the number and frequency of sessions. In our study, sessions were held twice per week, which may not have provided participants enough time to fully comprehend the material, whereas in other studies, sessions were held once a week.

The study by Khayatan (2017), which examined the effectiveness of sexual skills training on sexual schemas, sexual self-esteem, and sexual satisfaction in women attending counseling centers in Isfahan, also contradicts our results. In that study, sexual skills training had a positive effect on women's sexual self-esteem (Khayatan, 2017)s. This discrepancy may be due to the timing of the post-test. In Khayatan's study, the post-test was administered immediately after the training sessions, whereas in our study, the post-test was conducted four weeks after the intervention, which may have led to a decrease in the perceived level of sexual self-esteem. Other possible factors include differences in sample size and session frequency. In our study, classes were held twice per week, while in Khayatan's study, sessions were conducted once a week, which may have allowed participants more time to process and understand the content. Furthermore, the larger sample size in our study might have contributed to misunderstandings or reduced the effectiveness of the intervention. Additionally, the different study populations might have led to cultural disparities, contributing to the divergent findings.

No relevant study was found regarding the effect of individual sexual training on sexual self-esteem, making our research the first of its kind in this area. Our findings suggest that individual training methods may be more effective than group training in addressing marital sexuality. Designing and implementing individual training programs appears to have a valuable and constructive role in increasing awareness and improving marital quality of life.

5. Suggestions and Limitations

One limitation of the study was the lack of cooperation from some participants, which was addressed by building trust with them. Another limitation was the inability to hold sessions on fixed days of the week. To overcome this, the researcher adapted the schedule to meet participants' needs. Additionally, an unavoidable limitation was the absence of comparable studies on the effect of individual training on sexual self-esteem for direct comparison.

The findings of this study showed that neither individual nor group training significantly affected sexual self-esteem, but individual training was more effective than group training in improving sexual satisfaction. Therefore, it is recommended that individual training be used to enhance sexual satisfaction. It is also advised that educational designers and practitioners use the results of this study to hold workshops and sexual skills training courses individually to increase women's knowledge in areas such as obstetrics, women's health, and marital skills—particularly for midwifery students, health care providers, and public health personnel. Doing so would ensure that those responsible for educating clients have sufficient knowledge to deliver these topics effectively.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript.

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.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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