Effectiveness of Healthy Sexual Behavior in the Sexual Dysfunction of Addicted Women

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Abstract

Objective: The aim of this study was to investigate the effect of training healthy sexual behaviors on the reduction of sexual dysfunction in addicted women. **Method:** A quasi-experimental research design along with a pre-test-posttest/control group was used for the conduct of this study. The statistical population of this study included the addicted women who were under treatment in rehabilitation centers of Attar, Sepahan, Pak Mehr, and Congress 60 in 2015 in Isfahan. Voluntary sampling method was used to select the sample. Subsequently, after the implementation of the questionnaire, 30 participants were selected out of the 100 volunteers and were randomly assigned to two groups, i.e. experimental (n = 15) and control (n = 15). The experimental group participated in eight 90-minute training sessions and the control group did not receive any intervention. **Results:** The results showed that the training of healthy sexual behaviors affects the reduction of sexual dysfunction and its components in addicted women's. **Conclusion:** Training of healthy sexual behaviors can positively affect the addicted women's sexual dysfunction. Therefore, this method can be used in special addiction treatment centers in relation to women's addiction.

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Research on Addiction Quarterly Journal of Drug Abuse
Presidency of the I. R. of Iran
Drug Control Headquarters
Department for Research and Education

Vol. 10, No. 39, Autumn 2016
http://www.etiadpajohi.ir

Introduction

In recent years, the prevalence of drug use in men and women has increased; according to researchers' report, the rate of increase in women was significantly higher than that of men (Rahimi Movaghar, Malayerikhah Langroudi, Dalbarpour Ahmadi & Amin Esmaeali, 2011). In the subject of addiction, men are paid more attention than women, while women are the most vulnerable stratum in the cycle of addiction. In addition, the issue of female addiction is a hidden social problem because the traditional environment governing families and the society does not allow addicted women to declare their addiction. On the other hand, in Iranian culture, substance use in women is considered to be more abnormal than that in men. Therefore, addicted women encounter difficulties in receiving services such as the treatment and cessation of psychiatric disorders caused by drug use. This is so while addiction has an adverse effect, especially a psychological effect, on couples and other members of the family. Depression, sadness and grief, or disappointment and lack of pleasure are among these disadvantaged situations (Akin, & Iskender, 2011; Dalbudak et al., 2013).

On the other hand, family has a variety of functions, including the appropriate satisfaction of sexual needs. Women's sexual issues are multifactorial and rooted in biological, psychosocial, and environmental factors (Stead, Brown, Fallowfield, & Selby, 2003). Considering the many factors that affects women's sexual function, it is not surprising that this process gets deviated in addicted women and causes female sexual dysfunction (La Pera, Franco, Taggi, & Macchia , 2003). Today, the majority of psychiatrists and psychologists refer to the content of Diagnostic and Statistical Manual of Mental Disorders in defining female sexual dysfunction, which is defined as: sexual misconduct, including libido disorders (such as hypo sexual desire disorder in men), subjective arousal disorders (such as erectile dysfunction), orgasmic disorders (such as early ejaculation), and sexual dysfunctions (such as painful intercourse) where the symptoms of each category continues at least for six months or more (American Psychiatric Association, 2013).

Sexually dysfunctional behavior can lead to the loss of self-esteem, anxiety, depression, and personality problems. Also, its social consequences significantly affect divorce, violence, quality of life of couples, and subsequent relationships (Aslan, Beji, Gungor, Kadioglu, & Dikencik, 2008). In fact, there is considerable evidence that describes the close relationship between sexual activity and marital satisfaction, as well as between sexual dysfunction and family collapse (Spence, 2013). Regarding the multiple and multi-faceted effects of sexual dysfunction on both the individual and the family, it is necessary to use the best treatment methods to deal with it. Among these therapies and treatment methods, one can mention the training of healthy sexual behaviors. Unhealthy behavior is the type of sexual behavior that involves the increase of sexual pleasure from multiple sexual partners to the non-use of preventive devices (Santeli, 2008). These

behaviors are more common in people with substance abuse in such a way that a percentage of the transmission of infectious diseases is attributable to risky and unprotected sexually behaviors. Moreover, sexual dysfunction among addicts has been widespread due to social exclusion (Mohammadrazaghi, Rahimi-Movaghar, and Mehdi Hosseini, 2003). Researchers have found that there is a positive relationship between drug use and unhealthy sexual behaviors, which makes it difficult to treat drug use (Rawson, Washton, Domier, & Reiber, 2002). The problems of substance abuse and sexual dysfunction in women are more important than those in males due to the probability of pregnancy and, therefore, their fetus may be at risk (low birth weight, early delivery, malnutrition, abortion or neonatal abstinence syndrome). Hence, women constitute an important group in the planning of treatment for addicts. However, in Iran and most countries in the world, addiction treatment programs tailored to women's needs are either not available or are very rare. The aim of the present study was to investigate the effect of training healthy sexual behaviors on the reduction of addicted women's sexual dysfunction.

Method

Population, sample, and sampling method

A quasi-experimental research design along with a pre-test-posttest/control group was used for the conduct of this study. The statistical population of this study included the addicted women who were under treatment in rehabilitation centers of Attar, Sepahan, Pak Mehr, and Congress 60 in 2015 in Isfahan. The number of 100 individuals was selected via convenience sampling method. After the administration of the questionnaire to these 100 people, 30 participants were selected based on the cutoff point of the female sexual function index, and were randomly assigned into two groups (15 participants to the experimental group and 15 participants to the control group). Addicted women in this study were amphetamines users, methamphetamine users, cocaine users, and alcohol consumers, and in most cases, users of opiate drugs that are currently in the pathway to recovery via the maintenance medications, including methadone, opium, and buprenorphine. The inclusion criteria were: 1. Addicted drug users being recovered and 2. Sexually dysfunctional (according to the results of the questionnaire). Exit criteria also were unwillingness to attend the course and absence in more than two sessions.

Instrument

Female Sexual Function Index: This scale was designed by Rosen et al. (2000) and was validated on a group of women with sexual arousal disorder. It contains six dimensions that measure women's sexual function by 19 questions in terms of: 1) sexual desire; 2) stimulation or arousal; 3) vaginal lubrication; 4) orgasm; 5) sexual satisfaction; and 5) pain. The items in the dimension of sexual desire are scored from 1 to 5, while each item in the other dimensions, i.e. arousal,

lubrication, orgasm, satisfaction, and pain is scored from 0 to 5. In this way, the higher score represents better sexual function. The maximum score for each domain equals 6 and for the total index equals 36. The minimum score for the sexual desire domain is 1.2, for the sexual arousal, lubrication, orgasm, and pain is zero, for satisfaction is 0.8, and for the whole index is 2. Rosen et al. (2000) obtained the Cronbach's alpha coefficient of 0.89 for the scale. In Iran, the Cronbach's alpha coefficient of reliability was obtained equal to 0.85 and the appropriate cut-off score for the diagnosis of sexual dysfunction was set 28 (Mohamadi, Heidari & Faghihzadeh, 2008).

Procedure

After the receipt of the required permits for the conduct of this research and provision of coordination with the authorities, the researchers obtained the written and oral informed consent from the participants in the study and assured them that the information would be kept confidential and that the research would not bring any harm to them. In this research, all the participants attended the initial session; the initial assessment was carried out individually. A pre-test was carried out to detect sexual dysfunction. Then, the experimental group was trained in eight 90-minute group training sessions of healthy sexual behaviors (twice a week). However, the control group did not receive any interventions. One month after the completion of the training sessions, the two groups took post-test separately. This treatment plan was developed based on the following books: Healthy Sexual Behaviors (Ohadi, 2013), Cognitive Behaviour Therapy for Psychiatric Problems: A Practical Guide (Hawton et al., 1989; translated by Gasemzadeh, 2011), Treatment of Sexual Disorders (Spence, 1991; translated by Rahmati, 2012); Helping People with Sexual Problems: A Practical Approach for Clinicians (Trigwell, 2005; translated by Safarinia & Delir, 2011); Booklets resulting from Dr. Mohammad Reza Abedi's workshops (2011) and Dr. Ramezani's workshops (2013).

Table 1: The content of training sessions of healthy sexual behaviors

Session	*Objective*	*Content*
Preliminary	Introductory session, primary group assessment, and individual clinical interview	Interview and evaluation; examination of the current problem in the four stages of desire; arousal; orgasm; and sexual pain; ensuring the existence of sexual problem or sexual dysfunction; pre-test implementation
1	The expression of the treatment logic, the complete assessment of the problem, and the objectives of the training	Examining the reasons for the incidence of the problem, examining the history of sexual dysfunction; reviewing the medical history; examining the interest and love between couples; examining the type of frequency and quality of couples' sexual relations; getting familiar with the relationship between drug use and sexual intercourse; getting familiar with the relationship of consumption of methadone, buprenorphine, and opium maintenances with sexual relationship

Table 1: The content of training sessions of healthy sexual behaviors

Session	*Objective*	*Content*
2	Training to establish intimacy, provision of sexual information and knowledge	Reviewing the first session; getting familiar with the definition of intimacy; teaching how to establish intimacy and exercise its practices; getting familiar with woman and men's sex organs and their physiological actions and their hormones; teaching about the sensitive parts of the body and the role of clitoris in female orgasms; teaching the sexual response cycle and symptoms and signs of changes in these steps in men and women
3	Examination of couples' sexual fear, relaxation training, teaching different sex positions	Reviewing the previous session; assessing the quality of the first sexual intercourse with the wife; examining the first sexual experiences in childhood and adolescence in order to find the remaining fears from childhood; reviewing the period of puberty and how the person has dealt with it by the individual and his or her relatives, especially the his/her parents; teaching how to relax in order to reduce sexual tension; making an overview of couples' sexual attitudes; getting familiar with different intercourse positions; presenting relaxation tasks and different intercourse positions
4	Vaginal self-arousal training	Reviewing the previous session; reviewing the previous session tasks; self-examining and examining particular organs and genitals; performing genital manipulation; training of sexual imagination; training vaginal self-arousal; assigning homework
5	Concentration skills training, non-genital sensing, mental imagery	Reviewing the assignments; training concentration and attention skills; teaching how to pay attention to the centralized feelings to non-genital organs; investigating verbal communication and how to express emotions between couples; teaching emotional expression and verbalizing emotional feelings and sexual self-expression to spouse; providing assignments
6	Genital sensory training, familiarity with sex coolers, familiarity with psychiatric disorders, problem-solving training	Reviewing the previous session and assignments; eliminating the prohibition of touching the genital organs; providing information about sexual organs and sensitive points; teaching how to concentrate on sexual organs with regard to the stimulation and pleasure of the genital organs; getting familiar with the impact of conflict on sexual intercourse and the impact of disruptive factors; getting familiar with false sexual myths; getting familiar with sexual coolers in men and women; getting familiar with psychiatric disorders; getting familiar with empathy skills and sexual problem-solving
7	Familiarity with the effects of getting more beautiful, familiarity with compatible intercourse methods of dealing with the problem	Getting familiar with the effect of makeup and trimming in sexual arousal; teaching sexual intercourse tailored to couples' problems; training the simultaneous clitoral arousal and sexual intercourse; reviewing the issues pertaining to emotional and physical stroke and bedrooms; training behavioral techniques such as start and stop techniques; presenting homework
8	Evaluation of the achievement of therapeutic goals, post-test implementation	Reviewing previous sessions; evaluating the various techniques used by couples; providing feedback on the effectiveness or ineffectiveness of the treatment; fixing the existing flaws; providing answers and questions; evaluating the degree of satisfaction with the treatment; implementing the post-test

Results

Table 2: Descriptive statistics of variables of research by groups and type of test

Variables	*Groups*	*Pretest*		*Posttest*	
		Mean	*Standard deviation*	*Mean*	*Standard deviation*
sexual desire	Experimental	2.26	1.16	2.52	1.30
	Control	2.20	0.94	2.66	1.58
subjective arousal	Experimental	2.46	1.06	4.80	1.32
	Control	2.60	1.12	2.33	1.11
vaginal lubrication	Experimental	2.66	0.72	3.93	1.48
	Control	2.60	0.98	2.33	1.23
orgasms	Experimental	1.60	0.50	3.66	1.23
	Control	1.40	0.63	1.73	0.70
sexual satisfaction	Experimental	1.93	0.88	4.00	1.55
	Control	2.00	1.00	2.46	1.30
pain	Experimental	1.06	0.96	4.80	1.37
	Control	1.93	0.96	2.60	1.45

The mean (standard deviation) of the age of the experimental and control group was 30.50 (6.90) and 32.50 (5.41) respectively. In the experimental group, 10 people (66.66%) had primary and secondary education, 4 people (26.66%) had high school and high school diploma, one person (6.67%) had university education. In the control group, 8 people (53.33%) had primary and secondary education, 5 people (33.33%) had high school and diploma education, and 2 people (13.34%) had university education. The descriptive statistics of the variables studied by groups and type of test are presented in Table 2. In order to investigate the effectiveness of intervention, multivariate covariance analysis should be used. One of the assumptions of this analysis is that the distribution of variables is normal. The results of the Kolmogorov-Smirnov test showed that this default is in post-test scores in both groups (P> 0.05). The other default is the equality of error variances in two groups. The results of the Lone test showed that in the component of sexual desire (P>0.05, F=0.16), subjective arousal (P <0.05, F = 2.80), vaginal lubrication (P> 0.05, F = 0.15), orgasm (P>0.05, F=0.22), sexual satisfaction (P>0.05, F=0.39), pain (P>0.05, F=0.16 so this is assumption is establishment. The other assumption is the equality of the variance-covariance matrix, which results in the test of the box suggesting this assumption (P>0.05,F= 1.70). Therefore, multivariate analysis of covariance was performed and the results showed a significant difference (P<0.001, F=22.62, Wilks Lambda=0.34). To study patterns of difference, one-variable covariance analysis was used as follows.

Table 3: Results of single-variable covariance analysis to examine patterns of difference

Variables	*Change source*	*Mean of square*	*F statistics*	*Sig.*	*Effect size*	*Statistical power*
sexual desire	Pre test	1.60	0.75	0.39	-	0.13
	Group Membership	1.08	0.50	0.485	-	0.10
subjective arousal	Pre test	5.41	4.26	0.05	0.16	0.50
	Group Membership	26.57	20.90	0.001	0.48	0.99
vaginal lubrication	Pre test	0.005	0.003	0.96	-	0.05
	Group Membership	21.43	10.29	0.004	0.31	0.86
orgasms	Pre test	0.12	0.128	0.72	-	0.06
	Group Membership	26.33	26.13	0.001	54	0.99
sexual satisfaction	Pre test	0.20	0.12	0.73	-	0.06
	Group Membership	21.22	12.64	0.002	-0.36	0.92
pain	Pre test	0.01	0.007	0.934	-	0.05
	Group Membership	28.29	13.72	0.001	0.38	0.94

As shown in Table 3, except in the component of sexual desire in other components, training has been effective.

Discussion and Conclusion

The aim of this study was to investigate the effectiveness of teaching healthy sexual behaviors in the reduction of addicted women's sexual dysfunction. The results showed that the teaching of healthy sexual behaviors has been effective in the addicted women's sexual dysfunction. The researchers could not find any research in the literature to be consistent with the results of this study, but similar studies have been carried out that are indirectly consistent with the results of this study (Keshavarz Safiea, Noori & Hasani, 2015; Behboodi Moghadam et al. (2015), Afshar et al. (2012); Bull, Levine, Black, Schmiege, & Santelli (2012)).

In fact, the addicted women who under the path to recovery from drug use have experienced a high sexual function at the beginning of their consumption, and they have undergone the complications of drug use and the low sexual function after the long-term use of drugs. They mistakenly believed that they needed taking drugs or drug use to improve their sexual function and reduce their sexual dysfunction, and especially to experience orgasm. They also conceived that they would not be treated with therapy and psychotherapy. With the training of healthy sexual behaviors, this misconception was eliminated, and their confidence in the impact of non-drug education was gained in the initial sessions. In addition, since they had had no sexual relationship for several years and rarely experienced orgasmic experience after recovery, they had a very low level of sexual self-efficacy. They could achieve this by receiving training on healthy sexual behaviors. Finally, another misconception that the addicted under recovery had about the complications of long-term drug use (especially methamphetamine) was that sexual dysfunction caused by drug use, particularly crystal, is enduring in life. This misconception was corrected after they were explained that the sexual-related complications will be eliminated for up to six months after the recovery.

To explain the non-effectiveness of training of healthy sexual behaviors on sexual desire, one may argue that since the women under process of recovery took maintenance medications, such as methadone, buprenorphine, and opium (opium syrup), and methadone and opium reduces libido; therefore, the effect of the medication is remaining in the body of the experimental group. That is way this finding is believable. The women who receive higher doses of medications in methadone maintenance treatment centers receive a lower effect of this training on their sexual function than the women who receive lower doses of medication (opium) in congress 60. To explain the increased sexual arousal of addicted women in this trial, it can be said that there was homework about the topic of teaching sexual imagination, vaginal self-arousal training, introspection, and the examination of genital and non-genital organs in the training of healthy sexual behaviors that have led to an increase in sexual arousal in the experimental group.

To explain the effectiveness of this training in vaginal lubrication, the role of communication factors can be mentioned. Communication factors played an important role in the recovery process of participants, and this finding is consistent with many other findings that showed complaints about the sexual function of spouses were often rooted in communication problems between them. It is also consistent with the finding that argues that communication factors and family problems are the interpersonal factors that lead to a reduction in sexual desire (Nappi et al., 2010). Moreover, it can be said that the increased arousal, reduced stress and anxiety in the experimental group as a result of the effect of the technique of recording thoughts (clients' negative thoughts were assessed during the sessions), familiarity with their sexual coolers, and training about relaxation techniques have all led to an increase in vaginal lubrication.

In addition, to account for the effectiveness of teaching healthy sexual behaviors in orgasm, it can be stated that the teaching of practicing intimacy with their husbands and the assignment of homework in relation to the types of intimacy to the clients have resulted in the improvement in their relationship with their spouses, which had brought about the increase of orgasm in women. Secondly, the complications of the long-term use of narcotic drugs lead to the isolation of the addicted woman; her verbal and social skills are influenced by teaching emotional training and verbalizing emotional feelings; and she is trained how to express her feeling to her husband. All these factors are believed that have increased orgasm. Thirdly, the clients who use methamphetamine (crystal) undergo a long-term side effect during recovery, which is inattention and inadequate concentration; hence, the training of attention and focus can increase orgasm in these women. Fourth, these women were taught to have simultaneous clitoral arousal and sexual intercourse since they do did not reach orgasm only through intercourse. Indeed, the experimental group had no information about this, and they had the false impression that they should reach orgasm only through intercourse. This misconception had decreased their sexual

self-efficacy and had caused their repeated failures in sexual relationships. Training and the receipt of information could eliminate this common misconception. Fifth, they were able to experience orgasm through training of the proper methods of sexual intercourse in line with the clients' problems.

In terms of the effectiveness of this training in sexual satisfaction, it can be said that the techniques of healthy sexual behaviors in this field include the increase of sexual awareness and sexual skills, improvement of insights and understanding of systematic causes, decrease of sexual desire, expression of feelings, and behavioral interventions have had an effect on improving the women's sexual function and have brought about sexual satisfaction by exerting positive influences on their husbands, especially in terms of communication. In this regard, the results of research done by Parish et al. (2007) and Kim (2008) showed that the use of awareness-raising programs for the enrichment of the couples' sexual relationship, which is one of the components of the therapy in the present study, increased the level of satisfaction with sex life. Furthermore, to account for the reduction of the pain in the experimental group, it is possible to argue that teaching of Kegel exercises (loosening and tightening of the pelvic muscles) and training on muscular relaxation and abdominal respiration have been effective in reducing the pain of women under recovery.

One of the limitations of the present research was that the research was conducted only on addicted women; therefore, caution should be exercised in generalizing the findings to men. In addition, the present study was carried out on the addicted women presenting to Isfahan addiction treatment clinics. Due to the voluntary selection of participants, care and caution should be exercised in generalizing the results to other communities and groups. It is suggested that follow-up tests be conducted in subsequent studies to ensure the sustainability of the effect of the treatment period. Considering the effectiveness of the training of healthy sexual behaviors in addicted women's sexual dysfunction, it is suggested that special education and therapeutic centers use this method for addicted women to improve their sexual problems.

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