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Comparing the Effect of Solution-Focused Group Counseling and Individual Counseling Based on PLISSIT Model on Sexual Satisfaction of Women with High Body Mass Index

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ABSTRACT

Background & aim: obesity can negatively affect sexual function and obese women experience lower sexual satisfaction. This study compared the effect of solution-focused group counseling and individual counseling based on the PLISSIT model on sexual satisfaction of women with high body mass index.

Methods: This randomized clinical trial was conducted on 60 women with a BMI>30 who were randomly assigned to two groups of solution-focused group counseling and individual counseling based on the PLISSIT model. Data collection tools included a demographic, as well as Larson's sexual satisfaction questionnaire. Solution-focused counseling group received eight 45-minute counseling sessions, while the individual counseling group received three 60-minute sessions of counseling based on the PLISSIT model. Data were analyzed in SPSS software (version 16) using Chi-square, independent t-test, Mann-Whitney, and Wilcoxon tests.

Results: There was a significant difference in sexual satisfaction score between two groups after intervention and it was higher in solution-focused group counseling group (P=0.001). Also the score of sexual satisfaction was significantly higher in the dimensions of sexual attitude (P<0.001), quality of sex life (P<0.001), and sexual compatibility (P<0.001) in solution-focused group counseling group compared with individual counseling based on the PLISSIT model.

Conclusion: As evidenced by the obtained results, solution-focused group counseling can lead to increased sexual satisfaction of women with high BMI.

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Introduction

Sexual satisfaction is of paramount importance in marital life and one of the keys to a successful marriage (1). Sexual satisfaction as a mental evaluation includes an effective response arising from one's subjective evaluation of sexual relations in general, which in turn, affects people's general well-being (2). Sexual satisfaction refers to one's pleasant feeling of sexual activity. High levels of sexual satisfaction increase the quality of married life and stability of marital relationships throughout life. Sexual satisfaction is not merely physical pleasure, rather it encompasses all the emotions that persist after the positive and negative aspects of a sexual relationship (3).

According to studies, 40% of women experience sexual dysfunction and dissatisfaction during their married life (4). One third and one-fourth of these women suffer from lack or shortage of sexual desire and absence of orgasm, respectively (5). In their study, Tavakol et al. (2011) pointed to moderate sexual satisfaction of the majority of women (58.2%) referring to health centers in the south of

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Tehran (6). The results of a study conducted by Nasiri Dehsorkhi et al. (2015) on married women in Isfahan showed that 56% of women had low and moderate sexual satisfaction (7).

In Iran, sexual dissatisfaction has been cited as grounds for 40% of divorces (8). Two categories of factors are effective in women's sexual satisfaction. The first category encompasses psychological and socio-cultural factors, while the second category pertains to biophysical factors and physical health problems (9). In this regard, obesity is recognized as one of the factors affecting people's sexual satisfaction. It can act as a physical barrier to sexual intercourse, and sexual dysfunction and decreased sexual satisfaction will be inevitable in the case of women's physical inability to have sex (10).

In this regard, the study by Halpern (2005) demonstrated that body weight can affect sexual performance and satisfaction (11). Other studies have also referred to the effect of high BMI on sexual performance and satisfaction (10, 12). Along the same lines, in their study, Abu Ali et al. (2009) pointed out that obese women suffer from arousal and orgasm disorders (12). The following potential mechanisms are reportedly involved in obesity-related sexual dysfunction and decreased sexual satisfaction: exacerbation of medical problems, alterations in the level of hormones affecting sexual response and desire, and changes in body image (13).

Negative body image can lead to adverse psychosocial effects, including mental anorexia, bulimia, depression, social anxiety, sexual dysfunction, and decreased sexual satisfaction (14). Therefore, obesity is associated with poor body image, self-confidence, and reduced quality of life, all of which can lead to sexual dysfunction and decreased sexual satisfaction (10). In addition, sexual dissatisfaction may result in such problems as depression, and eventually, separation and divorce (15).

Many of these problems can be prevented by early diagnosis, as well as effective counseling and treatment methods, along with proper education of sexual issues to couples (16). Sexual counseling is one of the key elements in achieving optimal sexual health, proper sexual function, as well as a healthy and successful life (17). Sexual counseling strategies can help health care providers implement an appropriate and effective supportive approach in cases of sexual anxiety and problems (18).

Solution-focused group counseling is a strengths-based approach that emphasizes the resources that an individual possesses. This approach is among postmodern and new theories in the field of family counseling. Individual's past and even the existing problems are not matters of concern in this method, rather the existing solutions are the center of attention. The solution-focused approach believes that emphasis on the past and the analysis of foregoing problems is a time-consuming futile process (19). The effect of group counseling on sexual performance and satisfaction has been investigated in various studies (20).

Group counseling can provide a sense of security to take risks and interact spontaneously and freely with group members. Therefore, the needs of individual members can be addressed by drawing on peer experiences; moreover, this intervention is time-and cost-effective (21). Nevertheless, people may be less inclined to talk about sexual issues in the group due to the cultural, social, and religious differences, as well as the taboo nature of sex. Personal counseling is another method of sexual counseling.

In this method, the consultant and client meet in a private place to discuss the client's problems, his/her experienced discomfort, his dissatisfaction with life, and loss of sense of purpose. In these sessions, it is strived to help the person deal with life crises (22). PLISSIT model of sex therapy is an individual counseling method of sexual education. It is the most widely used intervention for the evaluation of sexual function applicable for people from all walks of society (23). This model examines the needs of individuals in a specific framework and provides the required measures and planning to solve their problems at four levels and reduce female sexual dysfunctions (24).

Various studies have been performed by Mehrabi et al. (25), Nejati et al. (26), and Rostamkhani et al. (27) on the effectiveness of PLISSIT model on sexual function and women's marital quality. In the same context, Seyed Moharremi et al. (28) conducted a study on the effect of group counseling on marital

satisfaction. In the mentioned studies, the intervention group was compared to the control group; nonetheless, no study has made a comparison between these two methods of counseling among women.

Nowadays in Iran, we are witnessing an increase in the prevalence of obesity and its consequences on peoples' marital life. Therefore, to find a suitable counseling method for obese women, the present study aimed to compare the impact of solution-focused group counseling and PLISSIT-based individual counseling on the sexual satisfaction of women with high BMI.

Materials and Methods

This randomized clinical was conducted on 60 women with a BMI>30 kg/m² who were randomly assigned to two groups of solution-focused group counseling and individual counseling based on the PLISSIT model. After obtaining the code of ethics (IR.MUMS.NURSE.REC.1398.073), the researchers referred to the health center of Khorasan Razavi province.

The multistage sampling method was employed in this study. Firstly, one center was selected by drawing lots out of five health centers of Mashhad. In a similar vein, two comprehensive urban health service centers were selected by drawing lots. Thereafter, one center was randomly selected as a solution-focused group counseling center and the other center was regarded as PLISSIT model-based individual counseling center. In each center, 30 married women with MBI> 30 who met the inclusion criteria were selected for the study.

The inclusion criteria were as follows: Iranian nationality, residency in Mashhad, living with spouse and monogamy, the age range of 20-45 years, no current pregnancy, no breastfeeding an infant under one year of age, no abnormal bleeding, ability for sexual intercourse, absence of chronic mental and physical problems in the last six months, women and her spouse's nonuse of drugs and alcohol. On the other hand, the exclusion criteria entailed: absence in counseling sessions more than once, the occurrence of a stressful event, such as the death of a loved one, accident, pregnancy, and unwillingness to continue the cooperation in the project.

The sample size was calculated based on two studies by Banai et al. (2016) entitled "Study of the effect of counseling based on PLISSIT model on sexual intimacy and satisfaction of breastfeeding women" (29) and Seyed Moharremi (28) who assessed the effect of group counseling on women's sexual satisfaction. Moreover, 95% confidence level and 90% test power were considered. The maximum sample size was calculated at 26 subjects who were increased to 30 cased in each group considering 15% sample attrition.

Data collection tools included: 1- Personal and midwifery information questionnaire: This form which consisted of 17 questions in two parts of examination and observation was completed by asking questions and measurements. Larson's Sexual Satisfaction Questionnaire (1998): It involves 25 items and reflects four factors, including the desire to have sexual relations, sexual attitude, quality of sex life, and sexual compatibility. The items include 13 negative and 12 positive items. The positive items are rated on a 5-point Likert scale ranging from never=1 to always=5, and the negative items are scored from never=score 5 to always=1. The **scale scores** range from 25-125. (30).

Bahrami et al. (2016) evaluated the validity and reliability of this questionnaire and reported a Cronbach's alpha of >0.7 for positive and negative items. Confirmatory factor analysis confirmed the final model of Larson sexual satisfaction. The Persian version of this instrument showed acceptable characteristics when applied to Iranian couples. Factor analysis showed that the sexual satisfaction questionnaire is a multidimensional construct. Considering the correct psychometric properties, this questionnaire can be used to measure sexual satisfaction in Iranian population (31).

Solution-focused group counseling group received eight 45-minute sessions of solution-focused counseling (twice a week). In the other group, PLISSIT-based counseling was presented in three 60-minute sessions (once a week). The content of the solution-focused group counseling sessions was as follows:

Session 1: fostering communication and familiarity, provision of the goals, rules, and

procedures of the sessions, instillation of hope for change in the participants,
Session 2: Familiarity with the basic principles of solution-focused consulting and its application, examining the active acceptance of responsibility in a relationship, formulating problem-solving circles
Session 3: Identifying the solutions for different problems of participants, familiarizing the participants with useful solutions, reinforcing them, and abandoning inappropriate solutions, finding a positive story,
Session 4: Commitment and instillation of hope in participants for solving problems, identifying and overcoming participants' resistance, talking about the future and measures, using the technique of scale questions
Session 5: Members' familiarization with exceptions, strengthening and highlighting exceptions, participants' realization of their capabilities and potentials
Session 6: Helping participants identify other methods of thinking, feeling, and behaving instead of the current problematic thinking, feeling, and behavior, helping participants to admire each other instead of criticizing, and performing the master key technique
Session 7: Helping participants to imagine their favorite future and a better world, helping participants to get out of the problem scope, identifying objective and desirable changes, using the technique of predictive task design
Session 8: Summarizing the sessions and arriving at a conclusion, using graded questions, thanking and appreciating the members for participating in the meeting

The content of the consultation sessions based on the PLISSIT model was presented as follows:
Session 1: Counseling begins by asking a few open-ended questions, followed by talking about sexual performance and satisfaction; thereafter, the client started talking. The counselor was informed of the wrong thoughts, misconceptions, incomplete information, and concerns of the client. Session 2: Consultant provides the client with necessary information on reproductive anatomy, physiology of sexual function, the sexual response cycle (in simple language through pictures), life cycle changes, and the impact of obesity on sexual performance and satisfaction. Session 3: In this session, suggestions and special information about the problem are provided to the client.

One month after the end of counseling sessions, the sexual satisfaction questionnaire was completed again in both groups. All the ethical considerations were observed in the study. Participants were ensured of the confidentiality of their information and their right to withdraw from the study at any time. There was no sample attrition in both groups. Finally, the data were analyzed in SPSS software (version 16) at 95% confidence level using Chi-square, independent, Mann-Whitney, and Wilcoxon tests. A p-value less than 0.05 was considered statistically significant.

Results

The mean age scores of subjects in the solution-focused group counseling group and PLISSIT-based counseling group were obtained at 39.30±3.03 39.97±4.50 years, respectively. In terms of education, 53.3% and 60% of women in the PLISSIT-based counseling group and solution-focused counseling group hold a diploma. Regarding profession, 63.3 and 70% of women in the PLISSIT-based counseling group and solution-focused counseling group were housewives, respectively. There was no significant difference between the two groups in terms of the mentioned characteristics, as well as husband's age and education and women's MBI ($P<0.05$) (Table 1). Moreover, the two groups were not different in terms of obstetric characteristics, including parity, mode of delivery, and age at menarche ($P<0.05$) (Table 2).

Based on the results, there was a significant difference in sexual satisfaction score between two groups after intervention and it was higher in solution-focused group counseling group ($P<0.001$). Also the score of sexual satisfaction was significantly higher in the dimensions of sexual attitude ($P<0.001$), quality of sex life ($P<0.001$), and sexual compatibility ($P<00.1$) in solution-focused group counseling group compared with individual counseling based on the PLISSIT model.

Table 1. Comparison of demographic characteristics of women in the two groups

	Individual counseling group based on the PLISSIT **model**	**Solution-focused group-counseling group**	**Significance level**
	N (%) **Mean ± SD**	**N (%)** **Mean ± SD**	
Age			
year	39.97±4.50	39.30±3.03	t=0.67 P=0.50
Husband's age			
Year	45.30±6.04	46.43±5.81	t=0.74 P=0.46
Body mass index			
Kg/m2	31.65±1.01	31.76±1.62	t=0.32 P=0.75
Education			
Junior high school	7 (23.3)	8 (26.7)	x2=1.01
Diploma	16 (53.4)	18 (60)	P=0.61
Academic	7 (23.3)	4 (13.3)	
Occupation			
housewife	19 (63.3)	21 (70)	x2=0.53
Employed	11 (36.7)	9 (30)	P=0.41
Husband's education			
Junior high school	3 (10)	4 (13.3)	
Diploma	19 (63.3)	18 (60)	x2=0.17 P=0.92
Academic	8 (26.7)	8 (26.7)	

In the solution-focused group-counseling group, the scores significantly improved in the dimensions of quality of sex life (P<0.001), sexual attitude (P<0.001), desire to have sex (P<00.1), and total sexual satisfaction (P<00.1) after the intervention, compared to the scores obtained before the intervention (P<0.001). Nonetheless, no significant increase was observed in the dimension of sexual compatibility (P=0.89).

Table 2. Comparison of obstetric characteristics of women in the two groups

Variable	**Individual counseling group based on the** PLISSIT **model**	**Solution-focused group-counseling group**	**Significance**
	N (%) **Mean ± SD**	**N (%)** **Mean ± SD**	
Parity			
1	10 (33.3)	10 (33.3	
2	6 (20)	7 (23.3)	x^2=0.54
3	8 (26.7)	9 (30)	P=0.91
≥4	6 (20)	4 (13.3)	
Mode of delivery			
C-section	8 (26.7)	9 (30)	
Vaginal	20 (66.7)	18 (60)	x^2 =0.36 P=0.83
Both	2 (6.7)	3 (10)	
Age at monarch			
Year	13.30±1.49	13.63±1.83	t=0.77 P=0.44

In the individual counseling group based on the PLISSIT model, the scores significantly increased in the dimensions of quality of sex life (P<0.001), sexual attitude (P=0.01), sexual compatibility (P=0.008), as well as total sexual satisfaction (P=0.001) after the intervention, compared to their scores before the intervention. However, no significant increase was detected in the desire to have sex (P=1.00).

Table 3. Comparison of mean and difference between mean scores of sexual satisfaction and its dimensions before and after intervention in women of the two groups

Sexual satisfaction and its dimensions group	Before the intervention Mean ±SD	After the intervention Mean ±SD	Results of Man Whitney test
Desire to have sex			
Individual counseling	22.30±2.17	22.30±2.52	z=0.001 p=1.00
group counseling	21.50±3.31	23.40±1.40	z=4.14 p<0.001
Results of Wilcoxon signed-rank test	P=0.43 Z=0.80	Z=1.52 P=0.13	-
Sexual attitude			
Individual counseling	24.53±2.26	26.10±1.92	Z=2.51 P=0.01
Group counseling	26.13±2.75	29.30±0.88	Z=4.23 P<00.1
Results of Wilcoxon signed rank test	P=0.02 Z=2.36	Z=6.13 P<0.001	-
Quality of sexual life			
Individual counseling	3.20±3.70	35.10±3.69	Z=4.80 P<00.1
Group counseling	30.87±5.51	38.33±1.71	Z=4.79 P<00.1
Results of Wilcoxon signed-rank test	Z=0.87 P=0.38	Z=3.61 P<0.001	-
Sexual compatibility			
Individual counseling	21.80±1.61	22.67±0.99	Z=2.63 P=0.008
Group counseling	23.67±4.12	24.03±0.90	z=0.14 P=0.89
Results of Wilcoxon signed-rank test	z=4.19 P<00.1	Z=3.96 P<0.001	-
Total sexual satisfaction			
Individual counseling	98.93±8.46	106.17±5.10	z=4.26 P<00.1
counseling Group	102±13.42	115.07±4.16	z=4.79 P<00.1
Results of Wilcoxon signed-rank test	Z=2.09 P=0.04	z=5.56 P<0.001	-

Discussion

The results of the present study demonstrated that after the intervention, the scores of women significantly increased in the solution-focused group counseling group and PLISSIT-based individual counseling group, except for the dimensions of sexual compatibility and desire to have sex, respectively. Mehrabi et al. (2016) conducted a study to determine the effectiveness of sexual counseling based on the PLISSIT model on the performance and quality of sex life of women with diabetes. They concluded that sexual counseling based on the PLISSIT model has a significant effect on women's performance and quality of sex life (25).

In a similar vein, Nejati et al. (2017) carried out a study on the effect of sexual counseling based on the PLISSIT model on the sexual function of pregnant women. The results of the stated study showed that in the post-intervention phase, the case and control groups significantly differed in the mean scores of sexual function and all its domains. In other words, sexual counseling based on the PLISSIT model had a significant effect on the improvement of female sexual function during pregnancy (26).

This discrepancy between the findings of the mentioned studies and the present research can be ascribed to the fact that in these two studies, the intervention group was compared with the control group. However, in the current study, the intervention was performed in both groups. Despite the significant increase in sexual satisfaction in women of both groups, it can be argued that decisions should be made about the type of counseling based on conditions, facilities, and human resources.

Seyed Moharrami et al. (2015) conducted a study entitled "Effect of solution-focused group counseling on family performance and marital satisfaction of women". The results of the referred study suggested that solution-focused group counseling has a significant effect on the family performance and marital satisfaction of women in the experimental group. Poor family functioning and low marital satisfaction in married women can be improved by solution-focused group counseling (28).

Mohammadi et al. (2017) performed a study to assess the effect of group counseling based on reality therapy on female sexual satisfaction. They concluded that after the intervention, the mean score of sexual satisfaction was significantly higher in the experimental group, as compared to the control group. In other words, group counseling based on reality therapy was effective in improving women's sexual satisfaction (32). The results of these two studies are consistent with the results of the present study, although the aforementioned studies merely investigated the effect of group counseling on women's sexual performance and satisfaction.

However, the present study made a comparison between these two methods, and they are consistent with the current study in terms of the effectiveness of group counseling. According to the obtained results, it can be argued that both group counseling and individual counseling sessions can exert positive effects on improving the marital satisfaction of women with high BMI. Group counseling satisfies the members' needs by the provision of a receptive environment, promotion of their sense of responsibility, and achievement of a successful identity, all of which in turn, reduce members' stress and anxiety and improve their performance.

The need to love and to be loved is well satisfied in the group, and group counseling can provide a suitable environment for the achievement of a successful identity and a sense of tranquility. Group counseling can provide a sense of security to take risks and interact spontaneously and freely with group members. Therefore, the needs of individual members can be addressed drawing on peer experiences; moreover, this intervention is time- and cost-effective

Group counseling is a method aiming at improving, following up, and training; moreover, it includes interpersonal processes and problem-solving strategies which are based on conscious thoughts, feelings, and behaviors (28). Solution-focused group counseling is effective in solving not only individual problems but also interpersonal problems and even individuals' roles. It can be stated that new solutions are created by changing previous faulty solutions and people's attitudes towards problems.

The study participants listened to their peers and were informed of their problems; therefore, they found that many of their problems were not as serious as they thought. In some cases, problems even convey the meaning of love and affection to the clients. It is noteworthy that in solution-focused counseling, clients' views on the problem underwent dramatic changes after a few sessions. Furthermore, people may be less inclined to talk about sexual issues in the group due to the cultural, social, and religious differences, as well as the taboo nature of sex.

Another method of sexual counseling is individual counseling. In this method, the consultant and client meet in a private place to discuss the client's problem, his/her experienced discomfort, his/het dissatisfaction with life, and

loss of sense of purpose. In these sessions, it is strived to help the person deal with life crises (33). PLISSIT model of sex therapy is an individual counseling method of sexual education. It is the most widely used intervention for the evaluation of sexual function applicable for people from all walks of society (34).

According to the results, it can be argued that the effectiveness of individual and group counseling may vary in different fields. In fact, the application and effectiveness of the used consulting methods differ according to the characteristics and conditions of recipients of services and consultations. This highlights the need for research to select the proper counseling method in every field. The effectiveness of counseling depends on establishing the right communication and gaining the trust of clients. This is possible when the service provider is aware of the method of counseling preferred by their clients.

In the present study, there was no difference between the effectiveness of individual and group counseling methods in women's sexual satisfaction, and both methods are applicable based on the conditions and facilities of counseling centers. Regarding the strengths of the current research, one can refer to gender homogeneity between group members and counselors, the novelty of the subject for women(since it has usually been a taboo and a neglected issue in caring for women), and women's enthusiastic participation in counseling sessions.

On the other hand, the notable limitations of this study include the self-report nature of the questionnaire, as well as economic, social, and cultural differences. Furthermore, people may be less inclined to talk about sexual issues in the group due to the cultural, social, and religious differences, as well as the taboo nature of sex. It is suggested that further studies be conducted on the effectiveness and comparison of other counseling methods, such as face-to-face training, peer-to-peer training, or teach-back training. Furthermore, the effect of methods or psychological therapies, such as cognitive-behavioral therapy (CBT) or positive psychology, should also be taken into account due to the effect of sexual disorders on women's psychological wellbeing.

Conclusion

Based on the results, both solution-focused group counseling and individual counseling based on the PLISSIT model had a significant effect on increasing the sexual satisfaction of women with high MBI. Regarding the use of these two methods, women's preferences and characteristics, as well as the conditions and facilities available in counseling centers and comprehensive health service centers, should be considered, and the most appropriate method should be selected.

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Conflicts of interest

Authors declared no conflicts of interest.

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