

Comparing the Effectiveness of Sexual Counseling Based on PLISSIT and BETTER Models on Sexual Self-disclosure in Women with Sexual Problems after Childbirth: A Randomized Trial

Abstract

Background: Sexual self-disclosure is one of the factors that affect sexual satisfaction. The aim of this study was to assess the efficacy of individual therapy using the Bring up, Explain, Tell, Timing, Educate, and Record (BETTER model) in comparison to individual therapy using the Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT model) in terms of increasing sexual self-disclosure in women with sexual problems after childbirth. **Materials and Methods:** This randomized trial was conducted in 2017 in Mashhad, Iran. 80 women with sexual problems within 4 weeks to 6 months after childbirth were randomized into two equal groups and received the interventions in 2 sessions of 60–90 minutes. The research instruments included a demographic questionnaire, the Female Sexual Function Index (FSFI) and Hulbert sexual self-disclosure index. Changes in mean (SD) scores of sexual self-disclosures between groups were assessed before and 4 weeks after the intervention and the results (mean changes) were compared between groups. The data analysis was conducted using independent t-test, paired t-test, Chi-square, analysis of covariance (ANOVA), and Mann-Whitney U test in SPSS ($p < 0.05$). **Results:** In the PLISSIT group, the mean (SD) sexual self-disclosure score at baseline was 43.80 (9.50) and after 4 weeks was 51.60 (8.30). In the BETTER group, at baseline and after 4 weeks the mean (SD) sexual self-disclosure score was, respectively, 44.10 (10.30) and 55.60 (8.20) ($Z = -2.5, p = 0.013$). **Conclusions:** The findings confirm the effectiveness of the BETTER counseling model in increasing sexual self-disclosure after childbirth.

Keywords: Postpartum, sexual dysfunctions, self disclosures, sex counseling

Introduction

Sexual self-disclosure is one of the factors that affect sexual satisfaction.^[1] Sexual self-disclosure involves the 3 dimensions of the ability to express feelings, the ability to express pleasant and unpleasant thoughts and beliefs, and make a clear decision even if it results in being deprived of benefits, or is difficult to do it emotionally, and the ability to sustain one's rights and not allow others to harass or use one's weakness.^[2] Sex therapists have found that discussing the sexual preferences of individuals increases sexual satisfaction and decreases sexual problems.^[3] Couples increase their sexual satisfaction through sexual self-discourse.^[4] Open conversations and finding ways to create intimacy can help couples to accept their roles as parents.^[5] Interest and sexual response can dramatically change after childbirth.

Many couples are not ready to adapt to these changes.^[6] Sexual self-disclosure affects sexual satisfaction; thus, couples should be encouraged to talk more about their emotions in order to obtain better sexual function during.^[7] According to the World Health Organization (WHO), the postpartum period is an ideal time for giving information or advice on sexuality and identifying women's sexual health and sexual function needs.^[8] It is necessary to design and use counseling, support, and special techniques to maintain and promote intimacy and sexuality in the postpartum period. The Permission, Limited Information, Specific Suggestions, and Intensive Therapy (PLISSIT) model is a standard model and one of the most commonly used.^[9]

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How to cite this article: Karimi F, Babazadeh R, Roudsari R, Asgharipour N, Esmaily H. Comparing the effectiveness of sexual counseling based on PLISSIT and BETTER models on sexual self-disclosure in women with sexual problems after childbirth: A randomized trial. Iran J Nurs Midwifery Res 2021;26:68-74.

Submission: 27-Nov-19. **Revised:** 07-Jul-2020
Accepted: 06-Oct-2020. **Published:** 18-Jan-2021

Farzane Karimi¹,
Raheleh
Babazadeh^{2,3},
Robab Latifnejad
Roudsari^{4,5},
Negar Asgharipour⁶,
Habibollah Esmaily⁷

¹Lecturer, Department of Medicine, Birjand branch, Islamic Azad University, Birjand, Iran, ²Nursing and Midwifery Care Research Center, Mashhad University of Medical Sciences, Mashhad, Iran, ³Department of Midwifery, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran, ⁴Nursing and Midwifery Care Research Center, Mashhad University of Medical Sciences, Mashhad, Iran, ⁵Department of Midwifery, School of Nursing and Midwifery, Mashhad University of Medical Sciences, Mashhad, Iran, ⁶Professor of Clinical Psychology, Psychiatry and Behavioral Sciences Research Center, Ibn-e-Sina Hospital, Faculty of Medicine, Mashhad University of Medical Sciences, Mashhad, Iran, ⁷Social Determinants of Health Research Center, School of Health, Mashhad University of Medical Sciences, Mashhad, Iran

Address for correspondence:
Dr. Raheleh Babazadeh,
School of Nursing and
Midwifery Mashhad University
of Medical Sciences University
Street, Mashhad, Iran.
E-mail: babazadehr@mums.
ac.ir

Access this article online

Website: www.ijnmrjournal.net

DOI: 10.4103/ijnmr.IJNMR_265_19

Quick Response Code:



Another model particularly for women in their postpartum period, is the Bring up, Explain, Tell, Timing, Educate, and Record (BETTER) model.^[10,11] Martinez recommended the use of the BETTER counseling model because of its simplicity and specific emphasis on improving dialogues concerning sexual dysfunction as a person-directed approach. The BETTER model is used particularly for individuals with chronic diseases such as cancer and women in their postpartum period.^[10] Because of the need for skills at the third and fourth levels of the PLISSIT model, midwives and nurses can only intervene at the first and second levels of this model. One of the limitations of this model is its linearity and proceeding from one level to the next in which the therapist cannot diagnose the necessity of returning to the previous level to resolve the patient's sexual concerns.^[12]

In contrast, the BETTER model can be assumed an ideal model for Iran's cultural context since the counselor starts dialogues and clarifies the importance of sexual issues for clients. Because of our religious and cultural tradition in Iran, women do not share their sexual problems with counselors and research studies in this domain have suggested the use of different counseling approaches to decrease women's postpartum sexual problems.^[12-14] Due to the abovementioned facts and the lack of studies comparing counseling approaches designed to reduce female postpartum sexual dysfunction, the present study was conducted to compare the effectiveness of counseling based on the conventional PLISSIT model and the BETTER model on sexual self-disclosure in women with sexual dysfunction after childbirth.

Materials and Methods

This 2-group randomized trial was conducted from August to March 2017 on 80 women referring to 8 healthcare centers in the city of Mashhad, Iran, with a sexual complaint within 4 weeks to 6 months after childbirth (Registration number: IRCT20170430033718N3).

For this purpose, 4 of the 5 main healthcare centers in Mashhad were selected randomly, from among which 4 comprehensive health service centers (2 urban and 2 rural) were selected using a simple random sampling method. Then, 2 urban and 2 rural health centers were randomly selected from the list of the comprehensive health service centers (8 centers in total); 4 were allocated to the PLISSIT group and 4 to the BETTER group (2 comprehensive health service center and 2 health centers). Then, in each center, the eligible subjects were selected and allocated to the intervention and control groups.

The study inclusion criteria were residency in Mashhad, married and the only spouse of their husband, 18-45 years of age, the ability to speak, healthy, singleton and term newborn in recent childbirth, Female Sexual Function Index (FSFI) score of equal to or less than 28^[15]

(The maximum score for each domain is 6 and for the total index is 36, and the appropriate cut-off point for the diagnosis of sexual dysfunction was determined as equal to or less than 28), and lack of any sexual dysfunction before and during pregnancy, at the 4 weeks to 6 months of the postpartum period, recommencement of sexual intercourse after delivery, lack of chronic diseases (diabetes mellitus and hypertension), and stress, anxiety, and depression scores of, respectively, less than 17, 9, and, 13 according to the Depression, Anxiety, and Stress Scales-21, and lack of any mental and psychological problems such as severe depression, delirium, severe anxiety, and Obsessive-Compulsive Disorder (OCD). Moreover, the women did not suffer from late postpartum hemorrhage, postpartum infection, thromboembolic disorder, pelvic detachment, and mastitis, and had a stable relationship with their husband. The study exclusion criteria consisted of participation in sexual counseling and training sessions, alcohol use or drug abuse, use of medications affecting sexual function by the mother or her husband. According to the study by Farnam *et al.*, the sample size, with 95% Confidence Interval (CI) and 80% test power (to produce an effect size equal to 65%), was calculated as 38 women in each group, and considering 20% sample loss, the final sample size was determined as 45 women in each group.^[14] A total of 90 women entered the study 10 of whom were excluded from the study before random allocation [Figure 1]. A written informed consent was obtained from all participants and the demographic and sexual characteristics information questionnaire, FSFI, and Hulbert Sexual Self-Disclosure Questionnaire were completed by all participants before randomization.

For the allocation of the participants, study participants (80 women) were apprised of the nature of the trial, and they were given a study number and a computer-generated list of random numbers was used. Participants were randomly assigned following simple randomization procedures (computerized random numbers) to 1 of 2 treatment groups. Participants were assigned randomly to 1 of the 2 groups (40 participants in each group) according to a preexisting list produced by a computer program that differed from a random number generator only in that it assigned an equal number of patients to each treatment group. The group assignments were concealed in a sealed, opaque envelope until the first session. The first researcher enrolled participants and consulted with women and the second author assigned participants to interventions.

Women in both PLISSIT and BETTER groups attended 2 sessions of one-on-one consultation weekly for 2 weeks in the counseling room of the given centers. Each session lasted 60-90 minutes. The consulting time was equal for all women in the 2 groups. The data collection instruments included a demographic and sexual characteristics information questionnaire, and the FSFI and Hulbert Sexual self-disclosure Questionnaire. The demographic

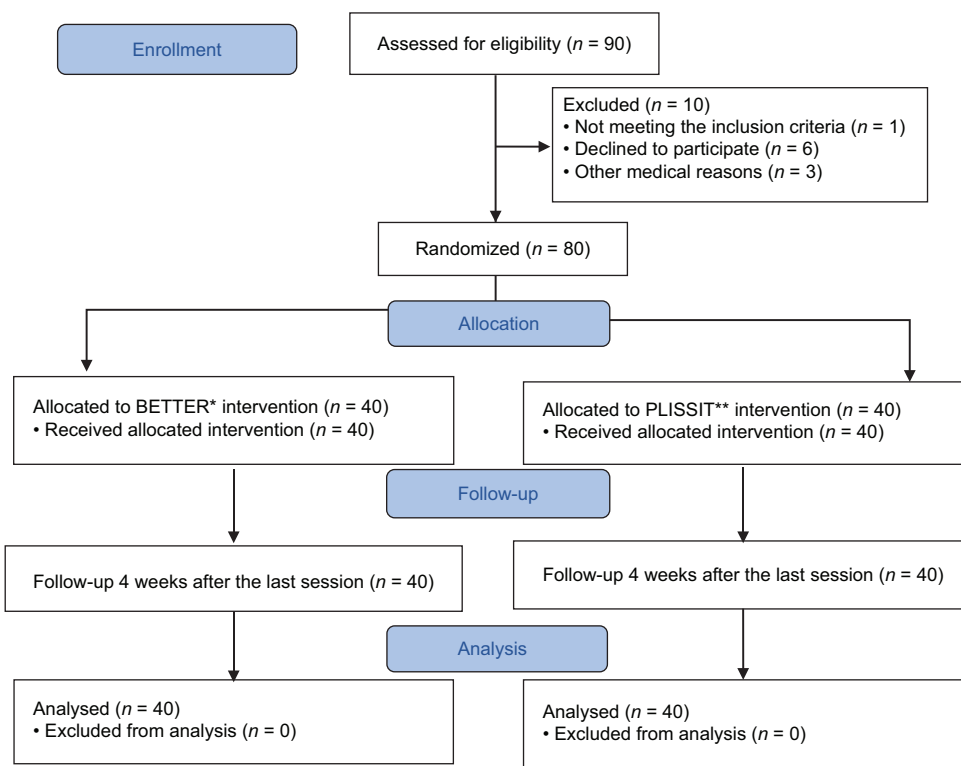


Figure 1: Flow diagram of the selection process of the participants. *Bring up, Explain, Tell, Timing, Educate, and Record. ** Permission, Limited Information, Specific Suggestions, and Intensive Therapy

and sexual characteristics information questionnaire contained 30 items; it was developed after reviewing the latest international books and articles. After its preparation, it was submitted to 7 faculty members and professors of Mashhad University of Medical Sciences, Mashhad, for validity assessment. The FSFI includes 19 items that evaluate female sexual functioning in the 6 domains of sexual desire, sexual arousal, vaginal lubrication, orgasm, sexual satisfaction, and pain during intercourse.^[16] Heydari and Faghihzadeh, in their study, reported a Cronbach's alpha coefficient of 0.70 for the FSFI.^[15] In the present study, the reliability of the FSFI was calculated using Cronbach's alpha coefficient ($\alpha = 0.82$). Hulbert Sexual self-disclosure Questionnaire contains 25 questions. The total score of the scale ranges from 0 to 100, with higher scores illustrating higher sexual self-disclosure, and lower scores indicating lower sexual self-disclosure.^[17] Taherian, reported a Cronbach's alpha coefficient of 0.91 for the Hulbert Sexual self-disclosure.^[17] In the current research, its reliability was confirmed with a Cronbach's alpha coefficient of 0.83. The PLISSIT model consists of 4 levels including Permission, Limited Information, Specific Suggestions, and Intensive Therapy. 1- *Permission*: The client is allowed to start talking about sensitive issues and her sexual problem and the counselor should listen to her without any judgment. 2- *limited information*: The counselor explains the female sexual response cycle and the postpartum period. In this stage, the counselor focuses on addressing and correcting myths. 3- *Specific Suggestions*:

Sensate focus is discussed and practiced. In addition, information is provided on postpartum dyspareunia, and potential solutions, including lubricants, pelvic floor physiotherapy for some causes of dyspareunia, and pelvic floor exercises. 4- *Intensive Therapy*: The researchers identify services to which women can be referred for more intensive or comprehensive treatment (social worker, sex therapist, and psychological and medical specialist). The BETTER model consists of the 6 levels of Bring up, Explain, Tell, Timing, Educate, and Record. 1- *Bringing up the issue*: The counselor raises sexual issues with clients at ease and encourages women to speak more about their problem and asks them about intimacy and relationship with their husbands after childbirth. 2- *Explaining*: The counselor explains the importance and the impact of sexual issues on an individual's quality of life (QOL). The counselor also explains the impact of intimacy and effective communication after childbirth and encourages the woman to talk more about her feelings and sexual problems with her husband. 3- *Telling*: The counselor assures the client of the provision of complete information for the resolution of their problems and information is provided on postpartum dyspareunia and potential solutions, including lubricants. 4- *Timing*: The counselor determines the counseling time as the client prefers. 5- *Training*: The counselor teaches the clients about the effects of childbirth complications and breastfeeding on their sexual life. The counselor also discusses and practices sensate focus and pelvic floor exercises with the client. 6- *Recording*: Assessments,

interventions, and therapeutic consequences are recorded by the counselor.^[10] To prevent sample loss, the researcher contacted the clients to remind them of counseling sessions.

After data collection and coding and their entry into the computer, data analysis was conducted using Kolmogorov-Smirnov test, Mann-Whitney U test, independent t-test, paired t-test, Chi-square test, and analysis of covariance (ANCOVA) in SPSS software (version 24.0, IBM Corporation, Armonk, NY, USA). A *P* value of less than 0.05 was considered significant.

Ethical considerations

This two-group randomized trial was approved by the Research Ethics Committee of Mashhad University of Medical Sciences with the code no. IR.MUMS.REC.1396.160 in July 2017. Written informed consent was obtained from all participants and they were assured that their information would be kept confidential.

Results

Based on the results of the study, the mean (SD) of women's age in the PLISSIT and BETTER groups were 31.70(5.40) years and 29.70(5.50) years, respectively. Furthermore, the two groups were found to be homogenous in terms of other demographic and sexual characteristics examined and compared before the intervention [Tables 1 and 2].

There was a significant difference in the mean (SD) total Hulbert score 4 weeks after the intervention in both groups, but this difference was higher in the BETTER counseling group 51.60 (8.30) vs. 55.60 (8.20); *p* = 0.013 [Table 3]. The sexual self-disclosure score had increased after the intervention by 7.80 (5.40) points in the PLISSIT group and 11.50 (6.40) points in the BETTER group. The Mann-Whitney test showed a significant difference in sexual self-disclosure score (*p* = 0.001). The Wilcoxon test in the PLISSIT group and paired t-test in the BETTER group showed that there was a significant difference in the sexual self-disclosure score after the intervention (*p* < 0.001) [Table 3]. Although the variation in the effect of sexual self-disclosure on the female sexual function was not significant, changes in sexual self-disclosure in the PLISSIT group was -4.4 points lower than that in the BETTER group [Table 4].

Discussion

It seems that the sexual self-disclosure of women in

the BETTER group had increased compared with that of the women in the PLISSIT group. Therefore, the result of this study showed that the BETTER model, which is client-centered and emphasizes the creation of an appropriate environment between the client and the counselor, will enable women to better express their sexual problems that will affect the treatment process, especially after childbirth.^[8] No study regarding the use of the BETTER and PLISSIT model intervention plans by women in their postpartum period regarding sexual self-disclosure was found in the literature review, so we examined the most relevant studies. Rehman *et al.* reported that sexual self-disclosure has a significant association with sexual satisfaction.^[18]

Karakas and Aslan found the BETTER model to be effective in the improvement of sexual functions and sexual satisfaction in women with 1-2 years infertility.^[19] They stated that The BETTER model helps women to express their sexual life problems, and prepares an appropriate treatment environment for their sexual function problems.

In another study, it was found that women with higher sexual self-disclosure gain higher scores in the frequency of sexual activity, orgasms, sexual desire, sexual satisfaction, and marital satisfaction.^[20] However, Bahrami *et al.* studied sexual function and sexual self-disclosure among 17 couples in unconsummated marriages, and reported that the Pearson correlation showed no relationship between sexual function and sexual self-disclosure in women and men.^[2]

In one study, it was concluded that the PLISSIT model had no significant impact on sexual function after childbirth and the use of other counseling approaches was suggested.^[21] A study on the effect of counseling based on the PLISSIT model on sexual functioning among 90 breastfeeding mothers 6 months postpartum found that sexual counseling based on the PLISSIT model was effective in promoting sexual functioning compared to the control group (no intervention).^[22] In another study, counseling based on the PLISSIT and sexual health models was effective in the improvement of sexual function, but individual therapy (PLISSIT model) was more effective than group therapy (Sexual Health Model).^[14]

In the BETTER model, the counselor starts the dialogue, clarifies the importance of sexual issues for clients, encourages the women to talk more about their problems, and tries to remove the taboo of talking about sexual concerns with their husbands that can act as an impetus to self-expression and sexual self-disclosure, and consequently, the removal of barriers to communicating about sex between couples that can be effective on sexual satisfaction.

A descriptive, exploratory study was conducted on mental health nurses to explore whether a specific model, the BETTER model, was useful in assisting

Table 1: Demographic characteristics of the participants

Variable	BETTER* Mean (SD)	PLISSIT** Mean (SD)	df	t	p
Age (year)	29.50 (7.50)	31.50 (7.40)	78	1.6	0.103
Spouse's age (year)	34.50 (7.80)	35.50 (6.40)	78	0.7	0.499

*Bring up, Explain, Tell, Timing, Educate, and Record. **Permission, Limited Information, Specific Suggestions, and Intensive Therapy

Table 2: Demographic characteristics of the participants in the BETTER and PLISSIT groups

Variable	BETTER* n (%)	PLISSIT** n (%)	Test	p
Education level				
Elementary	2 (5.00)	1 (2.50)	Z*****= -0.60	0.544
Middle school	6 (15.00)	3 (7.50)		
High school	10 (25.00)	12 (30.00)		
University education	22 (55.00)	24 (60.00)		
Spouse's education level				
Elementary	7 (17.50)	1 (2.50)	Z*****= -1.50	0.113
Middle school	7 (42.50)	6 (40.00)		
High school	10 (25.00)	10 (25.00)		
University education	16 (40.00)	23 (57.00)		
Occupational status				
Unemployed	35 (87.50)	30 (75.00)	$\chi^2=1.20$ *****,df=2	0.407
Student	1 (2.50)	2 (5.00)		
Employed	4 (10.00)	8 (20.00)		
Spouse's occupational status				
Self-employed	26 (65.00)	20 (50.00)	$\chi^2=2.70$ *****,df=2	0.265
Worker	4 (10.00)	3 (7.50)		
Employee	10 (25.00)	17 (42.50)		
Place of residence				
City	25 (62.50)	29 (72.50)	$\chi^2=0.90$ *****,df=1	0.340
Countryside	15 (37.50)	11 (27.50)		
Baby feeding method				
Breast milk	31 (77.50)	37 (92.50)	$\chi^2=3.90$ *****,df=2	0.157
Formula	5 (12.50)	1 (2.50)		
Both	4 (10.00)	2(5.00)		
Kind of recent delivery				
NVD***	18 (45.00)	13 (32.50)	$\chi^2=1.30$ *****,df=1	0.251
C-section****	22 (55.00)	27 (67.50)		
Contraceptive method				
Condom	22 (55.00)	23 (57.50)	$\chi^2=2.90$ *****,df=5	0.754
IUD*****	3 (7.50)	2 (5.00)		
OCP/Mini pill*****	4 (10.00)	7 (17.50)		
Injectable	2 (5.00)	3 (7.50)		
None	9 (22.50)	5 (12.50)		
Fear of unwanted pregnancy				
Yes	34 (85.00)	37 (92.50)	Fisher's exact	0.481
No	6 (15.00)	3 (7.50)		
Separate room for sexual intercourse				
Yes	39 (97.50)	39 (97.50)	Fisher's exact	1.000
No	1 (2.50)	1 (2.50)		

*Bring up, Explain, Tell, Timing, Educate, and Record. **Permission, Limited Information, Specific Suggestions, and Intensive Therapy, ***NVD: Normal vaginal delivery; ****: Csection****: Cesarean section; *****: IUD*****: Intrauterine device; *****: OCP*****: Oral contraceptive pill; *****: Mann Whitney; ***** :Chi square

mental health nurses in raising the topic of sexuality with their clients and becoming part of nurse practice. Participants described the transformation of their practice from one of avoiding issues of sexuality with patients to a position of inclusion, which became embedded within the practice. Participants did not tend to use the model in a structured way, and it appears that knowledge and awareness were more useful than the model itself.^[10]

One of the strengths of this study was the innovative implementation of sexual counseling based on the BETTER model for the first time after childbirth. Since the counseling sessions were conducted one-on-one, the good sample size could be taken into account as the other strength of this study. Among the limitations of this study was the impossibility to assess the sexual problems of women's marriage partners (men), so their reports about the absence of a sexual problem in their husbands were included in this study.

Table 3: Mean (SD) of sexual self-disclosure before and 4 weeks after the intervention in women in the PLISSIT* and BETTER groups**

Sexual self-disclosure	Group		Test	p
	BETTER, n=40, Mean (SD)	PLISSIT, n=40, Mean (SD)		
Before the intervention	44.10 (1.30)	43.90 (8.50)	$t^{****}=-0.10, df=780$	919
After the intervention	55.60 (6.20)	51.80 (6.30)	$Z^{*****}=-2.50$	0.013
Changes before and after the intervention between the groups	11.60 (5.40)	7.40 (7.80)	$Z^{*****}=-3.40$	0.001
Result	$Z^{***}=-5.40, p<0.001$ $t^{*****}=-11.3, df=39, p<0.001$			

PLISSIT*: Permission, Limited Information, Specific Suggestions, and Intensive Therapy. BETTER**: Bring up, Explain, Tell, Timing, Educate, and Record; ***: Wilcoxon; *****: t-test; *****: Mann-Whitney

Table 4: The results of analysis of covariance on the effect of sexual function on the total score of sexual self-disclosure when controlling the intervening variable

Variable	β	t	Standard error	p
Sexual self-disclosure before the intervention*	0.71	11.72	0.06	<0.001
PLISSIT** group	-4.40	-3.96	1.11	<0.001
BETTER*** group	0	0	0	0
FSFI changes*	0.03	0.46	0.06	0.645

*Intervening variable. **Permission, Limited Information, Specific Suggestions, and Intensive Therapy. ***Bring up, Explain, Tell, Timing, Educate, and Record

Conclusion

The BETTER sexuality model with an emphasis on sexual communication and determination of counseling time tailored to clients' preferences could have a greater impact on sexual self-disclosure in women. Therefore, this model can be used as a developed framework by midwives as a counseling approach, with ease of implementation, to postpartum sexual dysfunction. The further investigation of the effectiveness of the BETTER counseling model on the quality of sexual life in women after childbirth is recommended.

Acknowledgments

This article is the result of a Master's Thesis in Midwifery with the code no. 951749. We would like to express our gratitude to all the women who participated in this research.

Financial support and sponsorship

The Vice-Chancellor's Office for Research at Mashhad University of Medical Sciences

Conflicts of interest

Nothing to declare.

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