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Design and Validation of a Sexual Mindfulness-Based Intervention Package for Married Men with Sexual Dissatisfaction: A Qualitative Study

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A B S T R A C T

Purpose: The present study aimed to design and validate a sexual mindfulness-based intervention package for married men experiencing sexual dissatisfaction.

Methods and Materials: This qualitative study was conducted using an Interpretative Phenomenological Analysis (IPA) approach. The study population consisted of married men reporting sexual dissatisfaction and experts in sex therapy, psychology, and family counseling. Participants were selected through purposive sampling, and data collection continued until theoretical saturation was achieved. A total of 20 in-depth semi-structured interviews were conducted, including 10 married men with sexual dissatisfaction and 10 specialists. Data were analyzed using Interpretative Phenomenological Analysis with the assistance of MAXQDA software. Based on the extracted themes and categories, a sexual mindfulness-based intervention package was developed and subsequently evaluated for content validity through expert review and the Delphi method.

Findings: The qualitative analysis resulted in the identification of 68 open codes, 10 axial codes, and 5 overarching themes: disruption in sexual experience, mind–body disconnection, restrictive cultural and relational contexts, therapeutic requirements and intervention content, and intervention package structure and implementation. These findings provided the conceptual framework for the development of a structured intervention package consisting of 10 sessions, each lasting 80 minutes. Content validation demonstrated excellent levels of expert agreement, with a Content Validity Index (CVI) of 0.98 and a Content Validity Ratio (CVR) of 0.90, indicating strong relevance, clarity, and necessity of the intervention components. The inferential validation findings supported the adequacy and comprehensiveness of the package for addressing the multidimensional factors associated with sexual dissatisfaction among married men.

Conclusion: The findings suggest that sexual dissatisfaction among married men is a complex and multidimensional phenomenon influenced by cognitive, emotional, relational, and sociocultural factors. The sexual mindfulness-based intervention package developed in this study demonstrated strong content validity and theoretical coherence.

Keywords: *Sexual Mindfulness, Sexual Dissatisfaction, Married Men.*

1. Introduction

Sexual satisfaction is increasingly recognized as a central component of sexual health, relational adjustment, and overall psychological well-being. In contemporary sexual health literature, sexual satisfaction is not limited to the presence or absence of sexual dysfunction; rather, it reflects the subjective evaluation of sexual experiences, the perceived quality of intimacy, the congruence between sexual expectations and actual experiences, and the degree to which sexual interactions contribute to personal and relational well-being (Blondeel et al., 2024). This broader conceptualization is especially important in marital relationships, where sexual experience is deeply embedded in emotional intimacy, communication patterns, cultural expectations, gender norms, and the meanings that partners attach to their bodies, roles, and relational identity. Accordingly, sexual dissatisfaction among married men should not be reduced to a purely physiological or performance-based problem; it must be understood as a multidimensional phenomenon shaped by cognitive, affective, bodily, interpersonal, and sociocultural processes.

In marital and family studies, sexual quality has consistently been linked to relationship satisfaction. Evidence suggests that sexual satisfaction and relationship satisfaction influence one another over time, indicating that changes in sexual experience may predict subsequent changes in relational quality and sexual frequency (Park et al., 2023). This longitudinal perspective highlights the dynamic nature of sexuality within intimate relationships and suggests that sexual dissatisfaction can become a persistent relational stressor when it is not recognized and addressed. Similarly, research on couples' self-esteem has shown that sexual satisfaction and marital satisfaction are associated with self-evaluative processes within the couple relationship, suggesting that dissatisfaction in sexual life may affect not only relational functioning but also individuals' perceptions of personal adequacy and relational worth (Zarif et al., 2025). Therefore, interventions designed for married men with sexual dissatisfaction should attend not only to sexual symptoms but also to the underlying self-perceptions, relational meanings, and emotional responses that maintain dissatisfaction.

The significance of sexual satisfaction becomes more evident when considering the association between sexual quality and relationship functioning under conditions of distress. Studies have indicated that the association between sexual quality and relationship satisfaction may be particularly important when the sexual relationship is functioning poorly, because dissatisfaction can intensify relational vulnerability and reduce the couple's capacity for intimacy, reassurance, and mutual responsiveness (Busby et al., 2024). This finding is highly relevant to married men who experience sexual dissatisfaction, as sexual difficulties may activate feelings of shame, inadequacy, fear of failure, and avoidance of intimate communication. When these reactions remain unprocessed, they may create a cycle in which anxiety undermines sexual presence, impaired sexual experience reinforces negative self-evaluation, and reduced intimacy further weakens marital satisfaction. Thus, a therapeutic approach for this population must be sensitive to both intrapersonal and interpersonal dimensions of sexual dissatisfaction.

Despite the importance of sexual well-being, male sexual dissatisfaction remains underdiagnosed and undertreated in many healthcare and counseling contexts. Population-based evidence has identified gaps in the diagnosis and management of male sexual dysfunction, particularly among men with chronic health conditions and unmet healthcare needs (Mühle et al., 2025). Likewise, observational evidence from primary care has shown disparities in the management of sexual dysfunction, indicating that sexual problems are not always systematically assessed or adequately addressed in routine clinical encounters (Stanley et al., 2025). These findings point to the necessity of developing structured, evidence-informed, and clinically feasible intervention packages that can guide therapists in addressing male sexual dissatisfaction in a comprehensive manner. For married men, such packages should integrate sexual education, emotional awareness, body-based mindfulness practices, communication training, and relapse-prevention strategies.

A further challenge is that help-seeking for sexual problems is influenced by stigma, embarrassment, gender norms, and lack of awareness about available therapeutic services. Research on sex therapy help-seeking has shown that sexual dysfunction is prevalent in both clinical and community samples, but not all individuals experiencing sexual difficulties seek professional help (Lafortune et al., 2023). For men, cultural expectations surrounding masculinity, sexual competence, and performance may intensify reluctance to disclose sexual dissatisfaction. Men may interpret sexual difficulty as a threat to masculine identity, resulting in avoidance, silence, defensiveness, or overcontrol during sexual encounters. These processes can obstruct timely intervention and may transform a treatable

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sexual concern into a chronic source of marital distress. Therefore, intervention development must consider the lived experiences of men and the cultural meanings that shape their willingness to engage in therapy.

Sexual dissatisfaction is also shaped by gendered patterns in sexual expectations, communication, and relational participation. Network-analytic evidence on sexual satisfaction has demonstrated meaningful gender differences in how sexual satisfaction is organized and associated with related variables (Lingán-Huamán et al., 2025). Although the specific patterns may vary across cultural contexts, this body of evidence supports the idea that sexual satisfaction is not experienced identically by men and women. For married men, sexual dissatisfaction may involve performance anxiety, fear of not satisfying the partner, body shame, emotional inhibition, and difficulty communicating sexual needs. These features suggest that interventions for men should be tailored to masculine socialization patterns while avoiding reductive assumptions that define male sexuality only through performance, frequency, or physiological functioning.

The role of sexual health literacy is another important consideration in understanding marital sexual dissatisfaction. Research has shown that sexual health literacy is related to marital burnout through the mediating role of sexual satisfaction, indicating that inadequate knowledge and misunderstanding of sexual processes may contribute to relational exhaustion and dissatisfaction (Najafi et al., 2025). In many marital contexts, limited sexual education may lead to unrealistic beliefs about sexual performance, misinterpretation of bodily responses, and anxiety about normal variations in desire, arousal, and satisfaction. For married men, lack of accurate knowledge about sexual physiology and the sexual response cycle may intensify excessive cognitive monitoring and reduce embodied awareness during sexual encounters. Consequently, a sexual mindfulness-based intervention should include psychoeducation that improves sexual health literacy while also helping participants develop nonjudgmental awareness of bodily sensations and emotional states.

The effectiveness of psychological interventions for sexual and marital satisfaction has been supported in systematic review and meta-analytic evidence. Psychological interventions can improve sexual satisfaction and marital satisfaction by targeting cognitive appraisals, emotional regulation, communication skills, and relational patterns (Arab Bafrani et al., 2023). These findings provide a general empirical foundation for developing structured psychological packages for sexual dissatisfaction. However, many existing interventions are either broad marital interventions or symptom-focused sexual dysfunction treatments. There remains a need for integrated intervention models that specifically address the intersection of sexual shame, performance anxiety, mind–body disconnection, emotional regulation, couple communication, and cultural barriers among married men. Such integration is particularly compatible with mindfulness-based approaches, which emphasize awareness, acceptance, bodily presence, and nonjudgmental observation.

Mindfulness has gained increasing attention in the field of sexual therapy because sexual experience is strongly influenced by attention, embodiment, emotion regulation, and acceptance. A systematic review and meta-analysis of mindfulness-based therapies for sexual dysfunction indicated that mindfulness-based approaches can be beneficial for men and women experiencing sexual difficulties (Banbury et al., 2023). Mindfulness may improve sexual functioning by reducing evaluative self-monitoring, increasing attention to sensory experience, decreasing anxiety-driven avoidance, and strengthening acceptance of bodily responses. In the context of male sexual dissatisfaction, these mechanisms are especially relevant because performance anxiety often shifts attention away from embodied experience toward self-evaluation, anticipated failure, and concern about the partner's judgment. Sexual mindfulness, therefore, provides a therapeutic pathway for helping men return attention to present-moment bodily experience rather than remaining trapped in performance-based cognition.

Sexual mindfulness refers to the application of mindfulness principles to sexual experience, including present-moment awareness, nonjudgmental observation, acceptance of sensations and emotions, and compassionate attention toward the body and partner. A brief psychoeducational sexual mindfulness intervention has been shown to support sexual well-being, suggesting that even structured and concise mindfulness-based content can strengthen adaptive sexual awareness (Dawson et al., 2022). This finding is important for intervention development because it indicates that sexual mindfulness can be translated into practical therapeutic exercises, such as mindful breathing, body scanning, observing sexual thoughts without judgment, and cultivating acceptance of sexual sensations. For married men with sexual dissatisfaction, these

Iranian Journal of Educational Sociology
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techniques may reduce shame and anxiety while increasing bodily awareness and intimate presence.

Pilot evidence has also supported the feasibility of mindfulness in sex therapy and intimate relationship contexts. A randomized controlled pilot study in a cross-diagnostic group showed that mindfulness-informed sex therapy can be implemented in clinical settings and may be relevant across different sexual concerns (Krieger et al., 2023). This is particularly valuable for designing a package for married men because sexual dissatisfaction is often not a single isolated symptom but a cluster of experiences involving anxiety, reduced desire, impaired arousal, emotional disconnection, avoidance, and relational conflict. A cross-diagnostic mindfulness-based framework can therefore address the common psychological and relational processes that maintain sexual dissatisfaction, rather than limiting treatment to one diagnostic label.

Mindfulness may also moderate the association between conflict resolution and sexual and relationship satisfaction. Evidence suggests that mindfulness and sexual mindfulness can influence how couples manage conflict and how conflict resolution is associated with sexual and relational outcomes (Smedley et al., 2021). This finding underscores the relational relevance of sexual mindfulness. In marital relationships, sexual dissatisfaction often coexists with unresolved conflicts, lack of emotional intimacy, reduced quality time, and difficulty discussing sexual needs. By promoting nonreactivity, acceptance, and present-focused awareness, mindfulness may help individuals approach sexual communication with less defensiveness and greater openness. Therefore, a mindfulness-based sexual intervention package should not be limited to individual bodily awareness but should also include couple-based communication and intimacy exercises.

Although much of the intervention literature has focused on women's sexual health, relevant findings from female populations also demonstrate the potential of mindfulness-based approaches for improving sexual functioning. For example, mindfulness-based stress reduction has been reported to improve sexual performance among women with primary infertility, highlighting the role of stress reduction, emotional regulation, and bodily awareness in sexual functioning (Hosseini et al., 2024). Similarly, review evidence on strategies for improving sexual satisfaction during pregnancy and postpartum emphasizes the importance of educational, psychological, relational, and supportive interventions in addressing sexual satisfaction across sensitive life periods (Rahimi et al., 2025). While these populations differ from married men with sexual dissatisfaction, the underlying mechanisms—stress, body awareness, relational support, and sexual education—are highly relevant to the present study.

Relational context is also central to the sustainability of sexual satisfaction. Research on sustaining behaviors in long-distance relationships has demonstrated that intimacy and marital satisfaction are shaped by adaptive relational behaviors, suggesting that relationship maintenance processes are essential for preserving satisfaction under challenging circumstances (Tashkeh et al., 2024). Although married men with sexual dissatisfaction may not necessarily be in long-distance relationships, their sexual dissatisfaction may create emotional distance within the marriage. This internal distance can manifest as reduced communication, avoidance of intimacy, fear of rejection, and decreased shared emotional presence. Therefore, any intervention package designed for this population should address not only sexual techniques but also relational maintenance, intimacy-building, and structured couple dialogue.

Recent evidence from middle-aged men further confirms that sexual dissatisfaction is associated with multiple personal and contextual factors. Data from the Bavarian Men's Health Study showed that sexual dissatisfaction among middle-aged men is linked with various associated factors, reinforcing the need for multidimensional assessment and intervention (Schmalbrock et al., 2025). This multidimensionality is consistent with clinical observations that male sexual dissatisfaction may involve physiological concerns, psychological distress, relational dissatisfaction, lifestyle factors, and sociocultural scripts about masculinity and sexuality. Consequently, designing an intervention package requires an exploratory qualitative approach capable of capturing men's lived experiences, meanings, and perceived therapeutic needs rather than relying solely on pre-established symptom categories.

Taken together, the literature indicates that sexual dissatisfaction is a complex phenomenon with important implications for sexual health, marital satisfaction, self-esteem, help-seeking, and relational stability. Existing evidence supports the value of psychological interventions, mindfulness-based therapies, sexual mindfulness, psychoeducation, and relational communication strategies for improving sexual and marital outcomes (Arab Bafrani et al., 2023; Banbury et al., 2023; Dawson et al., 2022; Krieger et al., 2023; Smedley et al., 2021). At the same time, studies on male sexual dysfunction, healthcare gaps, and sexual dissatisfaction among men reveal the need for more targeted

Iranian Journal of Educational Sociology
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intervention models that are sensitive to men's embodied experiences, performance-related anxieties, emotional barriers, and cultural constraints (Mühle et al., 2025; Schmalbrock et al., 2025; Stanley et al., 2025). Therefore, developing and validating a sexual mindfulness-based intervention package for married men with sexual dissatisfaction can respond to a significant clinical and research gap.

The aim of the present study was to design and validate a sexual mindfulness-based intervention package for married men with sexual dissatisfaction using an interpretative phenomenological approach and expert-based content validation.

2. Methods and Materials

The present study was applied in purpose and conducted with a qualitative approach. Its main objective was to design and validate a sexual mindfulness-based intervention package for married men with sexual dissatisfaction. Considering the exploratory nature of the topic and the need for an in-depth understanding of individuals' lived experiences, an interpretative phenomenological approach was used. This approach enables a deep understanding of participants' perceptions, meanings, and subjective experiences in relation to the phenomenon under study and is considered an appropriate method for designing interventions based on lived experience.

The study population consisted of two main groups. The first group included scholars and specialists in the field of sexual therapy, including sex therapists, sexual psychotherapists, and family counselors who were professionally active in the cities of Kermanshah, Sanandaj, and Hamadan. These cities were selected to increase the diversity of experiences and the richness of qualitative data. The second group consisted of married men with sexual dissatisfaction whose sexual dissatisfaction had been confirmed using valid diagnostic instruments and who had referred to counseling and treatment centers.

Purposive sampling was used in this study, and sampling continued until theoretical saturation was reached. The inclusion criteria for specialists included at least three years of professional experience, possession of a valid professional license, and willingness to participate in the study. The inclusion criteria for married men included at least five years of marital life, an age range of 25 to 40 years, confirmed sexual dissatisfaction, relative mental health, and voluntary willingness to participate in the study. The exclusion criteria included unwillingness to continue the interview, providing superficial or unclear responses, and inability to understand or respond appropriately to the questions. Ultimately, theoretical saturation was achieved through 20 in-depth interviews, including 10 married men with sexual dissatisfaction and 10 specialists.

Table 1

Demographic Characteristics of Married Men with Sexual Dissatisfaction

Code	Age	Duration of Marriage	Educational Level	Occupation	Duration of Sexual Dissatisfaction
1	28	6 years	Bachelor's degree	Education sector employee	3 years
2	36	5 years	Bachelor's degree	Nurse	2 years
3	38	9 years	Bachelor's degree	Self-employed	4 years
4	42	12 years	Master's degree	Military personnel	2 years
5	48	20 years	Bachelor's degree	Self-employed	5 years
6	33	7 years	Bachelor's degree	Military personnel	3 years
7	33	5 years	Master's degree	Education sector employee	4 years
8	32	5 years	Master's degree	Government employee	5 years
9	35	9 years	Bachelor's degree	Artist	4 years
10	49	22 years	Master's degree	Self-employed	8 years

Table 2

Demographic Characteristics of Specialists

Code	Age	Gender	Field of Study	Academic Degree	Main Area of Expertise
1	45	Male	Family Counseling	PhD	Couple Therapy
2	43	Male	Family Counseling	PhD	Couple Therapy
3	50	Female	Clinical Psychology	PhD	Couple Therapy
4	38	Female	Psychiatry	Subspecialty Fellowship	Sex Therapy

Iranian Journal of Educational Sociology
E-ISSN: 2645-3460

5	40	Female	Family Counseling	PhD	Couple Therapy
6	44	Male	Family Counseling	PhD	Couple Therapy
7	45	Male	Clinical Psychology	PhD	Sex Therapy
8	42	Female	Clinical Psychology	PhD	Couple Therapy
9	43	Male	Family Counseling	PhD	Couple Therapy
10	39	Male	Clinical Psychology	PhD	Sex Therapy

The data collection instrument at this stage consisted of in-depth, semi-structured face-to-face interviews. The interviews were conducted in counseling centers and specialists' offices, and each interview lasted between 45 and 70 minutes. The interview questions were developed based on theoretical sources, the research literature, and the opinions of supervisors and advisors, and they were approved by relevant specialists before implementation. The flexibility of semi-structured interviews enabled the researcher to maintain the main interview framework while conducting deeper exploration of participants' lived experiences according to their responses.

To analyze the data, the interpretative phenomenological analysis method proposed by Smith, Flowers, and Larkin (2009) was used. In this method, after the interviews were fully transcribed, each text was read and reviewed several times to obtain an initial understanding of the participants' experiences. The interviews were then examined line by line, and meaning units were extracted. An initial code was assigned to each meaning unit, and similar codes were organized into conceptual clusters. Subsequently, subthemes and then main themes were extracted based on common patterns across the data. The process of coding and organizing the qualitative data was conducted using MAXQDA software.

3. Findings and Results

In total, 68 open codes, 10 axial codes, and 5 main themes were extracted. The main themes included disruption in the sexual experience of married men, mind–body disconnection in sexual experience, restrictive cultural and relational context, therapeutic requirements and intervention content, and the structure, implementation, and evaluation of the intervention package. Based on these findings, the sexual mindfulness-based intervention package was designed and developed.

Table 3

Main Themes, Axial Codes, and Open Codes Extracted from the Interpretative Phenomenological Analysis of the Interviews

Main Theme	Axial Code	Open Code
1. Disruption in the sexual experience of married men	1_1. Sexual shame and inadequacy	Feeling sexually inadequate
1. Disruption in the sexual experience of married men	1_1. Sexual shame and inadequacy	Body shame
1. Disruption in the sexual experience of married men	1_1. Sexual shame and inadequacy	Disliking one's body
1. Disruption in the sexual experience of married men	1_1. Sexual shame and inadequacy	Threat to masculine identity
1. Disruption in the sexual experience of married men	1_1. Sexual shame and inadequacy	Body comparison with others
1. Disruption in the sexual experience of married men	1_1. Sexual shame and inadequacy	Decreased sexual self-confidence
1. Disruption in the sexual experience of married men	1_1. Sexual shame and inadequacy	Feeling inadequate in satisfying the partner
1. Disruption in the sexual experience of married men	1_2. Sexual performance anxiety	Concern about the partner's satisfaction
1. Disruption in the sexual experience of married men	1_2. Sexual performance anxiety	Excessive self-monitoring
1. Disruption in the sexual experience of married men	1_2. Sexual performance anxiety	Fear of sexual failure
1. Disruption in the sexual experience of married men	1_2. Sexual performance anxiety	Negative anticipation of performance
1. Disruption in the sexual experience of married men	1_2. Sexual performance anxiety	Anxiety–dysfunction cycle
1. Disruption in the sexual experience of married men	1_2. Sexual performance anxiety	Intensification of anxiety-induced physiological dysfunction
2. Mind–body disconnection in sexual experience	2_1. Bodily and physiological unawareness	Unfamiliarity with the sexual response cycle
2. Mind–body disconnection in sexual experience	2_1. Bodily and physiological unawareness	Lack of awareness of sexual physiology
2. Mind–body disconnection in sexual experience	2_1. Bodily and physiological unawareness	Disconnection between mind and body
2. Mind–body disconnection in sexual experience	2_1. Bodily and physiological unawareness	Excessive cognitive focus
2. Mind–body disconnection in sexual experience	2_1. Bodily and physiological unawareness	Inability to recognize bodily cues
2. Mind–body disconnection in sexual experience	2_2. Ineffective emotion regulation	Inability to manage stress
2. Mind–body disconnection in sexual experience	2_2. Ineffective emotion regulation	Poor sleep quality
2. Mind–body disconnection in sexual experience	2_2. Ineffective emotion regulation	Chronic fatigue
2. Mind–body disconnection in sexual experience	2_2. Ineffective emotion regulation	Uncontrolled arousal
2. Mind–body disconnection in sexual experience	2_2. Ineffective emotion regulation	Impaired emotion regulation

Iranian Journal of Educational Sociology
E-ISSN: 2645-3460

3. Restrictive cultural and relational context	3_1. Shame and cultural taboos	Taboo nature of sexual issues
3. Restrictive cultural and relational context	3_1. Shame and cultural taboos	Cultural shame
3. Restrictive cultural and relational context	3_1. Shame and cultural taboos	Fear of judgment
3. Restrictive cultural and relational context	3_1. Shame and cultural taboos	Traditional gender roles
3. Restrictive cultural and relational context	3_1. Shame and cultural taboos	Men's resistance to expressing emotions
3. Restrictive cultural and relational context	3_1. Shame and cultural taboos	Sexual guilt
3. Restrictive cultural and relational context	3_2. Impairment in couple communication and intimacy	Inability to engage in sexual dialogue
3. Restrictive cultural and relational context	3_2. Impairment in couple communication and intimacy	Expectation of mind reading
3. Restrictive cultural and relational context	3_2. Impairment in couple communication and intimacy	Reduced emotional intimacy
3. Restrictive cultural and relational context	3_2. Impairment in couple communication and intimacy	Unresolved conflicts
3. Restrictive cultural and relational context	3_2. Impairment in couple communication and intimacy	Unequal sexual participation
3. Restrictive cultural and relational context	3_2. Impairment in couple communication and intimacy	Reduced quality time as a couple
4. Therapeutic requirements and intervention content	4_1. Sexual mindfulness- and compassion-based intervention	Sexual body scan
4. Therapeutic requirements and intervention content	4_1. Sexual mindfulness- and compassion-based intervention	Mindful breathing
4. Therapeutic requirements and intervention content	4_1. Sexual mindfulness- and compassion-based intervention	Observing thoughts without judgment
4. Therapeutic requirements and intervention content	4_1. Sexual mindfulness- and compassion-based intervention	Acceptance of sexual experience
4. Therapeutic requirements and intervention content	4_1. Sexual mindfulness- and compassion-based intervention	Compassion exercises
4. Therapeutic requirements and intervention content	4_1. Sexual mindfulness- and compassion-based intervention	Individual mindful bodily contact
4. Therapeutic requirements and intervention content	4_1. Sexual mindfulness- and compassion-based intervention	Couple-based mindful bodily contact
4. Therapeutic requirements and intervention content	4_2. Sexual education and healthy lifestyle	Sexual physiology education
4. Therapeutic requirements and intervention content	4_2. Sexual education and healthy lifestyle	Education on the mind–body connection
4. Therapeutic requirements and intervention content	4_2. Sexual education and healthy lifestyle	Sleep regulation
4. Therapeutic requirements and intervention content	4_2. Sexual education and healthy lifestyle	Healthy nutrition
4. Therapeutic requirements and intervention content	4_2. Sexual education and healthy lifestyle	Fatigue reduction
4. Therapeutic requirements and intervention content	4_2. Sexual education and healthy lifestyle	Body hygiene and self-care
5. Structure, implementation, and evaluation of the intervention package	5_1. Intervention structure and process	Designing an 8- to 12-session program
5. Structure, implementation, and evaluation of the intervention package	5_1. Intervention structure and process	Therapeutic alliance
5. Structure, implementation, and evaluation of the intervention package	5_1. Intervention structure and process	Stepwise approach
5. Structure, implementation, and evaluation of the intervention package	5_1. Intervention structure and process	Combination of individual and couple sessions
5. Structure, implementation, and evaluation of the intervention package	5_1. Intervention structure and process	Targeted homework assignments
5. Structure, implementation, and evaluation of the intervention package	5_2. Evaluation and quality assurance	Expert opinion
5. Structure, implementation, and evaluation of the intervention package	5_2. Evaluation and quality assurance	Pilot implementation
5. Structure, implementation, and evaluation of the intervention package	5_2. Evaluation and quality assurance	Clients' feedback
5. Structure, implementation, and evaluation of the intervention package	5_2. Evaluation and quality assurance	Content validity
5. Structure, implementation, and evaluation of the intervention package	5_2. Evaluation and quality assurance	Assessment of sexual satisfaction
5. Structure, implementation, and evaluation of the intervention package	5_2. Evaluation and quality assurance	Assessment of marital satisfaction

Iranian Journal of Educational Sociology
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Table 4

Ten-Session Sexual Mindfulness-Based Protocol

Session	Title	Objective	Content	Technique	Assignments
First	Introduction and formulation of sexual problems in married men	To increase insight into the nature of the sexual problem and reduce negative normalization	1. Introducing the structure of sessions and explaining the rules 2. Concept of inadequacy and performance anxiety 3. Normalizing the experience of sexual dissatisfaction	1. Motivational interviewing 2. Experience-based psychoeducation	1. Recording expectations from treatment 2. Recording personal experiences of sexual anxiety and inadequacy
Second	Performance anxiety and the dysfunction cycle	To identify the anxiety–performance dysfunction cycle	1. Concern about the partner's satisfaction 2. Excessive self-monitoring 3. Negative anticipation of performance	1. CBT chain analysis 2. Recording automatic thoughts	Thought and anxiety recording form in intimate situations
Third	Mind–body disconnection in sexual experience	To reconstruct bodily and physiological awareness	1. Sexual response cycle 2. Disconnection between mind and body	1. Sexual physiology education 2. Practice in attending to bodily sensations	Daily nonjudgmental recording of bodily sensations
Fourth	Emotion regulation and stress	To reduce anxious arousal and improve emotion regulation	1. Role of stress, sleep, and fatigue 2. Impaired emotion regulation	1. Progressive relaxation 2. Diaphragmatic breathing	1. Daily breathing practice 2. Modification of one lifestyle component
Fifth	Body shame and masculine identity	To reduce body shame and redefine healthy masculinity	1. Cultural shame 2. Threat to masculine identity	1. Cognitive restructuring 2. Compassion exercises	1. Compassion practice toward the body 2. Writing about the experience of shame without judgment
Sixth	Sexual body scan	To increase mindfulness in bodily sexual experience	1. Bodily awareness 2. Nonjudgmental observation	1. Sexual body scan 2. Gradual attention to sensations	Daily body scan practice
Seventh	Mindfulness in arousal	To reduce excessive control over performance	1. Uncontrolled arousal 2. Presence in the moment	1. Mindfulness during mild arousal 2. Observing thoughts without judgment	Mindfulness practice during low-level arousal
Eighth	Sexual communication and intimacy	To improve sexual dialogue and emotional intimacy	1. Expressing needs 2. Eliminating the expectation of mind reading	1. Sexual communication skills training 2. Couple-based mindful attention practice	Structured dialogue with the spouse
Ninth	Integration of skills	To transfer skills to real sexual experience	Integration of mindfulness, emotion regulation, and bodily awareness	1. Gradual mindful exposure 2. Mindful bodily contact exercises	1. Bodily contact practice without the goal of orgasm
Tenth	Consolidation and relapse prevention	To maintain achievements and reduce the likelihood of relapse	1. Reviewing progress 2. Identifying relapse risk factors	1. Relapse prevention plan 2. Future self-monitoring	1. Personal maintenance plan 2. Scheduling future practices

To validate the qualitative data and ensure the accuracy of the findings, several strategies were used, including continuous review and rereading of the data and interview texts by the researcher, participant review, and the use of expert opinions in the field of sexual therapy. In some parts of the analysis, the active participation of individuals was also used to increase interpretative accuracy.

The validation of the sexual mindfulness-based intervention package was conducted in two stages. In the first stage, the Delphi method was used with the participation of 10 specialists in sex therapy, psychology, and family counseling. At this stage, the content of the sessions, objectives, order of presentation, and feasibility of the package were evaluated over several rounds. After each round, expert feedback was collected, and the necessary revisions were applied. Finally, relative consensus among the experts was achieved based on the level of agreement in the evaluations.

In the second stage, to quantitatively assess the content validity of the package, the Content Validity Ratio (CVR)

Iranian Journal of Educational Sociology
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and the Content Validity Index (CVI) were used. CVR was used to assess the necessity of each component of the package, and CVI was used to evaluate the relevance, clarity, and simplicity of the session content.

The results showed that the CVI value was 0.98 and the CVR value was 0.90, indicating that the intervention package had desirable and acceptable content validity.

Finally, the results of this section of the study indicated that the designed package had appropriate qualitative and quantitative support and could be used in subsequent stages of research and implementation in therapeutic contexts.

Table 5

Results of CVI Calculation from the Specialists' Perspective for Each Session of the Mindfulness Intervention Package

Session Number	Irrelevant	Needs Revision	Relevant	Completely Relevant	CVI Value
Session 1	0	0	1	9	1.00
Session 2	0	0	0	10	1.00
Session 3	0	0	2	8	1.00
Session 4	0	1	0	9	1.00
Session 5	0	0	1	9	1.00
Session 6	0	0	1	9	1.00
Session 7	0	1	1	8	0.90
Session 8	0	0	0	10	1.00
Session 9	0	0	0	10	1.00
Session 10	0	1	1	8	0.90

Table 6

Content Validity Ratio by Session

Session Number	Not Necessary	Useful but Not Necessary	Essential	CVR Value
Session 1	0	0	10	1.00
Session 2	0	0	10	1.00
Session 3	0	1	9	0.90
Session 4	0	2	8	0.80
Session 5	0	1	9	0.90
Session 6	0	2	8	0.80
Session 7	0	2	8	0.80
Session 8	0	0	10	1.00
Session 9	0	0	10	1.00
Session 10	0	2	8	0.80

During the selective coding stage, the axial categories were integrated around a central category. Final analysis revealed that "Enhancement of the Social Status of Arabic Language Teachers in Iraq" constituted the core category of the study. The remaining categories were conceptualized as contextual conditions, intervening factors, strategies, and consequences associated with this core category.

Within this framework, foundational infrastructures and social flourishing function as contextual conditions shaping the formation of social status. Institutional inefficiency operates as an intervening factor that simultaneously constrains development and stimulates institutional reform. Comprehensive teacher empowerment emerged as the principal strategy for improving social status, while institutional development was identified as the ultimate outcome of the process.

4. Discussion and Conclusion

The present study aimed to design and validate a sexual mindfulness-based intervention package for married men experiencing sexual dissatisfaction. The findings of the qualitative phase resulted in the extraction of 68 open codes, 10 axial codes, and 5 major themes, including disruption in the sexual experience of married men, mind–body disconnection in sexual experience, restrictive cultural and relational context, therapeutic requirements and intervention content, and the structure, implementation, and evaluation of the intervention package. Based on these themes, a

Iranian Journal of Educational Sociology
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structured intervention package consisting of ten 80-minute sessions was developed. Furthermore, the content validation process demonstrated excellent levels of expert agreement, with a Content Validity Index (CVI) of 0.98 and a Content Validity Ratio (CVR) of 0.90, indicating that the package possessed strong relevance, clarity, necessity, and practical applicability. Overall, the findings suggest that sexual dissatisfaction among married men is a multidimensional phenomenon that cannot be adequately understood solely through biological or physiological frameworks but must also be conceptualized through cognitive, emotional, relational, and sociocultural perspectives.

One of the most important findings of the study was the identification of sexual shame, feelings of inadequacy, and performance anxiety as central components of sexual dissatisfaction among married men. Participants described experiences characterized by fear of failure, excessive self-monitoring, concern about partner satisfaction, and threats to masculine identity. These findings are consistent with evidence indicating that sexual dissatisfaction among men is often associated with psychological and relational factors rather than merely sexual dysfunction itself. Schmalbrock et al. demonstrated that sexual dissatisfaction among middle-aged men is influenced by a wide range of psychosocial and health-related variables, highlighting the multidimensional nature of male sexual dissatisfaction (Schmalbrock et al., 2025). Similarly, studies examining sexual quality and relationship functioning have shown that when individuals perceive deficiencies in their sexual relationships, they often experience lower self-esteem, increased anxiety, and greater relational distress (Busby et al., 2024; Zarif et al., 2025). The present findings expand this literature by illustrating how feelings of sexual inadequacy and performance concerns emerge as lived experiences that directly influence men's perceptions of themselves and their intimate relationships.

The findings also revealed that mind–body disconnection represents a major mechanism underlying sexual dissatisfaction. Participants frequently reported excessive cognitive focus during sexual interactions, difficulty attending to bodily sensations, limited awareness of physiological responses, and an inability to remain present during intimate experiences. This finding aligns closely with mindfulness-based conceptualizations of sexual functioning. According to mindfulness theory, adaptive sexual experiences require awareness of bodily sensations, present-moment attention, and reduced judgment toward internal experiences. Excessive self-monitoring and cognitive preoccupation interfere with these processes and contribute to sexual difficulties (Banbury et al., 2023). Previous studies have similarly shown that mindfulness-based interventions can improve sexual functioning by reducing cognitive distraction and enhancing embodied awareness during sexual experiences (Dawson et al., 2022; Krieger et al., 2023). Therefore, the identification of mind–body disconnection as a major theme provides strong theoretical justification for integrating mindfulness practices into interventions designed for men experiencing sexual dissatisfaction.

Another significant finding concerned the role of ineffective emotion regulation, stress, poor sleep quality, chronic fatigue, and uncontrolled arousal. Participants frequently described emotional and physiological states that interfered with sexual engagement and satisfaction. These findings support the growing body of evidence suggesting that sexual functioning is strongly influenced by broader emotional and psychological processes. Mindfulness-based approaches have consistently been associated with improved emotional regulation, stress reduction, and enhanced awareness of emotional experiences, all of which contribute to healthier sexual functioning (Banbury et al., 2023; Hosseini et al., 2024). The findings also correspond with research demonstrating that psychological interventions improve sexual satisfaction by addressing emotional and cognitive processes that maintain dissatisfaction and distress (Arab Bafrani et al., 2023). Consequently, the inclusion of breathing exercises, relaxation techniques, emotion regulation strategies, and lifestyle modifications within the intervention package appears theoretically and empirically justified.

The third major theme identified in the study emphasized the influence of restrictive cultural and relational contexts. Participants described sexual issues as highly stigmatized and often associated with shame, guilt, fear of judgment, and traditional gender expectations. Men frequently reported difficulties discussing sexual concerns with their spouses and expressed beliefs that emotional expression was inconsistent with cultural expectations of masculinity. These findings are consistent with evidence suggesting that help-seeking behaviors for sexual concerns are often constrained by stigma and cultural norms surrounding sexuality and gender roles (Lafortune et al., 2023). Furthermore, healthcare studies have identified substantial gaps in the diagnosis and treatment of male sexual dysfunction, suggesting that social and cultural barriers may contribute to the underrecognition of sexual dissatisfaction among men (Mühle et al., 2025; Stanley et al., 2025). The present

findings therefore highlight the importance of addressing cultural narratives and gendered expectations within therapeutic interventions rather than focusing exclusively on sexual symptoms.

The findings related to impaired couple communication and reduced emotional intimacy also deserve particular attention. Participants described unresolved conflicts, reduced quality time with partners, unequal participation in sexual interactions, and expectations that partners should intuitively understand their needs without explicit communication. These findings are strongly supported by relationship research demonstrating that sexual satisfaction and relationship satisfaction are reciprocally related and mutually reinforcing (Park et al., 2023). Similarly, studies have shown that sexual quality becomes increasingly important when relational functioning deteriorates, suggesting that communication problems and unresolved conflicts can amplify sexual dissatisfaction (Busby et al., 2024). Evidence from studies on sustaining intimacy in relationships further supports the notion that adaptive relational behaviors are essential for maintaining emotional closeness and marital satisfaction over time (Tashkeh et al., 2024). Therefore, the inclusion of communication skills training and couple-based mindfulness exercises within the intervention package appears highly consistent with contemporary relational research.

An important contribution of the study lies in the identification of sexual mindfulness and self-compassion as core therapeutic components. The qualitative findings suggested that participants benefited conceptually from practices such as mindful breathing, sexual body scanning, acceptance of sexual experiences, nonjudgmental observation of thoughts, and compassion-based exercises. These components are strongly supported by previous research. Mindfulness-based therapies have been associated with improvements in sexual functioning and sexual satisfaction across a range of populations experiencing sexual difficulties (Banbury et al., 2023). Sexual mindfulness interventions have also been shown to enhance sexual well-being by increasing awareness, reducing judgment, and facilitating greater engagement with present-moment experiences (Dawson et al., 2022). Moreover, pilot investigations of mindfulness-based sex therapy have demonstrated feasibility and positive clinical outcomes in individuals presenting with diverse sexual concerns (Krieger et al., 2023). The convergence between the present qualitative findings and previous empirical evidence strengthens confidence in the relevance of mindfulness-based approaches for addressing male sexual dissatisfaction.

The inclusion of psychoeducational components addressing sexual physiology, the sexual response cycle, and the mind–body relationship was another noteworthy aspect of the intervention package. Participants frequently described uncertainty regarding sexual processes and misconceptions about sexual performance. These findings align with research emphasizing the importance of sexual health literacy in sexual and marital outcomes. Sexual health literacy has been linked to sexual satisfaction and lower levels of marital burnout, suggesting that individuals who better understand sexual processes are more likely to experience satisfying intimate relationships (Najafi et al., 2025). Similarly, review studies examining interventions designed to improve sexual satisfaction have repeatedly highlighted the value of educational and psychoeducational strategies as foundational components of effective treatment programs (Rahimi et al., 2025). Accordingly, the integration of sexual education into the intervention package appears essential for correcting misconceptions and fostering more realistic expectations regarding sexual functioning.

The findings also suggest that sexual satisfaction should be viewed as an important indicator of overall sexual health and well-being. Participants frequently linked their sexual dissatisfaction with broader concerns regarding relationship quality, emotional fulfillment, and life satisfaction. This perspective is consistent with contemporary sexual health literature, which conceptualizes sexual satisfaction as a multidimensional indicator of sexual well-being and relational functioning (Blondeel et al., 2024). Sexual satisfaction has also been shown to predict future changes in relationship satisfaction, indicating that improvements in sexual experiences may have long-term implications for marital quality (Park et al., 2023). Therefore, interventions targeting sexual dissatisfaction may produce benefits extending beyond sexual functioning alone, contributing to broader improvements in relational and psychological well-being.

The high content validity indices obtained during the validation process further support the appropriateness of the developed intervention package. The Delphi process resulted in substantial consensus among experts regarding the relevance, clarity, necessity, and feasibility of the package components. The obtained CVI and CVR values exceeded commonly accepted thresholds for content validation, indicating that the intervention package possesses strong theoretical coherence and clinical

Iranian Journal of Educational Sociology
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relevance. The high level of expert agreement likely reflects the package's comprehensive integration of mindfulness practices, psychoeducation, emotional regulation strategies, communication training, and relational interventions. Importantly, these elements are all supported by existing empirical literature and correspond closely to the themes identified through participants' lived experiences. Such alignment between qualitative findings, theoretical frameworks, and expert evaluations enhances the credibility and potential applicability of the intervention package.

Overall, the findings suggest that sexual dissatisfaction among married men emerges from the interaction of multiple psychological, relational, cultural, and bodily factors. Rather than representing a single clinical symptom, sexual dissatisfaction appears to be embedded within broader experiences of self-evaluation, emotional regulation, partner communication, cultural expectations, and embodied awareness. The intervention package developed in this study addresses these interconnected dimensions through a structured mindfulness-based framework that promotes bodily awareness, emotional acceptance, sexual knowledge, self-compassion, and relational intimacy. Consequently, the package offers a theoretically grounded and clinically relevant approach for addressing sexual dissatisfaction among married men and may contribute to improvements in both sexual well-being and marital functioning.

Several limitations should be considered when interpreting the findings of this study. First, the study employed a qualitative design with purposive sampling, which may limit the generalizability of the findings to broader populations of married men. Second, participants were recruited from specific geographical regions and counseling settings, and their experiences may not fully represent men from different cultural, socioeconomic, or educational backgrounds. Third, data were based on self-reported experiences, which may have been influenced by social desirability, memory bias, or reluctance to disclose sensitive sexual information. Fourth, although the intervention package demonstrated strong content validity, its clinical effectiveness was not examined in an experimental or longitudinal design. Finally, the perspectives of spouses were not directly incorporated into the qualitative analysis, potentially limiting understanding of couple-level dynamics associated with sexual dissatisfaction.

Future studies should evaluate the effectiveness of the developed intervention package through randomized controlled trials and longitudinal follow-up assessments. Researchers may compare the package with other evidence-based sexual and marital interventions to determine its relative efficacy. Future investigations should also examine the mechanisms through which sexual mindfulness influences sexual satisfaction, emotional regulation, and relationship quality. Including spouses or couples as participants could provide a more comprehensive understanding of relational processes associated with sexual dissatisfaction. Additionally, future research may adapt and validate the intervention package for different age groups, cultural contexts, and clinical populations experiencing sexual concerns.

Clinicians working with married men experiencing sexual dissatisfaction should adopt a multidimensional perspective that addresses cognitive, emotional, relational, cultural, and physiological factors simultaneously. Treatment programs may benefit from integrating mindfulness practices, psychoeducation regarding sexual health and physiology, communication skills training, and self-compassion exercises. Counseling centers can incorporate structured sexual mindfulness protocols into existing therapeutic services to improve accessibility and consistency of care. Mental health professionals should also create safe and nonjudgmental environments that encourage men to discuss sexual concerns openly and seek professional support. Finally, educational initiatives aimed at increasing sexual health literacy and reducing stigma surrounding male sexual difficulties may contribute to earlier intervention and improved sexual well-being among married couples.

Authors' Contributions

Authors equally contributed to this article.

Declaration

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

Transparency Statement

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

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

All procedures performed in studies involving human participants were under the ethical standards of the institutional and, or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

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