International Journal of Advanced Studies in Sexology
© Sexology Institute of Romania
Vol. 4(1), 2022, pp. 82-90

https://www.sexology.ro/jurnal
ISSN 2668-7194 (print), ISSN 2668-9987 (online)
DOI: 10.46388/ijass.2022.4.9

INTEGRATIVE-STRATEGIC APPROACH IN ORGASM DISORDER - CASE STUDY

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Abstract

Objectives: This paper addresses the disorder of orgasm in women, from an integrative-strategic point of view. Through this paper we summarize the impact of various aspects of individual life on sexuality, taking into account a multitude of variables related to self and self-construction, such as biological, behavioral, cognitive, existential, emotional, spiritual or psychodynamic.
We are specifically interested in whether certain aspects of the individual's life affect sexual dysfunction.
Method: The case study presents the case of a patient who requested psychotherapy stating that she does not have an orgasm. The psychotherapeutic model used was the integrative-strategic one, structured on the six psychological axes, in the approach of each axis specific therapeutic interventions learned in the training of the psychotherapist at the Association for Research, Counseling and Integrative Psychotherapy were applied. The working period was from August 2020 to December 2021.
Results: The orgasm disorder may persist, being affected by the couple's life, family history, parental patterns, body image, self-esteem and various coping mechanisms.
Conclusions: It is necessary to have several approaches and the continuation of psychotherapy, both individually and as a couple, in order to observe favorable results in disturbing the patient's orgasm.

Keywords: sexual dysfunction, orgasm disorder, psychotherapy, integrative-strategic.

INTRODUCTION

What is orgasm and how to achieve orgasm in women

Orgasm is a transient sensation of intense pleasure, which is accompanied by a series of physiological changes in the body. In women, orgasm seems to be less common than in men, and this is often difficult for some women. [1]

Objective indicators to show that orgasm has occurred have been sought for several years. Kinsey et al. proposed the "sudden cessation of strenuous movements and extreme tensions of previous sexual activity and the resulting peace of mind" as the most obvious evidence that orgasm had occurred in women. [2]

Masters and Johnson described the onset of orgasm as a "feeling of suspense or stopping." To serve as a clear marker of orgasm, however, the indicator must involve a body change that is unique to orgasm.

This necessarily excludes simple measures, such as high blood pressure, heart and respiratory rate, or even a woman's own vocalizations, as such events can occur during high levels of sexual arousal that fail to culminate in orgasm. [3]

Orgasms depend on a lot of factors, differ from woman to woman, and between them, depending on the method of stimulation, whether you are with a partner or not, and depend on where you are in the menstrual cycle. Some women sometimes feel a rhythmic throbbing of the muscle around the vagina, sometimes not. Most women describe it as a feeling of completion, as if you have crossed a threshold and something is over. The variety of factors make the definition of orgasm almost impossible, but if we reduce orgasm to the essentials is: involuntary release of sexual tension. [4]

Orgasms can be induced by erotic stimulation of a variety of genital and non-genital areas. The clitoris and vagina (especially the anterior wall, including Halban's fascia and urethra) are the most common sites of stimulation, but stimulation of the periurethral glands [5], breast / nipple [3], mental imagery or fantasy [3], [6] or hypnosis [7] to induce orgasm. Orgasms have been observed to occur during sleep [2], [8], [9], so consciousness is not an absolute requirement. Cases of "spontaneous orgasm" have occasionally been described in the psychiatric literature in which no obvious sexual stimulus can be found [10]. The precise mechanism that triggers orgasm has been the subject of debate for many years, but no definitive mechanisms have been identified yet.

A woman's sexual interest depends on a wide range of factors, such as: an attractive partner who respects and accepts them as they are, the feeling of trust and affection in the relationship, trust and health, both emotional and physical, the feeling of to be wanted by a partner, to be approached in a way that makes them feel special, explicit erotic cues, such as pornographic literature or movies, to see or hear other people having sex. [4]

A consistent finding in the literature has been that only about half of women who experience orgasm difficulties also report and associated stress. This may suggest that orgasms are less important for women's sexual satisfaction than for men. Evidence is provided to suggest that orgasms are important for women's sexual satisfaction. Lack of stress seems to be related to the lower consistency of women's orgasm during sexual intercourse and not to the less important orgasms themselves.

Contrary to current suggestions that the inability to orgasm during vaginal intercourse indicates psychological immaturity, there are data suggesting that the consistency of female orgasm in all forms of partner sexual activity is associated with sexual autonomy (ie the extent to which one's sexual characteristics are self-determined).

Sexuality and sexual dysfunction influence a woman's quality of life

The role of sexuality in sexual satisfaction is often studied from a gender perspective (Baumeister, Vohs, 2004; Karney, Bardbury, 1995; Petersen, Hyde, 2010). For example, women, more often than men, feel sexual intercourse as a reflection of the quality of the relationship and view sexuality from a more emotional / interpersonal perspective, while men tend to focus on meeting sexual needs (Birnbaum, Laser-Brandt, 2002; Birnbaum, Reis, Mikulincer, Gillath, Orpaz, 2006). Gender affiliation moderates the association between sexual activity and the feelings and behaviors within the relationship. For example, in a study using daily journals, Birnhaum et al. to a greater extent of consolidating behaviors for the relationship, related to a higher quality of the relationship and to a lesser extent of behaviors harmful to the relationship. The perceived response capacity of the partner may be a mechanism involved in the association between sexual and marital satisfaction, an association mediated by changes in the perception of the partner, seen as attentive, caring, sensitive to needs. Sexual satisfaction stimulates intimacy, closeness, and security (Hazan, Shaver, 1994). Given that sexuality is an important component of quality of life, it is necessary to understand sexual dysfunction, followed by effective treatments for sexual problems [12].

Poor sexual function, including low sexual stimulation / desire, difficulty reaching orgasm and the presence of pain during intercourse, were reported by approximately 58% of women in the United States in 2014. The prevalence is

higher than for depression, social anxiety and other common forms of psychopathology.

The underlying processes of sexual dysfunction are not fully explained by researchers. One of these processes refers to the way in which sexual dysfunction causes a subjective distress related to sexual life. A large number of studies suggest that there is a complex relationship between women's sexual function and their subsequent emotional responses. In many cases, women have sexual dysfunction without a high level of subjective distress. Rosen and colleagues concluded that although sexual desire decreases with age, the personal distress associated with this decreased desire also decreases. In other cases, women are severely affected by sexual dysfunction, in the absence of severe sexual dysfunction. For example, Stephenson and colleagues found that women with a personal history of childhood sexual abuse had sexual dysfunction distress, even in the context of intense sexual desire / stimulation.

Barlow's model of sexual dysfunction reflects the complex relationships between sexual function, attention, and affection. The model argues that individuals with sexual dysfunction engage in sexual situations with negative affections and expectations, and the focus is subsequently drawn to non-erotic stimuli, including external stressors, body image concerns, and perceived consequences of poor sexual performance. This focus on non-erotic stimuli during intercourse causes anxiety and maintains a low level of stimulation, through distractions, resulting in a continuous low performance and a subsequent avoidance of signs and sexual situations. Barlow's model has led to the development of effective techniques for treating sexual dysfunction, such as systematic desensitization and sustained meditation. Barlow's model explains the link between sexual function and distress / subjective disorder using a primary mechanism: avoidance. Poor sexual function leads to subsequent behavioral and / or experiential avoidance, and avoidance maintains the negative affections and expectations that initiate the dysfunctional sexual cycle during subsequent sexual experiences. The role of avoidance is essential in maintaining this circular and self-consolidating model. Avoiding a negative experience prevents learning new mechanisms, which would correct the overestimation of the probability of occurrence and / or the severity of the anxious results. Similarly, after a negative sexual experience, avoidance prevents learning that poor sexual function is harmless, thus maintaining the negative stress and anxiety associated with sexual activity. Arguments against this model include explanations that many women - with sexual dysfunction - continue to engage in intense sexual activity and respond to sexual situations, so avoidance is not the only mechanism for maintaining sexual distress. Also, although the model specifies among the consequences of sexual dysfunction the distraction from useful erotic signs (such as sexual pleasure), the consequence with the greatest potential stressor for the individual has not yet been identified. Other researchers have developed a mechanism to develop alternative or additional that maintains the stress related to sexual activity - the repeated experience of justified negative consequences.

In some cases, sexual dysfunction is not harmless, but can lead to disruptive sexual activities and / or conflicts with your partner. In these situations, sexual distress is maintained by reinforcing the idea that sexual activity is part of a threatening emotional environment. Thus, if the sexual stimulation of the woman stops the involvement in sexual activities and triggers the partner's anger towards her, the sexual difficulty can be seen as an adaptive response to the negative relational context. Stephenson and Meston concluded in their 2015 study that poor sexual function decreases a woman's sexual pleasure, stops a couple from engaging in sexual activity, and decreases their partner's pleasure and influences sexual distress. These results are consistent with the assumption that sexual consequences are a factor in maintaining sexual dysfunction and explain why in some cases poor sexual function is a stressor for women. [12]

Correlations between marital satisfaction and sexual dysfunction

Marital relationship is defined in terms of: marital satisfaction, dyadic adjustment and style of communication and conflict resolution. Marital satisfaction is the degree of satisfaction with certain aspects of the marital relationship, but also with the relationship as a whole. According to previous studies, marital satisfaction refers to the subjective and global assessment of the relationship. It also refers to a situation in which couples express satisfaction, happiness, living together. The concept of marital satisfaction is a multifaceted and multidimensional concept, including psychological, socioeconomic and spiritual components. The measurement of marital satisfaction varies depending on the researcher and the operational definition. The criteria for a satisfying marital relationship are variable and may depend on unique sets of imposed cultural norms, obligations, and values. Marital satisfaction is influenced by many factors - for example, the sexual relationship that provides security and pleasure is mentioned as one of the most important factors in many studies.

The authors of a 2014 study [15] concluded that marital satisfaction is significantly linked to sexual satisfaction, with the hypothesis of the impact of sexual satisfaction on marital satisfaction being supported by other researchers. An inverse association is mentioned between age and sexual satisfaction, in the sense that sexual satisfaction increases inversely with the age of the participants (the lower it is, the higher the satisfaction).

Increasing the level of education is also associated with increased sexual satisfaction. Ji identified a positive correlation between education and sexual satisfaction, with Ji and Norling arguing that education can affect economic stability - educated couples are more likely to achieve economic stability, leading to increased marital and sexual satisfaction.

Marital satisfaction is related to the level and quality of general health, life satisfaction and a sense of loneliness. Sexual perceptions have a positive relationship with certain behaviors, which ensures the continuity of the marital relationship. Sexual inactivity can be a sign of marital problems. Sexual satisfaction is also linked to the duration of the marriage, with people married for less than 15 years reporting a more satisfying sex life than those married for longer (more than 15 years) [16]. In dyad-type relationships, both partners manifest their own characteristics, which affect the transactions made within the relationship. Marriage, an intimate and solid dyad-type relationship, is a powerful form of communication and provides the socially accepted context for sexual activities. Understanding, projection and positive perceptions are relevant components of empathy and predict the functioning of the relationship.

Because sexual satisfaction and empathy are interpersonal in nature, spouses are more likely to be empathetic about their partner's sexual satisfaction compared to other providers of such information. Understanding your partner's perception of sexual satisfaction and functioning is important in managing sexual problems. In some studies on the accuracy of individual perceptions of the sexual satisfaction of the couple's partner, it was found that men tend to overestimate the sexual satisfaction of their partners, while in women this behavior is not observed. Other studies contradict this claim, proving that women overestimate the sexual satisfaction of their partners [17]. Fallis (2014), investigating 84 couples, concluded that perceptions of partner sexual satisfaction were correlated with self-reported sexual satisfaction for both men and women. Men tended to underestimate the level of sexual satisfaction of their partners, while women did not underestimate or underestimate the sexual satisfaction of their partners. In general, men and women had very high perceptions of accuracy and impartiality about the sexual satisfaction of their partners. Gungor (2015) found that perceptions related to partner sexual dysfunction and dissatisfaction were not correlated with personal, self-identified sexual problems - and in general, men's sexual problems, to a greater extent than women's problems, were not perceived correctly by their partners. Lack of female communication, lack of female sen-

suality, impotence and premature ejaculation were the least correctly perceived issues by partners. When the partner's sexual problem was related to vaginal penetration, men identified vaginismus (one-fifth of men did not identify vaginal penetration disorder). Anorgasmia is another dysfunction, in which women frequently provide false information, mimicking orgasm. At the collective level, there are certain sexual scenarios in which a woman's orgasm should precede a man's orgasm, and when orgasm is unlikely, women do not want to suffer negative consequences, such as hurting their partner's feelings, or losing the positive consequences. such as partner satisfaction. Studies in other clinical specimens in Turkey have shown that vaginismus is the most common dysfunction (ranging from 41.7% to 73%). According to another study, the most common problem of men with partners suffering from vaginismus is premature ejaculation (50%), suggesting the interaction of premature ejaculation with vaginismus. [11]

APPROACH

Orgasmic disorder in women

According to DSM V, orgasm disorders in women have as diagnostic criteria: marked delay of orgasm, very low frequency of orgasm, or absence of orgasm or very low intensity of orgasmic sensations. Any of the following symptoms should be present in all or almost all (approx. 75-100%) sexual intercourse (in certain particular situations, or if generalized, in all situations) (criterion A). As a period, the symptoms of Criterion A persisted for a minimum of about 6 months (Criterion B) and cause significant clinical discomfort to the individual (Criterion C).

Sexual dysfunction is not best explained by a mental disorder without a sexual component or as a consequence of a severe relationship problem or other major stressors and cannot be attributed to the effects of a substance or medical condition (Criterion D).

In general, the association between certain personality traits, psychopathology and orgasmic dysfunction has not been generally supported by evidence. Compared to women who do not have this disorder, some women with an orgasm disorder may have more difficulty communicating sexual problems. Overall sexual satisfaction is not closely linked to experiencing orgasm. Many women describe great satisfaction but do not reach orgasm. Difficulties with orgasm in women are often associated with problems with sexual interest and arousal.

In addition to the "permanent / acquired" and "generalized / situational" subtypes, the following five factors should be considered in the assessment, diagnosis, and diagnosis of orgasmic disorder in women, as they may be relevant to etiology or treatment: partner factors sexual, partner's health); couple factors (reduced communication, differences between partners regarding the desire for sexual activity); factors related to the individual's vulnerability (negative self-image, history of sexual or emotional abuse), psychiatric comorbidity (depression, anxiety) or stressors (job loss, grief); cultural / religious factors (inhibitions related to the prohibition of sexual activity, attitude towards sexuality); medical factors relevant to prognosis, evolution and treatment. Each of these factors may contribute differently to the symptoms that make up the clinical picture of women with this disorder.

METHOD

Strategic integrative psychotherapy is a state-of-the-art approach in the field of integrative psychotherapy, combining the main existing psychotherapeutic approaches and presenting means of intervention and psychotherapeutic strategies adapted to the needs of the client / patient. [13]

The strategic integrative model of the self was created by Oana Maria Popescu and Loredana Ileana Vîşcu within the Association for Research, Counseling and Integrative Psychotherapy. The innovation of the model consists in approaching the structuring of the personality from a complex perspective, by placing the self consisting of four domains: the basal self, the central self, the plastic sign and the exter-

nal self, intersected by psychological axes: biological, cognitive, emotional, psychodynamic, existential and family Drobot, Popescu, 2013). Each term of the model is based on research and psychological theories, conclusions about attachment and neurobiology and common factors in psychotherapy (relational, strategic and transtheoretical), the existing guidelines being recognized and used successfully in various schools of integrative psychotherapy. [14]

The biological axis includes aspects such as the genome and epigenome, vulnerability and genetic resilience, body image, body image, mental patterns about disease and health, the influence of the attachment system on the immune system and psychosomatic diseases.

The cognitive axis refers to cognitive maps, perfectionism and self-esteem, integrating the model of cognitive-behavioral psychotherapy.

The emotional axis refers to the system of attachment, emotions, intersubjectivity and the conditions of valorization, integrating elements from person-centered psychotherapy, gestalt therapy, interpersonal psychotherapy and attachment theory.

The psychodynamic axis integrates basic elements of psychoanalysis, transactional analysis and ego parts therapy along the following dimensions: subpersonalities, inner counselor, ego states, life scenario, transfer and countertransference, psychological games and transpositions.

The existential axis includes: the four fundamental worries (death, existential isolation, responsibility / autonomy and meaning of life), personal time, contact models and aspects related to spirituality, integrating elements of existential psychotherapy, gestalt therapy and mind theory.

The family axis refers to family roles and structures, the place of the individual in the family and transgenerational patterns, integrating elements from various family approaches in psychotherapy.

Case story:

E.R. 39 years old, married for 12 years, with an 8 year old daughter, with a job at a multinational company in the field of administration, applied for psychotherapy in August 2020 and the reason for requesting it was to improve the quality of life and personal development. After the first sessions, the patient mentioned that her biggest desire is to be able to have an orgasm, never experiencing this condition.

Patient E.R. he comes from a family from Mehedinți County, being the second child born. After giving birth, a few months later she remained in the care of her grandparents, near her hometown, together with her sister, until the age of 7 when she returned to the city to start primary school. The parents visited them on the weekends and occasionally spent a few days with them in the city. After 18 years she settled in Timișoara, studied at a human profile college, met her husband with whom she married after 10 years.

The relationship with the sister is not the most harmonious. The sister was preferred by her grandmother and mother, a preference manifested both verbally and by material favoritism felt by E.R. constantly in her life. Even the inheritance of an apartment belonged only to her sister, which was done without the patient's knowledge and when she found out the truth, the explanation offered by her parents and sister was: "you went to study, what would you need the money for the apartment?". The sister, in adolescence, had many rebellious behaviors, and among those mentioned by the client are specifically those related to the multiple partners that the sister had, many sexual relations of the sister. She tells about her sister that she was very beautiful, but she was very often devalued and used by men, having a lot of sex without having a single partner, behaviors that were punished at home by physical abuse from parents who did not know how to control or control her. stop her from what she was doing. The sister ended up marrying an underworld, has two children, but ended up not having a high quality of life, still suffering verbal, emotional, sexual, physical abuse from her husband.

About the marriage with her husband, she says that it is based on trust, love, respect and a lot of gratitude. Her husband supports her to develop, gives them financial stability, is a

wonderful father but through the personality he has, he sometimes has a critical attitude towards E.R. In terms of sexuality, the husband was her first partner. She states that she is satisfied during sexual intercourse but does not reach orgasm, she has never had an orgasm, neither alone nor with her husband. They have a constant, open sexual relationship, they want to advance as a couple from the perspective of sexuality, he takes care to give her a long foreplay, a caress as she wants but she fails to reach orgasm.

PROCEDURE

The applied therapeutic strategy was according to the integrative-strategic model, on the psychological axes: biological, cognitive, emotional, psychodynamic, existential and familial.

The meetings had a regular, weekly frequency, applying various techniques and practical exercises, depending on the objective of each meeting result.

Following the therapeutic work with the patient, we can record the following, specific to each psychological axis:

• Biological axis:
- Body scheme: the patient does not feel good with her body, she has always been fatter
- Psychosomatic mechanisms: when she feels undervalued by her husband or there are verbal conflicts, certain physical symptoms such as bloating appear.
- Orgasm disorder

• Cognitive axis:
- Low self-esteem
- Limiting beliefs such as „As long as he criticizes me I will not be able to have an orgasm"
- Central beliefs: „I am not allowed to be sexually happy"
- Perfectionism: „I'm not good enough", „I'm doing something wrong"
- Abandonment scheme: „if I always confront my husband, I think he will leave"
- Defensive: it's definitely my fault

• Emotional axis:
- Anxiety attachment, dependent
- Suppressed, repressed emotions: Joy was not allowed, did not express anger, sadness
- Victimization
- Anxiety
- Neurotic guilt

• Psychodynamic axis:
- Life scenario: „if I am happy ... then I will have negative consequences ... I will be excluded, abandoned"
- Injunctions: „don't be important", „don't feel"
- Drivers: „Be Perfect", „Try Hard", „Be Careful"
- She positions herself as a child in relation to her husband, she perceives him as a critical parent

• Family axis
- The model of the unhappy mother who never feels good and is always a victim
- Dysfunctional family models in which there is no harmony and fulfillment
- Sister's pattern: „if you feel good sexually, you will suffer, you will be beaten"
- Lack of identification: identified with her sister and her abuse

• Existential axis:
- Fear of death
- Poor time management - it is difficult to find time to take care of oneself, her priorities are the others: the girl, the husband, the house, the job

Applied Therapeutic Interventions: Emotion Management Techniques, Anxiety, Progressive Muscle Relaxation, Assertiveness Learning, Constructivism, Relaxation Training, Time Management Techniques, Working with Limiting Beliefs, Hypnotic Guided Imaging, Transactional Analysis Specific Techniques, Scenario Change life, positioning as an adult in any situation, separation from the extended family (parents and sister), increasing the feeling of personal value, specific techniques that are meant to accept oneself.

Cognitive-behavioral therapy used specifically for female orgasmic disorder was also applied and aimed to promote changes in attitudes and sexually relevant thoughts, decrease anxiety, and increase orgasmic capacity and satisfaction.

Recommended behavioral exercises to induce these changes included directed masturbation, sensitive focusing, and systematic desensitization. Sex education, communication skills training, and Kegel exercises have also been included in cognitive-behavioral treatment programs for anorgasmia.

The patient also received recommendations from the bili therapy area, watching movies that would stimulate her so that she would know herself.

CONCLUSIONS

This paper confirms the theory that we need to take into account the personality structure of each individual, self-approach considering the factors that can influence sexual dysfunction: biological factors, cognitive factors, emotional factors, family factors, psychodynamic factors and existential factors.

The following directions are recommended to be in the direction of putting more effort into exploring the factors associated with sexual inhibition, the anxiety of having an orgasm and thus maintaining the orgasm disorder.

We will continue working according to the therapeutic strategy, on the axes and in addition the recommendation to the patient is to work on relaxation training, to find constant sports activities to help her get out of this static energy because the body can release many stored traumas.

It is recommended in the future, in addition to continuing individual therapy through techniques and interventions in the integrative-strategic area and couple psychotherapy.

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