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L'intimité et le bien-être sexuel chez les couples ayant un faible désir sexuel

par

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L'intimité et le bien-être sexuel chez les couples ayant un faible désir sexuel

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Résumé

Le trouble de l'intérêt pour l'activité sexuelle ou de l'excitation sexuelle (TISES) est la dysfonction sexuelle la plus commune chez la femme (Witting et al. 2008) et une des raisons les plus fréquentes de consulter en thérapie de couple ou sexuelle (Doss et al., 2004; Emond et al. 2024; Péloquin et al. 2019). Le TISES a été introduit dans le DSM-5 en 2013 et est défini par l'absence ou la diminution de l'intérêt pour l'activité sexuelle (p. ex., de pensées érotiques ou de fantasmes, d'initiation de l'activité sexuelle, etc.) – c'est-à-dire, un faible désir sexuel – et l'absence ou la diminution de l'excitation ou du plaisir sexuel et/ou de sensations génitales ou non génitales dans au moins 75% des activités sexuelles (APA, 2013). Le TISES doit engendrer une détresse significative chez l'individu et est souvent accompagné de détresse sexuelle (p.ex., stress à propos des problèmes sexuels, se sentir inadéquat sexuellement), d'anxiété et de symptômes dépressifs (Jabs et Brotto, 2018; Rosen et al. 2009; Derogatis et al., 2008). Le TISES peut entraîner des conséquences tant pour la femme que pour son partenaire, résultant en un bien-être sexuel moindre comparativement à des couples contrôles (Rosen et al., 2018). Il est donc essentiel d'examiner l'apport des facteurs interpersonnels dans la recherche sur le TISES, et ce, de façon dyadique, afin de mieux prendre en compte l'interdépendance entre les partenaires. L'intimité (le dévoilement de soi, le dévoilement perçu par le partenaire, la réponse empathique perçue du partenaire) est d'ailleurs un facteur interpersonnel qui a été positivement associé au bien-être sexuel (la satisfaction sexuelle, la détresse sexuelle, la fonction sexuelle) dans la littérature (Bergeron et al. 2021; Bois et al. 2013; Bois et al. 2016). Cette étude dyadique transversale visait donc à examiner les associations entre les trois composantes de l'intimité et les trois issues du bien-être sexuel chez les couples dont la femme présente un TISES diagnostiqué, ainsi que l'effet modérateur du type de couple (hétérosexuel cisgenre vs diversité de

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genre/sexuelle). Pour ce faire, les deux membres du couple (N=263 couples) ont complété des questionnaires auto-rapportés de 50 à 70 minutes à l'aide de la plateforme sécurisée *Qualtrics*. La majorité des individus avec un TISES ($M_{\text{age}} = 34.16$, $SD = 9.95$) s'identifiait comme femme cisgenre (n=239), alors que 24 s'identifiait à la diversité de genre. Pour les partenaires ($M_{\text{age}} = 35.71$, $SD = 10.56$), 239 s'identifiait comme femme ou homme cisgenre et 22 à la diversité de genre (p. ex., transgenre, non-binaire). Les résultats démontrent que pour les partenaires des femmes présentant un TISES, une réponse empathique perçue plus élevée était associée positivement à leur propre satisfaction et fonction sexuelles et à une moins grande détresse sexuelle, ainsi qu'à une meilleure satisfaction sexuelle chez la femme avec un TISES. Le type de couple a aussi modéré les associations entre la réponse empathique perçue et la fonction sexuelle, de telle sorte que lorsque les femmes avec un TISES appartenant à un couple de la diversité sexuelle ou de genre rapportaient une réponse empathique perçue plus élevée, elles rapportaient également une meilleure fonction sexuelle. De plus, lorsque les partenaires appartenant à un couple cisgenre hétérosexuel rapportaient une réponse empathique perçue plus élevée, les femmes avec un TISES rapportaient une meilleure fonction sexuelle. Renforcer les sentiments de proximité et de connexion grâce à des interventions cliniques axées sur l'intimité pourrait aider les couples confrontés au TISES à surmonter les défis sexuels et améliorer leur bien-être sexuel. Le grand échantillon diversifié de couples cliniques, le modèle dyadique et l'utilisation de modérations basées sur le genre et l'orientation sexuelle distinguent cette étude de celles dans la littérature existante. Cependant, le devis transversal de l'étude ne permet pas d'inférer de causalité, et l'utilisation de mesures auto-rapportées doit être prise en compte lors de l'interprétation des résultats. Néanmoins, les résultats soulignent l'importance de comprendre les dynamiques interpersonnelles entourant le TISES, mettant en lumière l'effet positif potentiel de l'intimité sur le bien-être sexuel des deux partenaires. Les effets modérateurs du type de couple

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sur l'intimité et la fonction sexuelle soulignent également la nécessité d'inclure un échantillon diversifié de couples dans les études sur la sexualité.

Mots-clés : Intimité, bien-être sexuel, trouble de l'intérêt pour l'activité sexuelle ou de l'excitation sexuelle, couples, dyadique

Abstract

Sexual Interest/Arousal Disorder (SIAD) is the most commonly reported sexual dysfunction among women (Witting et al. 2008) and one of the primary reasons to seek sex and couple therapy (Doss et al., 2004; Emond et al., 2024; Péloquin et al., 2019). SIAD was introduced into the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013 combining the formerly distinct diagnoses of hypoactive sexual desire disorder and sexual arousal disorder. It is characterized by the absence or decrease in interest in sexual activity (e.g., erotic thoughts or fantasies, initiation of sexual activity, etc.)—that is, low sexual desire—and the absence or decrease in sexual arousal or pleasure and/or genital or non-genital sensations in at least 75% of sexual activities (APA, 2013). SIAD must cause significant distress for the individual and is often accompanied by sexual distress (e.g., stress about sexual problems, feeling sexually inadequate), anxiety, and depressive symptoms (Jabs and Brotto, 2018; Rosen et al., 2009; Derogatis et al., 2008). SIAD is associated with sexual difficulties for both the woman and her partner, resulting in lower sexual well-being compared to control couples (Rosen et al., 2018). Consequently, it is crucial to examine the interpersonal factors involved in SIAD using a dyadic perspective in order to capture the interdependency between partners. Intimacy has been one interpersonal factor found to be positively related to sexual well-being in previous research (i.e., Bergeron et al. 2024; Bois et al. 2016). The aim of this study was to examine the associations between the three components of intimacy (self-disclosure, perceived partner disclosure and perceived partner responsiveness) and sexual well-being (sexual satisfaction, sexual distress, sexual function) among couples in which one partner was diagnosed with SIAD, using a dyadic cross-sectional design. The moderating role of couple type (cisgender heterosexual vs sexual/gender diverse couples; SGD) was also assessed. To do so, both partners (N=263

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couples) completed online questionnaires of 50 to 70 minutes through the secure online survey platform *Qualtrics*. Most individuals with SIAD ($M_{age}= 34.16$, $SD=9.95$) identified as cisgender women ($n=239$), while 24 identified as gender diverse (e.g., transgender, non-binary). As for partners ($M_{P2}= 35.71$, $SD= 10.56$), the majority identified as cisgender, man or woman, ($n = 230$), and 33 as gender diverse. Results showed that partners of women with SIAD's higher perceived partner responsiveness was associated with their own greater sexual satisfaction, greater sexual function and lower sexual distress, and with the women with SIAD's greater sexual satisfaction. Couple type also moderated the associations between perceived partner responsiveness and sexual function, such that when women with SIAD in a sexual/gender diverse couple reported greater perceived partner responsiveness, their own sexual function was greater. Additionally, when partners in a cisgender heterosexual couple reported greater perceived partner responsiveness, the women with SIAD's sexual function was also greater. Enhancing feelings of closeness and connection through clinical interventions focusing on intimacy could help couples with SIAD cope with the sexual challenges related to this sexual dysfunction and contribute to improving their sexual well-being. The large and diverse clinical sample of couples coping with SIAD, diagnosed according to DSM-5 criteria, the dyadic design, allowing for the examination of cross-partner effects, and the use of moderation to examine the role of couple type in the associations between intimacy and sexual well-being, all represent strengths of this study. However, the cross-sectional design limits our ability to establish causation, and the interpretation of results should consider the reliance on self-report questionnaires. Findings underscore the importance of understanding interpersonal dynamics in SIAD, highlighting the potential positive impact of intimacy on sexual well-being for both women with SIAD and their partners. The moderating effects of couple type on the association between intimacy and sexual

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function also underlines the importance of including a diverse sample of couples in research on sexual dysfunction.

Key words: Intimacy, sexual-well-being, sexual interest/arousal disorder, couples, dyadic

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Intimacy and Sexual Well-being in Couples Coping with Sexual Interest/Arousal Disorder

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Abstract

Background: Clinically low sexual desire, such as Sexual Interest/Arousal Disorder (SIAD), is one of the most common sexual issues reported by women and a leading reason for seeking sex and couple therapy. Consequently, it is crucial to examine contributing interpersonal factors to better address the needs of these couples. Intimacy is one such factor found to be positively related to sexual well-being, yet never studied in SIAD.

Aim: Using a dyadic cross-sectional design, this study examined the associations between the three components of intimacy (self-disclosure, perceived partner disclosure and perceived partner responsiveness) and sexual well-being among 263 couples coping with SIAD. The moderating role of couple type (cisgender heterosexual vs sexual/gender diverse couples) was also assessed.

Method: 263 individuals with SIAD ($M_{age}= 34.16$) and their partners ($M_{age}= 35.71$) completed questionnaires of 50 to 70 minutes through the secure online survey platform *Qualtrics*.

Outcomes: Main outcomes included: The Global Measure of Sexual Satisfaction (GMSEX); The Sexual Distress Scale and the Sexual Function Evaluation Questionnaire (SFEQ).

Results: Partners of women with SIAD's higher perceived partner responsiveness was associated with their own greater sexual satisfaction, greater sexual function and lower sexual distress, and with the women with SIAD's greater sexual satisfaction. Couple type also moderated the associations between perceived partner responsiveness and sexual function, such that when women with SIAD in a sexual/gender diverse couple reported greater perceived partner responsiveness, their own sexual function was greater and when partners in a cisgender heterosexual couple reported greater perceived partner responsiveness, the women with SIAD's sexual function was greater.

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Clinical Implications: Enhancing feelings of closeness and connection through clinical interventions focusing on intimacy could help couples with SIAD cope with the sexual challenges related to this sexual dysfunction and improve their sexual well-being.

Strengths & Limitations: Strengths of this study include the large and diverse clinical sample of couples coping with SIAD, diagnosed according to DSM-5 criteria; the dyadic design, allowing for the examination of cross-partner effects; and the use of moderation to examine the role of couple type in the associations between intimacy and sexual well-being. However, the cross-sectional design limits our ability to establish causation, and the interpretation of results should consider the reliance on self-report questionnaires.

Conclusion: Findings underscore the importance of understanding interpersonal dynamics in SIAD, highlighting the potential positive impact of intimacy on sexual well-being for both women with SIAD and their partners. The moderating effects of couple type on the association between intimacy and sexual function also underlines the importance of including a diverse sample of couples in research on sexual dysfunction.

Keywords: Intimacy, sexual-well-being, sexual interest/arousal disorder, couples, dyadic

INTRODUCTION

At some point in the course of their romantic relationship, most long-term couples are likely to experience conflicting sexual interests or sexual desire¹. Studies suggest that couples who experience greater differing levels of sexual desire encounter higher sexual distress on a daily basis and over time²⁻⁴. Sexual desire discrepancy is therefore one of the most frequent reasons for seeking sex and couple therapy⁵⁻⁷. A common cause of couples' experience of sexual desire discrepancy is when one of the romantic partners is coping with Sexual Interest/Arousal Disorder (SIAD¹; American Psychiatric Association [APA]⁸).

Sexual Interest/Arousal Disorder is a female sexual dysfunction introduced into the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013 (combining the formerly distinct diagnoses of hypoactive sexual desire disorder and sexual arousal disorder) and characterized by reduced sexual interest and arousal as well as sexual distress, i.e., sexuality-related negative emotions (e.g., worry, feeling of inadequacy, frustration)⁹⁻¹¹. In fact, according to population-based prevalence rates, 39% of women indicate having low sexual desire, 26% report low sexual arousal, and 30% of those with low desire also experience sexual distress, making SIAD the most common sexual dysfunction among women^{9,11}. Controlled studies indicate that women with SIAD are more likely to report higher sexual distress, lower relational and sexual satisfaction, and lower overall sexual function, i.e., sexual desire, arousal, and orgasm¹²⁻¹⁵. Partners of women with SIAD also experience sexual difficulties, such that heterosexual male partners report lower sexual function, sexual satisfaction (subjective evaluation

¹ The term SIAD was used to refer to the DSM-5 diagnosis Female Sexual Interest/Arousal Disorder (FSIAD). We have dropped the word "female" from this label in order to be inclusive of all women (e.g., cisgender women, transgender women, intersex individuals) and all individuals who were assigned female at birth.

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of the positive and negative aspects of one's sexual relationship¹⁶), and sexual communication, as well as more sexual distress than control partners¹⁵.

Taken together, these findings highlight the need to examine interpersonal factors among couples coping with SIAD and to adopt a dyadic approach, since both partners experience lower sexual and relationship well-being and higher distress.

Given that couples with SIAD often face multiple sexual challenges, identifying factors that can enhance their well-being is essential. Intimacy is one interpersonal factor that has been associated with better sexual well-being¹⁷⁻²⁰. Although studies on intimacy and sexual well-being (i.e., sexual satisfaction, sexual distress, and sexual function) within clinical samples of sexual dysfunction are still limited and focus on genito-pelvic pain, they support the positive role of intimacy^{18,19}. As intimacy can foster emotional connection, closeness, and open communication^{21,22}, it may help couples adapt to the sexual challenges brought upon by SIAD^{17,23}. The present study examined the role of intimacy on the sexual well-being of couples coping with SIAD.

Interpersonal Factors and Sexual Desire

Despite the conceptualization of sexuality as an interpersonal construct^{24,25}, interpersonal factors at play in sexual desire have been overlooked. Some studies have demonstrated an association between sexual desire and relationship factors among community samples, including, among others, marital satisfaction, relationship quality, as well as conflicts and communication²⁶⁻³⁰. For example, using a cross-sectional design, Brezsnayak and Whisman (2004) found that higher marital satisfaction was associated with higher sexual desire for both wife and husband in a sample of community married couples. A daily diary study also showed that women's sexual desire on a given day depended on how much satisfaction, closeness and commitment they had

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felt towards their partner on the previous day, suggesting that relational factors play a role in daily sexual desire²⁷.

Theoretical models also suggest that sexual desire can be triggered by relational factors, as proposed in Basson's intimacy-based *Biopsychosocial model of women's sexual response*³¹. According to this model, intimacy could have a stronger influence than physiological factors on female sexual function, whereby the lack of emotional intimacy could diminish desire and arousal, resulting in lower sexual satisfaction within the couple^{32,33}. Emerging theories, such as the *Interpersonal Emotion Regulation Model of Women's Sexual Dysfunction*²⁵, also support the need to conceptualize interpersonal factors, including intimacy, as pivotal influencers of couples' sexual outcomes. This model suggests that one's distal or proximal interpersonal factors are associated with one's own relational, sexual and psychological functioning as well as that of one's partner. Proximal factors are those present before, during, or immediately after sexual activity, and can affect ongoing sexual dysfunction (e.g., sexual motivation). In contrast, distal factors refer to the relational dynamics or contexts that exist prior to the onset of sexual dysfunction and influence how couples interact and navigate challenges together²⁵. This model suggests that intimacy could be a distal factor influencing couples' sexual well-being when coping with sexual dysfunction, since interactions between couples where partners feel more understood, cared for and validated can encourage better sexual and relationship adjustment^{25,34}.

Intimacy and Sexual Well-being

Intimacy encompasses three components: self-disclosure, perceived partner disclosure and perceived partner responsiveness²². It is an interpersonal and dynamic process wherein an individual shares feelings, thoughts, and personal information with a partner, and interprets their partner's response as understanding, validating, and caring²². Intimacy thus evolves through

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multiple interactions considered intimate by both partners, making it a recursive process that develops over time. As partners engage in these interactions, they foster a closer bond. This model of intimacy and its components have been validated by several studies³⁶⁻³⁸.

Results from previous studies among community couples suggest that intimacy could play a key role in fostering positive outcomes in couples³⁹⁻⁴². Yet, there are a limited number of studies focusing on intimacy and sexual well-being^{18,19,43} within clinical samples experiencing sexual dysfunction. However, the few published studies to date showed a positive association between intimacy and specific aspects of sexual well-being. In an observational study on the association between intimacy, sexual distress and sexual satisfaction in a sample of 50 women diagnosed with genito-pelvic pain and their partners, women's greater observed empathic response was associated with their own greater sexual satisfaction and their own lower sexual distress, as well as their partner's lower sexual distress¹⁹. Women's greater observed self-disclosure was associated with their own greater sexual satisfaction, and their partner's lower sexual distress. Partners' higher observed self-disclosure was associated with their own greater sexual satisfaction and with lower sexual distress in the women with genito-pelvic¹⁹. These findings corroborate the results of a prior cross-sectional study on intimacy, sexual satisfaction, and sexual function in a sample of heterosexual couples coping with women's genito-pelvic pain¹⁸. Another study on heterosexual couples coping with genito-pelvic pain reported similar findings using a dyadic daily diary design¹⁷. On days when the couple was sexually active, greater perceived partner's empathic response from women was associated with their own greater sexual function and greater sexual satisfaction, as well as that of their partner's¹⁷. Unfortunately, the majority of studies on intimacy and sexual well-being have primarily focused on heterosexual

couples, while the few that included gender or sexually diverse couples often did not consider their gender or sexual orientation in the primary analyses^{40,43}.

Gender and Sexual Diversity

Few studies on women's sexual dysfunction have included diverse samples based on gender and sexual orientation^{44,45}. Some studies among community samples have reported differences in sexual well-being between heterosexual individuals and sexual/gender diverse individuals (SGD). One cross-sectional study demonstrated that sexual function and sexual satisfaction differed by sexual orientation among adults in the United States, as sexual diverse men and women experienced more sexual function difficulties than heterosexual individuals, and gay and bisexual men reported lower sexual function compared to heterosexual men⁴⁶. Another study showed differences in levels of sexual satisfaction based on sexual orientation, where bisexual women and men reported less sexual satisfaction than heterosexual and lesbian/gay women and men⁴⁷. It is possible that heteronormative scripts or minority stress contribute to the differences between the sexuality of cisgender heterosexual individuals and that of SGD individuals, as these factors can play different roles in shaping the sexual experiences of these two groups, thereby influencing their sexual well-being in distinct ways^{48,49}. Nevertheless, the results remain scarce and inconsistent, making it difficult to form clear hypotheses about these differences. Hence, with the exception of Jodouin and colleagues' study (2021) on sexual desire discrepancy and sexual distress in community couples, previous studies on low sexual desire have mainly focused on cisgender heterosexual couples, overlooking the experience of sexual and gender diverse couples coping with SIAD. Given the mixed findings of prior studies concerning the sexual well-being of sexual and gender diverse individuals, it is crucial to investigate potential distinctions within a clinical sample. This is particularly relevant as this group often

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experiences greater distress compared to individuals without sexual dysfunction¹⁵. More inclusive samples ensure broader applicability of findings across diverse populations, notably within clinical settings.

AIMS

The present dyadic study first aimed to examine cross-sectional associations between the three components of intimacy (i.e., self-disclosure, perceived partner self-disclosure and perceived partner responsiveness) and sexual well-being (i.e., sexual satisfaction, sexual distress and sexual function) among couples coping with SIAD. Based on the *Interpersonal Emotion Regulation Model of Women's Sexual Dysfunction*²⁷, and previous empirical results^{17,19,40}, it was hypothesized that both women coping with SIAD and their partners' greater scores on the three separate components of intimacy would be associated with their own greater sexual satisfaction and sexual function as well as their own lower sexual distress. As for cross-partner associations, given the lack of dyadic studies on SIAD in the literature, we did not formulate a hypothesis. The second aim of this study was to examine the moderating role of couple type (cisgender heterosexual couples vs SGD couples) in the associations between intimacy and sexual well-being. Because little is still known about gender and sexual diverse couples coping with SIAD and given the limited results on sexual well-being among gender/sexual diverse individuals, we did not formulate a hypothesis for this aim.

METHODS

Participants

The sample consisted of 263 couples ($M_{ageP1} = 34.16$, $SD = 9.95$; $M_{ageP2} = 35.71$, $SD = 10.56$) who had been together for an average of nine years ($SD = 7.7$). Participants were recruited as part

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of a bi-center longitudinal study. Recruitment took place at two sites, Université de Montréal, Montreal, Canada and Dalhousie University, Halifax, Canada, through mostly online advertisement (e.g., Facebook, Instagram, blogs, Kijiji). Couples were eligible to participate if they were 18 years of age or older, residing in Canada or the United States, and in a relationship for at least one year with a minimum of four in-person contacts per week within the last month. One member of the couple had to identify as a woman or be an individual who was assigned female at birth and meet the DSM-5 diagnostic criteria for SIAD⁸. Couples were ineligible if the woman with SIAD was pregnant, breastfeeding, less than a year postpartum, trying to conceive, receiving hormonal therapy related to sexual desire (oral contraceptive accepted), or receiving a treatment for SIAD at the beginning of the study.

A total of 292 couples were initially enrolled in the study following the clinical interview. Of those, 27 couples had at least one partner who did not complete the survey and 2 couples were withdrawn for failing attention checks which were embedded in the baseline survey. These couples were therefore not included in the final sample, resulting in a total of 263 couples. Most individuals with SIAD identified as cisgender women ($n=239$), while 24 identified as gender diverse. As for partners, the majority identified as cisgender, man or woman, ($n = 230$), and 33 as gender diverse. In terms of sexual orientation, most women with SIAD identified as heterosexual ($n=174$), as well as the majority of partners ($n=207$), while 89 women with SIAD and 56 of partners identified with sexual diversity. This sample was well educated with an average of 16.14 years ($SD = 2.97$) of schooling since first grade for women with SIAD and 15.09 years ($SD = 3.13$) for partners, with most participants occupying a full-time job. Detailed sociodemographic characteristics of the sample are listed in Table 1.

Procedure

This study was part of a larger prospective bicentric study conducted at [BLIND FOR REVIEW]. The larger study design included three time points of data collection (baseline, 6-month, and 12-month follow-up) along with 56 daily diary surveys completed after the baseline. One prior publication [BLIND FOR REVIEW] used the data from the baseline. The present study included the baseline surveys only. Data collection took place between December 2020 and May 2022. Interested participants contacted our research team through email to schedule an eligibility call of about 15 minutes. If participants were found to be eligible after this first screening call, a semi-structured clinical interview was scheduled with the individual with low sexual desire to determine if their difficulties met the SIAD diagnostic criteria⁸. A consent form was sent to the individual with SIAD prior to the interview. The semi-structured clinical interviews were administered by graduate clinical psychology students trained in assessing sexual difficulties, supervised by a registered psychologist specialized in sex and couple therapy. Eligible couples were then sent online questionnaires of 50 to 70 minutes through the secure online survey platform *Qualtrics* and were asked to complete them separately. To ensure that the participants completed their survey within the four-week deadline, they received a phone call reminder after two days and two weeks, and online automated email reminders from *Qualtrics* after one week and three weeks. Each participant received a compensation of CAD\$15 (or 11.04\$ USD) after the completion of the baseline questionnaire either in the form of gift cards or electronic money transfer. This study was approved by both institutions' research ethics boards.

Measures

Demographics

Participants completed a short demographic questionnaire assessing their ethnicity, menopause status, sexual orientation, gender, economic status, age, education, the duration and the status of their romantic relationship, the use of contraceptives and the duration of SIAD. Gender identity was measured following prior recommendations^{50,51} at the time of study design with the following item: “Which best describes your current gender (i.e., today that is, for the purposes of this survey)? (Please select all that apply.)”. The answer options were “Man”; “Woman”; “Indigenous (e.g., Two-Spirit) or other cultural gender identity (e.g., Fa'afafine)”; “Non-binary (e.g., genderfluid, genderqueer)”; and “I identify my gender as something else (with specification)”. Following best practices, participants’ sexual orientation was assessed using the following question^{50,52}: “People describe their sexual orientation in different ways. Which expression best describes your current sexual orientation? If no expression describes yourself, check ‘Not listed’ and write the answer that describes you personally”. Responses options were: “Bisexual”; “Asexual”; “Gay”; “Lesbian”; “Straight/Heterosexual”; “Pansexual”; “Queer”; “I have not figured out my sexual orientation or am in the process of figuring it out (Questioning)”; or “Not listed (with specification)”.

Intimacy

Relational intimacy was assessed based on the *Interpersonal Process Model of Intimacy*²² and adapted from the diary measure of Laurenceau, Barrett and Rovine (2005). Participants rated eight items on a 7-point Likert scale ranging from 1 (*not at all*) to 7 (*a lot*). This questionnaire is divided in three subscales which reflect the components of intimacy according to Reis and Shaver (1988) involving: (1) two items measuring self-disclosure (e.g., *How much do you disclose your*

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feelings to your partner?); (2) two items measuring perceived partner self-disclosure (e.g., *How much does your partner disclose their feelings to you?*) and; (3) four items measuring perceived partner responsiveness (e.g., *How much do you feel your partner understands you?*). Higher scores in each of the three subscales indicate a greater level of this specific component of intimacy within the relationship. This questionnaire demonstrated good construct validity whereby all three subscales were found to predict intimacy in a romantic relationship, as well as good internal consistency³⁷. In the current study, Cronbach's alphas for intimacy were .85 for women with SIAD and .85 for partners.

Sexual Satisfaction

Sexual satisfaction was assessed using the *Global Measure of Sexual Satisfaction*⁵³ (GMSEX). Participants rated five items on a 7-point bipolar scale indicating their global satisfaction towards their sexuality: good-bad, pleasant-unpleasant, positive-negative, satisfying-unsatisfying, valuable-worthless. Total scores range from 5 to 35, with higher scores indicating greater sexual satisfaction. This questionnaire has shown good internal consistency ($\alpha = .87$ for women with SIAD and $\alpha = .92$ for partners) as well as a good two-week and three-month test-retest reliability^{15,16}. In the current study, Cronbach's alphas were .87 for women with SIAD and .87 for partners.

Sexual Distress

Sexual distress was measured using the *Sexual Distress Scale*¹⁰. This measure consists of five items rated on a 4-point Likert scale ranging from 0 (*never*) to 4 (*always*) evaluating participants' negative emotions (e.g., frustration, distress, worry, stress, inadequate) towards their sexuality (e.g., *How often did you feel distressed about your sex life? How often did you feel frustrated by your sexual problems?*). Total scores vary from 0 to 20 with a higher score

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indicating greater sexual distress. This measure demonstrated good internal consistency among men and women¹⁰. In the present study, Cronbach's alphas were .86 for women with SIAD and .87 for partners.

Sexual Function

Sexual function was measured with the *Sexual Function Evaluation Questionnaire (SFEQ)*⁵⁴, which includes the best 16 items from the Natsal-SF Clinical Version and the National Sexual Outcomes Group 1, gathered into four factors: Problem Distress, Partner Relationship, Overall Sex Life, Sexual Confidence. For the purpose of this study, one single factor of this measure was used, i.e., Problem Distress, which assesses different sexual difficulties based on seven categories: (1) interest in sex, (2) enjoyment during sex, (3) excitement/arousal during sex, (4) pain during sex, (5) difficulty reaching climax (orgasm), (6) reaching climax too quickly and (7) vaginal dryness/erectile difficulties. Participants were initially asked to indicate if they had experienced any sexual difficulties within the past four weeks (response options included: "yes," "no," "did not engage in sexual activity due to [problem]," or "did not engage in sexual activity, but for another reason."). Following the scoring guidelines, those who responded "yes" were further prompted to assess the distress level (i.e. severity) associated with the issue on a scale ranging from 1 (*not distressed at all*) to 4 (*highly distressed*). A response of "no" was scored as 0, while "did not have sex due to [problem]" was assigned a score of 4 (indicating high distress). If the response was "did not have sex, but for a different reason," it was marked as missing for scoring purposes. To account for potential measurement biases, a dyadic Complementary confirmatory Factor Analysis (CFA) with distinguishable dyads was conducted using the WLSMV estimator for categorical variables. We then saved standardized factor scores from this model for further analysis. This dyadic CFA analysis showed acceptable model fit: $\chi^2 (275) =$

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682.41, $p < .001$; CFI = 0.89; TLI = 0.87; RMSEA = 0.075, 90% CI [0.07, 0.08]. Higher scores indicate a lower sexual function.

Data Analysis

Descriptive analyses were computed in SPSS 26.0 to examine sample characteristics and normality of variables, as well as bivariate correlations to ensure the interdependence of both partners' scores. The study hypotheses were tested by computing path analyses using the Actor-Partner Interdependence Model (APIM)⁵⁷ on Mplus 8.0⁵⁶. APIM analyses allow examination of the actor effect, i.e., the associations between one's report of intimacy and one's own sexual well-being (i.e., sexual satisfaction, sexual distress, sexual function) and partner effects, i.e., the associations between one's reported intimacy and one's partner's sexual well-being, while also controlling for the interdependence of both partners' scores. The dyads in this sample were considered distinguishable as one member of the couple, who self-identified as a woman and/or female bodied, had received a diagnosis of SIAD (Partner 1). Partners of women with SIAD were assigned as Partner 2.

Three APIM models were tested, one for each sexual well-being outcome (sexual satisfaction, sexual distress and sexual function). All three components of intimacy (self-disclosure, perceived partner disclosure and perceived partner responsiveness) were included simultaneously in each model. To determine if the associations between intimacy and sexual well-being varied based on gender identity and sexual orientation, moderation analyses were also conducted within every model. To do so, one dichotomous variable named "couple type" was created based on both partners' gender identities and sexual orientations to determine whether the couple belonged to a sexual and/or gender diverse couple or not (0 = sexual and/or gender diverse couple, i.e., couple in which at least one partner does not identify as cisgender man or woman

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and/or does not identify as heterosexual; 1 = heterosexual cisgender couple). An interaction term was then created with each intimacy component and added to each model as a further step.

The maximum likelihood parameter estimates with standard errors and chi-square test (MLR) were used and missing data were treated using Full Information Maximum Likelihood (FIML)⁵⁷. Each model tested was fully saturated, resulting in perfect fit indices (i.e., $\chi^2 = 0$; $df = 0$, Comparative Fit Index (CFI) = 1.00; Tucker Lewis Index (TLI) = 1.00; Root-Mean-Square Error of Approximation (RMSEA) = 0.00).

Since no sociodemographic covariate (e.g., age, duration of the relationship, duration of SIAD, number of children, education, employment and income) showed a correlation coefficient greater than 0.30 with one or more components of sexual well-being, none were included in the models.

RESULTS

Descriptive Statistics

The sample's sociodemographic information is presented in Table 1. Means and standard deviations for intimacy, sexual satisfaction, sexual distress, and sexual function for women with SIAD and their partners are presented in Table 2.

Bivariate Associations

Correlations between variables are shown in Table 3. The findings indicated small to medium correlations between the variables of women with SIAD and their partners. The results of the correlations showed preliminary support for most of our hypotheses.

Actor-Partner Interdependence Models

Sexual Satisfaction

A first model was tested examining the dyadic associations between the three components of intimacy and sexual satisfaction (Figure 1). Results showed both actor and partner effects. Partners' higher perceived partner responsiveness was positively associated with their own greater sexual satisfaction ($\beta = .27, p = .001$) and with women with SIAD's greater sexual satisfaction ($\beta = .18, p = .018$), both with small effect sizes. No significant actor effects were found between the three subscales of intimacy and sexual satisfaction for women with SIAD. This model explained 8.4% of the variance in women with SIAD's sexual satisfaction and 14.8% in partners' sexual satisfaction.

Moderation analyses indicated no significant effect of the interaction terms including the three intimacy constructs and the dichotomous variable "couple type" on sexual satisfaction. Therefore, the couple's sexual/gender identity did not act as a significant moderator of the associations between intimacy and sexual satisfaction.

Sexual Distress

A second model was tested examining the associations between the three components of intimacy and sexual distress (Figure 2). The results indicated one significant actor effect, showing that when partners reported greater perceived partner responsiveness, they also reported lower levels of sexual distress ($\beta = -.22, p = .008$), with a small effect size. Additionally, a marginally significant actor effect was observed whereby greater partners' perceived partner disclosure was associated with their own lower levels of sexual distress ($\beta = -.13, p = .062$). There was no significant association between self-disclosure and sexual distress for partners. No

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significant actor or partner effect between any of the three intimacy subscales and sexual distress was found for women with SIAD. This model explained 1.9% of the variance in sexual distress for women with SIAD and 9.2% of the variance for partners.

Moderation analyses did not reveal significant interactions between the three intimacy constructs and the dichotomous variable “couple type” on sexual distress. Therefore, the couple’s sexual/gender identity did not act as a significant moderator of the association between intimacy and sexual distress.

Sexual Function

A third model was tested examining the associations between the three components of intimacy and sexual function (Figure 3). Results showed only one significant positive actor effect, whereby when partners reported greater perceived partner responsiveness, they also reported greater sexual function ($\beta = .16, p = .024$), with a small effect size. No other significant effect was found between any of the three intimacy subscales and sexual function. This model explained 2.1% of the variance in sexual function for women with SIAD and 5.5% of the variance for partners.

Results for the moderating role of couples’ sexual/ gender identity (couple type) are shown in Table 4. The association between women with SIAD’s perceived partner responsiveness and their own sexual function was moderated by couples’ sexual/gender identity as the dichotomous sexual and gender diverse couple type interaction term was significant ($b = -0.43, SE = 0.16, p = .007$), with a moderate effect size. The simple slopes test reported in Table 4 indicated that when women with SIAD in an SGD couple reported higher perceived partner responsiveness, they also reported better sexual function. The association between partners’ perceived partner responsiveness and the women with SIAD’s sexual function was also

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moderated by couples' sexual/gender identity as the dichotomous cisgender heterosexual couple type interaction term was significant ($b = 0.39$, $SE = 0.16$, $p = .014$), with a moderate effect size. The simple slopes test reported in Table 4 indicated that when partners belonging to a cisgender heterosexual couple reported higher perceived partner responsiveness, women with SIAD indicated having better sexual function. Couples' sexual/gender identity did not act as a significant moderator between self-disclosure, perceived partner disclosure and sexual function.

DISCUSSION

The present study examined cross-sectional associations between intimacy, i.e., self-disclosure, perceived partner disclosure, perceived partner responsiveness, and the three components of sexual well-being, i.e., sexual satisfaction, sexual distress, and sexual function in a large sample of couples coping with SIAD. The moderating role of couple type (cisgender heterosexual couples vs SGD couples) in the associations between intimacy and sexual well-being was also assessed. Results showed that when partners reported greater perceived partner responsiveness, that is, perceived the women's responses as more understanding, validating and empathic, they reported greater sexual satisfaction, greater sexual function and lower sexual distress. Greater partners' perceived partner responsiveness was also associated with greater sexual satisfaction in women with SIAD. Moderations based on couple type revealed that when women with SIAD belonging to an SGD couple reported higher perceived partner responsiveness, they also reported greater sexual function. Additionally, when partners belonging to a cisgender heterosexual couple reported higher perceived partner responsiveness, women with SIAD reported greater sexual function. Findings corroborate previous work concerning associations between intimacy and sexual well-being in couples coping with sexual dysfunction¹⁷ and underscore the importance of assessing interpersonal factors when treating SIAD, as they can

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play a key role in both partners' sexual satisfaction, function and distress, as per the *Interpersonal Emotion Regulation Model of Women's Sexual Dysfunction*²⁵.

Intimacy and Sexual Satisfaction

Partners' perceived partner responsiveness was associated with both their own and women with SIAD's greater sexual satisfaction. These results support and extend previous findings on intimacy and sexual well-being in couples coping with women's sexual dysfunction^{17,19}. An observational study conducted among 50 couples coping with genito-pelvic pain showed that greater perceived partner responsiveness was associated with greater sexual satisfaction for both partners and women¹⁹. A recent daily diary study on perceived partner responsiveness, sexual satisfaction and sexual function in couples coping with genito-pelvic pain also showed that when partners reported greater perceived partner responsiveness, their own and the women's sexual satisfaction was higher¹⁷. These results show that not only can receiving an understanding and caring response from a partner heighten sexual satisfaction, but also that providing such a response can be beneficial^{57,58}. Responsiveness may help partners engage more openly in conversations about their sexuality, where they can comfortably share their likes, dislikes, and expectations. As partners feel more understood, validated, and cared for, it may become easier for them to use more effective emotion regulation strategies, such as problem-solving, to find alternatives that better meet both partners' needs, making the sexual experience more valuable and enjoyable for both⁵⁹.

Intimacy and Sexual Distress

Partners' perceived partner responsiveness was associated with their own lower sexual distress. These findings align with existing literature on SIAD and prior research on intimacy. For instance, a study examining intimacy, sexual satisfaction, and sexual distress among couples

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coping with genito-pelvic pain showed that partners who perceived greater empathic responses from their partner with pain reported experiencing less sexual distress¹⁹. It has been demonstrated that partners of individuals with SIAD tend to experience higher levels of sexual distress compared to control partners¹⁵. This may be explained by the fact that partners could feel responsible for their significant other's sexual difficulties. It is possible that partners of women with SIAD develop feelings of sexual inadequacy and worry, i.e., sexual distress, due to their lack of understanding of the reasons for their partner's decreased sexual arousal and/or desire⁶⁰. However, when partners feel understood, accepted, and supported by their significant other grappling with a sexual difficulty, it could alleviate sexual anxieties and feelings of inadequacy, thereby reducing overall sexual distress.

Intimacy and Sexual Function

Partners' perceived partner responsiveness was also associated with their own greater sexual function. This result is in line with findings from a daily dyadic study in couples coping with genito-pelvic pain, which showed that when partners' perceived partner responsiveness was higher, their sexual function was also greater, meaning that when partners felt understood and cared for, they experienced greater desire, arousal and orgasm¹⁷. Partners of women with SIAD report more difficulties with their orgasmic and erectile functioning compared to partners of women with no sexual difficulties¹⁵. Since women with SIAD might be less responsive to sexual/erotic cues and sexual advances⁸, their partners might find themselves fully concentrating on stimulating and maintaining the women's arousal during sexual activities, possibly creating performance anxiety on their part. They may find themselves increasingly attentive to cues indicating their partner's lack of arousal, diverting their focus towards less enjoyable aspects of the sexual encounter, thereby contributing to sexual function difficulties. In fact, performance

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anxiety and cognitive distraction have been found to play a major role in sexual dysfunction^{61,62}. Conversely, when a partner feels understood and supported by their significant other with SIAD, they may approach sexual activities with a different perspective, prioritizing closeness over performance and consequently enhancing their sexual function.

Couple Type as a Moderator of the Association Between Intimacy and Sexual Well-being

Results showed that couple type, i.e., belonging to a cisgender heterosexual couple vs to an SGD couple, played a moderating role for women with SIAD's sexual function. When women with SIAD belonging to an SGD couple reported higher perceived partner responsiveness, they also reported better sexual function. Based on the *Minority Stress Model*^{49,63}, individuals from minority groups face additional stressors due to their stigmatized social status. For women with SIAD in SGD couples, this means enduring stress associated with both their sexual dysfunction and the societal pressures they face. Research suggests that chronic stress can lead to reduced genital arousal in women⁶⁴, potentially affecting sexual function in SGD couples. Understanding from their partners may play a crucial role for women with SIAD in SGD relationships, as it could alleviate some of their stress, and hence improve their sexual function.

Results also showed that when partners belonging to a cisgender heterosexual couple reported higher perceived partner responsiveness, women with SIAD indicated having better sexual function. Heteronormativity often dictates that women assume nurturing caregiving roles, extending into their relationships with male partners^{48,65}. When male partners feel cared for, understood, and validated, their emotional needs are likely to be fulfilled, perhaps making them more receptive to their partners' sexual preferences or discomfort regarding sexual dysfunction. Indeed, as they might feel more satisfied within their relationship, they may become more willing to explore alternatives to conventional sexual activities, aligning more closely with the woman

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with SIAD's sexual needs. This, in turn, could lead to improved sexual function for women with SIAD in heterosexual relationships.

Beyond Self-Disclosure and Intimacy

The study's results indicated that self-disclosure did not show any significant associations with the three dimensions of sexual well-being in women with SIAD or their partners, suggesting that intimacy-related disclosure plays a lesser role in sexual well-being compared to responsiveness. Importantly, apart from the moderation results, no actor associations between intimacy and sexual well-being were found for women with SIAD, with also only one partner effect related to their well-being, i.e., partners' perceived partner responsiveness. This suggests that factors beyond relational dynamics, such as intimacy, may have a greater impact on the sexual well-being of women with SIAD. This is further demonstrated by the small to moderate effect sizes found in the results, suggesting that other factors indeed play an important role in the sexual well-being of these couples, potentially even more so for women with SIAD. For instance, according to the *Heteronormativity Theory of Low Sexual Desire*, for women in a relationship with a man, sexual desire could be influenced by factors such as the unequal division of caregiving labor, the maternal role vis-à-vis their partner, objectification, and societal norms regarding sexual initiation⁴⁸. These facets of the relationship might not be remediable solely by enhancing intimacy within the couple. Consequently, other dimensions of the relationship could hold more significance in the sexual well-being of women with SIAD, particularly for those in heterosexual relationships.

Strengths, Limitations and Futures Studies

One major strength of the present study lies in its comprehensive approach to both independent and dependent variables. Sexual well-being was measured via three components

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(sexual satisfaction, sexual distress, and sexual function), which sets it apart from previous research that often focused on only two of these constructs^{17-19,43,66}. Additionally, intimacy was measured following the well validated theoretical *Interpersonal Process Model of Intimacy*^{36,37} and also included its three facets (self-disclosure, perceived partner disclosure, perceived partner responsiveness). Findings as a whole also shed light on the ways in which distal interpersonal factors could influence sexual outcomes for couples and provide support for the *Interpersonal Emotion Regulation Model of Women's Sexual Dysfunction*²⁵. Moreover, incorporating both partners allowed us to move beyond intra-individual conceptualizations of sexual dysfunction and to examine dyadic cross-partner effects, showing that intimacy is important for both the person with SIAD and their partner. Women diagnosed with SIAD met the DSM-5 criteria as confirmed through semi-structured interviews, contributing to high internal validity. The large sample was inclusive of sexual and gender diversity, with 34.8% of individuals with SIAD identifying with sexual diversity and 10.1% with gender diversity. Additionally, 20.5% of partners identified with sexual diversity and 12.6% with gender diversity. This is particularly important as the limited diversity in couples and sexuality research can lead to biases and constrain our understanding of the challenges experienced by couples across all gender identities and sexual orientations⁶⁷. To our knowledge, this study on intimacy and SIAD is the first to incorporate gender and sexual orientation for both partners as moderators in the main analyses. However, most of the sample identified as White, limiting the generalization of the results to a more ethnically diverse population. Additionally, results indicated small to moderate effect sizes, implying that other factors influence the sexual well-being of these couples. As the findings of this study are correlational, we cannot infer causation. Hence, it would be important to conduct longitudinal or daily diary studies on intimacy and sexual well-being among couples with SIAD

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to better understand the directionality and influence of intimacy on sexual satisfaction, sexual distress and sexual function.

Clinical Implications

Given that sexual desire ranks among the most common motivations for individuals to seek sex and couple therapy⁵⁻⁷, and that couples coping with SIAD are more likely to experience sexual and relational difficulties and distress than couples without sexual dysfunction¹⁵, it is important to develop clinical interventions that can better respond to their needs. Since intimacy is a modifiable factor, fluctuating on a day-to-day basis⁴¹, it is a promising target for sex and couple therapy interventions for SIAD. Specifically, results indicated more positive associations between intimacy and sexual well-being for partners of women with SIAD, highlighting the necessity of including partners in therapy. Indeed, their involvement in therapy may serve as a critical step to help promote better overall sexual well-being within these couples. Strengthening feelings of connection and closeness through enhanced intimacy may render sexual difficulties more manageable for partners as well as afflicted women. Findings also suggest that focusing on partner responsiveness may yield more significant therapeutic benefits than self-disclosure.

Conclusions

Findings highlight the significance of focusing on the interpersonal dynamics surrounding SIAD, extending beyond women's role in their sexual difficulties and that of biological factors. Perceived partner responsiveness was positively associated with all aspects of sexual well-being for partners and with sexual satisfaction for women/individuals coping with SIAD. Whether couples belonged to a sexual/gender diverse couple also influenced the relationship between intimacy and sexual well-being, as moderations showed that a higher perceived partner responsiveness for women with SIAD in an SGD couple and for men partners in a cisgender

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heterosexual couple was associated with greater sexual function for women with SIAD. Findings support a dyadic approach to treatment. Intimacy is modifiable and as such can play a key role in sex and couple therapy for SIAD.

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Annexes

Table 1 Sample characteristics (*N* = 263 couples)

Characteristics	Women with SIAD <i>M</i> ± <i>SD</i> or <i>n</i> (%)	Partners <i>M</i> ± <i>SD</i> or <i>n</i> (%)
Age (years)	34.16 ± 9.95	35.71 ± 10.56
Sexual Orientation		
Straight/heterosexual	174 (66.2%)	207 (78.7%)
Bisexual	35 (13.3%)	17 (6.5%)
Lesbian	13 (4.9%)	17 (6.5%)
Gay	0 (0.0%)	2 (0.8%)
Asexual	4 (1.5%)	1 (0.4%)
Pansexual	17 (6.5%)	8 (3.0%)
Queer	12 (4.6%)	8 (3.0%)
Questioning	5 (1.9%)	3 (1.1%)
Not listed	3 (1.1%)	0 (0.0%)
Gender		
Cisgender	239 (90.9%)	230 (87.5%)
Gender minority	24 (9.1%)	33 (12.5%)
Indigenous (e.g., two-spirit)	2 (0.8%)	0 (0.0%)
Non-binary (e.g., genderfluid)	15 (5.7%)	10 (3.8%)
Transgender	7 (2.7%)	7 (2.7%)
Other	2 (0.8%)	3 (1.1%)
Annual individual income		
\$000-\$39,999	47 (17.8%)	40 (15.2%)
\$40,000-\$99,999	117 (44.5%)	113 (42.9%)
\$100,000-\$159,999	75 (28.5%)	83 (31.6%)
\$160,000-and over	22 (8.4%)	25 (9.5%)
Relationship duration (months)	108.66 ± 92.42	-
SIAD duration (months)	85.03 ± 92.69	-
Employment		
Employed inside/outside of the home (full-time)	149 (56.7%)	195 (74.1%)
Employed inside/outside of the home (part-time)	31 (11.8%)	16 (6.1%)
Student (full-time or part-time)	46 (17.5%)	27 (10.3%)
Unemployed	11 (4.2%)	11 (4.2%)
Other ^a	26 (9.9%)	14 (5.3%)
Education (in years)	16.14 ± 2.97	15.09 ± 3.13
Culture		
Québécois/French Canadian	118 (44.9%)	105 (39.9%)
English Canadian	110 (41.8%)	111 (42.2%)
White	73 (27.8%)	81 (30.8%)
European	31 (11.8%)	31 (11.8%)
Other ^b	52 (19.8%)	61 (23.2%)

Note. *M* = mean; *SD* = standard deviation; SIAD = Sexual interest/arousal disorder.

^aIncludes Unemployed, Retired, Parental leave, Unable to work due to disability and Other

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^bIncludes Indigenous (e.g., First Nations, Métis, Inuit), American, South Asian, East Asian, Southeast Asian, Middle Eastern/Central Asian, Hispanic, Latino/Latina/Latinx, Latin American, Black/African American, African, Biracial/Multiracial, Native Hawaiian

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Table 2. *Descriptive statistics for intimacy, sexual satisfaction, sexual distress and sexual function for women with SIAD and their partners.*

Variables	Women		Partners	
	<i>M</i> (range)	<i>SD</i>	<i>M</i> (range)	<i>SD</i>
Intimacy	48.06 (20-63)	9.05	46.85 (15-63)	9.41
Perceived partner disclosure	9.14 (2-14)	3.35	10.26 (2-14)	3.03
Self-disclosure	10.75 (4-14)	2.63	9.44 (2-14)	3.05
Perceived partner responsiveness	22.84 (7-28)	4.66	22.02 (5-28)	4.92
Sexual satisfaction	21.91 (5-35)	6.54	24.37 (5-35)	6.46
Sexual distress	12.00 (0-20)	4.33	8.05 (0-20)	4.72
Sexual function	.07 (-2.58-3.61)	1.32	.18 (-1.84-3.11)	.94

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Table 3. *Bivariate correlations between intimacy, sexual satisfaction, sexual distress and sexual function for women with SIAD and their partners*

Variables	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. Perceived partner disclosure P1	-	-	-	-	-	-	-	-	-	-	-
2. Perceived partner disclosure P2	.03	-	-	-	-	-	-	-	-	-	-
3. Self-disclosure P1	.07	.36**	-	-	-	-	-	-	-	-	-
4. Self-disclosure P2	.44**	.19**	-.14*	-	-	-	-	-	-	-	-
5. Perceived partner responsiveness P1	.51**	.11	.22**	.20**	-	-	-	-	-	-	-
6. Perceived partner responsiveness P2	.26**	.32**	.10	.41**	.38**	-	-	-	-	-	-
7. Sexual satisfaction P1	.16**	.12	.08	.09	.22**	.24**	-	-	-	-	-
8. Sexual satisfaction P2	.14*	.25**	.15*	.19**	.10	.33**	.33**	-	-	-	-
9. Sexual distress P1	.08	-.03	.01	.11	.04	.07	-.12*	-.04	-	-	-
10. Sexual distress P2	-.02	-.21**	-.14*	-.02	-.12	-.24**	-.16**	-.49**	.14*	-	-
11. Sexual function P1	-.06	-.07	.03	-.07	-.09	-.10	-.34**	-.13*	.28**	.03	-
12. Sexual function P2	-.03	-.10	-.04	-.16**	-.07	-.21**	-.14*	-.24**	-.01	.38**	.18**

Note. P1 = women with SIAD, P2 = non-SIAD partners

* $p < .05$; ** $p < .01$ *** $p < .001$

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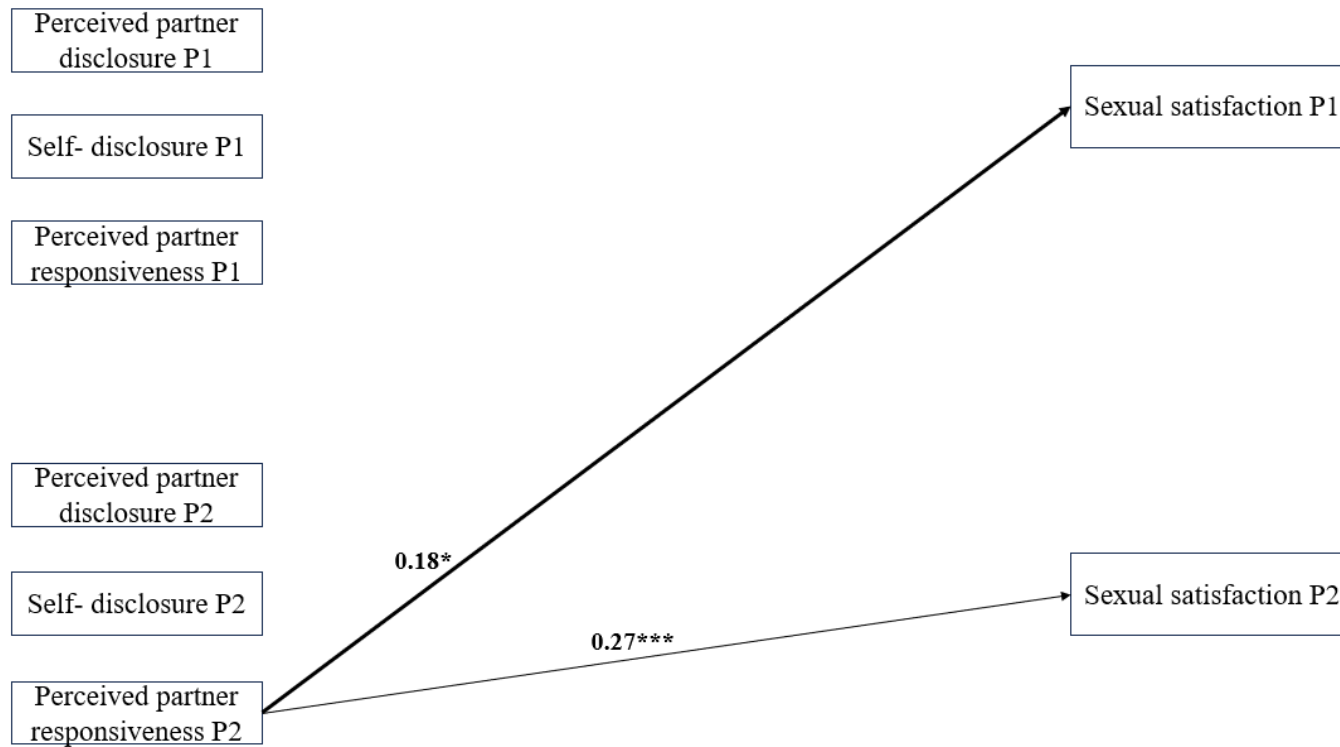
Table 4. Associations between women with SIAD and partner’s perceived partner responsiveness (PPR) and sexual function based on couple type

Fixed effects	Estimate (SE) ^a	<i>p</i>	95% CI	
			Lower	Upper
<i>Actor Effect</i>				
Women with SIAD PPR	0.04 (0.09)	0.71	-0.15	0.22
Couple type	0.22 (0.13)	0.08	-0.03	0.47
Women with SIAD PPR X Couple’s type	-0.43 (0.16)	0.01	-0.75	-0.12
<i>Simple slope tests for couple type – Actor effect</i>				
Women with SIAD PPR, cisgender heterosexual couple	0.04 (0.09)	0.71	-0.15	0.22
Women with SIAD PPR, sexual minority couple	-0.40 (0.13)	0.01	-0.66	-0.14
<i>Partner Effect</i>				
Partner PPR	-0.17 (0.07)	0.02	-0.32	-0.03
Couple type	0.22 (0.13)	0.08	-0.03	0.47
Partner PPR X Couple’s type	0.39 (0.16)	0.01	0.08	0.69
<i>Simple slope tests for couple type – Partner effect</i>				
Partner PPR, cisgender heterosexual couple	-0.17 (0.07)	0.02	-0.32	-0.03
Partner PPR, sexual minority couple	0.21 (0.14)	0.12	-0.05	0.48

Note. ^a = estimates are unstandardized regression coefficients, SE = standard error, Z = estimate divided by standard error, CI = confidence interval. PPR = perceived partner responsiveness
Coefficients in bold are significant at *p* < .05.

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Figure 1. Actor–partner interdependence model of the associations between intimacy and sexual satisfaction in individuals with SIAD and their partners

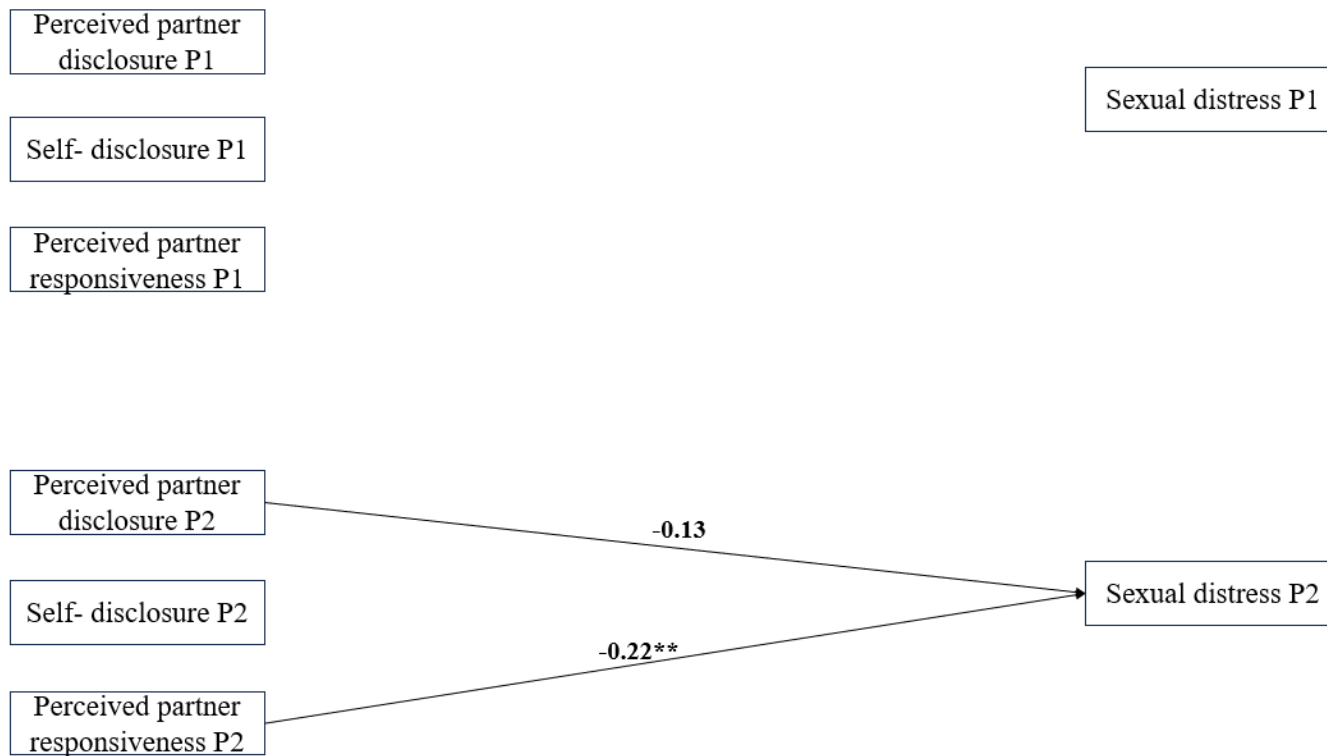


Note. Considering that these are distinguishable dyads, P1 refers to individuals with SIAD and P2 refers to non-SIAD partners. We depicted partner effects in bold and actor effects in a regular black line. To simplify presentation, only significant standardized coefficients are depicted in this figure. All covariances between intimacy subscales and between sexual and relationship outcomes were estimated in the model.

* $p < .05$ ** $p < .01$ *** $p < .001$

INTIMACY AND SEXUAL WELL-BEING IN COUPLES COPING WITH SIAD

Figure 2. Actor–partner interdependence model of the associations between intimacy and sexual distress in individuals with SIAD and their partners

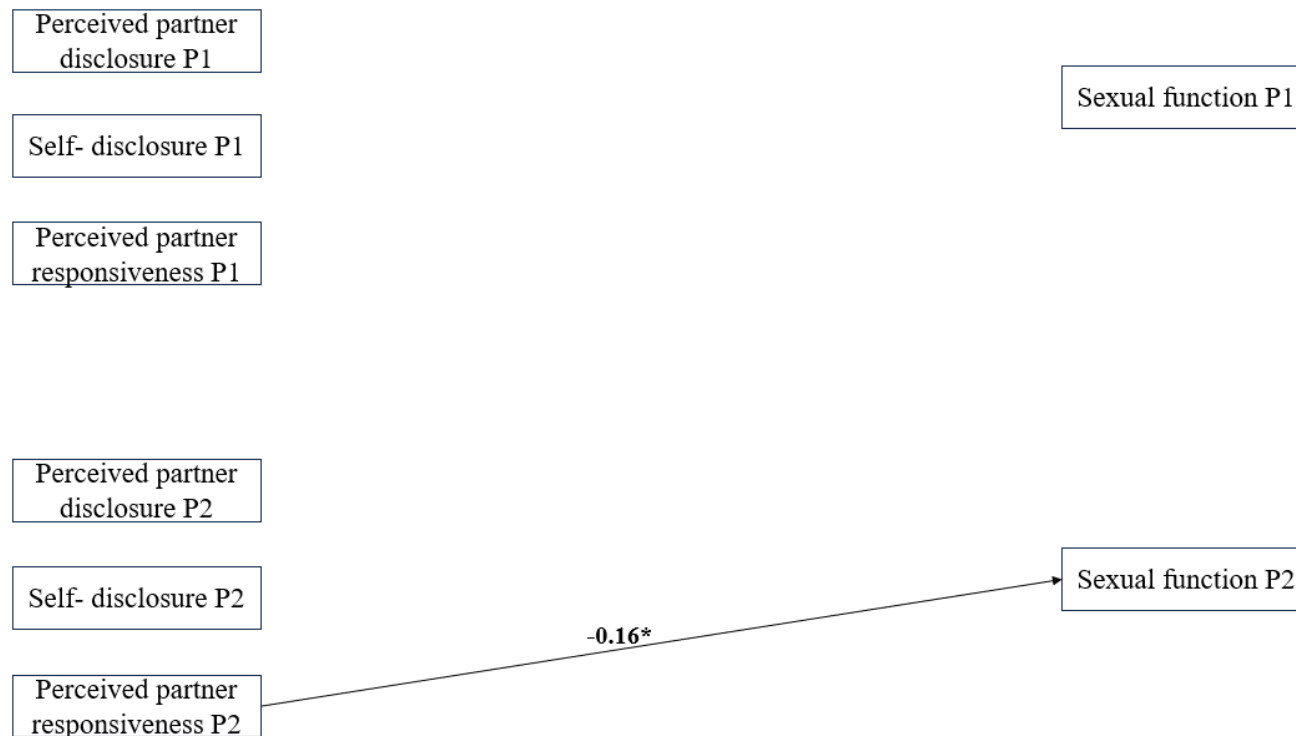


Note. Considering that these are distinguishable dyads, P1 refers to individuals with SIAD and P2 refers to non-SIAD partners. To simplify presentation, only significant standardized coefficients are depicted in this figure. All covariances between intimacy subscales and between sexual and relationship outcomes were estimated in the model.

* $p < .05$ ** $p < .01$ *** $p < .001$

INTIMACY AND SEXUAL WELL-BEING IN COUPLES COPING WITH SIAD

Figure 3. Actor–partner interdependence model of the associations between intimacy and sexual function in individuals with SIAD and their partners



Note. Considering that these are distinguishable dyads, P1 refers to individuals with SIAD and P2 refers to non-SIAD partners. To simplify presentation, only significant standardized coefficients are depicted in this figure. All covariances between intimacy subscales and between sexual and relationship outcomes were estimated in the model.

* $p < .05$ ** $p < .01$ *** $p < .001$