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SEXUAL PORTRAIT OF COUPLES SEEKING RELATIONSHIP THERAPY

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This study sought to provide information about the sexual well-being of 298 mixed-sex couples seeking relationship therapy and determined the extent to which problems with sexual functioning and dyadic adjustment of both partners are associated with sexual satisfaction. Partners completed measures of dyadic adjustment, sexual satisfaction, and sexual functioning. Thirty percent of couples reported a clinically significant sexual problem. Compared to their male partners, the women were more likely to report a sexual problem as well as lower dyadic adjustment, sexual satisfaction, and overall sexual functioning. Path analysis indicated that relationship adjustment uniquely predicted individuals' own sexual satisfaction; problems in sexual functioning uniquely predicted own and partner sexual satisfaction. Findings underscore the need to address sexual problems in relationship therapy.

Couples seek relationship therapy for many different reasons. Given the demonstrated strong links between sexual well-being and relationship quality and quality of life (Byers, 2005; Davison, Bell, LaChina, Holden, & Davis, 2009; McNulty, Wenner, & Fisher, 2016), it is likely that many of these couples are also experiencing poor sexual well-being. Yet, little is known about the sexual well-being of couples seeking relationship therapy even though such information has important implications for the training of relationship therapists as well as for treatment. Based on theories of psychological well-being, we conceptualized sexual well-being broadly as the individual's cognitions and affect about their sexual relationship (Byers & Rehman, 2014). As such, we defined sexual well-being as "an affective response arising from one's subjective evaluation of the positive and negative dimensions associated with one's sexual relationship" (Lawrance & Byers, 1995, p. 514).

The goal of this study was to provide much needed information about the sexual well-being of distressed mixed-sex (male–female) couples seeking relationship therapy as well as the extent to which specific sexual concerns (i.e., problems with sexual functioning) are associated with these

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couples' sexual well-being over and above the contribution of the relationship well-being. This information speaks directly to the question of whether there is a need for all relationship therapists to be trained to assess and treat sexual well-being directly. Based on the belief that poor sexual well-being is rooted in relationship problems, many therapists assume that sexual concerns will resolve when relationship problems have been addressed successfully. Although necessary, addressing relationship problems is often not sufficient to resolve all of a couple's sexual issues. This is because some causes of sexual difficulties do not reside in the couple (e.g., traumatic sexual history, negative sexual attitudes, biophysical factors) and specific sexual interventions are thus necessary (Brotto et al., 2016; McCarthy & Thestrup, 2008). Even when therapists are aware that they need to address sexual problems directly, a lack of training prevents many from doing so (Harris & Hays, 2008; Miller & Byers, 2009; Reissing & Di Giulio, 2010). For example, Miller and Byers (2009) found that clinical psychologists do not routinely ask clients about sexual problems, lack self-efficacy in this area, and are only somewhat willing to treat sexual concerns. Harris and Hays (2008) also reported that a lack of sexuality education and supervision, poor perceived knowledge of sexuality, and discomfort with sexuality matters all keep marital therapists from talking about sex with their clients. These findings thus leave us wondering whether couples receiving relationship therapy are getting what they need when it comes to sexuality.

Theoretical Framework

A number of authors have emphasized the importance of sexual well-being for couples (for reviews, see Byers & Rehman, 2014; Sprecher & Cate, 2004; Schwartz & Young, 2009). The current study was grounded in social exchange theories and guided by the Interpersonal Exchange Model of Sexual Satisfaction (IEMSS; Lawrance & Byers, 1995) because it integrates dyadic factors and has received strong empirical support (Byers & Rehman, 2014; Peck, Shaffer, & Williamson, 2005). The IEMSS states that sexual satisfaction is higher if: (a) sexual rewards are high and sexual costs are low; (b) actual levels of sexual rewards/costs compare favorably to expected levels of rewards/costs; (c) the sexual rewards and costs of the two partners are equal; and (d) the couple experiences high satisfaction with the nonsexual aspects of the relationship. Rewards refer to exchanges that are pleasurable and gratifying; costs refer to exchanges requiring physical or mental effort or producing pain, embarrassment, or anxiety.

Sexual Well-being of Couples Presenting for Relationship Therapy

According to the IEMSS, any sexual exchange (e.g., level of affection expressed, use of sex toys, oral sex) can be experienced as a sexual reward and/or a sexual cost depending on the nature of the sexual interaction and the individual's appraisal of it (Lawrance & Byers, 1995). Nonetheless, within a social exchange framework, experiencing a sexual problem (i.e., a problem with desire, arousal, lubrication, and orgasm) typically constitutes an important sexual cost for both members of the couple (Cropanzano & Mitchell, 2005; Rosen, Santos-Iglesias, & Byers, 2017). Furthermore, individuals report lower sexual well-being when either they or their partner has a sexual problem (Brotto et al., 2016; MacNeil & Byers, 1997). What is not known is the prevalence of sexual problems in couples seeking relationship therapy, even though this information is important to a full understanding of their sexual well-being.

Within the framework of the IEMSS, sexual satisfaction is influenced by the overall balance of sexual rewards to costs rather than any specific sexual reward or cost. As such, some individuals report high sexual satisfaction despite experiencing a sexual problem (Byers & Rehman, 2014; MacNeil & Byers, 1997). Thus, it is important to determine the sexual satisfaction of couples presenting for relationship therapy. Brassard, Péloquin, Dupuy, Wright, and Shaver (2012), in the only study examining sexual satisfaction in couples seeking relationship therapy, found that more than 60% of the partners were clinically dissatisfied with their sex life. However, they assessed sexual dissatisfaction using a measure that has been critiqued because it assesses aspects of the sexual relationship other than satisfaction (Byers, 1999). Therefore, we used the sexual satisfaction measure with the strongest psychometric support (Mark, Herbenick, Fortenberry, Sanders, & Reece, 2014)—the Global Measure of Sexual Satisfaction (GMSEX; Lawrance, Byers, & Cohen, 2011).

To inform assessment and treatment, it is also important to determine whether poor sexual well-being is experienced disproportionately by the male or female partner in couples seeking

relationship therapy. Most researchers in Canada and the United States have not found gender differences in sexual satisfaction in community samples of individuals in a relationship and couples (e.g., Butzer & Campbell, 2008; Byers & MacNeil, 2006; Lawrance & Byers, 1995; McNulty & Fisher, 2008; also see Sprecher & Cate, 2004 for a review) or relationally distressed couples (Brassard et al., 2012; Péloquin, Brassard, Lafontaine, & Shaver, 2014). However, nationally representative studies conducted in the United States, the United Kingdom, Canada, Australia, and New Zealand have found higher percentages of men than women reporting one or more sexual problem (Laumann, Paik, & Rosen, 1999; Mercer et al., 2003; Nicolosi et al., 2006).

Predicting the Sexual Satisfaction of Relationally Distressed Couples

In keeping with the IEMSS, researchers have shown in community samples that both men and women who are less satisfied with their overall relationship or experience sexual problems or dysfunctions report lower sexual satisfaction (Carpenter, Nathanson, & Kim, 2009; Fisher et al., 2015; Rosen et al., 2017). Dundon and Rellini (2010) also showed that women's relationship well-being is associated with their sexual satisfaction over and above the effects of sexual problems. However, researchers have not examined the unique associations of relationship adjustment and sexual functioning with sexual satisfaction in relationally distressed couples.

Studies of sexual well-being have traditionally focused on individual factors, neglecting dyadic factors as predictors of both partners' sexuality (Byers & Rehman, 2014; DeLamater & Hyde, 2004). Yet, the IEMSS proposes that the partner's experience of the sexual relationship impacts the individual's sexual satisfaction over and above their own experiences (Byers & MacNeil, 2006). That is, an individual's dyadic adjustment and sexual functioning would be expected to affect both their own and their partner's sexual well-being. There is some evidence to support this view. For example, Mark and Jozkowski (2013) found that men's and women's dyadic adjustment was significantly associated with both their own and their partner's sexual satisfaction. In addition, men and women whose partner report poorer sexual functioning are less sexually satisfied (Rosen, Heiman, Long, Fisher, & Sand, 2016; Rosen et al., 2017; Smith & Pukall, 2014), even after accounting for their own level of sexual functioning (Fisher et al., 2015). However, the reciprocal and unique effects of sexual problems and dyadic adjustment on each partner's sexual satisfaction have not be studied in couples seeking relationship therapy. Therefore, we conducted a dyadic assessment—that is, we assessed the contributions of sexual problems and dyadic adjustment of both members of the couple to each member's sexual satisfaction.

It is also possible that greater discrepancies between partners, rather than each individual's experience, impact sexual satisfaction. This is in keeping with the IEMSS which posits that individuals experience lower sexual satisfaction when they perceive inequality between their own and their partner's levels of rewards and costs in the sexual relationship. The partner who experiences more problems in sexual functioning and/or lower dyadic adjustment would have higher costs resulting in lower sexual satisfaction for both partners. However, researchers have not examined the contributions of discrepancies in relationship satisfaction or sexual functioning to sexual well-being in any couple types. However, there is some indirect evidence to support the proposed relationships. Studies conducted using community samples of individuals and couples have found that discrepancies in partners' general and daily sexual desire are associated with lower sexual satisfaction in women but not in men (Bridges & Horne, 2007; Davies, Katz, & Jackson, 1999; Mark, 2014; Mark & Murray, 2012). This suggests that examining the contributions of couple discrepancies to sexual well-being could provide additional understanding of low sexual well-being within the context of the relationship.

Current Study

The overall aim of this study was to present a portrait of the sexual well-being of couples seeking relationship therapy. Our first goal was to document the prevalence of sexual problems in mixed-sex couples seeking relationship therapy and compare their level of sexual satisfaction to couples in the community. We used a control community sample to interpret the sexual satisfaction of our sample because our measure of sexual satisfaction does not have a clinical cut-off score. We also investigated the extent to which male and female partners differ in sexual well-being. Based on the IEMSS and using the Actor–Partner Interdependence Model (APIM;

Kenny, Kashy, & Cook, 2006), our second goal was to examine the contributions of both partners' dyadic adjustment and sexual problems to their sexual satisfaction. In an exploratory manner, we also examined whether discrepancies in dyadic adjustment and sexual functioning were associated with sexual satisfaction in both partners. We posed the following research questions and hypotheses with respect to couples seeking relationship therapy: (RQ1) In what percentage of couples does the man, the woman, or both report a clinically significant sexual problem? (RQ2) How does their sexual satisfaction compare to the sexual satisfaction of couples in the community? (RQ3) Are there gender differences in sexual well-being (sexual problems, sexual satisfaction)? We also examined gender differences in dyadic adjustment to provide a context for any gender differences in sexual well-being; (H1) There will be a reciprocal influence between partners such that, for both men and women, own and partner's better dyadic adjustment and sexual functioning will be uniquely associated with higher sexual satisfaction of both partners; (RQ4) Within couples, to what extent are discrepancies in dyadic adjustment and sexual functioning associated with sexual satisfaction?; (RQ5) Are there gender differences in the strength of associations between discrepancies in partners' dyadic adjustment and sexual functioning and sexual satisfaction?

METHOD

Participants

The sample included 298 mixed-sex couples seeking relationship therapy at a private practice in Montreal. Couples were recruited over a 2.5-year period from 2013 to 2015. The majority of couples were French speaking (91.6%) and Caucasian (95.2%). The mean age was 43 for men (*SD* = 10 years; range = 24–76) and 41 for women (*SD* = 9 years; range = 22–71). On average, partners had been together for 13.7 years (*SD* = 10.2; range = less than 1–49 years). Just under half of the couples (45%) were married, the remainder (55%) were cohabiting. The majority of couples (83%) had at least one child, with 20% identifying themselves as a stepfamily. More than half of the men (60%) and women (65%) had a university degree. Annual income was equal or greater than CA$50,000 for 86% of men and 55% of women. On average, couples reported experiencing relationship difficulties for 4.5 years (*SD* = 5.5 years); 34% had previously sought relationship therapy.

Measures

Participants could choose to complete the measures in French or English.

Demographic information. Participants provided sociodemographic (e.g., age, income, education, ethnic background) and relationship information (e.g., relationship status, number of children, duration of relationship, duration of relationship difficulties).

Dyadic Adjustment Scale (DAS; Spanier, 1976; French translation by Baillargeon, Dubois, & Marineau, 1986). The DAS is a 32-item scale measuring dyadic adjustment (e.g., "How often do you discuss or have you considered divorce, separation, or terminating your relationship?", "Do you confide in your mate?"). Items are rated on varying rating scales, and the total score is computed by summing all items (score range = 0–151). Higher scores indicate higher relationship adjustment, and scores lower than 100 indicate clinically significant relationship distress. Following the procedure used by Mark and Murray (2012) to create a desire discrepancy scores between partners, we used the absolute value of the difference between the man's and woman's scores on the DAS to create a relationship adjustment discrepancy score (range = 0–151). Higher scores indicate a greater discrepancy between the two partners. The DAS has demonstrated reliability and validity in both French (Baillargeon et al., 1986) and English (Spanier, 1976; α = .89 in the current study).

Global Measure of Sexual Satisfaction (GMSEX; Lawrance et al., 2011). The GMSEX assesses satisfaction with the sexual relationship using five subjective evaluation items rated on a seven-point bipolar scale: *good–bad, pleasant–unpleasant, positive–negative, satisfying–unsatisfying, valuable–worthless*. Items are summed to obtain the total score (range = 5–35); higher scores indicate greater sexual satisfaction. The GMSEX has shown reliability and validity in both French (Péloquin et al., 2014) and English (Lawrance et al., 2011; α = .92 in the current study).

Arizona Sexual Experiences Scale (ASEX; McGahuey et al., 2000; French translation by Bourassa, 2011). The ASEX assesses difficulties in five aspects of sexual function (i.e., sex drive, arousal, vaginal lubrication/erection, ability to reach orgasm, and satisfaction from orgasm). Items are rated on a 6-point scale and summed to form a total score (ranging from 5 to 30). Higher scores indicate poorer sexual functioning. A total score equal or greater than 19, any one item with a score equal or greater than 5, or any three items with a score equal or greater than 4 indicates a possible sexual dysfunction. As with calculation of the dyadic adjustment discrepancy score—we used the absolute value of the difference between the man's and woman's scores on the ASEX to create a sexual functioning discrepancy score (range = 0–25). The ASEX has demonstrated reliability and validity in both French (Bourassa, 2011) and English (McGahuey et al., 2000; $\alpha = .84$ in the current study).

Procedure

During the first intake session, couples were informed about the study by their therapist. After obtaining informed consent, participants were instructed to complete the questionnaires at home without consulting their partner. Questionnaires were returned by mail in separate and sealed envelopes prior to the next session. Couples received no compensation for their participation, but the results of their questionnaires were provided to their therapist to inform therapy. Most couples invited to participate agreed to take part in the research and returned their questionnaire (response rate >95%). Ethical approval for this study was obtained from the ethics review board at the University of Montreal.

Control Couples

A community sample of 126 English-speaking Canadian mixed-sex couples was used as a comparison group with respect to reported levels of sexual satisfaction (RQ2). These couples were part of a previously published study (Péloquin et al., 2014). The mean age was 33 for the men (SD = 11 years; range = 20–80 years) and 31 for the women (SD = 10; range = 20–78 years). On average, partners had been together for 6 years (SD = 7.8; range = 1–61 years); 43% were married and 57% were cohabiting. The majority of couples did not have children (82%). More than half of the sample had a university degree (63%) and participants had an individual average annual income of CA$44,700. The majority of participants were Caucasian (95%). Participants' mean score on the four-item version of the Dyadic Adjustment Scale (Sabourin, Valois, & Lussier, 2005) was above the clinical cutoff score, indicating overall relationship satisfaction in this sample. These participants completed the GMSEX and a number of other measures not relevant to the current study.

A series of 2 (gender) × 2 (sample: distressed vs. community) repeated-measures MANOVAs were conducted to compare the sociodemographic characteristics of the control and distressed couples (our main sample). Couples recruited in the community were significantly younger ($F(1,377) = 148.22$, $p < .001$, $\eta_p^2 = 0.28$), had been in their relationship ($F(1,377) = 50.98$, $p < .001$, $\eta_p^2 = 0.12$) and cohabiting ($F(1,377) = 27.28$, $p < .001$, $\eta_p^2 = 0.07$) for a shorter period, and had a lower annual income ($F(1,377) = 89.99$, $p < .001$, $\eta_p^2 = 0.19$) than the distressed couples. The two samples did not differ on education.

RESULTS

Prevalence of Problems in Sexual and Relationship Functioning

Means and standard deviations for the main study variables are presented in Table 1. With respect to sexual problems, 25% of women and 8% of men fell within the clinical range on the Arizona Sexual Experiences Scale. Both partners reported clinically significant sexual problems in 2% of couples, whereas both partners reported no clinically significant sexual problems in 70% of the couples (RQ1). With regard to dyadic adjustment, 65% of women and 53% of men reported clinically significant relationship distress on the Dyadic Adjustment Scale. Both partners reported scores within the clinical range in 43% of the couples, whereas both partners reported scores within the normal range in 25% of the couples.

We examined gender differences in dyadic adjustment and sexual functioning in two ways (RQ3). First, using the McNemar test to account for the nonindependence of dyadic data, we

Table 1
Correlations, Means, and Standard Deviations for Relationship Adjustment, Sexual Problems, and Sexual Satisfaction among Men and Women

Variable	*M*	*SD*	1	2	3	4	5	6
1. Men's dyadic adjustment	97.54	15.41		−.13*	.50***	.54***	−.18**	.34***
2. Men's sexual problems	12.32	3.73			−.40***	−.11	.16**	−.21***
3. Men's sexual satisfaction	23.64	6.94				.30***	−.38***	.60***
4. Women's dyadic adjustment	94.25	16.16					−.24***	.43***
5. Women's sexual problems	15.78	4.35						−.55***
6. Women's sexual satisfaction	23.21	7.30						

Note. $N = 298$ couples.
*$p < .05$; **$p < .01$; ***$p < .001$.

compared the percentage of men and women who fell within the clinical range with respect to dyadic adjustment and overall sexual functioning. Significantly more women than men fell within the clinical range on dyadic adjustment and sexual problems, $p < .001$. Next, we used a repeated-measures MANOVA to compare men's and women's mean dyadic adjustment, sexual functioning, and sexual satisfaction scores, with gender as a repeated measure for the couple. On average, the women reported significantly poorer dyadic adjustment, $F(1,297) = 14.53$, $p < .001$, $\eta_p^2 = 0.05$, lower sexual satisfaction, $F(1,297) = 3,95$, $p = .048$, $\eta_p^2 = 0.01$, and poorer overall sexual functioning, $F(1,297) = 133.93$, $p < .001$, $\eta_p^2 = 0.31$ than did the men (see Table 1). Note that effects size <0.06 are considered small, those between 0.06 and 0.14 are considered medium, and those greater than 0.14 are considered large (Cohen, 1988). To clarify these findings, we conducted another repeated-measures MANOVA examining gender differences in specific aspects of sexual functioning using the individual ASEX items (see Table 2). Compared to the men, the women reported more problems on all dimensions of sexual functioning, $F(5,293) = 37,42$, $p < .001$, $\eta_p^2 = 0.40$. We also compared the percentage of men and women reporting a problem on each dimension (score above 4; see Table 2). More women than men reported difficulties on all five dimensions. Low sexual desire was the most frequently reported sexual problem for both men and women, whereas difficulty reaching orgasm was least often reported by men and low satisfaction with orgasm was least often reported by women.

Comparing Sexual Satisfaction in Distressed and Community Couples

A 2 (gender) × 2 (sample: distressed vs. community) repeated-measures MANOVA was used to compare sexual satisfaction between distressed couples (this sample) and couples recruited in the general community (Péloquin et al., 2014) (RQ2). To account for sample differences, we controlled for age, relationship duration, and annual income. The distressed couples ($M = 23.43$, $SD = 7.12$) reported significantly lower sexual satisfaction than did the community couples ($M = 27.88$, $SD = 7.33$), $F(1,399) = 23.18$, $p < .001$, $\eta_p^2 = 0.06$.

Predicting Partners' Sexual Satisfaction

Correlations were computed between main variables (see Table 1). Small to strong correlations were found between men's and women's relationship and sexual variables, confirming that

Table 2
Means, Standard Deviations, and Percentages of Men and Women who Score Above the Clinical Cut Point for Sexual Problems

ASEX item	Men			Women			Repeated-measures MANOVA testing gender differences
	M	*SD*	%	*M*	*SD*	%	
1. Sexual desire	2.88	1.16	25.5	3.78	1.18	53.8	$F(1,297) = 82.20$, $p < .001$, $\eta_p^2 = 0.22$
2. Sexual arousal	2.46	.92	12.1	3.31	1.03	37.5	$F(1,297) = 108.27$, $p < .001$, $\eta_p^2 = 0.27$
3. Capacity to keep an erection (men)/ difficulty with lubrication (women)	2.13	.92	8.7	2.89	1.05	22.5	$F(1,297) = 84.12$, $p < .001$, $\eta_p^2 = 0.22$
4. Capacity to reach orgasm	2.28	.85	6.7	3.11	1.17	29.9	$F(1,297) = 98.28$, $p < .001$, $\eta_p^2 = 0.25$
5. Satisfaction with orgasm	2.41	.92	9.8	2.68	1.20	18.3	$F(1,297) = 11.38$, $p < .001$, $\eta_p^2 = 0.04$

Note. $N = 298$ couple.

the dyadic data were nonindependent. For both men and women, own dyadic adjustment, sexual functioning, and sexual satisfaction were all positively associated. We also computed correlations, separately for men and women, to identify potential control variables among the sociodemographic variables. The small magnitude of these correlations ($r < .30$) suggest that it was not necessary to control for these variables (Cohen, 1988).

Path analyses based on the Actor–Partner Interdependence Model (APIM; Kenny et al., 2006) were conducted to examine the effects of both partners' dyadic adjustment and sexual functioning on each partners' sexual satisfaction (H1). APIM analyses account for the nonindependence of dyadic data. Maximum likelihood estimation and nonparametric bootstrapping (1,000 samples) were used to test the proposed model, using the AMOS software. Dyadic adjustment and sexual function scores for both partners were included in a single model to test their unique associations with sexual satisfaction. Direct paths were drawn from an individual's dyadic adjustment and sexual function to their own sexual satisfaction (actor effects) and to their partner's sexual satisfaction (partner effects). The results are shown in Figure 1. Men's and women's dyadic adjustment predicted their own sexual satisfaction, but not their partner's sexual satisfaction, as indicated by nonsignificant partner effects. Men's and women's problems in sexual functioning negatively predicted their own and their partner's sexual satisfaction.

Association between Partner Discrepancies and Sexual Satisfaction

We conducted a second path analysis to examine the effect of the discrepancies in dyadic adjustment ($M = 12.12$; $SD = 9.55$) and sexual functioning ($M = 5.12$; $SD = 3.67$) on both partners' sexual satisfaction (RQ4). Both discrepancy scores were included in a single analysis predicting both partners' sexual satisfaction. Results are shown in Figure 2. A greater discrepancy between partners' sexual functioning predicted lower sexual satisfaction in both partners. To test for possible gender differences in this association (RQ5), men's and women's paths were constrained to be equal and a chi-square difference test was used to compare the constrained model to

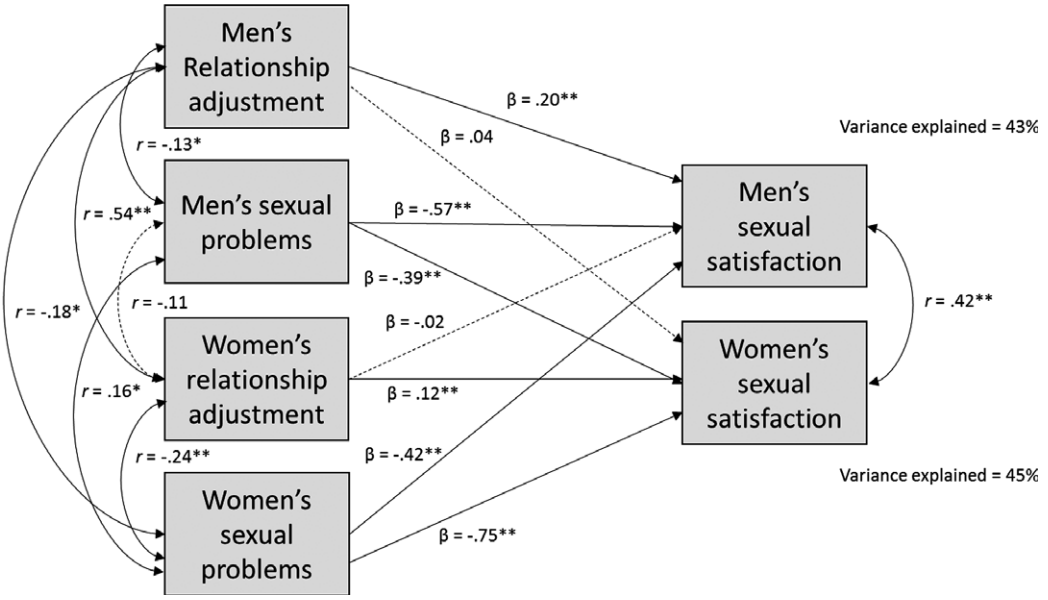

Figure 1. Path analysis showing relationship adjustment and sexual problems predicting sexual satisfaction in both partners. Standardized coefficients are shown. *$p < .05$; **$p < .01$. Dashed lines represent nonsignificant paths.

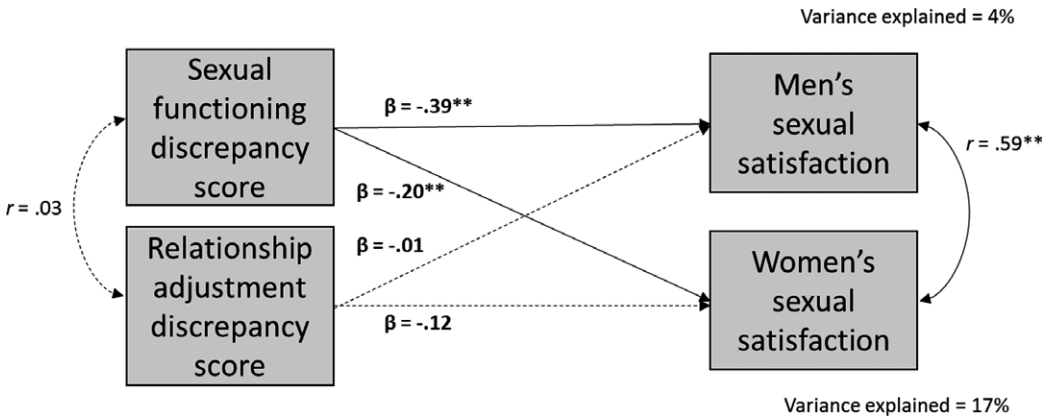

Figure 2. Path analysis showing discrepancy between partners' relationship adjustment and sexual functioning predicting sexual satisfaction in both partners. Standardized coefficients are shown. **$p < .01$. Dashed lines represent nonsignificant paths.

the unconstrained model. The two models differed significantly, $\Delta\chi^2$ (1, N = 298) = 4.83, p = .028, indicating that a greater discrepancy between partners' sexual functioning was more strongly associated with men's than with women's sexual satisfaction. Discrepancy in dyadic adjustment was not related to the sexual satisfaction of either partner.

DISCUSSION

Little is known about the sexual well-being of couples seeking relationship therapy. Moreover, there have been few studies considering the concurrent contribution of relationship and sexual factors to the sexual well-being of each partner using dyadic designs, especially in clinical populations. Addressing these limitations, this study provides valuable information about the sexual well-being

of both members of couples seeking relationship therapy as well as about the unique contributions of dyadic adjustment and problems with sexual functioning to both partners' sexual well-being.

Sexual Well-Being of Couples Seeking Relationship Therapy

Our results suggest that reduced sexual well-being and sexual problems are prevalent in relationally distressed couples. We found that, in 30% of the couples in our sample, at least one partner's score suggested that they were experiencing a clinically significant sexual problem. This percentage is higher than what is typically found in community samples using similar criteria for assessing sexual problems (Burri & Spector, 2011; Mercer et al., 2003). For example, Mercer et al. (2003) found the prevalence rates of 6.2% in men and 15.6% in women. Furthermore, couples in our sample reported lower satisfaction than did couples from a control sample of community couples and this difference was statistically significant. These results are especially compelling because this study was conducted in the Province of Quebec in Canada in which attitudes tend to be more liberal than in other parts of Canada or the United States (Hyde, DeLamater, & Byers, 2018). Thus, the prevalence of sexual problems and reduced sexual satisfaction may be even higher among clinical couples who hold more negative attitudes about sexuality or have more difficulty communicating about sex with their partner—both negative sexual attitudes and poor sexual communication are associated with lower sexual well-being (Jones, Robinson, & Seedall, 2017; MacNeil & Byers, 2009; Mark & Jozkowski, 2013).

The results also provide information about the types of sexual problems that are most common among individuals seeking relationship therapy. That is, low sexual desire was the most common problem, experienced by more than half of the women and more than a quarter of the men. Although we cannot conclude causation from these correlational data, this suggests that individuals who face problems and conflicts in their relationship are less likely to want to engage in sexual activity with their partner (low desire). This interpretation is in keeping with a U.S. study that showed that relationship dissatisfaction is associated with lower sexual frequency (McNulty et al., 2016). In addition, a significant minority of the men (6.7–12.1%) and women (18.3–37.5%) reported experiencing clinically significant problems with arousal, erection/lubrication, or orgasm, pointing to the need for a comprehensive assessment of all sexual problems in these couples.

Our results also suggest that women who seek relationship therapy experience lower sexual satisfaction and more problems (overall and in all areas of sexual functioning) than their male partner. Of note, the magnitude of the gender difference on sexual satisfaction was small suggesting that, consistent with the work of Brassard et al. (2012), the men and women are more similar than different in their overall appraisal of their sexual relationship. However, the effect size for overall sexual functioning was large. Our results thus corroborate results from research using community samples that more women than men report sexual problems (Mercer et al., 2003; Nicolosi et al., 2006) and extends this finding to couples seeking relationship therapy. Of note, our measure, the ASEX, does not assess sexual dysfunction in that it does not evaluate distress. Thus, the extent to which men and women presenting for relationship therapy would be diagnosed with a sexual disorder is not known.

Sexual Problems Predicting Sexual Satisfaction

Results from our APIM analyses provide support for the IEMSS by showing that, for both men and women, dyadic adjustment and sexual problems were significant and concurrent predictors of sexual satisfaction. More specifically, sexual problems in either partner were associated with lower sexual satisfaction in both partners even after controlling for each partner's dyadic adjustment. These findings are consistent with the past studies using community samples from the United States, Canada, Brazil, Germany, Japan, and Spain that have highlighted the impact of sexual problems on the sexual well-being of both members of the couple (Fisher et al., 2015; Rosen et al., 2016). This indicates that sexual problems experienced by either partner are experienced as an important sexual cost. Sexual problems may also cause changes to the sexual relationship such as lower frequency of sexual activity, more routine sexual script, or increased anxiety (Fisher, Rosen, Eardley, Sand, & Goldstein, 2005; Patrick et al., 2005) that result in an overall less favorable balance of sexual rewards and costs and, in turn, in lower sexual satisfaction. Relationally distressed couples may be especially likely to experience these negative changes to their sex life in the face of

sexual problems because of the other significant relationship challenges they face—such as decreased mutual understanding and empathy, increased conflicts and distance, accumulated frustrations and deceptions (Gurman, 2008). Sexual problems may add to these relationship difficulties, increasing the burden for these couples and possibly limiting their capacity to cope with and properly address the sexual problems together, resulting in lower sexual satisfaction in both partners.

Our findings suggest that low sexual satisfaction can arise as a result of both the partners' individual poor sexual functioning as well as the discrepancy between the partners' sexual functioning. That is, in keeping with the IEMSS component that greater partner inequality in sexual rewards and costs results in lower sexual satisfaction, we found that the greater the discrepancy between partners' sexual functioning, the less sexually satisfied both partners were. In other words, couples in which partners both report high sexual functioning or low sexual functioning tend to be more sexually satisfied than are couples in which partners differ on sexual functioning. The former situation is likely related to the lower sexual costs experienced by both partners. The latter case may indicate that when both partners experience some degree of sexual problems, they may have fewer negative emotions about their sexual problems (e.g., anxiety, guilt, shame) or be better able to understand and adapt their sex lives to accommodate each other, resulting in lower perceived costs or more equality in sexual costs for both partners. However, these results need to be interpreted in light of the fact that the women in our sample reported poorer sexual functioning than the men, particularly with respect to sexual desire. As such, the sexual functioning discrepancy may largely reflect men with partners who report poor sexual functioning and low desire specifically and not vice versa. In keeping with the traditional sexual script (Wiederman, 2005), it may be that men's sexual satisfaction is strongly affected by having sex less frequently than desired or with a partner who is complying but not interested. The discrepancy in desire may also lead to more conflict in the relationship, which then affects women's sexual satisfaction. The discrepancy in sexual functioning explained more variance in women's (17%) than in men's sexual satisfaction (4%), suggesting that women may be more affected by this discrepancy. This is consistent with the past research showing that, compared to men, women are more aware of relational inequalities (Hatfield, Utne, & Traupman, 1979).

Dyadic Adjustment Predicting Sexual Satisfaction

Consistent with previous research in community samples, we found significant bivariate associations between dyadic adjustment and both own and partner sexual satisfaction (McNulty et al., 2016). We extended this research by showing that poorer dyadic adjustment was related to men's and women's own lower sexual satisfaction but not to their partner's sexual satisfaction (actor effect only) when all variables (including sexual problems) are tested concurrently in a single dyadic model. This may be because partners' dyadic adjustment was strongly associated with each other. This suggests that, in a context where both partners experience relational distress, the extent to which the partner is dissatisfied in the relationship does not impact sexual well-being over and above the individual's own level of unhappiness. This interpretation is consistent with our finding that the discrepancy in dyadic adjustment was not associated with sexual well-being. In contrast, even in the context of relational distress, each partner's sexual functioning independently contributed to the partners' sexual well-being. This may be because partners' sexual functioning was only weakly (albeit significantly) associated with each other or, alternatively, because the link between sexual problems and sexual satisfaction is more proximal (i.e., compared to the impact of relationship distress, the impact of sexual problems is more salient in partners' sexual life). Together, these results suggest that sexual problems impact partners' sexual satisfaction directly, above the contribution of relational distress, and support the idea that not all problems in sexual well-being are uniquely rooted in relationship problems.

Limitations and Future Directions

The study presents some limitations. First, it is impossible to determine whether sexual problems cause relationship distress in these couples from our cross-sectional data. Longitudinal Canadian and American studies suggest a bidirectional link between sexual functioning and satisfaction, and relationship well-being (Byers, 2005; McNulty et al., 2016). Future studies should

evaluate how changes in relationship and sexual functioning change over time to uncover the nature of causal relations among relational well-being and sexual well-being. Research is also needed to inform the timing and effectiveness of interventions for addressing concurrent relationship and sexual problems in relationally distressed couples. For instance, it is important to determine when to treat relationship issues before sexual issues (or vice versa) or treat them concurrently. It is also important to determine whether the markers of change in the context of relational therapy are similar for men and women—for example, improvement in the sexual functioning of one partner results in significant improvement in the other partner's sexual well-being or relationship adjustment. Qualitative research examining couples' experience during therapy and perception of the factors that improved their sexual well-being would also inform how best to treat sexual problems in the context of relationship therapy.

Second, the use of self-report measures may have contributed to shared method variance (Podsakoff, MacKenzie, & Podsakoff, 2012). However, this could not account for observed partner effects. In addition, as the ASEX does not allow for formal diagnosis of sexual dysfunctions, future studies should use other methods that can identify clinically significant sexual dysfunctions, such as an independent assessment by a clinician or health professional, to evaluate the contributions of sexual problems and dyadic adjustment to sexual well-being in both partners. Moreover, in keeping with the New View of Women's Sexual Problems (Tiefer, 2001), comparing the sexual functioning of men and women using the ASEX (or any other measure of sexual functioning) may induce an androcentric (male-oriented) bias regarding what constitutes a "sexual problem".

Finally, although this study offers a unique perspective on the sexual-well being of distressed couples, more studies are needed that incorporate other aspects of these men's and women's subjective experience (in addition to relationship and sexual satisfaction). For instance, it is important to investigate the role of intimacy, partner support, and subjective distress associated with men's and women's sexual well-being as well as to evaluate more comprehensive models of factors affecting sexual well-being. This information would further inform interventions to address the sexual well-being of relationally distressed couples.

Implications for Relationship Therapists

Many couples in our sample reported a positive sex life despite relationship problems, including high sexual satisfaction and no clinically significant sexual problems. Nonetheless, the prevalence of sexual problems and decreased sexual satisfaction underscores the importance of conducting a proper evaluation of sexual well-being for all couples seeking relationship therapy, and women in particular, regardless of the initial reason for seeking therapy. As clients do not always readily volunteer information about sexual problems (Risen, 2010), the responsibility to inquire about sexual well-being rests on the therapist's shoulders. In doing so, therapists need to strive to understand how the couple's relational difficulties feed into their sexual problems and vice versa.

The finding that problems with sexual functioning were associated with overall sexual well-being over and above the contributions of dyadic adjustment suggests that it is important for couple therapists to directly treat sexual problems being experienced by either partner and not solely treat relationship distress with the hope that sexual well-being will naturally follow. The finding that the discrepancy in sexual functioning was associated with sexual well-being suggests that therapists may need to pay special attention to couples in which only one partner reports sexual problems; these couples may be at higher risk of being dissatisfied with their sex life. Although interventions strictly targeting relationship issues are likely helpful in enhancing sexual well-being, their impact may be limited when sexual problems fuel relationship dissatisfaction, conflicts, and distance between partners. Relational interventions may also have limited impact when the causes of the sexual problem lie outside of the relationship, for example, in social or emotional factors. Inappropriate use of relationship interventions to address sexual problems may exacerbate sexual distress and reduce the couple's hope that their sexual problem will be resolved (McCarthy & Thestrup, 2008).

Our results underscore the importance of ensuring that all relationship therapists are trained to assess sexual well-being, integrate sexual problems and dissatisfaction into their conceptualization of relational difficulties, provide specific sexual interventions, and know when to

refer to a specialist in sex therapy. Such training should seek to enhance the knowledge, comfort, and self-efficacy of therapists (Harris & Hays, 2008; Miller & Byers, 2009). Recent research suggests that most graduate training programs in marriage and family therapy value and offer training in sexuality as part of their curriculum, but several barriers often preclude offering in-depth training on all aspects of human sexuality (Zamboni & Zaid, 2017). Providing adequate training in sexuality will ensure that the needs of all couples seeking relationship therapy are addressed properly and reduce the likelihood of premature therapy termination or relapse in relationship or sexual distress.

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