

1 Running Head: SEXUAL COMMUNAL MOTIVATION IN LOW DESIRE COUPLES

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6 **Sexual communal motivation in couples coping with low sexual interest/arousal:**

7 **Associations with sexual well-being and sexual goals**

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26 **Abstract**

27 Women coping with female sexual interest/arousal disorder (FSIAD) report lower sexual and
28 relationship satisfaction compared to healthy controls. In community samples, high *sexual*
29 *communal strength* (i.e., the motivation to meet a partner's sexual needs) is associated with
30 higher sexual desire and satisfaction, but high *unmitigated sexual communion* (i.e., the
31 prioritization of a partner's needs to the exclusion of one's own needs) is associated with lower
32 sexual satisfaction. People higher in sexual communal strength report engaging in sex for
33 *approach goals* (i.e., to enhance intimacy in their relationship), but not for *avoidance goals* (i.e.,
34 to avert conflict or a partner's disappointment) and this is one reason why they report greater
35 sexual desire. In the current sample of 97 women diagnosed with FSIAD and their partners we
36 investigated the association between sexual communal strength and unmitigated sexual
37 communion and sexual well-being (i.e., sexual desire, sexual satisfaction and sexual distress) and
38 sexual goals (i.e., approach and avoidance goals). Women who reported higher sexual communal
39 strength were more likely to pursue sex for approach goals and their partner reported greater
40 sexual satisfaction. When partners reported higher sexual communal strength, they reported
41 higher sexual desire, but when they reported higher unmitigated sexual communion, they
42 reported higher sexual distress. Additional associations emerged for couples who engage in sex
43 more (compared to less) frequently. Our findings demonstrate that being motivated to meet a
44 partner's sexual needs is associated with greater sexual well-being for couples coping with
45 FSIAD, but when this motivation involves neglecting one's own needs, people do not report
46 greater sexual well-being and instead, partners report higher sexual distress.

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49 Introduction

50 Low sexual desire is a common complaint, particularly among women [1]. In large scale,
51 nationally representative surveys, nearly a quarter of women report low sexual desire lasting
52 several months over the past year, and for 7% to 30% of women, low sexual desire is
53 accompanied by significant distress [2–4]. Female Sexual Interest/Arousal Disorder (FSIAD) is
54 the clinical diagnosis for a female sexual dysfunction characterized by low sexual desire and/or
55 arousal accompanied by distress, and which is not better accounted for by another medical or
56 psychiatric condition [5]. For a diagnosis of FSIAD, women must report reduced or low levels of
57 at least three of the following symptoms during at least 75% of their sexual encounters and for at
58 least six months: desire for sex, sexual fantasies/thoughts, initiation and receptivity of sexual
59 activity, sexual pleasure, desire elicited by sexual stimuli, and/or genital or non-genital
60 sensations [5]. Etiological models of FSIAD acknowledge the importance of interpersonal
61 factors [6] in the maintenance of low desire and associated distress, and couples therapy is
62 frequently a first-line intervention [7]. However, we know very little about the interpersonal
63 factors that might be protective for women’s low desire and FSIAD couples’ associated
64 difficulties.

65 Women coping with FSIAD report lower health-related quality of life, including more
66 depressive symptoms, and lower sexual and relationship satisfaction compared to healthy
67 controls [8–10]. In fact, women with FSIAD who are partnered are five times more likely to
68 report sexual and relationship distress compared to affected women who are unpartnered [4],
69 underscoring the interpersonal context of the disorder. Although few studies have included the
70 partners of women with FSIAD, the existing research suggests that partners report negative
71 consequences as well. Compared to partners of women not coping with a sexual dysfunction,

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72 partners of women with FSIAD report lower sexual and relationship satisfaction and more sexual
73 distress [10]. In an early small study of 40 couples, couples coping with low desire ($N = 20$),
74 reported a more limited sexual repertoire and less pleasure and enjoyment during sex than
75 healthy controls ($N = 20$) [11], as well as more frequent sexual disagreements and dissatisfaction
76 with their frequency of sexual activities [12]. In a qualitative study, both partners in couples
77 coping with low desire tended to blame each other for the problem [13].

78 While no single cause of FSIAD has been identified [14], risk factors for the
79 development and maintenance of FSIAD include biological, psychological, interpersonal, and
80 sociocultural factors [6]. Therefore, a biopsychosocial approach to assessment and treatment that
81 takes relationship factors as well as the woman's partner into account has been recommended
82 [6,14]. Despite these recommendations and the fact that low sexual desire and arousal frequently
83 occur in the context of a romantic relationship, there has been limited focus on the role of
84 interpersonal factors [4]. However, there is promising, initial evidence that interpersonal factors,
85 such as relational and partner-focused sexual motivational factors, play an important role in
86 maintaining sexual issues in couples coping with a sexual dysfunction [4,12,15]. For example, in
87 a community sample of women—about half of whom reported sexual dysfunction—perceptions
88 of poor relationship quality or of a partner's sexual dysfunction were connected to women's low
89 desire/arousal [15]. Given that both partners report negative consequences of FSIAD [10] and
90 partnered women with FSIAD report greater distress than their unpartnered counterparts [4],
91 additional research investigating the relational and motivational factors that maintain these
92 sexual issues and the well-being of both partners is crucial for the further development of
93 interventions for couples coping with FSIAD. In the current research, we investigate the role of
94 two novel interpersonal factors—*sexual communal strength* (SCS; i.e., the motivation to meet a

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97 partner's sexual needs) and *unmitigated sexual communion* (USC; i.e., a focus on meeting a
 98 partner's needs to the exclusion of one's own needs)—in the sexual well-being (i.e., sexual
 99 desire, sexual satisfaction, and sexual distress) and sexual goals (i.e., approach and avoidance
 100 sexual goals) of affected couples [16].

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101 **Sexual communal motivation and sexual well-being**

102 Women with FSIAD in relationships often continue to engage in sex despite experiencing
 103 low desire [17], and their motivations for doing so may be associated with both partners' sexual
 104 well-being. Theories of sexual communal motivation suggest that responsiveness to a partner's
 105 sexual needs (i.e., high sexual communal strength; SCS) even during times when partners have
 106 different sexual desires can have benefits for romantic relationships [18,19]. Associations
 107 between SCS and sexual and relationship well-being have been examined in experimental [18],
 108 longitudinal [19], and daily experiences studies [19]. In a sample of couples in long-term
 109 relationships, people higher in SCS reported higher daily sexual desire and were more likely to
 110 maintain higher sexual desire over time [16]. Even among couples coping with a sexual
 111 dysfunction (e.g., genito-pelvic pain/penetration disorder), higher SCS is associated with better
 112 sexual function, of which one component is sexual desire, for both partners [20]. More
 113 intuitively, people with partners higher in SCS feel more satisfied in their relationships and more
 114 committed to maintaining their relationship over time, compared to people with partners lower in
 115 SCS [19]. In fact, in both community [21] and clinical samples of women coping with a sexual
 116 dysfunction [20], on days when one partner reported higher SCS, the other partner reported
 117 greater sexual and relationship satisfaction. One reason that women with low desire report for
 118 engaging in sex is to make their partners happy [17] and the extent to which this is communally
 119 motivated may be associated with sexual well-being.

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120 Previous findings also suggest that SCS can help couples navigate sexual discrepancies or
 121 maintain sexual and relationship satisfaction during times when sexual desire is low. People in
 122 romantic relationships who were higher in SCS were motivated to meet a partner's sexual needs
 123 even on days when they experienced lower sexual desire than their partner and in turn, both
 124 partners reported higher sexual and relationship satisfaction [18]. In a sample of new-parent
 125 couples—a time when desire and satisfaction tend to decline and sexual problems are more likely
 126 to arise [22,23]—having a partner who was higher in SCS was associated with greater sexual and
 127 relationship satisfaction for both new mothers and new fathers [24]. However, we do not yet
 128 know whether SCS will be associated with sexual well-being in couples coping with chronic,
 129 distressing sexual desire, as is the case with couples coping with FSIAD. In a qualitative study,
 130 one strategy that women report engaging in to manage desire discrepancies in their relationship
 131 includes trying to understand or meet their partner's needs, which closely parallels SCS, and they
 132 report this strategy to be at least somewhat helpful in better navigating differences in desire [25].
 133 Therefore, higher SCS may be associated with greater sexual well-being for both partners in
 134 couples coping with FSIAD.

135 Although being motivated to be responsive to a partner's sexual needs can be associated
 136 with greater sexual well-being for both partners, if the motivation to meet a partner's sexual
 137 needs is extreme and excludes one's own needs—termed high unmitigated sexual communion
 138 (USC)—this is no longer associated with greater sexual well-being and, instead, may be
 139 associated with poorer well-being [16,26]. Unmitigated communion differs from communal care
 140 in that it involves self-neglect [26], see also [27]. Thus, it is possible to be high in SCS without
 141 also being high in USC, as demonstrated in prior research [20,21]. Prior research has also
 142 demonstrated that whereas communion is associated with positive views of the self and others,

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143 and better interpersonal well-being and health, unmitigated communion is negatively associated
 144 with these factors [28]. Individuals high in unmitigated communion regularly neglect their own
 145 needs and well-being and are overly concerned with the needs of their partner, which takes the
 146 value of interpersonal connectedness to an unhealthy extreme [26]. In fact, when relationship
 147 stress was high, people higher in unmitigated communion experienced lower positive affect and
 148 higher levels of anxiety, depression, and negative affect [29].

149 In the sexual domain specifically, on days when people reported higher USC, they
 150 reported lower sexual and relationship satisfaction [21]. In addition, in a clinical sample of
 151 couples coping with the woman's pain during sex, on days when women reported higher USC,
 152 they reported lower sexual satisfaction and sexual function, and both partners reported lower
 153 relationship satisfaction [20]. These findings suggest that sexual communal motivation that
 154 excludes one's own needs might be associated with both partners' lower sexual and relationship
 155 satisfaction for couples coping with sexual problems. In clinical cases of women coping with
 156 FSIAD, it is common for women to report accepting a partner's sexual advances due to fears
 157 about losing the relationship, but then feeling dissatisfied with the sexual encounter [7].
 158 Therefore, high unmitigated sexual communal may be associated with poorer sexual well-being
 159 for both partners.

160 **Sexual communal motivation and sexual goals**

161 A person's broader motivation to meet their partner's sexual needs may also be
 162 associated with their specific goals for engaging in sex with their partner. That is, SCS and USC
 163 might be differentially associated with a person's *reasons* for engaging in sex. Approach-
 164 avoidance motivational theory has been applied to sexuality and identifies two broad categories
 165 of goals for engaging in sex. *Approach sexual goals* involve engaging in sex in pursuit of

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168 positive outcomes, such as to promote intimacy or express love for a partner, whereas *avoidance*
 169 *sexual goals* involve engaging in sex to avert negative outcomes, such as to avoid conflict or the
 170 loss of a relationship [16,30,31]. In one daily experience study of long-term couples, those higher
 171 in SCS reported engaging in sex more for approach goals, but not for avoidance goals, and
 172 higher approach sexual goals are one reason why people higher in SCS reported higher daily
 173 sexual desire [16]. In contrast, people higher in USC tend to place greater attention on negative
 174 cues during sex, such as feeling bored or distracted, and less attention on positive sexual cues,
 175 such as their partner's responsiveness [21]. Women with FSIAD seeking therapy commonly
 176 report lower approach goals for sex (i.e., to connect with their partner) and higher avoidance
 177 goals (i.e., to avoid losing their partner) [7]—which is consistent with studies comparing women
 178 with a sexual dysfunction to healthy controls [32]—and their goals may be differentially
 179 associated with their SCS and USC.

180 Among couples coping with FSIAD, one partner's sexual communal motivation may also
 181 be associated with their partner's sexual goals. Research has demonstrated that, among women
 182 with low sexual desire, partner-specific characteristics including whether a partner is motivated
 183 to meet her sexual needs or if she feels her partner has sexual needs that she cannot meet, are
 184 associated with the woman's feelings of desire [33]. Research with community samples has
 185 found that on days when one partner is higher in SCS, the other partner focuses more on positive
 186 cues during sex, such as their connection with their partner and the partner's responsiveness [21].
 187 People higher in SCS are also perceived by their partner as more responsive during sex [19].
 188 Therefore, among couples coping with FSIAD, it is possible that one partner's SCS will be
 189 associated with either partner's higher sexual approach goals. In contrast, previous work has
 190 shown no significant associations between SCS and avoidance goals for sex [16].

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195 In prior research, having a partner higher in unmitigated sexual communion was not
 196 associated with a greater focus on either positive or negative cues during sex [21]. Given that
 197 people higher in unmitigated communion are overly concerned about meeting their partners'
 198 needs [34], it is possible that, in the sexual domain, having a partner higher in USC is associated
 199 with a greater likelihood of engaging in sex to avoid upsetting them (i.e., for higher avoidance
 200 sexual goals). However, although people higher in unmitigated communion often perceive that
 201 their partner experiences more negative feelings about them such as annoyance or
 202 disappointment [35], it is not clear if these perceptions are accurate. In one study, some women
 203 with low sexual desire self-identified as self-sacrificing, martyr figures, having joyless sex driven
 204 solely by their partner's needs [13]. However, these ostensibly self-sacrificial acts, when
 205 unmitigated by one's own needs, may be motivated by a desire to avoid negative outcomes (e.g.,
 206 conflict or losing the relationship) and, in turn, be associated with the very outcomes that the
 207 person wishes to avoid [36]. Therefore, among couples coping with FSIAD, it is possible that
 208 one partner's USC will be associated with both partner's higher sexual avoidance goals.

209 **Current study**

210 In the current study, we recruited a sample of couples coping with FSIAD to investigate
 211 the role of SCS and USC in the sexual well-being (i.e., dyadic sexual desire, sexual satisfaction,
 212 sexual distress) and sexual goals (i.e., approach and avoidance sexual goals) of both women with
 213 FSIAD and their partners. We expected that when women or their partners were higher in SCS,
 214 both partners would report greater sexual well-being and stronger approach goals for sex, but
 215 that when women and partners were higher in USC both partners would report lower sexual
 216 well-being and stronger avoidance goals for sex. Previous research testing links between sexual
 217 communal motivation and well-being has been conducted with community couples who engaged

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221 in sex once a week or more, on average [e.g., 16] or specifically on days when couples engaged
222 in sex [e.g., 20, 36, 37]. In fact, people higher in SCS are more likely to engage in sex even when
223 their desire is low [18], and sexual frequency is associated with relationship and sexual
224 satisfaction [38,39]. But, many women coping with FSIAD avoid sex with their partner [7,40]. It
225 is possible that in couples coping with FSIAD, the associations between SCS and USC and
226 sexual well-being might be driven by how frequently the couple reports engaging in sex.
227 Therefore, we conducted additional, exploratory tests of whether any associations were
228 moderated by how frequently the couple engaged in sex. Given that very little is known about
229 evidence-based targets for intervention in the treatment of FSIAD and no studies have focused
230 on the interpersonal factors that are associated with the well-being of both members of couples
231 coping with FSIAD, the current study will provide novel insight into factors that might protect
232 couples coping with chronic low desire from lower sexual well-being.

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233 **Materials and methods**

234 **Participants**

235 To be eligible for the study individuals had to be 18 years or older, and both partners had
236 to agree to participate. Additional eligibility criteria included couples being in a committed
237 relationship for a minimum of six months, having previous sexual experience, seeing each other
238 in person at least four times each week, having English language fluency, and not currently
239 undergoing hormonal therapy (hormonal contraceptives were allowed). We were interested in
240 recruiting established couples coping with FSIAD, therefore required a minimum relationship
241 length of six months. In addition, we were interested in the sexual experiences of couples coping
242 with FSIAD, and therefore recruited couples who were geographically close to each other and
243 saw each other regularly so they would have the opportunity to engage in sexual activity.

244 A total of 215 women completed a brief telephone screening conducted by a research
245 assistant to determine preliminary eligibility, and 174 of these women met the initial eligibility
246 criteria to continue to the clinical interview. The telephone screen included verification of
247 inclusion and exclusion criteria, initial verification of FSIAD symptoms (but not a complete
248 clinical assessment), and confirmation that their partner was willing to participate in the study.
249 The most common reason for exclusion based on the brief telephone screening was that the
250 woman did not meet their criteria of having persistent low desire accompanied by distress
251 (meaning it was extremely unlikely they would meet the diagnostic criteria for FSIAD). Of these
252 174 women, 31 women were no longer interested in participating, which left 143 women who
253 then completed the clinical interview. Women underwent a psychodiagnostic semi-structured
254 telephone clinical interview conducted by either a clinical psychologist or a senior PhD student
255 in Clinical Psychology (supervised by a clinical psychologist) to determine if they met diagnostic
256 criteria for FSIAD. Of these, 25 women did not meet the criteria for FSIAD, following the
257 psychodiagnostic clinical interview. The remaining 21 exclusions were due to one or both
258 partners not completing the survey within the four-week allotted time ($n = 6$) or failing attention
259 checks embedded in the survey ($n = 15$).

260 Our final sample included 97 women with FSIAD and their partners ($N_s = 88$ men, 6
261 women, 3 other) recruited from both online (from Kijiji, Facebook, Twitter and Reddit) and
262 physical advertisements (in hospitals, universities, and community buildings) from September
263 2016 to May 2018 across North America. Only 1.0% of data were missing for partners' sexual
264 orientation. Table 1 provides complete participant demographics.

265 Using the Actor Partner Interdependence Model (APIM) power Shiny app [41] and
266 associations between SCS and relationship satisfaction from previous cross-sectional research

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267 with community couples [19] where the actor effect = .32 and the partner effect = .24, we had
 268 95% power to detect our effects in the current sample. That is, based on these estimated effect
 269 sizes, a sample of 93 couples was needed to detect the effects at 95% power.

270 Table 1. *Sample Demographics (N = 97 Couples)*.

Characteristic	Women		Partners	
	<i>M</i> (range) or <i>n</i>	<i>SD</i> or %	<i>M</i> (range) or <i>n</i>	<i>SD</i> or %
Age (years)	31.03	7.73	32.25	9.27
	(19.07 - 57.48)		(19.07 - 70.34)	
Ethnicity				
African American/Black	2	2.1%	2	2.1%
Asian American/Asian	9	9.4%	9	9.4%
Caucasian/White	69	71.9%	74	77.1%
East Indian	1	1%	1	1%
Hispanic/Latino/Latina	4	4.2%	2	2.1%
Middle Eastern/Central Asian	3	3.1%	3	3.1%
Biracial/Multiracial	3	3.1%	3	3.1%
Other	5	5.2%	2	2.1%
Annual income (household; CAD\$)				
\$0—19,999	13	13.6%	-	-
\$20,000—39,999	16	16.7%	-	-
\$40,000—59,999	15	15.7%	-	-
\$60,000—79,999	20	20.8%	-	-
\$80,000—99,999	11	11.5%	-	-

≥ \$100,000	21	21.9%	-	-
Relationship status				
Dating	10	10.3%	-	-
Cohabiting	26	26.8%	-	-
Common-law	13	13.4%	-	-
Engaged	7	7.2%	-	-
Married	41	42.3%	-	-
Self-identified sexual orientation				
Straight/Heterosexual	68	70.1%	82	84.5%
Bisexual	15	15.5%	6	6.2%
Queer	4	4.1%	2	2.1%
Pansexual	4	4.1%	-	-
Lesbian	3	3.1%	3	3.1%
Asexual	1	1.0%	3	3.1%
Other	2	2.1%	-	-
Relationship duration (months)				
	92.03	85.25	-	-
	(7.5 – 419)			
FSIAD duration (months)				
	54.65	63.14	-	-
	(3 – 372)			
Study variables				
Sexual communal strength	2.36	.65	3.13	0.51
	(0.50 - 3.67)		(1.83 - 4.0)	

Unmitigated sexual communion	2.53 (1 - 4.33)	.78	3.62 (1.67 – 5.0)	0.66
Approach sexual goals	5.47 (1.67 -7.0)	1.22	6.29 (2.67 – 7.0)	0.80
Avoidance sexual goals	4.14 (1 – 7)	1.50	3.14 (1 – 7)	1.64
Dyadic sexual desire	17.64 (0 – 43)	9.05	39.57 (6 – 54)	8.22
Sexual satisfaction	20.98 (5 – 35)	5.48	23.80 (10 – 35)	6.22
Sexual distress	30.08 (7 – 50)	9.85	17.66 (0 – 50)	10.35

271 *Note.* FSIAD duration was based on self-report and separate from the inclusion assessment.

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275 **Procedure**

276 Participants who were eligible for the study were screened and diagnosed through a
 277 telephone clinical interview by a clinical psychologist to confirm FSIAD. This clinical interview
 278 was developed based on prior studies' models [9,42] and refined based on our teams' clinical
 279 expertise. The research assistant then spoke briefly to the other partner in the relationship to
 280 confirm their interest in participating in the study. Couples who decided to participate in the

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281 study received an individualized link to the online consent form and once consent was provided,
282 participants were then directed to the online survey. Qualtrics online survey software was used to
283 distribute the surveys. Members of each couple were required to complete the survey within four
284 weeks and were instructed to do so separately and without discussing their responses with each
285 other. As part of the follow-up protocol, a series of reminders to complete the survey was sent
286 out to participants. After completing the survey, participants received online resources for
287 sexuality and relationships. Once both members of the couple completed the survey, they were
288 each compensated with an \$18 CAD gift card to Amazon.com/ca. The studies were approved by
289 the authors' institutional research ethics boards.

290 The current data were collected as part of a larger study investigating interpersonal
291 factors that are associated with the sexual, psychological, and relationship well-being of couples
292 coping with FSIAD. The study was advertised as a study of women with low sexual desire and
293 their partners. One of our key goals is tested in the current paper—the role of SCS and USC in
294 women and partners' sexual well-being. Some data from the larger study have also been
295 published in which we compared this sample of couples coping with FSIAD to a control sample
296 on measures of personal, relational and sexual well-being [10]. See also Rosen et al. [10] for full
297 sample and procedural details.

298 **Measures**

299 All questionnaires can be found in the Supporting Information (S1 File).

300 **Socio-demographics.** Participants reported their ethnicity, gender, sexual orientation,
301 and age. Women also reported their relationship status and duration of FSIAD (see S1 File).

302 **Sexual communal strength.** SCS was measured with six items that were previously
303 adapted from a general measure of communal strength [43]. The measure of SCS has been used

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304 in previous research [e.g., 16] and has been shown to be a valid and reliable measure of the
 305 motivation to be communally responsiveness to a partner's sexual needs (for more information
 306 see S1 File). Respondents indicate their extent of agreement with each item (e.g., "How happy
 307 do you feel when satisfying your partner's sexual needs") on a scale from 0 (*not at all*) to 4
 308 (*extremely*). Scores on this scale are averaged and can range from zero to four, with higher scores
 309 indicating greater motivation to meet their partner's sexual needs (FSIAD women $\alpha = .73$;
 310 partners $\alpha = .67$).

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311 **Unmitigated sexual communion.** To measure the extent to which participants focus on
 312 their partner's sexual needs to the exclusion of themselves, six items were previously adapted
 313 from a validated measure of unmitigated communion [20,37,44]. For additional information
 314 about the reliability and validity of this measure, see S1 File. Example items include: "It is
 315 impossible for me to satisfy my own sexual needs if they interfere with the needs of my partner,"
 316 and "I always place my partner's sexual needs above my own." Items were rated on a five-point
 317 scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Scores on this scale are averaged and can
 318 range from one to five, with higher scores indicating higher prioritization of a partner's sexual
 319 needs in neglect of one's own needs (FSIAD women $\alpha = .76$; partners $\alpha = .66$).

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320 **Approach and avoidance sexual goals.** Sexual goals were assessed with a 12-item
 321 measure used in previous research [30,45]. A version of this measure—the Sexual Motivations
 322 Scale-Revised—was originally validated by Cooper, Shapiro and Powers [43]. The current
 323 version is a truncated version with only the two subscale factors relevant to the context of
 324 romantic relationships. Participants rated the importance of six approach (e.g., "to promote
 325 intimacy in my relationship") and six avoidance (e.g., "to prevent my partner from falling out of
 326 love with me") interpersonal goals in influencing their decision to engage in sex on seven-point

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329 scales ranging from 1 (*not at all important*) to 7 (*extremely important*). The mean is calculated
330 for each subscale. Higher approach sexual goal scores indicate stronger goals toward potential
331 positive outcomes, while higher avoidance sexual goal scores indicate stronger goals away from
332 potential negative outcomes, (FSIAD women approach goals $\alpha = .86$; partners $\alpha = .83$; FSIAD
333 women approach goals $\alpha = .84$; partners $\alpha = .91$).

334 **Sexual desire.** Dyadic sexual desire for participants' own partners was assessed with the
335 seven items of the partner-focused dyadic sexual desire subscale from the 14-item Sexual Desire
336 Inventory [SDI-2; 46], as per Moyano, Vallejo-Media, and Sierra's [47] recommendation. Items
337 are rated from 0 (*no desire*) to 8 (*strong desire*). Example items include: "When you have sexual
338 thoughts, how strong is your desire to engage in sexual behaviour with a partner?" and "During
339 the last month, how often have you had sexual thoughts involving your partner?" Scores on this
340 subscale are summed and can range from 0 to 56, with higher scores indicating higher levels of
341 dyadic sexual desire for one's partner, (FSIAD women sexual desire $\alpha = .79$; partners $\alpha = .85$).

342 **Sexual satisfaction.** Overall sexual satisfaction was assessed with the Global Measure of
343 Sexual Satisfaction scale (GMSEX) [48]. Participants are asked to describe their overall sexual
344 relationship with their partner in five bipolar dimensions (i.e., very bad/good,
345 unpleasant/pleasant, negative/positive, satisfying/unsatisfying, and worthless/valuable) on a 7-
346 point scale ranging from 1 to 7. Ratings are summed, and total scores can range from five to 35,
347 with higher scores indicating greater sexual satisfaction, (FSIAD women sexual satisfaction $\alpha =$
348 $.87$; partners $\alpha = .92$).

349 **Sexual distress.** Sexual distress was assessed with the 13-item Female Sexual Distress
350 Scale-Revised (FSDS-R) [49]. Participants rated on a 5-point Likert-type scale how frequently
351 they experienced distress (e.g., stress or guilt) about their sex lives. Intensity of distress is rated

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352 from 0 (*not at all*) to 4 (*extremely*). Ratings are summed, and total scores can range from 0 to 52,
353 with higher scores indicating higher sexual distress. Although the FSDS-R was originally
354 developed specifically for women, it uses gender-neutral language and has been validated in men
355 [50], (FSIAD women sexual distress $\alpha = .91$; partners $\alpha = .92$).

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356 **Sexual intercourse frequency.** Sexual intercourse frequency was measured with one
357 item: "During the past 4 weeks, how often did you and your partner engage in sexual intercourse
358 with vaginal penetration?" Response options were 0 (not at all), 1 (once or twice), 2 (once a
359 week), 3 (2-3 times a week), 4 (4-5 times a week), 5 (once a day), or 6 (more than once a day).

360 Data analyses

361 Data were analyzed with multilevel modeling using mixed models in SPSS Version 23.0
362 where partners were nested within couples to account for the non-independence of couple data
363 [51]. Analyses were guided by the Actor Partner Interdependence Model. All models included
364 women and their partners' SCS and USC as predictors. We ran separate models for each
365 outcome (five models in total for the main analyses). In the analyses, we assessed the
366 associations between women's and partners' SCS and USC and their own outcomes (i.e., actor
367 effects) and the associations between women's and partner's SCS and USC and their partner's
368 outcomes (i.e., partner effects). The coefficients reported are unstandardized betas, interpreted as
369 the change in the outcome for every one-unit increase in the predictor. These coefficients act as
370 indications of the size of the effect. Correlations among all study variables are reported in Table
371 2.

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375 Table 2. *Correlations Among All Study Variables.*

Variable	1	2	3	4	5	6	7
1. Sexual Communal Strength	-.14	.63**	.39**	.10	-.02	.31**	.09
2. Unmitigated Sexual Communion	.55**	.09	.25*	.25*	-.08	.08	.12
3. Approach Sexual Goals	.31**	.31**	.14	.03	.12	.28**	.20*
4. Avoidance Sexual Goals	.01	.16	.14	.14	-.08	-.14	.34**
5. Sexual Desire	.14	.04	.04	-.05	-.64**	.17	-.24*
6. Sexual Satisfaction	.10	-.01	.07	.00	.21*	.42**	-.35**
7. Sexual Distress	-.05	.18	.14	.06	-.12	-.63**	.08

376 *Note.* Correlations are among all study variables. Women's correlations are above the diagonal;
 377 partner's correlations are below the diagonal; bolded correlations are between women and
 378 partner reports.

379 * $p < .05$. ** $p < .01$.

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383 Results

384 Associations between sexual communal motivation and sexual well- 385 being

386 First, we tested associations between women with FSIAD and their partner's sexual
 387 communal motivation (SCS and USC) and both partners' sexual well-being (i.e., sexual desire,
 388 sexual satisfaction, sexual distress). Consistent with predictions and reported in Table 3, when

389 women with FSIAD reported higher SCS, they reported higher sexual desire for their partner (p
390 = .042), and when partners reported higher SCS, partners also reported higher sexual desire ($p =$
391 .003). However, there were no significant associations between USC and sexual desire. In
392 addition, and as predicted, when women with FSIAD reported higher SCS, both women ($p =$
393 .001) and their partners reported greater sexual satisfaction ($p = .01$; see Table 3). Contrary to
394 predictions, when partners reported higher SCS, neither women with FSIAD nor their partners
395 reported feeling more sexually satisfied. When women with FSIAD or their partners reported
396 higher USC, there were no significant associations with sexual satisfaction.

397 Table 3. *Associations Between Sexual Communal Strength and Unmitigated Sexual Communion and Sexual Well-Being.*

	W's sexual desire		P's sexual desire		W's sexual satisfaction		P's sexual satisfaction		W's sexual distress		P's sexual distress	
	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>
W's SCS	3.73 (1.81)	2.06*	2.13 (1.59)	1.34	3.68 (1.08)	3.41***	3.29 (1.25)	2.64**	1.61 (2.01)	.80	-2.99 (2.15)	-1.39
P's SCS	-3.95 (2.11)	-1.87	5.63 (1.85)	3.04*	2.05 (1.25)	1.63	2.72 (1.45)	1.87	.45 (2.34)	.19	-5.33 (2.47)	-2.16*
W's USC	-.11 (1.51)	-.07	-2.07 (1.32)	-1.57	-1.17 (.89)	-1.31	.11 (1.03)	.11	.02 (1.67)	.02	-.11 (1.82)	-.06
P's USC	-.42 (1.60)	-.26	1.75 (1.40)	1.25	-.90 (.95)	-.95	-1.20 (1.10)	-1.09	2.91 (1.77)	1.64	5.08 (1.89)	2.69**

398 Note. W = women; P = partner; SE = standard error; SCS = sexual communal strength; USC = unmitigated sexual communion.

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

400 We also tested sexual distress, a negative indicator of sexual well-being. When partners
401 reported higher SCS, they reported lower sexual distress ($p = .034$), but when partners reported
402 higher USC, they reported higher sexual distress ($p = .009$). However, there were no associations
403 between partner's sexual communal motivation and women's sexual distress or between
404 women's sexual communal motivation and their own or their partner's sexual distress.

405 Table 4. *Associations Between Sexual Communal Strength and Unmitigated Sexual Communion and Sexual Goals*

Predictors	W's approach sexual goals		P's approach sexual goals		W's avoidance sexual goals		P's avoidance sexual goals	
	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>	<i>b</i> (SE)	<i>t</i>
W's SCS	.71 (.24)	2.91**	.33 (.16)	2.11*	-.04 (.31)	-.14	-.26 (.35)	-.77
P's SCS	-.00 (.28)	-.01	.37 (.18)	2.01*	.43 (.36)	1.20	-.42 (.40)	-1.05
W's USC	.04 (.20)	.18	-.25 (.13)	-1.89	.45 (.26)	1.75	.20 (.29)	.71
P's USC	-.07 (.21)	-.34	.26 (.14)	1.86	-.02 (.27)	-.07	.54 (.30)	1.79

406 *Note.* W = women; P = partner; SE = standard error; SCS = sexual communal strength; USC = unmitigated sexual communion.407 * $p < .05$. ** $p < .01$. *** $p < .001$.

408 **Associations between sexual communal motivation and sexual goals**

409 Next, we tested associations between women with FSIAD and their partner's sexual
410 communal motivation (SCS and USC) and both partners' sexual goals. When women with
411 FSIAD reported higher SCS, both they ($p = .005$) and their partners ($p = .037$) reported having
412 sex more for approach goals (see Table 4). In addition, when partners reported higher SCS, they
413 reported having sex more for approach goals ($p = .047$), but there was no association with
414 women's approach goals. As expected, there were no significant associations between SCS and
415 avoidance sexual goals for either partner. There were also no significant associations between
416 USC and approach or avoidance sexual goals for either partner.

417 We also ran all analyses reported above with age and relationship duration controlled.
418 With two exception, all of the effects remain significant. The exceptions were that the
419 association between men's SCS and approach goals and the association between women with
420 FSIAD's SCS and desire become marginal when relationship duration is controlled ($p = .053$ and
421 0.066 , respectively).

422 **Correction for multiple tests**

423 Given the multiple tests conducted in this study, using a false discovery rate (FDR) of
424 15%, we applied the Benjamini, Krieger, and Yekutieli (BKY) adaptive linear step-up procedure
425 [52] to our findings. This method reduces risk of Type 1 error by using the p -value distribution to
426 calculate adjusted alphas for each significant test. Five of the above-reported associations
427 between sexual communal motivation and sexual well-being remained significant using this
428 procedure. Women's SCS remained positively associated with their own sexual satisfaction, their
429 own sexual approach goals, and their partner's sexual satisfaction. Partner's SCS remained
430 positively associated with their own sexual desire, and partner's USC remained positively

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431 associated with their own sexual distress. However, four effects were not retained when
432 controlling for an FDR of .15, meaning there is a greater likelihood of these being false positives
433 and they should be interpreted with caution. These effects include the associations between
434 women's SCS and their own desire and their partner's approach goals, and the association
435 between a partner's SCS and their own distress and sexual approach goals.

436 **Exploring differences by sexual intercourse frequency**

437 In the next set of analyses, we conducted exploratory tests of whether the associations
438 between sexual communal motivation and sexual well-being are moderated by sexual intercourse
439 frequency. Previous research has shown that women with FSIAD may avoid circumstances in
440 which sexual activity is likely to occur and engage in sexual avoidance behaviour with their
441 partner [7,40]. In fact, in the current sample, about a quarter (23.7%) of the couples did not
442 engage in sexual intercourse in the past four weeks. The average sexual intercourse frequency
443 was about once or twice in the past four weeks. Our measures of SCS and USC are focused on
444 meeting a partner's sexual needs, which might be more relevant when couples are engaging in
445 regular sexual activity. Therefore, in a series of exploratory analyses, we tested whether the
446 effects differed for couples who engage in more frequent intercourse compared to couples who
447 report infrequent intercourse. The multiple testing correction was not applied to the sexual
448 frequency moderations as these are exploratory analyses and the correction is meant for
449 predicted effects. Only one of the significant effects reported above was moderated by sexual
450 intercourse frequency; frequency of intercourse significantly moderated the association between
451 partners' SCS and their own approach sexual goals, $b = 0.33$, $SE = 0.16$, $t(87.09) = 2.11$, $p =$
452 $.038$, 95% CI (0.019, 0.65). Follow-up simple effects tested at ± 1 standard deviation revealed
453 that, for couples who reported more frequent intercourse, partners higher in SCS reported higher

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454 approach goals for sex, $b = 0.62$, $SE = 0.22$, $t(86.98) = 2.85$, $p = .005$, 95% CI (0.19, 1.05).
 455 However, when frequency of intercourse was low, there was no association between partners'
 456 SCS and their approach goals, $b = -0.05$, $SE = 0.26$, $t(87.39) = -0.17$, $p = .86$, 95% CI (-0.57,
 457 0.48). A number of additional moderations by sexual intercourse frequency emerged for effects
 458 that were not significant in the main analyses. Overall, these analyses revealed that additional
 459 associations between sexual communal motivation and sexual well-being and sexual goals are
 460 significant only for couples who engage in more frequent intercourse. Sexual intercourse
 461 frequency moderated the association between partners' SCS and their own sexual satisfaction (b
 462 $= 2.80$, $SE = 1.20$, $t(88.07) = 2.33$, $p = .022$, 95% CI (0.42, 5.18). As shown in Table 5, simple
 463 effects tests revealed that when couples report having more frequent intercourse, partners' SCS
 464 was associated with their own higher sexual satisfaction, but when sexual intercourse frequency
 465 was low, partners' SCS was not associated with their sexual satisfaction.

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469 Table 5. *Simple Effects of Sexual Communal Motivation on Own and Partner's Sexual*
 470 *Satisfaction (I.e., Actor and Partner Effects) at Low and High Levels of Sexual Intercourse*
 471 *Frequency*

	Own sexual satisfaction (i.e., actor effects)					
	<i>b</i>	<i>SE</i>	<i>t</i>	<i>df</i>	<i>p</i>	<i>95% CI</i>
Low sexual intercourse frequency						
P's SCS	-0.15	1.99	-0.07	88.48	0.941	-4.09, 3.80

P's USC	1.33	1.57	0.398	88.59	0.398	-1.79, 4.46
W's USC	0.76	1.16	0.66	88.24	0.514	-1.54, 3.05
High sexual intercourse frequency						
P's SCS	5.39*	1.65	3.27	87.70	0.002	2.11, 8.66
P's USC	-3.25*	1.33	-2.45	88.20	0.016	-5.88, -0.61
W's USC	-3.94*	1.43	-2.75	88.61	.007	-6.78, -1.10
Partner sexual satisfaction (i.e., partner effects)						
Low sexual intercourse frequency						
P's USC	-1.73	1.44	-1.20	88.62	.233	-4.60, 1.13
W's USC	1.69	1.31	1.29	88.18	.200	-0.91, 4.30
High sexual intercourse frequency						
W's USC	-3.43*	1.44	-2.39	88.36	.019	-6.29, -0.58

472 Note. W = women; P = partner; SE = standard error; SCS = sexual communal strength; USC =
473 unmitigated sexual communion. Partner = whichever person is the partner of the person reporting
474 USC. Low and high sexual intercourse frequency represent simple effects tests conducted at +/-
475 1 standard deviation of sexual intercourse frequency.

476 * $p < 0.05$.

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480 Sexual intercourse frequency also significantly moderated the association between
481 women's USC and their own, $b = -2.37$, $SE = 0.95$, $t(88.05) = -2.51$, $p = .014$, 95% CI (-4.25, -
482 0.49), and their partners' sexual satisfaction, $b = -2.59$, $SE = 0.95$, $t(88.34) = -2.73$, $p = .008$,
483 95% CI (-4.48, -0.70), and partners' USC and their own sexual satisfaction, $b = -2.32$, $SE = 1.02$,
484 $t(87.65) = -2.27$, $p = .026$, 95% CI (-4.35, -0.29). Simple effects tests revealed that, when couples
485 reported having more frequent intercourse, women's higher USC was associated with their own
486 lower sexual satisfaction as well as their partner's lower sexual satisfaction (see Table 5). When
487 couples reported having more frequent intercourse, partner's USC was associated with their own
488 lower sexual satisfaction (see Table 5). However, when couples reported having less frequent
489 intercourse, women's USC was not associated with their own sexual satisfaction or their
490 partner's sexual satisfaction (see Table 5). When couples reported having less frequent
491 intercourse, partner's USC was also not associated with their own sexual satisfaction (see Table
492 5) or women with FSIAD's sexual satisfaction (see Table 5). In sum, when couples reported
493 having more (but not less) frequent intercourse, women's higher USC was associated with both
494 partners' lower sexual satisfaction, and partner's higher USC was associated with their own
495 lower sexual satisfaction.

496 Given that the question about sexual frequency was limited to intercourse (and was not
497 inclusive of all sexual activity) and may be interpreted differently based on gender and sexual
498 orientation, we re-ran all moderations by sexual intercourse frequency with only the mixed-sex
499 cis-gender couples. That is, we removed eight couples where partners identified as a woman or a
500 trans person or either partner selected 'other' for their gender. In the remaining sample of mixed-
501 sex cis-gender couples ($N = 89$), all of the significant moderations by sexual intercourse
502 frequency remained significant.

503 Discussion

504 The current research adds to a growing body of literature highlighting the role of
 505 interpersonal factors in how women and couples cope with a sexual dysfunction
 506 [10,20,32,34,39,53–56]. In the current study, we demonstrate that being communally motivated
 507 to meet a partner’s sexual needs was associated with greater sexual well-being in a sample of
 508 couples coping with FSIAD. When women coping with FSIAD were higher in SCS they
 509 reported having sex more for approach goals and both they and their partner report higher sexual
 510 satisfaction. Partners who were higher in SCS also reported higher sexual desire and sexual
 511 satisfaction (although the association between partner’s higher SCS and their own sexual
 512 satisfaction was only retained for couples who engaged in more frequent intercourse). We also
 513 found preliminary evidence that when women with FSIAD report higher SCS, they also report
 514 higher sexual desire and their partner report higher approach sexual goals, and when partners
 515 reported higher in SCS, they report lower distress and higher approach goals. However, although
 516 consistent with theory and prior research with community samples [16] and other populations of
 517 couples coping with sexual problems [20,37], these effects were not retained with the multiple
 518 comparison correction, suggesting that there is a greater chance of these effects being false
 519 positives and more evidence is needed.

520 When the motivation to meet a partner’s sexual needs is to the exclusion of a person’s
 521 own needs—higher USC—women and partners no longer reported greater sexual well-being,
 522 and in some cases, USC was associated with poorer well-being, particularly among couples
 523 reporting more frequent intercourse. That is, when partners of women with FSIAD reported
 524 higher USC they reported higher sexual distress. And, for couples who reported engaging in
 525 more frequent intercourse (approximately once a week or more), when women were higher in

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531 USC, both women and partners reported lower sexual satisfaction, and when partners were
 532 higher in USC, partners felt less sexually satisfied. Higher USC was not associated with lower
 533 sexual well-being for couples engaging in less frequent intercourse.

534 Overall, the effects found in the current study between SCS and sexual well-being were
 535 small to moderate. Although a woman's SCS was associated with her partner's sexual satisfaction
 536 and sexual approach goals, most of the significant effects are primarily actor (as opposed to
 537 partner) effects—that is, associations between a person's own sexual communal motivation and
 538 their own sexual well-being. In addition, when entered together as predictors, SCS is more
 539 strongly associated with sexual well-being than USC. After accounting for SCS, most of the
 540 associations between USC and sexual well-being were not significant.

541 **Sexual communal strength**

542 The current findings are consistent with past research on the positive associations of SCS
 543 with sexual well-being for both community [19,21] and clinical [20,37] samples of couples. Past
 544 research has found that people higher in SCS are more likely to maintain desire over time, even
 545 in a sample of long-term couples where desire tends to decline [16]. In past work with
 546 community couples, when a person's own desire was lower than their partner's desire, people
 547 higher in SCS tended to focus more on the benefits of having sex for their partner and their
 548 relationship and less on the costs of engaging in sex, and in turn, they were more likely to engage
 549 in sex in these situations and both partners report greater sexual satisfaction as a result [18]. It is
 550 possible that, even though couples in the current sample are coping with low desire, SCS helps
 551 them focus on the positive aspects of sex (e.g., intimacy, physical pleasure for self and
 552 partner)—as is encouraged in psychosocial treatments of low sexual desire [57]—and, in turn,
 553 they may be more open to sexual activity. In the current sample, when partners of women coping

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557 with FSIAD were higher in SCS, they also reported higher sexual desire, which is consistent
 558 with finding in community samples of long-term couples [16,31], and suggests that being
 559 motivated to meet a partner's sexual needs is also linked to one's own sexual well-being. In the
 560 current sample, women coping with FSIAD who reported higher SCS also reported higher sexual
 561 desire, although this finding was not retained with a multiple comparison correction.

562 We found that SCS was associated with feeling more sexually satisfied; when women
 563 with FSIAD were higher in SCS, both they and their partner reported higher sexual satisfaction.
 564 This finding is consistent with past research with community couples in which people higher in
 565 SCS were more likely to engage in sex when their desire was low (but their partner's desire was
 566 high), and both partners reported feeling more sexually satisfied [58]. In the current study, when
 567 couples coping with FSIAD had more (as opposed to less) frequent intercourse, partners' SCS
 568 was associated with them feeling more sexually satisfied. In previous research, the partners of
 569 individuals higher in SCS indicated that their partner was more responsive to their needs during
 570 sex, and perceptions of partner responsiveness was one main reason why they reported greater
 571 satisfaction [19]. Therefore, it is possible that women with FSIAD higher in SCS have partners
 572 who report greater sexual satisfaction because they perceive their FSIAD partner as more
 573 responsive. Future research is needed to test this possibility.

574 Consistent with previous research [16], when women with FSIAD were higher in SCS,
 575 they were more likely to engage in sex for approach goals, such as to enhance intimacy in their
 576 relationship. Previous work in community couples [16] has found that having stronger approach
 577 goals for sex is one reason why people higher in SCS report higher sexual desire. Therefore,
 578 having sex more for approach goals might be one path through which women with FSIAD who
 579 are high in SCS experience higher sexual desire. In our exploratory analysis, we found that when

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582 partners were higher in SCS, they were more likely to have sex for approach goals, but this was
583 only among couples who reported more frequent intercourse. Perhaps if sex is infrequent, higher
584 SCS does not translate into higher approach goals, or perhaps measures of sexual motivation are
585 more difficult to complete when sexual frequency is low. There was no association between SCS
586 and avoidance goals, suggesting that when couples coping with FSIAD are communally
587 motivated to meet their partner's sexual needs, they do not do so to avoid negative consequences,
588 such as conflict or a partner's disappointment. Instead, it seems that SCS is associated with
589 women with FSIAD being more oriented towards the positive aspects of the sexual experience,
590 consistent with research with community couples [21]. For women coping with FSIAD, being
591 higher in SCS and having higher approach goals might mean adapting the couple's sexual
592 repertoire to accommodate the women with FSIAD's low interest/arousal (e.g., engaging in
593 activities that are more stimulating for the woman with FSIAD), which may be associated with
594 higher levels of desire and arousal. In fact, one model of women's sexual response patterns—the
595 intimacy-based circular model of women's sexual response [59]—proposes that emotional
596 intimacy can motivate a woman to be more open to a sexual encounter (i.e., she may be
597 motivated to engage in sex to experience emotional intimacy, akin to approach sexual goals), and
598 in turn, she experiences more sexual arousal and desire, and, ultimately, sexual satisfaction.

599 **Unmitigated sexual communion**

600 Although meeting a partner's sexual needs was linked to benefits for couples coping with
601 FSIAD, if the motivation to meet a partner's sexual needs was extreme and did not take into
602 account the person's own needs, couples did not report greater sexual well-being, and, at times,
603 USC was linked with lower sexual well-being. That is, when women were higher in USC, there
604 were no significant associations with their own or their partner's sexual well-being and when

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606 partners were higher in USC, partners reported more sexual distress. Similarly, in a daily
 607 experience study of couples coping with another female sexual dysfunction, on days when
 608 women were higher in USC, her partner did not report greater sexual well-being and instead
 609 reported being less satisfied with the relationship, and when partners were higher in USC, they
 610 reported poorer sexual function [including lower desire for sex; 20]. Previous research on
 611 unmitigated communion more broadly has also shown that although people higher in unmitigated
 612 communion are overly focused on meeting their partner's needs, they may be more concerned
 613 about being the one to provide care to their partners than whether or not their partner's needs are
 614 actually being met [26,34]. When partners of women with FSIAD are higher in USC, they might
 615 be focused on "fixing" the women's low desire without aiming to understand her true feelings
 616 and interests, resulting in more negative emotions surrounding the sexual relationship.
 617 Alternatively, it could be that partners higher in USC feel they are not meeting their partner's
 618 sexual needs (since she has low desire) and this experience is distressing.

619 In an exploratory analysis, we found that some associations between USC and sexual
 620 well-being were only significant for couples who reported engaging in more frequent sexual
 621 intercourse. That is, among couples who report more (compared to less) frequent intercourse,
 622 women's higher USC was associated with their own and their partner's lower sexual satisfaction.
 623 In research on general unmitigated communion, whereas people lower in unmitigated
 624 communion reported higher well-being when providing support to their partners, people higher
 625 in unmitigated communion did not experience greater well-being during support provision [60].
 626 Findings such as these suggest that unmitigated communion is not associated with greater
 627 personal well-being when providing care to close others. People higher in unmitigated
 628 communion often have trouble asserting their own needs, which is related to lower well-being

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631 [26,35]. Therefore, women with FSIAD who are higher in USC may have trouble
 632 communicating their sexual needs to their partners and may resign to engage in sex based on
 633 their partner's desires. When a woman with FSIAD is solely focused on meeting her partner's
 634 sexual needs, neglects her own needs, and acquiesces to having more frequent sex, this may
 635 negatively impact both partners. Previous research shows that pressure to conform to
 636 conventional feminine ideals—such as a willingness to have sex as well as being perceptive to
 637 and being able to satisfy a partner's sexual needs—are more pronounced in women who are
 638 coping with sexual problems [61]. Women with FSIAD higher in USC who have more frequent
 639 intercourse may be feeling pressure to focus on their partner's sexual needs while devaluing their
 640 own needs, which is associated with lower sexual satisfaction for both partners. In addition,
 641 consistent with past work in community samples [21], when partners were higher in USC, they
 642 also reported lower sexual satisfaction. These findings suggest that, for partners of women with
 643 FSIAD, engaging in sex is most consequential (and negatively associated with partners' sexual
 644 satisfaction) when they are higher in USC. Although partners higher in USC are solely focused
 645 on meeting their partner's needs, women with FSIAD do not report greater sexual well-being
 646 associated with this focus, and their partners report lower sexual satisfaction. Future research is
 647 needed to further explore these possibilities.

648 Finally, although there is some evidence that people higher in USC focus on negative
 649 cues during sex [21], in the current study, we did not find that people higher in USC had stronger
 650 avoidance sexual goals, such as having sex to avoid conflict or their partner's disappointment. In
 651 fact, USC was not significantly associated with approach or avoidance sexual goals. Since, in the
 652 current study, sexual goals were partner-focused, it is possible that people high in USC are more
 653 motivated to meet their partner's needs as a way to regulate their own anxiety (and not to pursue

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656 positive or avoid negative relational outcomes). People high in unmitigated communion
 657 generally aim to provide care to close others as a way to restore their own self-esteem [34], and it
 658 is possible that applied to sexuality, this means that their reasons for engaging in sex might be
 659 more focused on regulating their own emotions. Indeed, in one study, among women coping with
 660 coital pain, their reason for engaging in sex with their partner included to restore their own image
 661 of themselves as a “real woman” or good relationship partner and to mitigate their own feelings
 662 of guilt [61].

663 **Strengths and limitations**

664 The current study has several strengths. It established the importance of two novel
 665 interpersonal factors—SCS and USC—for the sexual well-being and sexual goals of couples
 666 coping with FSIAD and included the perspectives of both partners. Much of the previous
 667 research on women with clinically low desire has not included partners or considered a dyadic
 668 perspective [1,4,13,62], even though both partners are often included in psychotherapy for sexual
 669 dysfunctions, such as FSIAD [56,63]. To our knowledge, there are currently no empirically-
 670 supported couple-based treatment studies for FSIAD [56]; the lack of studies on interpersonal
 671 factors means that which factors to target in couples therapy have not been empirically based
 672 [63].

673 The current study also has limitations. The study is correlational and cannot confirm the
 674 causal direction of the effects. However, our theorized direction of effects is in line with theory
 675 and past research, including an experimental study in which enhancing people’s focus on their
 676 partner’s sexual needs (i.e., high sexual communal strength) led them to expect higher sexual and
 677 relationship satisfaction in an imagined situation of desire discrepancy with their partner

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683 [16,18,64]. Our study is also limited in that asking about sexual intercourse may not be relevant
684 for some couples and is not inclusive of all partnered sexual activity.

685 It is also possible that the associations are bidirectional in FSIAD, where sexual well-
686 being leads to SCS and USC. In addition, while we postulated about possible mechanisms, such
687 as focusing on positive aspects of sex as mediating links between SCS and higher sexual desire
688 and satisfaction, given the cross-sectional nature of our data, we did not test these mechanisms in
689 the current research. Future longitudinal research following couples coping with FSIAD over
690 time could help clarify the direction and mechanisms of the effects and test whether sexual
691 communal motivation is linked to changes in sexual well-being and goals over time. Finally, the
692 internal consistency of the measures of SCS and USC—while acceptable—were lower for
693 partners than women with FSIAD. It is possible that it is more difficult to complete or interpret
694 measures about meeting your partner’s sexual needs or that meeting a partner’s sexual needs has
695 a different meaning when your partner has FSIAD. For example, one of the items on the SCS
696 measure asks, “How high a priority for you is meeting the sexual needs of your partner?” For
697 people with a partner who has FSIAD, it might be a high priority for them to be able to meet
698 their partner’s sexual needs, but since their partner’s need might be to *not* engage in sex or their
699 partner may express fewer sexual needs, this question might have a different meaning. Thus,
700 future work might consider assessing the motivation to meet a partner’s sexual needs when their
701 partner’s need is to *not* engage in sex, as has been assessed in couples transitioning to parenthood
702 [24]. In samples of couples coping with a sexual dysfunction, it might be more important to
703 examine how a person responds to the affected women’s disinterest in sex as opposed to their
704 sexual needs.

705 **Conclusions**

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707 In sum, our results suggest that when couples coping with FSIAD report higher SCS, they
708 also experience greater sexual satisfaction and desire and have intercourse more for approach
709 goals, but when sexual communal motivation is not mitigated by the person's own agency (high
710 unmitigated sexual communion), this is not associated with greater sexual well-being and instead
711 is associated with higher sexual distress and lower sexual satisfaction (findings for sexual
712 satisfaction were only for couples who engaged in more frequent intercourse). The results
713 suggest that promoting SCS, while maintaining a focus on one's own needs, might be a target for
714 improving the sexual well-being of couples with FSIAD. The findings of the present study
715 contribute to an emerging body of research on sexual dysfunction and sexual motivation [65],
716 and point to novel interpersonal variables that could inform the development of empirically
717 based interventions for couples coping with FSIAD.

718 **Supporting Information**

719 **S1 File. All questionnaires and information on sexual communal motivation measures.**

720

721 **Acknowledgments**

722 We thank Justin Dubé, Serena Corsini-Munt, Kathy Petite, Megan Muise, and Emily
723 Coté for their assistance as well as the couples who participated in this research.

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