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Comparing the Effectiveness of a Sexual Intelligence Educational–Counseling Package and Johnson's Emotionally Focused Therapy on Sexual Relationships Among Women Experiencing Marital Conflict

Zahra. Jalali Asil[1], Seyed Hamid. Atashpour[2*], Hadi. Farhadi[2]

[1] Department of Counceling, Isf.C., Islamic Azad University, Isfahan, Iran
[2] Department of Psychology, Isf.C., Islamic Azad University, Isfahan, Iran

*** Corresponding author email address**: hamid.atashpour@iau.ac.ir

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A B S T R A C T

Objective: Marital conflict can reduce emotional intimacy and the quality of sexual relationships. The present study aimed to compare the effectiveness of a sexual intelligence educational–counseling package and Johnson's Emotionally Focused Therapy (EFT) in improving sexual relationships among women experiencing marital conflict.

Methods and Materials: This study employed a quasi-experimental three-group pretest–posttest design with a two-month follow-up. A total of 54 married women experiencing marital conflict who sought services at counseling centers in Shahrekord were selected using convenience sampling and randomly assigned to three groups: sexual intelligence education–counseling, Johnson's Emotionally Focused Therapy, and control (18 participants per group). The two intervention groups received 10 weekly two-hour intervention sessions, whereas the control group received no intervention. Data were collected using the Sexual Relations subscale of the Hurlbert Index of Sexual Assertiveness (HISA; Hurlbert, 1992) and analyzed using repeated-measures analysis of variance (ANOVA) and the Bonferroni post hoc test in SPSS version 23.

Findings: The results of the repeated-measures ANOVA indicated that the main effect of time ($p < .001$), the time × group interaction effect ($p = .048$), and the between-group effect ($p = .041$) were statistically significant for sexual relationships. The Bonferroni post hoc test further showed that a statistically significant difference existed only between the sexual intelligence education–counseling group and the control group. In contrast, the difference between the Emotionally Focused Therapy group and the control group, as well as the difference between the two intervention groups, was not statistically significant ($p > .05$).

Conclusion: The sexual intelligence educational–counseling package significantly improved sexual relationships among women experiencing marital conflict, whereas Johnson's Emotionally Focused Therapy did not produce a statistically significant effect. The implementation of the sexual intelligence educational–counseling package in family counseling centers is recommended as an intervention for improving the quality of couples' sexual relationships.

Keywords: *sexual intelligence, Johnson's Emotionally Focused Therapy, sexual relationship, marital conflict, married women.*

1. Introduction

Marital relationships constitute one of the most important interpersonal contexts in adult life and are closely associated with psychological well-being, emotional security, life satisfaction, and sexual health. The quality of marital functioning is shaped by a complex interaction of emotional, cognitive, behavioral, interpersonal, and sexual factors, and disturbances in any of these domains may gradually contribute to relational dissatisfaction and persistent marital conflict. Relationship satisfaction is not a static construct but rather an outcome that may either be maintained or decline over time depending on the quality of communication, emotional responsiveness, conflict management, attachment security, intimacy, and the extent to which partners are able to address each other's relational and sexual needs (Righetti et al., 2022). Contemporary research has further emphasized that sexual functioning and sexual satisfaction are not peripheral aspects of marital life; instead, they represent central dimensions of overall relationship quality and may influence the durability, stability, and psychological health of intimate partnerships (Sharma & Saxena, 2025; Zarif et al., 2025). Accordingly, sexual difficulties in the context of marital conflict should be understood as both an outcome of relational distress and a factor capable of intensifying emotional distance and dissatisfaction between partners.

Marital conflict refers to recurrent disagreements, negative interaction patterns, emotional tension, and unresolved incompatibilities between spouses that interfere with effective relational functioning. Such conflicts may involve communication problems, financial disagreements, family boundaries, emotional disengagement, diminished cooperation, and sexual dissatisfaction. When conflict becomes chronic, spouses may increasingly experience frustration, resentment, emotional withdrawal, and reduced intimacy. Evidence indicates that marital conflict is closely associated with emotional divorce and that intimacy can play a substantial mediating role in the relationship between persistent conflict and emotional separation between spouses (Nikogoftar, 2021). From this perspective, one of the most clinically significant consequences of unresolved marital conflict is the deterioration of emotional and sexual intimacy. Sexual interactions may become less frequent, less satisfying, more conflict-laden, or increasingly disconnected from emotional closeness. Consistent with this interpretation, research among women has demonstrated a meaningful association between sexual satisfaction and marital conflict, suggesting that greater sexual dissatisfaction tends to coexist with more severe marital difficulties (Razeghi et al., 2020). Therefore, interventions designed for women experiencing marital conflict need to address not only overt disagreements but also the sexual, emotional, and cognitive processes that sustain relational distress.

Sexual relationships within marriage are multidimensional and cannot be reduced solely to the frequency of intercourse or physiological sexual functioning. Healthy sexual relationships depend on a combination of mutual desire, safety, communication, consent, assertiveness, emotional intimacy, responsiveness, realistic expectations, sexual self-knowledge, and the capacity to negotiate differences in preferences and needs. Sexual satisfaction is particularly dependent on the quality of interpersonal exchanges that occur before, during, and outside sexual activity. A meta-analysis examining couples' sexual communication showed that dimensions of sexual communication are systematically related to both sexual satisfaction and overall relationship satisfaction, underscoring the role of open, responsive, and constructive communication in the sexual domain (Mallory, 2022). Similarly, the development of sexual assertiveness has been recognized as an important psychological process through which individuals communicate sexual preferences, establish boundaries, express desires, and protect personal autonomy within intimate relationships (López Alvarado et al., 2020). When individuals lack such competencies, sexual interactions may become characterized by avoidance, misunderstanding, unexpressed needs, or compliance rather than mutual engagement, all of which may contribute to dissatisfaction and marital strain.

Sexual functioning is also closely intertwined with emotional processes. Emotional responses such as anxiety, shame, anger, fear of rejection, resentment, and emotional withdrawal can substantially influence sexual desire, arousal, engagement, and satisfaction. A broad review of the literature on emotion regulation and sexuality showed that difficulties in regulating emotions are associated with impaired sexual function and reduced sexual satisfaction, whereas more adaptive emotion-regulation capacities may facilitate healthier and more satisfying sexual experiences (Fischer et al., 2022). These findings are particularly relevant to women experiencing marital conflict because repeated negative interactions with a spouse may activate intense emotional responses that subsequently interfere with sexual closeness. Moreover, the ability to recognize,

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

understand, and appropriately manage emotions appears to be associated with sexual well-being. Research among university students has demonstrated significant relationships between emotional intelligence and sexual satisfaction, suggesting that individuals with greater emotional awareness and regulatory capacity may be better able to navigate interpersonal and sexual experiences (Özbay & Balaban, 2024). Related evidence has also linked emotional intelligence and sexual self-efficacy with broader indicators of subjective well-being in intimate and developmental contexts (Thomas et al., 2024).

The concept of sexual intelligence provides a potentially useful framework for integrating many of these cognitive, emotional, communicative, and interpersonal capacities. Sexual intelligence can be conceptualized as an individual's ability to develop accurate self-knowledge regarding sexuality, recognize and communicate sexual needs, understand the emotional and relational meaning of sexual behavior, evaluate sexual beliefs and expectations, respect personal and interpersonal boundaries, and make adaptive decisions that promote sexual health and relational well-being. Recent work on the measurement of sexual intelligence has emphasized its relevance for the evaluation of sexual health and has supported the view that sexual intelligence represents a meaningful psychological construct rather than merely a collection of isolated sexual skills (Husain et al., 2024). Sexual intelligence therefore extends beyond sexual knowledge in the narrow educational sense. It encompasses the capacity to understand one's sexual self, critically evaluate learned cultural or familial beliefs, communicate effectively with a partner, regulate emotions in sexual contexts, and adapt sexual behavior in ways that are consistent with mutual satisfaction and relational values.

The relevance of sexual intelligence becomes especially apparent when sexual problems occur in the context of marital conflict. Women may enter marriage with sexual schemas, beliefs, expectations, and communication patterns shaped by family socialization, cultural norms, media exposure, previous experiences, and limited access to accurate sexual education. Maladaptive beliefs may contribute to shame, avoidance, inability to communicate preferences, difficulties in establishing sexual boundaries, or rigid expectations regarding sexual roles. In this context, education directed toward sexual intelligence may help women identify and modify inaccurate beliefs, improve sexual self-awareness, strengthen emotional and communicative skills, and develop healthier responses to sexual disagreements. Previous intervention research has provided support for this approach. Sexual intelligence training has been shown to improve marital intimacy, suggesting that developing sexual self-awareness and relational sexual competencies may positively influence broader dimensions of marital closeness (Jalali Asil et al., 2017). Moreover, sexual intelligence-based education has been associated with improvements in sexual function and marital adjustment, indicating that interventions targeting sexual intelligence may influence both specifically sexual outcomes and general marital functioning (Salmanpour et al., 2022).

More recent research has provided additional evidence regarding the application of sexual intelligence interventions among individuals experiencing marital difficulties. A specialized sexual intelligence counseling–training package designed for women with marital conflict has been reported to improve sexual assertiveness, sexual self-concept, and interpersonal circumplex marital problems (Jalali Asil et al., 2026). These findings suggest that a structured intervention focused on sexual intelligence may influence several psychological mechanisms that are directly relevant to the quality of sexual relationships. Sexual assertiveness may facilitate clearer expression of desires and limits, sexual self-concept may influence confidence and comfort in intimate interactions, and improvement in interpersonal marital problems may reduce relational barriers to satisfying sexual engagement. Such results also support the possibility that sexual intelligence interventions may be particularly useful for women whose sexual difficulties are embedded within broader patterns of marital conflict rather than arising solely from biological or medical causes.

The importance of integrating sexuality with broader relational functioning is further supported by studies examining the connections among emotional intelligence, love styles, conflict, and sexual satisfaction. A latent profile analysis demonstrated that relationship love styles may be associated with different patterns of conflict, emotional intelligence, and sexual satisfaction, highlighting the heterogeneity of intimate relationships and the need to consider relational and emotional processes together rather than in isolation (Castillo-López et al., 2025). Likewise, sexual satisfaction is meaningfully embedded in couples' overall relational functioning, including self-esteem and marital satisfaction (Zarif et al., 2025). Sexual satisfaction may also function as a psychological mechanism linking other forms of marital distress to communication-related processes. For example, sexual satisfaction has been identified as a mediator in the relationship between marital

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

burnout and communication beliefs among married women, suggesting that deterioration in the sexual relationship may serve as an important pathway through which broader marital strain is expressed and maintained (Najafi et al., 2026). These findings reinforce the clinical value of interventions that directly address sexual functioning when working with marital conflict.

Another relevant framework for understanding sexual relationship quality is the developmental model of marital competence. According to this perspective, adaptive relationship functioning depends on competencies such as constructive conflict resolution, forgiveness, secure attachment, and effective interpersonal regulation. Empirical evidence indicates that these relational competencies are associated with sexual satisfaction, suggesting that satisfying sexuality often emerges within a broader context of emotional security and competent dyadic functioning (Allsop et al., 2021). Thus, improving sexual relationships may require more than sexual education alone. It may also require interventions that modify emotional and attachment-based patterns operating within the couple relationship. This perspective is especially relevant for couples in which sexual dissatisfaction is maintained by negative emotional cycles, fear of rejection, attachment insecurity, withdrawal, or persistent conflict.

Emotionally Focused Therapy, developed primarily by Sue Johnson and colleagues, is one of the most prominent attachment-based approaches to couple intervention. Emotionally Focused Therapy conceptualizes relational distress as being maintained by rigid negative interactional cycles that are organized around unmet attachment needs and maladaptive emotional responses. Rather than focusing primarily on communication techniques or cognitive restructuring, the therapy seeks to help individuals access primary emotions, recognize attachment-related vulnerabilities, express needs more directly, and restructure interactions so that partners become more emotionally accessible, responsive, and engaged. By transforming negative interaction cycles and strengthening attachment security, Emotionally Focused Therapy is expected to improve emotional closeness and, indirectly, sexual intimacy. Research comparing Emotionally Focused Couple Therapy with other therapeutic approaches has shown beneficial effects on marital conflict and emotion regulation, providing support for its use in distressed relationships (Ghahari et al., 2021).

The potential influence of Emotionally Focused Therapy on sexual relationships is theoretically compelling because sexual intimacy and attachment security are closely interconnected. Individuals who experience their partner as emotionally available and responsive may be more willing to express sexual needs, tolerate vulnerability, and engage in mutually satisfying intimacy. Conversely, attachment insecurity, emotional disconnection, and repeated experiences of rejection may contribute to avoidance or dissatisfaction in sexual interactions. Longitudinal evidence has shown that attachment changes occurring during Emotionally Focused Couple Therapy are associated with sexual satisfaction outcomes and that improvements may remain observable over extended follow-up periods (Wiebe et al., 2019). Other research has similarly reported the effectiveness of emotionally focused couple therapy in relation to attachment style and sexual satisfaction among couples (Niknam, 2019). These findings indicate that attachment-focused interventions may improve sexual functioning by modifying the emotional architecture of the couple relationship rather than targeting sexuality directly.

Nevertheless, the mechanisms of change in sexual intelligence interventions and Emotionally Focused Therapy are fundamentally different. Sexual intelligence-based interventions directly address sexual knowledge, self-awareness, beliefs, schemas, communication, assertiveness, emotional management in sexual contexts, and the construction of realistic and mutually satisfying sexual goals. In contrast, Emotionally Focused Therapy primarily targets attachment needs, primary emotions, negative interaction cycles, emotional accessibility, and relational responsiveness. Consequently, although both approaches may theoretically improve sexual relationships, they may do so through distinct pathways. A sexual intelligence intervention may have a more direct effect on sexual communication and behavior, whereas Emotionally Focused Therapy may influence sexuality indirectly through enhanced emotional security and relational intimacy. Direct empirical comparisons between these approaches therefore have substantial theoretical and clinical value.

The need for such comparisons is reinforced by evidence showing that relationship satisfaction and sexual behavior are shaped by a wide range of contextual and psychosocial influences. Studies among young adults have demonstrated meaningful associations between sexual behavior and relationship satisfaction, emphasizing that sexual experiences need to be interpreted in relation to the overall quality of the intimate relationship (Sharma & Saxena, 2025). Research examining sociosexuality and infidelity-related intentions similarly indicates that sexual attitudes and

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

relationship satisfaction interact with individual and gender-related factors in complex ways (Pricope et al., 2026). Even among clinical populations facing major health challenges, family and sexual life remain important components of psychosocial adjustment and life satisfaction, illustrating the broader significance of intimate and sexual functioning for psychological quality of life (Stańska et al., 2026). These findings collectively demonstrate that sexual well-being has relevance across developmental stages and life circumstances and should be treated as an integral component of relational and psychological health.

At the same time, contemporary psychological interventions increasingly need to account for the changing social and informational environments in which individuals develop beliefs about intimacy and sexuality. The expansion of technology-mediated education, digital learning environments, and artificial intelligence has created new possibilities for disseminating information, facilitating learning, and supporting psychological education (Shahbazi Koohi et al., 2024). Although technology itself does not replace therapeutic relationships or structured psychological interventions, the broader movement toward accessible and individualized learning underscores the importance of evidence-based educational packages that can provide systematic, understandable, and clinically relevant skills. In the field of sexual health, structured educational–counseling programs may be especially valuable when inaccurate information, sociocultural inhibition, or insufficient sexual self-knowledge contributes to marital distress.

Taken together, the available evidence suggests that marital conflict, sexual dissatisfaction, emotional dysregulation, attachment insecurity, poor sexual communication, and maladaptive sexual beliefs are closely interconnected. Existing studies support the role of sexual intelligence in sexual health and marital adjustment (Husain et al., 2024; Salmanpour et al., 2022), the importance of sexual assertiveness and communication in healthy sexuality (López Alvarado et al., 2020; Mallory, 2022), and the contribution of emotional and attachment processes to sexual satisfaction (Fischer et al., 2022; Wiebe et al., 2019). Research also indicates that relationship satisfaction is sustained by adaptive relational competencies and may deteriorate when negative interaction patterns become entrenched (Allsop et al., 2021; Righetti et al., 2022). Although both sexual intelligence-based interventions and Emotionally Focused Therapy appear theoretically and empirically relevant to women experiencing marital conflict, relatively limited evidence is available regarding their comparative effectiveness specifically for improving sexual relationships. Establishing whether a targeted sexual intelligence educational–counseling package offers advantages over an established attachment- and emotion-focused treatment could contribute to more precise treatment selection and more effective intervention planning in family and marital counseling settings.

Therefore, the present study aimed to compare the effectiveness of a sexual intelligence educational–counseling package and Johnson's Emotionally Focused Therapy in improving sexual relationships among women experiencing marital conflict.

2. Methods and Materials

2.1. Study design and Participant

The present study employed a quasi-experimental design with three parallel groups, including two intervention groups and one control group, and assessments conducted at pretest, posttest, and a two-month follow-up. The statistical population consisted of all married women who attended counseling centers in Shahrekord and reported experiencing marital conflict. The required sample size was estimated using Cohen's sample size criteria, assuming a medium effect size of .05, a statistical power of .75, and a significance level of .05. Based on these parameters, 18 participants were required for each group. Accordingly, a total of 54 eligible married women were enrolled in the study. Following approval of the research protocol by the relevant ethics committee under the ethical approval code IR.IAU.KHUISF.REC.1400.353, participants were recruited through convenience sampling. Women who met the eligibility criteria were subsequently allocated through simple randomization, using a random-number table, to one of three groups: the sexual intelligence educational–counseling group (n = 18), Johnson's Emotionally Focused Therapy group (n = 18), or the control group (n = 18). During the screening phase, all potential participants completed the Sanaei Marital Conflict Questionnaire, and women who obtained a total score greater than 126 were considered eligible for participation. At the pretest stage, all participants also completed the Hurlbert Index of Sexual Assertiveness (HISA), with the items corresponding to the Sexual Relations subscale used to assess the primary outcome variable.

The inclusion criteria were voluntary willingness to participate in the study, being in a permanent marital relationship, being between 20 and 40 years of age, having

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

been married for at least five years, obtaining a score above 126 on the Sanaei Marital Conflict Questionnaire, not having reached menopause, having no acute or chronic psychiatric disorder as confirmed by a psychiatrist or clinical psychologist, and having no physical illness that could substantially affect sexual functioning or interfere with attendance at the intervention sessions. Additional inclusion criteria were not concurrently receiving psychological or psychotherapeutic interventions, not undergoing medical treatment specifically related to sexual problems, and not using medications known to affect sexual functioning, including psychiatric medications and medications used for the management of hypertension or diabetes. The exclusion criteria consisted of withdrawal of consent or unwillingness to continue participation, absence from more than two intervention sessions, failure to complete assigned therapeutic homework, or the emergence of any condition that made continued participation in the study impossible. Following the pretest assessment, the first intervention group received the sexual intelligence educational–counseling package developed specifically for women experiencing marital conflict, while the second intervention group received Johnson's Emotionally Focused Therapy. Both interventions consisted of 10 weekly sessions, each lasting approximately two hours. The control group received no psychological intervention during the study period. Immediately after completion of the interventions, all three groups completed the posttest assessment, and the same assessments were administered again two months later during the follow-up phase. At both posttest and follow-up, the Sexual Relations subscale of the HISA, comprising Items 7, 10, 13–20, and 22–24, was administered to assess changes in the participants' sexual relationships over time.

2.2. Measures

The primary outcome variable, sexual relationship quality, was assessed using the Sexual Relations subscale of the Hurlbert Index of Sexual Assertiveness (HISA), developed by Hurlbert (1992). The original HISA consists of 25 items and assesses two broad dimensions: expression of sexual emotions and feelings and sexual relations. Given the specific objectives of the present study, only the Sexual Relations subscale was used in the statistical analyses. This subscale comprises Items 7, 10, 13–20, and 22–24. Items are rated on a five-point Likert-type scale ranging from "always" to "never," with Items 13, 14, and 20 reverse-scored. Higher scores on this subscale indicate a more favorable status with respect to sexual relationships and greater adaptive functioning in the sexual domain. Although participants completed the full questionnaire, only scores pertaining to the Sexual Relations subscale were extracted and analyzed in the present study. Hurlbert (1992) reported a test–retest reliability coefficient of .86 and a Cronbach's alpha coefficient of .89 for the original instrument, indicating satisfactory temporal stability and internal consistency. The Persian version of the instrument has also demonstrated satisfactory psychometric properties, with a Cronbach's alpha coefficient of .80 reported in an Iranian validation study. In the present sample, the internal consistency of the Sexual Relations subscale was also evaluated using Cronbach's alpha and was found to be acceptable, indicating adequate reliability for assessing sexual relationship functioning among the participating women.

Marital conflict was assessed using the Sanaei Marital Conflict Questionnaire, developed in 2000. This 42-item self-report instrument is designed to assess the severity and multidimensional nature of conflict within marital relationships. It measures seven dimensions of marital conflict, including decreased cooperation between spouses, decreased sexual relations, increased emotional reactions, increased attempts to recruit children's support during marital disagreements, increased individual relationships with one's own relatives, decreased family relationships with the spouse's relatives and friends, and separation of financial affairs. Each item is scored on a five-point Likert-type scale ranging from 1 to 5, resulting in a possible total score ranging from 42 to 210. The maximum score for each subscale is determined by multiplying the number of items in that subscale by five. Higher total and subscale scores represent greater marital conflict, whereas lower scores indicate a more favorable marital relationship. During the instrument-development process, the original 55-item pool underwent item analysis, and 13 items were removed based on their correlations with the total questionnaire and corresponding subscales, resulting in the final 42-item version. The questionnaire has been reported to possess satisfactory content validity. In a subsequent psychometric evaluation conducted by Dehghan (2001) with a sample of 30 participants, the Cronbach's alpha coefficient for the total scale was .71. Reliability coefficients for the seven dimensions were reported as .73 for decreased cooperation, .60 for decreased sexual relations, .74 for increased emotional reactions, .81 for increased recruitment of children's support, .65 for increased relationships with one's

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

own relatives, .81 for decreased family relationships with the spouse's relatives and friends, and .69 for separation of financial affairs. Other evaluations have likewise supported the overall internal consistency of the questionnaire. In the present study, the instrument was used during the screening phase, and a total score greater than 126 was considered indicative of a sufficient level of marital conflict for inclusion in the study.

2.3. Interventions

The sexual intelligence educational–counseling intervention was administered over 10 weekly two-hour sessions and was specifically designed to improve sexual awareness, adaptive sexual beliefs, emotional competence, communication, and relationship functioning among women experiencing marital conflict. The first session focused on welcoming participants, introducing the counselor, establishing a psychologically safe and confidential therapeutic environment, facilitating familiarity among group members, explaining the overall structure and rules of the sessions, introducing the concept of sexual intelligence, and assigning initial homework. The second session reviewed the previous homework and emphasized identifying sexual needs, preferences, boundaries, and beliefs, increasing sexual self-awareness, and examining patterns of sexual learning derived from family, media, and broader sociocultural influences. The third session focused on correcting inaccurate or dysfunctional beliefs regarding sexuality and introducing the principles of healthy and mutually satisfying sexual relationships. The fourth session addressed the identification and modification of negative sexual schemas and maladaptive cognitive patterns related to sexuality. The fifth session emphasized strengthening skills for managing emotions and sexual behaviors, improving relationship quality, and resolving sexual conflicts constructively. In the sixth session, participants explored the distinction between sexual activity and sexual intimacy and learned strategies for developing warm, meaningful sexual relationships grounded in emotional closeness. The seventh session focused on sexual communication skills tailored to the unique characteristics of each intimate relationship, respecting interpersonal differences, managing sexual disagreements without damaging the relationship, and applying problem-solving skills based on a more adaptive understanding of the couple's relational dynamics. The eighth session examined the psychological, cultural, and spiritual dimensions of sexuality and encouraged participants to reconsider their individual and couple-level sexual goals and values. The ninth session involved developing a constructive mental representation of a healthy future sexual relationship, formulating plans for the continued development of sexual intelligence, and identifying realistic short- and long-term sexual and relational goals. The final session consisted of a comprehensive review of the intervention content, an introduction to mindfulness principles relevant to intimate and sexual functioning, questions and answers, final experiential exercises, group feedback, and provision of an individualized guide to facilitate continued practice and maintenance of acquired skills after the intervention.

Johnson's Emotionally Focused Therapy intervention was also delivered in 10 weekly two-hour sessions and was based on the principles of Emotionally Focused Therapy, with particular emphasis on attachment needs, emotional processing, and restructuring maladaptive interactional cycles. The first session focused on introductions, establishment of therapeutic rapport, initial assessment of the nature and severity of the presenting problems, exploration of participants' expectations and concerns, conceptualization of the relational problem, explanation of the treatment rationale and general therapeutic principles, and clarification of treatment rules. During the second session, assessment continued with particular attention to identifying negative interactional cycles, problematic patterns of couple interaction, attachment-related barriers, and overarching therapeutic goals; a therapeutic alliance and agreement regarding the treatment process were also consolidated. The third session focused on accessing salient attachment-related experiences, facilitating the acceptance of previously unacknowledged primary emotions, clarifying core emotional responses, and helping participants recognize and accept their role within recurring negative interactional cycles. The fourth session emphasized emotional expression, emotional acceptance, deeper engagement with emotional experience, and promotion of more adaptive modes of interpersonal interaction. During the fifth session, therapeutic work centered on restructuring interactional patterns, articulating attachment-related wishes and needs, and identifying new solutions to longstanding relational problems. The sixth session sought to facilitate more intimate engagement between participants and their spouses, increase acceptance of emerging emotional and interpersonal positions, and restructure the couple relationship around greater emotional accessibility and responsiveness. The seventh session emphasized the

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

importance of expressing sexual desires and relational needs and employed techniques such as tracking, reflection, and guided confrontation to increase awareness of attachment styles and their implications for intimate relationships. The eighth session assisted participants in developing greater self-focus, identifying their own emotional and relational needs, and learning to acknowledge and communicate these needs adaptively. During the ninth session, the therapist facilitated and directed new patterns of interaction between spouses, supported the replacement of negative interactional cycles with more positive and secure patterns, and encouraged participants to identify new solutions to persistent relational difficulties. The tenth and final session involved a comprehensive review and consolidation of material covered during treatment, facilitation of intimate, constructive, and reciprocal conversations, identification of therapeutic gains, and reinforcement of changes achieved over the course of the intervention to enhance their maintenance following termination.

2.4. Data Analysis

Data were analyzed using IBM SPSS Statistics version 23. Descriptive statistics, including the mean and standard deviation, were calculated to summarize participants' scores on the study variables across the pretest, posttest, and two-month follow-up assessments. To evaluate within-group changes over time, between-group differences, and the interaction between time and group membership, repeated-measures analysis of variance (ANOVA) was performed. This analytical approach allowed simultaneous examination of the main effect of time, the main effect of group, and the time × group interaction across the three assessment points. When statistically significant omnibus effects were identified, Bonferroni-adjusted post hoc comparisons were conducted to determine which specific groups or assessment occasions differed significantly from one another while controlling for inflation of the familywise Type I error rate associated with multiple comparisons. Statistical significance was established at $p < .05$ for all analyses.

3. Findings and Results

The demographic characteristics of the participants were examined across the sexual intelligence educational–counseling group, Johnson's Emotionally Focused Therapy group, and control group. Regarding age, in each of the three groups, 16 participants were aged 31–40 years and 2 participants were aged 20–30 years, indicating a highly similar age distribution across the study groups. Regarding duration of marriage, 4 participants in the sexual intelligence group, 3 in the Emotionally Focused Therapy group, and 3 in the control group had been married for 5 years; 12, 11, and 10 participants, respectively, had been married for 6–10 years; and 2, 4, and 5 participants, respectively, had been married for 11 years or longer. In terms of number of children, 8 participants in the sexual intelligence group, 7 in the Emotionally Focused Therapy group, and 6 in the control group had one child; 8, 8, and 9 participants, respectively, had two children; and 2, 3, and 3 participants, respectively, had three or more children. Overall, the demographic distributions indicated that the three groups were relatively comparable in terms of age, duration of marriage, and number of children.

Table 1

Mean and Standard Deviation of Sexual Relationship Scores Across the Three Assessment Times

Variable	Assessment	Control Group M	Control Group SD	Sexual Intelligence Group M	Sexual Intelligence Group SD	Emotionally Focused Therapy Group M	Emotionally Focused Therapy Group SD
Sexual relationship	Pretest	29.38	2.11	29.11	2.92	29.55	2.66
Sexual relationship	Posttest	29.88	2.49	31.00	3.02	31.66	2.80
Sexual relationship	Follow-up	29.88	2.32	31.05	2.41	31.38	2.42

As presented in Table 1, the three groups had relatively similar mean sexual relationship scores at pretest, with means of 29.38 for the control group, 29.11 for the sexual intelligence educational–counseling group, and 29.55 for the Emotionally Focused Therapy group. At posttest, the mean score increased to 31.00 in the sexual intelligence group and 31.66 in the Emotionally Focused Therapy group, whereas the control group showed only a small increase to 29.88. At the two-month follow-up, the mean sexual relationship score remained higher than the pretest level in both intervention

PWJ
Psychology of Woman Journal
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groups, with means of 31.05 and 31.38 for the sexual intelligence and Emotionally Focused Therapy groups, respectively, while the control group remained at 29.88. Thus, descriptively, both intervention groups demonstrated greater improvement in sexual relationship scores from pretest to posttest and follow-up than the control group, with the gains appearing to be largely maintained at follow-up.

Before conducting the repeated-measures analysis of variance, the relevant statistical assumptions were examined. The Shapiro–Wilk test indicated that sexual relationship scores were normally distributed at the pretest (W = .95, p = .051), posttest (W = .95, p = .084), and follow-up (W = .97, p = .191), as all significance values exceeded .05. Levene's test was also nonsignificant at pretest (F = .38, p = .681), posttest (F = .17, p = .836), and follow-up (F = .10, p = .902), supporting the assumption of homogeneity of error variances across the groups. Box's M test was nonsignificant (M = 16.15, p = .254), indicating that the variance–covariance matrices could be considered homogeneous across the study groups. However, Mauchly's test of sphericity was statistically significant (W = .51, p = .001), indicating that the assumption of sphericity had been violated. Accordingly, the Greenhouse–Geisser correction was applied when interpreting the within-subject effects in the repeated-measures ANOVA.

Table 2

Results of Repeated-Measures Analysis of Variance for Sexual Relationship Scores

Effect	Source	Sum of Squares	df	Mean Square	F	p	Partial η²	Power
Within-subject	Time	77.19	1.34	57.34	21.14	< .001	.29	.99
Within-subject	Time × Group	17.28	2.69	6.42	2.36	.048	.28	.96
Within-subject	Error (Time)	186.18	68.65	2.71	—	—	—	—
Between-subject	Group	8997.34	2	8997.34	93.08	.041	.14	1.00
Between-subject	Error	844.09	51	16.53	—	—	—	—

As shown in Table 2, after applying the Greenhouse–Geisser correction because of the violation of the sphericity assumption, the main effect of time on sexual relationship scores was statistically significant, F(1.34, 68.65) = 21.14, p < .001, partial η² = .29. This result indicates that sexual relationship scores changed significantly across the pretest, posttest, and follow-up assessments. The time × group interaction was also statistically significant, F(2.69, 68.65) = 2.36, p = .048, partial η² = .28, indicating that the pattern of change in sexual relationship scores over time differed significantly among the three groups. In addition, the between-subject effect of group was statistically significant, F(2, 51) = 93.08, p = .041, partial η² = .14. The reported partial eta squared suggested that approximately 14% of the variance in sexual relationship scores was attributable to differences among the study groups. The statistical power reported for the between-group effect was 1.00, indicating sufficient power for detecting group differences. Given the significant effects of time and group, as well as the significant time × group interaction, Bonferroni-adjusted pairwise comparisons were conducted to identify the specific differences between assessment times and study groups.

Table 3

Bonferroni Post Hoc Comparisons of Assessment Times and Study Groups for Sexual Relationship Scores

Comparison Type	Reference Condition	Comparison Condition	Mean Difference	SE	p
Time	Pretest	Posttest	-1.50	0.29	< .001
Time	Pretest	Follow-up	-1.42	0.30	< .001
Time	Posttest	Follow-up	0.07	0.14	.607
Group	Control group	Sexual intelligence group	-0.66	0.78	.041
Group	Control group	Emotionally Focused Therapy group	-1.14	0.78	.148
Group	Sexual intelligence group	Emotionally Focused Therapy group	-0.48	0.78	.541

The Bonferroni-adjusted pairwise comparisons presented in Table 3 showed that sexual relationship scores differed significantly between the pretest and posttest assessments (mean difference = -1.50, SE = 0.29, p < .001) and between the pretest and two-month follow-up assessments (mean difference = -1.42, SE = 0.30, p < .001). In contrast, the

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

difference between posttest and follow-up was not statistically significant (mean difference = 0.07, SE = 0.14, p = .607). These findings indicate that sexual relationship scores improved significantly from pretest to posttest and that this improvement was maintained through the two-month follow-up period. Regarding between-group comparisons, a statistically significant difference was observed between the sexual intelligence educational–counseling group and the control group (mean difference = -0.66, SE = 0.78, p = .041), indicating a significant effect of the sexual intelligence intervention relative to the absence of intervention. However, the difference between the Emotionally Focused Therapy group and the control group was not statistically significant (mean difference = -1.14, SE = 0.78, p = .148), nor was the difference between the sexual intelligence group and the Emotionally Focused Therapy group statistically significant (mean difference = -0.48, SE = 0.78, p = .541). Therefore, the findings suggest that the sexual intelligence educational–counseling package produced a statistically significant improvement in sexual relationships among women experiencing marital conflict compared with the control condition, whereas Johnson's Emotionally Focused Therapy did not demonstrate a statistically significant effect relative to the control group. Furthermore, no statistically significant difference in effectiveness was observed between the two active interventions.

4. Discussion

The present study aimed to compare the effectiveness of a sexual intelligence educational–counseling package and Johnson's Emotionally Focused Therapy in improving sexual relationships among women experiencing marital conflict. The findings showed that sexual relationship scores changed significantly over time and that the pattern of change differed across the three study groups. Bonferroni-adjusted comparisons indicated that sexual relationship scores increased significantly from pretest to posttest and from pretest to the two-month follow-up, whereas the difference between posttest and follow-up was not statistically significant. This pattern suggests that the improvements observed following intervention were maintained during the follow-up period. At the between-group level, the sexual intelligence educational–counseling group differed significantly from the control group, indicating that the sexual intelligence intervention was effective in improving sexual relationships. In contrast, the difference between the Emotionally Focused Therapy group and the control group was not statistically significant, and no statistically significant difference was found between the two active intervention groups. Thus, although both intervention groups demonstrated descriptive improvements over time, only the sexual intelligence educational–counseling package produced a statistically significant advantage over the control condition.

The significant effect of the sexual intelligence educational–counseling package is consistent with the conceptualization of sexual intelligence as a multidimensional capacity involving sexual self-awareness, accurate knowledge, communication, recognition of sexual needs, management of sexual emotions, and adaptive decision-making in intimate contexts. Sexual intelligence extends beyond factual knowledge about sexuality and includes the ability to understand one's own sexual preferences, boundaries, emotional responses, and relational expectations. Husain et al. emphasized that sexual intelligence is a meaningful construct for evaluating sexual health and reflects competencies that can influence the quality of sexual functioning and intimate relationships (Husain et al., 2024). Therefore, an intervention that directly addresses sexual beliefs, sexual schemas, communication patterns, emotional regulation, and sexual goal setting would be expected to produce meaningful changes in how women experience and manage sexual interactions within marriage.

The present findings also align with previous intervention studies demonstrating the beneficial effects of sexual intelligence training on marital and sexual outcomes. Jalali Asil et al. reported that sexual intelligence training improved marital intimacy, suggesting that greater sexual self-awareness and more adaptive sexual communication may strengthen the emotional and relational dimensions of marital life (Jalali Asil et al., 2017). Similarly, sexual intelligence-based education has been shown to improve sexual function and marital adjustment, indicating that interventions based on this construct can influence both the sexual and broader relational domains (Salmanpour et al., 2022). More recent evidence has shown that a sexual intelligence counseling–training package for women with marital conflict can improve sexual assertiveness, sexual self-concept, and interpersonal marital problems (Jalali Asil et al., 2026). The present findings extend these earlier observations by showing that such a package can also improve the sexual relationship itself among women experiencing marital conflict.

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

One possible explanation for the effectiveness of the sexual intelligence intervention is its direct focus on maladaptive sexual beliefs and negative sexual schemas. Women experiencing marital conflict may develop or maintain distorted beliefs about sexuality, sexual roles, entitlement, desirability, rejection, or the acceptability of expressing sexual needs. These beliefs may be influenced by family socialization, sociocultural norms, previous experiences, and lack of accurate sexual education. When such schemas remain unexamined, they can contribute to avoidance, dissatisfaction, emotional inhibition, or difficulties in negotiating sexual differences. The intervention used in the present study specifically addressed recognition and modification of maladaptive sexual schemas and misconceptions, which may have allowed participants to reinterpret sexual experiences in a less threatening and more adaptive manner. This mechanism is compatible with the broader literature indicating that sexual attitudes, emotional capacities, and relational patterns are associated with sexual satisfaction and conflict (Castillo-López et al., 2025).

Another important component of the sexual intelligence package was the enhancement of sexual communication and assertiveness. Participants were encouraged to identify their sexual needs, communicate preferences and boundaries, respect interpersonal differences, and resolve sexual disagreements without damaging the relationship. These competencies are strongly supported by prior research. Sexual assertiveness has been identified as an important aspect of healthy sexual functioning because it enables individuals to express desires, establish boundaries, and participate actively in sexual decision-making (López Alvarado et al., 2020). Likewise, a meta-analysis of couples' sexual communication demonstrated that more effective sexual communication is associated with both greater sexual satisfaction and higher relationship satisfaction (Mallory, 2022). Therefore, the observed improvement in sexual relationships may partly reflect greater openness, clearer communication, and increased confidence in expressing sexual needs following the intervention.

The effectiveness of the intervention may also be explained through its emphasis on emotional management within sexual contexts. Sexual relationships are sensitive to emotional states, and unresolved anger, shame, anxiety, resentment, or fear of rejection can substantially interfere with sexual desire, engagement, and satisfaction. The intervention included training in emotion management, recognition of sexual emotions, and development of more adaptive responses to relational difficulties. A scoping review of emotion regulation and sexuality has shown that emotion-regulation processes are closely associated with sexual function and sexual satisfaction (Fischer et al., 2022). Moreover, emotional intelligence has been positively associated with sexual satisfaction, suggesting that individuals who are better able to identify and regulate emotional experiences may also function more effectively in intimate relationships (Özbay & Balaban, 2024). Related evidence has also demonstrated associations among emotional intelligence, sexual self-efficacy, and subjective well-being (Thomas et al., 2024). From this perspective, the sexual intelligence intervention may have improved sexual relationships by simultaneously enhancing cognitive, emotional, and communicative capacities.

The present results are also consistent with studies showing a reciprocal relationship between sexual satisfaction and broader marital functioning. Razeghi et al. found a significant relationship between sexual satisfaction and marital conflict among women, indicating that deterioration in the sexual domain is closely related to increased marital difficulties (Razeghi et al., 2020). Similarly, sexual satisfaction has been associated with marital satisfaction and self-esteem among couples (Zarif et al., 2025). Najafi et al. further demonstrated that sexual satisfaction may mediate the relationship between marital burnout and communication beliefs among married women, highlighting the central role of sexuality in broader patterns of marital distress (Najafi et al., 2026). These findings support the interpretation that improvement in sexual functioning may contribute not only to more satisfying sexual encounters but also to broader relational adjustment and reduced conflict.

The significant improvement from pretest to posttest and its maintenance at the two-month follow-up is particularly important. The absence of a significant difference between posttest and follow-up suggests that the gains were not merely short-term reactions to treatment participation but were sustained for at least two months after completion of the intervention. This maintenance may be related to the skill-based nature of the sexual intelligence package. Participants were not only provided with information but also engaged in self-reflection, homework, communication exercises, problem-solving, goal setting, and planning for the continued development of sexual intelligence. Such components may facilitate the generalization of treatment gains to daily marital life. This is consistent with the broader literature emphasizing that relationship satisfaction is maintained when couples develop durable competencies in

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

communication, emotional responsiveness, conflict management, and relational adaptation (Allsop et al., 2021; Righetti et al., 2022).

The findings regarding Johnson's Emotionally Focused Therapy require more careful interpretation. Although the Emotionally Focused Therapy group demonstrated descriptive increases in sexual relationship scores from pretest to posttest and follow-up, the between-group comparison with the control group was not statistically significant. This finding differs somewhat from previous studies reporting beneficial effects of Emotionally Focused Therapy on marital conflict, emotion regulation, attachment, and sexual satisfaction. Ghahari et al. found that Emotion-Focused Couple Therapy was effective in reducing marital conflict and improving emotion regulation (Ghahari et al., 2021). Niknam also reported improvements in attachment style and sexual satisfaction following emotionally focused couple therapy (Niknam, 2019). In addition, long-term evidence has indicated that attachment changes occurring during Emotionally Focused Couple Therapy can be associated with improved sexual satisfaction, with some effects maintained over extended follow-up periods (Wiebe et al., 2019). Therefore, the absence of a significant between-group effect in the present study should not be interpreted as evidence that Emotionally Focused Therapy is generally ineffective for sexual or marital difficulties.

Several explanations may account for this discrepancy. First, the primary target of Emotionally Focused Therapy is not sexual behavior itself but the restructuring of attachment-related emotional processes and negative interaction cycles. Changes in sexual functioning may therefore occur indirectly and may require a longer period to emerge than changes produced by a targeted sexual intervention. Sexual intelligence training, in contrast, directly addresses sexual beliefs, communication, sexual schemas, emotional responses during sexual interactions, and the management of sexual disagreements. Given that the primary outcome of the present study was specifically the sexual relationship, the directness of the sexual intelligence intervention may have provided an advantage. The relatively brief 10-session format may also have been more sufficient for teaching concrete sexual competencies than for producing deeper attachment restructuring through Emotionally Focused Therapy.

Second, participants in the present study were women experiencing marital conflict rather than couples simultaneously participating in treatment. Emotionally Focused Therapy was originally conceptualized as a dyadic intervention in which both partners actively participate in identifying negative interaction cycles and developing more secure attachment-based responses. When only one spouse participates, some of the relational mechanisms central to the intervention may be more difficult to activate fully. In contrast, sexual intelligence training includes several individual competencies, such as self-awareness, belief modification, sexual self-concept, emotional regulation, and assertiveness, that can be strengthened even when only one partner participates. This difference may help explain why the sexual intelligence intervention showed a statistically significant effect whereas the Emotionally Focused Therapy condition did not.

Third, sexual relationship quality is influenced by multiple factors extending beyond attachment. Research has shown that love styles, conflict patterns, and emotional intelligence are jointly associated with sexual satisfaction (Castillo-López et al., 2025), while communication, forgiveness, attachment, and conflict resolution quality are all related to sexual satisfaction within marital competence frameworks (Allsop et al., 2021). Therefore, targeting attachment alone may not be sufficient for producing rapid changes in sexuality when maladaptive sexual beliefs, low sexual assertiveness, poor communication, or limited sexual knowledge are also present. The sexual intelligence intervention used in the current study addressed several of these domains simultaneously, which may account for its stronger statistical performance relative to the control group.

The lack of a statistically significant difference between the two intervention groups is also noteworthy. This finding indicates that although only the sexual intelligence group differed significantly from the control group, the magnitude of difference between the two active treatments was not large enough to establish superiority of one over the other. The descriptive improvements observed in both groups suggest that each intervention may influence sexual relationships through different mechanisms. Emotionally Focused Therapy may strengthen emotional accessibility and attachment security, whereas sexual intelligence training may enhance sexual self-awareness, communication, assertiveness, and cognitive flexibility in sexual situations. Relationship and sexual satisfaction are influenced by numerous psychological and contextual variables (Pricope et al., 2026; Sharma & Saxena, 2025), and it is therefore plausible that different therapeutic pathways can produce overlapping benefits.

The broader significance of these findings is reinforced by evidence showing that sexual and relational functioning

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

remain important dimensions of psychological adjustment across diverse populations and life circumstances. Sexual life, family functioning, and social adjustment have been shown to contribute meaningfully to life satisfaction even among individuals facing substantial medical and psychosocial challenges (Stańska et al., 2026). At the same time, expanding forms of technology-based learning and artificial intelligence-supported education highlight the increasing potential for structured psychoeducational approaches to enhance access to psychological and sexual health information (Shahbazi Koohi et al., 2024). Accordingly, structured sexual intelligence interventions may have practical value as relatively focused, skills-based approaches that can be incorporated into family counseling, marital enrichment, and sexual health programs.

5. Conclusion

Overall, the present findings support the use of a sexual intelligence educational–counseling package for improving sexual relationships among women experiencing marital conflict. The intervention appears to be particularly relevant because it directly addresses sexual beliefs, schemas, communication, emotional management, sexual assertiveness, and relational problem-solving. Although Johnson's Emotionally Focused Therapy did not demonstrate a statistically significant advantage over the control condition in the present study, its descriptive improvement and prior empirical support suggest that it may still be useful, especially when attachment insecurity and emotional disconnection constitute the primary mechanisms of marital distress. The findings therefore highlight the value of matching therapeutic approaches to the specific mechanisms underlying sexual and marital difficulties.

6. Limitations and Suggestions

The present study had several limitations that should be considered when interpreting the findings. Participants were recruited through convenience sampling from counseling centers in a single city, which limits the generalizability of the results to women in other geographical, cultural, socioeconomic, and clinical contexts. The sample size was relatively modest, with 18 participants in each group, which may have reduced statistical sensitivity for detecting small differences between the two active interventions. The intervention was conducted only with women, and spouses were not simultaneously included in the treatment process, which is particularly relevant to the interpretation of the Emotionally Focused Therapy findings because this approach is fundamentally relational and dyadic. The primary outcome was assessed using a self-report questionnaire, which may be influenced by social desirability, recall bias, and participants' willingness to disclose information concerning sexuality. In addition, the follow-up period was limited to two months, and therefore the long-term stability of intervention effects could not be determined. Finally, the study focused on sexual relationship scores and did not simultaneously evaluate potentially relevant mediating variables such as sexual assertiveness, emotional regulation, attachment security, sexual self-concept, or marital intimacy.

Future studies should replicate the present research with larger and more diverse samples drawn from different cities, cultural groups, and socioeconomic backgrounds to improve the external validity of the findings. Randomized controlled trials with adequate statistical power are recommended to permit more precise comparison of sexual intelligence training with Emotionally Focused Therapy and other evidence-based interventions. Future research should also include both spouses, particularly when evaluating couple-based approaches, to determine whether dyadic participation produces stronger effects on sexual and relational outcomes. Longer follow-up periods, such as six months or one year, would help clarify whether improvements are maintained over time. Researchers should also investigate potential mediators and moderators of treatment effectiveness, including sexual assertiveness, attachment style, emotional intelligence, sexual self-concept, duration of marriage, severity of marital conflict, and baseline sexual satisfaction. Mixed-methods designs could additionally provide richer information regarding participants' subjective experiences of change and the specific therapeutic components perceived as most useful.

Family counselors, couple therapists, psychologists, and sexual health professionals may consider incorporating structured sexual intelligence education into interventions for women experiencing marital conflict, particularly when difficulties involve poor sexual communication, inaccurate sexual beliefs, low sexual self-awareness, or problems expressing sexual needs and boundaries. Practitioners should assess the specific mechanisms contributing to each client's difficulties before selecting an intervention and should distinguish cases primarily characterized by sexual knowledge and communication deficits from those dominated by attachment insecurity and emotional disconnection. Sexual intelligence programs may be

PWJ
Psychology of Woman Journal
E-ISSN: 3041-8615

integrated with broader marital counseling approaches to address both sexual and relational dimensions simultaneously. Counseling centers may also benefit from developing culturally appropriate educational materials, homework exercises, and follow-up programs that reinforce skills after treatment completion. Where feasible, involving both partners may further strengthen the transfer of acquired skills into everyday marital interactions and improve the sustainability of therapeutic gains.

Authors' Contributions

Authors equally contributed to this article.

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

Transparency Statement

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

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