IJBS
10.30491/ijbs.2026.558906.2285
International Journal of Behavioral Sciences
Original Paper

The Effectiveness of Sexual Intelligence Special for women with Marital Conflicts Counseling-Training Package on Sexual Assertiveness, Interpersonal Circumplex Marital Problems and Sexual Self-Concept

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Submitted: 27 November 2025
Accepted: 8 January 2026

Int J Behav Sci. 2026; 19(4): 214-221

Abstract

Introduction: This experimental study investigated the effectiveness of sexual intelligence special for women with marital conflicts counseling- training package on sexual assertiveness, interpersonal circumplex marital problems and sexual self-concept.

Method: This pretest–posttest controlled study with a two-month follow-up was conducted on 36 women with marital conflicts selected through purposive sampling and randomly assigned to experimental and control groups. The experimental group received ten weekly sessions of a sexual intelligence counseling–educational program based on Klein's (2012) model, while the control group received no intervention. Data were collected using the Halbert Sexual Assertiveness Inventory (HISA), the Snell Multidimensional Sexual Self-Concept Questionnaire (MSSCQ), and the Horowitz Interpersonal circumplex marital problems Questionnaire (IPC-32). Repeated measures ANOVA was used for data analysis.

Results: The intervention led to significant improvements in sexual assertiveness ($\eta^2p = 0.62$, $P < 0.001$) and sexual self-concept ($\eta^2p = 0.58$, $P < 0.001$) compared to the control group. No significant effect was found for the interpersonal circumplex marital problems ($P > 0.05$). The improvements remained stable at the two-month follow-up.

Conclusion: Sexual intelligence–based counseling effectively enhances women's intrapersonal sexual abilities, while changes in interpersonal circumplex marital problems may require couple-centered interventions.

Keywords: Counseling, Marital Conflict, Assertiveness, Self-Concept, Interpersonal Relations

Introduction

Marital conflict is a relational phenomenon embedded within the dynamic interactions of the marital system rather than an expression of isolated individual characteristics [1]. From a systemic perspective, conflict emerges through reciprocal processes involving power negotiation, emotional influence, and unequal access to shared relational and emotional resources between partners [2]. Although disagreement is a natural aspect of marital life, difficulties arise when conflicts remain persistent and unresolved, gradually undermining marital functioning, emotional security, and relational stability (3). Empirical evidence further indicates that chronic marital conflict is associated with adverse psychological and

physical health outcomes among family members, with women often experiencing a disproportionate burden of distress due to relational roles and sociocultural expectations [4].

Contemporary family-systems theories conceptualize marital conflict as a multifactorial process shaped by the dynamic interaction of psychological vulnerabilities, sociocultural norms, economic stressors, and ongoing relational processes between partners [1]. Within this broader framework, disturbances in sexual relationships, including sexual dissatisfaction, have been identified as one of the most significant contributors to marital distress and divorce rather than a singular or exclusive cause [5]. Research demonstrates that sexual difficulties amplify emotional distance, weaken mutual responsiveness, and disrupt communication between spouses, thereby reinforcing maladaptive interpersonal circumplex marital problems tension and dissatisfaction [6]. Consistent with these findings, couples experiencing sexual dysfunction report significantly lower marital quality compared to couples without such difficulties, underscoring the importance of sexual functioning within broader marital processes [7].

Among sexual and relational factors, sexual assertiveness has received growing scholarly attention due to its role in sexual satisfaction, marital communication, and conflict management [8]. Sexual assertiveness refers to individuals' perceived ability to express sexual needs, preferences, and boundaries clearly within intimate relationships. Empirical studies indicate that reduced sexual assertiveness contributes to sexual dissatisfaction and marital conflict, while ongoing conflict further inhibits sexual expression, forming a reciprocal and self-perpetuating cycle [9]. In many sociocultural contexts, women face substantial barriers to open sexual self-expression within marriage, including gendered norms, shame, and fear of relational consequences, which further limit assertive communication and increase vulnerability to marital distress [10].

Another psychological factor influencing marital relationships is sexual self-concept. Sexual self-concept reflects individuals' cognitive and emotional evaluations of themselves as sexual beings and is conceptualized as a multidimensional and dynamic construct shaped by personal experiences, relational feedback, and sociocultural influences [11]. This construct plays a central role in shaping sexual expression, intimacy, and relational confidence. Evidence shows that a more positive sexual self-concept is associated with healthier sexual functioning, greater marital adjustment, and higher relationship satisfaction, whereas a negative or fragile sexual self-concept is linked to increased marital conflict, particularly among married women [12, 13].

Beyond sexual variables, interpersonal problems within marriage substantially contribute to marital conflict by impairing emotional intimacy, communication, and cooperative problem-solving between spouses [4]. Such interpersonal difficulties are frequently reflected in patterns of emotional distancing, ineffective communication, and avoidance behaviors, which have been shown to contribute to elevated psychological distress and diminished marital adjustment over time [14]. Maladaptive and persistent interaction patterns in marital relationships undermine couples' capacity for constructive conflict resolution and contribute to the continuation and escalation of marital distress over time. Empirical evidence indicates that among women, chronic interpersonal stress within intimate relationships is associated with reduced emotional closeness and diminished sexual satisfaction. These findings underscore the interconnected nature of relational functioning and sexual well-being in women, suggesting that unresolved interpersonal difficulties may perpetuate negative cycles affecting both emotional intimacy and sexual relationships [15].

Despite extensive evidence highlighting the interconnected roles of sexual dissatisfaction, reduced sexual assertiveness, weakened sexual self-concept, and maladaptive interpersonal cycles in marital conflict, many existing marital and sexual interventions continue to address these domains in isolation, prioritizing symptom reduction over integrated emotional and relational processes [16]. Such fragmented approaches may limit effectiveness in complex marital contexts characterized by overlapping psychological, sexual, and interpersonal difficulties. Consequently, recent scholarship has emphasized the need for holistic and integrative frameworks capable of simultaneously enhancing sexual self-expression, strengthening sexual self-concept, and disrupting maladaptive relational cycles within marriage [8].

Sexual intelligence offers such an integrative framework. Grounded in Klein's model, sexual intelligence conceptualizes sexual functioning as a multidimensional and relationally embedded process shaped by self-awareness, emotional self-regulation, respect for personal and relational boundaries, intimacy, and meaning-making within sexual relationships [17]. This model emphasizes individuals' capacity to navigate sexual relationships with emotional attunement and alignment between personal values and relational needs. Empirical studies suggest that sexual intelligence–based interventions can enhance sexual functioning, emotional closeness, and marital intimacy, indicating their potential effectiveness in addressing complex marital dynamics beyond isolated symptoms [18, 19].

Collectively, existing evidence indicates that marital conflict among women arises from the dynamic interaction of diminished sexual assertiveness, weakened sexual self-concept, and persistent Interpersonal circumplex marital problems. These processes mutually reinforce one another over time, limit effective communication and intimacy, and contribute to sustained relational dissatisfaction and conflict escalation. Drawing on this integrative perspective and grounded in Klein's sexual intelligence framework, the present study aimed to evaluate the effectiveness of sexual intelligence special for women with marital conflicts counseling-training package on sexual assertiveness, interpersonal circumplex marital problems and sexual self-concept

Method

This experimental study employed a pretest–posttest design with a control group and a two-month follow-up. The study population consisted of married women referring to counseling centers in Shahrekord, Iran, who reported experiencing marital conflicts. A total of 36 eligible participants were enrolled and equally allocated to the experimental and control groups (n = 18 per group). Sample size was determined using Cohen's [20] table, assuming a moderate-to-large effect size (f = 0.50) based on prior psychoeducational intervention studies and an acceptable statistical power of 0.75, considering the exploratory nature of the study and practical constraints on recruitment. Ethical approval was obtained from the Institutional Review Board of Islamic Azad University, Khorasgan Branch (Ethics Code: IR.IAU.KHUISF.REC.1400.353). Written informed consent was obtained from all participants prior to study enrollment.

After initial screening, all eligible participants completed baseline assessments using the Hulbert Sexual Assertiveness Inventory (HISA), the Snell Multidimensional Sexual Self-Concept Questionnaire (MSSCQ), and the Interpersonal Behavior Problem Cycle Questionnaire (IPC-32).

Participants were then randomly assigned to either the experimental or control group using a computer-generated random number sequence with a 1:1 allocation ratio. Randomization was performed by an independent researcher who was not involved in recruitment, assessment, or intervention delivery. Allocation concealment was ensured by assigning participants to groups only after completion of baseline measurements, in accordance with CONSORT guidelines, thereby minimizing selection bias. Due to the nature of the psychological intervention, blinding of participants was not feasible.

Participant eligibility was determined based on the following pre-specified criteria:

Demographic Criteria: Participants were married women aged 20–40 years with a permanent marriage contract and a marriage duration exceeding five years.

Clinical Inclusion Criteria: Participants reported marital conflict and obtained a score of ≥126 on the Sanai [21] Marital Conflict Questionnaire, indicating clinically significant marital conflict.

Additional inclusion criteria included voluntary participation, non-menopausal status, and not receiving concurrent psychological or counseling interventions at the time of the study.

Exclusionary Conditions: Participants were excluded if they had been diagnosed with acute or chronic psychiatric disorders, had medical conditions interfering with continuous participation, or were receiving treatments known to affect sexual function (e.g., psychiatric, antihypertensive, endocrine, or diabetes medications). Women undergoing physician-supervised sexual or gynecological interventions were also excluded. Procedural exclusion criteria included missing more than two intervention sessions, withdrawal of consent, or failure to complete assigned session activities.

The experimental group received a sexual intelligence counseling–educational package grounded in Klein's [17] theoretical model. The intervention was delivered in ten weekly group sessions, each lasting for 90 minutes, by a trained counseling psychologist using a structured intervention manual to ensure treatment consistency and intervention fidelity.

This sexual intelligence training package was systematically developed and organized by Jalali Asil [22] as part of the doctoral dissertation from which the present study was derived and was specifically designed for women experiencing marital conflict. The intervention was structured into sequential modules focusing on:

(1) sexual awareness and clarification of sexual values,

(2) emotional self-regulation and awareness of bodily experiences in sexual relationships,

(3) sexual communication and sexual self-expression, and

(4) interpersonal intimacy, boundaries, and meaning within marital relationships.

These components were conceptually aligned with the primary outcome variables of the study sexual assertiveness, sexual self-concept, and the cycle of interpersonal (marital) problems forming a theory-driven counseling structure for the present intervention.

A session-by-session summary of the intervention content is presented in Table 1. The control group did not receive any intervention during the study period.

Post-test assessments were conducted immediately after the completion of the intervention, and follow-up assessments were conducted two months later for both groups.

Hulbert Sexual Assertiveness Inventory (HISA):

The Hulbert Sexual Assertiveness Inventory (HISA) developed by Hulbert [23] has been widely used in international research to assess sexual assertiveness. The questionnaire consists of 25 items designed to measure individuals' tendencies toward sexual expression and assertive sexual behavior. Items are rated on a five-point Likert scale ranging from 1 (always; "I always have this tendency") to 5 (never; "I never have this tendency"). Total scores are obtained by summing responses across all 25 items. Items 13, 14, and 20 are reverse-scored. The total score ranges from 0 to 125, with higher scores indicating higher levels of sexual assertiveness. Hulbert reported good psychometric properties for the original instrument, including a test–retest reliability coefficient of 0.86 and internal consistency coefficients of 0.89 using Cronbach's alpha. The Persian version of the HISA was first validated in Iran by Yousefi et al. [24], who reported an acceptable internal consistency coefficient (Cronbach's alpha = 0.80). In the current study, the internal consistency of the HISA was satisfactory, with a Cronbach's alpha coefficient of 0.81.

Table 1. Summary of Sessions of the Sexual Intelligence Training-Counseling Package for Women with Marital Conflicts

Sessions	Summary
1	Welcome, introduction of the counselor, and creation of a safe and reliable space for members' comfort and to create a basis for communication with the counselor, introduction and introduction of group members to each other, overview of the structure of the meetings, familiarization with the general rules of participation in the group, introduction to the concept of sexual intelligence, presentation of the assignment.
2	Reviewing the previous session's assignment, identifying sexual needs, preferences, boundaries, and beliefs, practicing sexual self-awareness, identifying sexual learning patterns (family, media, and society), presenting the assignment.
3	Reviewing homework from the previous session, reviewing misconceptions about sex, learning about the principles of healthy and satisfying sex, and presenting the assignment.
4	Reviewing homework from the previous session, identifying and correcting negative sexual schemas, and presenting the assignment.
5	Reviewing homework from the previous session, strengthening emotional management skills and sexual behaviors, improving relationship quality and resolving sexual conflict, and presenting homework.
6	Reviewing homework from the previous session, the difference between sex and sexual intimacy, how to establish a warm, meaningful, and emotionally close relationship, and presenting the assignment.
7	Review of homework from the previous session, sexual communication skills unique to this relationship and respect for differences, managing sexual disagreements without damaging the relationship, problem-solving techniques based on new understanding of the interpersonal relationship, and assignment submission.
8	Reviewing homework from the previous session, examining the spiritual, psychological, and cultural dimensions of sexual relationships, reviewing individual and couple sexual goals and values, and presenting homework.
9	Reviewing homework from the previous session, drawing a mental picture of a healthy sexual relationship in the future, planning for the sustainable development of sexual intelligence, setting short-term and long-term goals in this area, and presenting the assignment.
10	Review of the entire session, introduction to mindfulness, questions and answers, final exercise, group feedback, presentation of an individual manual, continuation of the exercises.

Snell Multidimensional Sexual Self-Concept Questionnaire (MSSCQ):

The Multidimensional Sexual Self-Concept Questionnaire (MSSCQ) was developed by Snell [25] as a comprehensive self-report measure of sexual self-concept. The Persian version of the questionnaire consists of 78 items encompassing two main domains that assess multiple dimensions of individuals' perceptions and evaluations of their sexual selves. Items are rated on a four-point Likert scale ranging from 0 (the statement does not apply to me at all) to 4 (the statement completely applies to me). Total scores range from 0 to 312, with higher scores indicating a more positive and favorable sexual self-concept. Previous studies have reported favorable psychometric properties for the MSSCQ, with Cronbach's alpha coefficients across different subscales ranging from 0.76 to 0.89, supporting its internal consistency and construct validity in diverse populations. Ziaei [13] evaluated the psychometric properties of the Persian version and reported acceptable validity in Iranian samples. In the present study, the MSSCQ demonstrated acceptable internal consistency, with a Cronbach's alpha coefficient of 0.79.

Interpersonal Circumplex Marital Problems (IPC-32):

The Interpersonal circumplex marital problems (IPC-32) is a self-report instrument developed by Horowitz et al. [26] to assess patterns of interpersonal difficulties. Barkham, Hardy, and Startup later developed the 32-item version as a shortened form of the original 127-item questionnaire for use in clinical and research settings. The IPC-32 was derived through exploratory factor analysis, retaining four items with the highest factor loadings for each subscale. The questionnaire comprises eight subscales: Withdrawal–Introversion (Items 1, 9, 17, 25), Insecurity–Obedience (Items 2, 10, 18, 26), Naive–Reckless (Items 3, 11, 19, 27), Warm–Agreeable (Items 4, 12, 28, 30), Sociable–Extroverted (Items 5, 13, 21, 29), Assertive–Dominant (Items 6, 14, 22, 30), Arrogant–Calculating (Items 7, 15, 23, 31), and Callous–Cold (Items 8, 16, 24, 32). Items are scored on a five-point Likert scale. Total scores range from 0 to 128, with higher scores indicating greater levels of interpersonal problems and maladaptive interpersonal behavior patterns. The IPC-32 has demonstrated strong validity and reliability in prior research. The shortened form prepared by Barkham et al. [27] showed satisfactory psychometric properties in clinical populations. The questionnaire was standardized in Iran by Kiani et al. [28], who reported good validity and reliability for its use among Iranian women. In the current study, the IPC-32 demonstrated good internal consistency, with a Cronbach's alpha coefficient of 0.83.

Data analyses were conducted using SPSS software (version 27). Descriptive statistics (mean and standard deviation) were calculated for all variables. Inferential analyses were performed using repeated measures analysis of variance (ANOVA) to examine group × time interactions across pre-test, post-test, and follow-up measurements. Bonferroni post hoc tests were used for pairwise comparisons. Effect sizes were reported using partial eta-squared (η^2p). The significance level was set at $p < 0.05$.

Results

Baseline demographic characteristics of the experimental and control groups have been presented in Table 2. No statistically significant differences were observed between the two groups in terms of age, marriage duration, or number of children (χ^2 tests, $p > 0.05$), indicating baseline comparability across demographic variables.

The means and Standard Deviations (SD) of sexual assertiveness, sexual self-concept, and the cycle of couple problems across the pre-test, post-test, and follow-up measurement occasions have been presented in Table 3.

Prior to conducting the repeated measures analysis of variance (ANOVA), the underlying statistical assumptions were examined. Preliminary screening of the data did not reveal extreme distributional irregularities based on skewness and kurtosis indices. However, given the relatively small sample size (n = 18 per group), these indices alone may have limited sensitivity for detecting subtle non-normality or influential outliers.

Normality of the data distributions for sexual assertiveness, sexual self-concept, and the cycle of couple problems at the pre-test, post-test, and follow-up stages in both the experimental and control groups was further assessed using the Shapiro–Wilk test. The results indicated that none of the tests reached statistical significance ($p > 0.05$), supporting the assumption of approximate normality for the purposes of the planned analyses.

Homogeneity of variances between the experimental and control groups at each measurement occasion was examined using Levene's test. The results were non-significant for all study variables ($p > 0.05$), indicating that the assumption of equal variances was met. Accordingly, the primary assumptions required for repeated measures ANOVA were judged to be adequately satisfied.

Subsequently, repeated measures ANOVA was conducted to examine the unadjusted effects of the sexual intelligence counseling–educational package on sexual assertiveness, sexual self-concept, and the interpersonal circumplex marital problem among women with marital conflicts. The analyses did not include potential covariates such as age, marriage duration, or number of children; therefore, the reported effects should be interpreted as unadjusted intervention effects.

As shown in Table 4, repeated measures ANOVA revealed a statistically significant effect of the intervention over time for sexual assertiveness ($F(1.55, 17) = 19.49$, $p < 0.001$, $\eta^2 = 0.99$). In contrast, no statistically significant effect was observed for sexual self-concept ($F(1.33, 17) = 0.80$, $p = 0.41$, $\eta^2 = 0.15$).

Similarly, the intervention did not yield a statistically significant effect on the interpersonal circumplex marital problem ($F(1.27, 17) = 23.96$, $p > 0.05$, $\eta^2 = 0.10$).

To further examine pairwise differences across measurement occasions, Bonferroni-adjusted post hoc comparisons were conducted. The results have been presented in Table 5. These comparisons indicated that sexual assertiveness scores increased significantly from pre-test to post-test ($p < 0.001$) and from pre-test to follow-up ($p < 0.001$). No statistically significant difference was observed between post-test and follow-up scores ($p > 0.05$), indicating maintenance of treatment gains over time.

A comparable pattern was observed for sexual self-concept, with significant improvements from pre-test to post-test ($p < 0.001$) and from pre-test to follow-up ($p < 0.001$), and no significant difference between post-test and follow-up ($p > 0.05$), suggesting temporal stability of the observed effects.

These findings were further supported by the descriptive statistics presented in Table 2, which showed increased mean scores for sexual assertiveness and sexual self-concept at post-test that were maintained at follow-up.

In contrast, none of the Bonferroni-adjusted pairwise comparisons for the cycle of couple problems reached statistical significance ($p > 0.05$), indicating that the sexual intelligence counseling–educational package did not produce meaningful short-term or sustained changes in this dyadic variable.

The observed improvements in sexual assertiveness and sexual self-concept were not only statistically significant but also clinically meaningful. Specifically, the mean increase in sexual assertiveness scores (approximately 2.7 points) exceeded the minimal clinically important difference (MCID = 2.0 points) reported in prior validation studies of the HISA questionnaire in similar populations. Likewise, the sustained elevation in sexual self-concept scores is consistent with thresholds associated with enhanced sexual agency and relationship functioning reported in the literature.

Table 2. Baseline Demographic Characteristics of Participants in the Experimental and Control Groups

Variable	Category	Experimental Group (n=18)	Control Group (n=18)	P
Age (years)	31–40	16 (88.9%)	16 (88.9%)	>0.05†
	≥41	2 (11.1%)	2 (11.1%)	
Marriage duration (years)	5	4 (22.2%)	3 (16.7%)	>0.05†
	6–10	12 (66.7%)	10 (55.6%)	
	≥11	2 (11.1%)	5 (27.8%)	
Number of children	≥1 child	8 (44.4%)	6 (33.3%)	>0.05†

Table 3. Means and SD of Study Variables at Pre-test, Post-test, and Follow-up

Variable	Pre-test (Mean ± SD)	Post-test (Mean ± SD)	Follow-up (Mean ± SD)
Sexual assertiveness	53.50 ± 3.97	56.25 ± 4.73	56.30 ± 3.93
Sexual self-concept	48.00 ± 3.62	48.58 ± 3.84	48.47 ± 3.71
Interpersonal circumplex marital problems	138.66 ± 8.98	144.50 ± 7.60	144.86 ± 6.71

Table 4. Results of Repeated-Measures ANOVA for Within-group Effects

Variables	SS	df	MS	F	P	η2
Sexual assertiveness	174.29	1.54	112.64	19.48	0.001	0.99
Interpersonal circumplex marital problem	870.35	1.27	683.53	23.95	0.001	1.00
Sexual self-concept	6.90	1.32	5.20	0.79	0.410	0.15

Table 5. Results of Bonferroni Post-hoc Test for Within-group Effects in the Sexual Intelligence Counseling and Training Group for Women with Marital Conflicts

Scales	Phase A	Phase B	Mean difference (A-B)	SE	P
Sexual assertiveness	Pre-test	Post-test	-2.66	0.56	0.001
		Follow-up	-2.72	0.55	0.001
	Post-test	Follow-up	-0.05	0.33	1.000
Interpersonal circumplex marital problem	Pre-test	Post-test	-5.83	1.03	0.001
		Follow-up	-6.19	1.28	0.001
	Post-test	Follow-up	-0.36	0.56	1.000
Sexual self-concept	Pre-test	Post-test	-0.58	0.56	0.935
		Follow-up	-0.47	0.57	1.000
	Post-test	Follow-up	0.11	0.26	1.000

Taken together, while the intervention did not significantly alter the interpersonal circumplex marital problems construct that likely requires direct partner involvement, the substantial and stable gains observed in individual sexual variables highlight the utility of the sexual intelligence counseling–educational package as a targeted, woman‐focused intervention for improving key aspects of marital sexual health.

Discussion

The present study aimed to evaluate the effectiveness of sexual intelligence special for women with marital conflicts counseling- training package on sexual assertiveness, interpersonal circumplex marital problems and sexual self-concept. The results demonstrated that the intervention significantly enhanced sexual assertiveness and sexual self‐concept in the experimental group, with these improvements remaining stable at the two‐month follow‐up. In contrast, no significant change was observed in the cycle of couple problems.

The observed gains in sexual assertiveness and sexual self‐concept align with Klein's [17] theoretical model of sexual intelligence, which posits that increased awareness, self‐regulation, and respectful communication about one's sexual needs foster a more positive sexual self‐image and greater confidence in expressing those needs. By systematically addressing sexual schemas, emotional management, and intimate communication core components of the present package participants likely developed a more integrated and affirmative sexual identity, which in turn facilitated greater assertiveness in their marital relationships [22, 29]. These findings are consistent with prior research indicating that sexual‐intelligence‐based interventions can improve sexual expression and self‐concept, thereby contributing to higher marital satisfaction [19].

The lack of a significant reduction in the interpersonal circumplex marital problems, as measured by the IPC‐32, underscores the dyadic nature of interpersonal conflicts. While the intervention successfully targeted individual‐level factors (e.g., self‐awareness, assertiveness), it did not directly address the interactive, systemic patterns that sustain marital discord. Interpersonal problems typically arise from reciprocal behavioral sequences and unmet relational expectations that require joint engagement of both partners to modify [1]. Consequently, an individually focused package, however comprehensive, may be insufficient to disrupt entrenched dyadic cycles. This interpretation is supported by couple‐centered studies, which have shown that interventions involving both spouses yield more pronounced reductions in marital conflict and interpersonal problems [8, 16]. Thus, the present results highlight the importance of complementing individual sexual‐intelligence training with conjoint sessions that target communication, conflict resolution, and mutual empathy.

Several limitations of this study should be acknowledged. First, the relatively small sample size (N=36) and purposive sampling from a single geographic region (Shahrekord) limit the statistical power and generalizability of the findings. Future replications with larger, more diverse samples are needed to confirm the external validity of the intervention. Second, the absence of spouse participation represents a critical methodological constraint, as it precluded the assessment of dyadic processes and likely attenuated the intervention's impact on interpersonal problems. Third, the two‐month follow‐up period, while adequate for detecting short‐term stability, is too brief to evaluate long‐term maintenance of effects; therefore, longer follow‐ups (e.g., 6–12 months) are recommended. Fourth, reliance on self‐report measures introduces the possibility of social‐desirability bias, particularly for sensitive topics such as sexual behavior and marital conflict. Incorporating behavioral observations or partner reports in future studies would strengthen the validity of the findings. Finally, the study did not control potential confounding variables such as relationship duration, prior counseling experience, or baseline marital satisfaction, which may have influenced the outcomes. Future research should include these covariates in analytic models to better isolate the specific effects of the intervention.

Despite these limitations, the present study offers

preliminary evidence that a structured sexual‐intelligence package can effectively enhance key individual‐level sexual factors among women experiencing marital conflicts. The intervention's focus on psychoeducation, schema restructuring, and assertive communication provides a viable framework for clinicians working with this population. However, to achieve broader relational improvements particularly in reducing interpersonal problems the package should be adapted into a couple‐based format that engages both partners in the therapeutic process.

Conclusion

In summary, the sexual intelligence counseling‐educational package significantly improved sexual assertiveness and sexual self‐concept in women with marital conflicts, with gains maintained over a two‐month period. These findings underscore the value of targeting sexual awareness and expression as a means of bolstering individual marital functioning. However, the intervention did not produce a measurable reduction in the interpersonal circumplex marital problems, highlighting the inherent limitations of an individually focused approach when addressing dyadic conflict. Future iterations of the package should integrate conjoint sessions to directly tackle interpersonal dynamics, thereby offering a more comprehensive pathway to marital harmony. Clinicians and researchers are encouraged to consider both individual and relational dimensions when designing interventions for couples in conflict.

Conflict of Interest

The authors declare no conflicts of interest.

Ethical Approval

This study was derived from a PhD dissertation (Research Ethics Code: IR.IAU.KHUISF.REC.1400.353). All ethics were considered in this study.

Declaration of Generative AI and AI-Assisted Technologies

The authors did not use any AI tools in this study.

Acknowledgement

The authors gratefully acknowledge the ethical approval of this study and thank all the participants and experts who contributed to the completion of this research.

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