**A Comparison of Approach and Avoidance Sexual Goals in Couples with Vulvodynia and Community Controls**

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**Abstract**

***Background.*** Provoked vestibulodynia (PVD) is a prevalent form of vulvodynia that interferes with the sexual and relational functioning of affected couples. Approach and avoidance sexual goals are known to be associated with the sexual and relationship well-being of both women with PVD and their partners. Yet whether sexual goals differ in couples coping with PVD, compared to community couples, is unknown.

***Aims.*** Building upon an established motivational model, this study compared the approach and avoidance sexual goals of women with PVD and their partners to a control sample of community women and their partners. This study also compared the sexual goals of women with PVD to those of their partners.

***Methods.*** Women diagnosed with PVD and their partners (*N* = 161) and control couples (*N* = 172) completed measures of approach and avoidance sexual goals.

***Main Outcome Measure.*** Approach and Avoidance Sexual Goals Questionnaire.

***Results.*** Women with PVD reported lower approach and higher avoidance sexual goals than control women, while partners of women with PVD did not differ from control partners in their sexual goals. Women with PVD also reported lower approach and higher avoidance sexual goals compared to their partners, while there were no differences between partners in the control sample.

***Clinical Implications.*** Given that avoidance sexual goals have been linked to negative sexual and relational outcomes, clinicians could strive to help couples with PVD become aware of their sexual motives, with the aim of reducing avoidance sexual goals and bolstering approach sexual goals.

***Strengths & Limitations.***This is the first study to empirically document differences in sexual goals between couples affected by PVD and community couples. Limitations include the study’s correlational design, differences in the demographic characteristics between samples, and the homogeneity of participants’ sexual orientation.

***Conclusions.*** Findingssuggest that the sexual goals ofwomen affected by PVD differ from those of community women and from their partners and support sexual goals as targets for psychological interventions to help couples coping with PVD.

***Keywords:***  provoked vestibulodynia, vulvodynia, couples, sexual motivation, sexual goals

**Introduction**

 Provoked vestibulodynia (PVD), a subtype of vulvodynia characterized by acute pain in the vulvar vestibule, is the most frequent cause of pain during intercourse in pre-menopausal women [1]. Although precise etiology is unknown, multiple biological, psychological, and interpersonal factors contribute to the development and maintenance of PVD [2]. PVD is associated with psychological and sexual impairments for both affected women and their romantic partners, such as increased psychological distress, and decreased sexual function and satisfaction (see [2] for a review). Sexual motivation is emerging as a key factor that is relevant to women with vulvo-vaginal pain, prompting recommendations that it be targeted in psychological interventions to help women adapt to the condition [3-5]. Although sexual goals, defined as the outcomes that people pursue when engaging in sex, are associated with the sexual and relational functioning of women with PVD and their partners [5,6], whether sexual goals differ for couples affected by PVD compared to community couples is unknown. Given that PVD renders sexual intercourse painful and that affected women report many relationship fears and guilt as a result [7], it is possible that they tend to engage in intercourse primarily to avoid negative consequences (avoidance goals), compared to women without pain, who may engage in intercourse most often to pursue positive outcomes (approach goals). Determining the presence and nature of such differences could help to account for the sexual impairments that are commonly observed in couples affected by PVD, and may support sexual goals as targets of interventions to help these women and their partners. The current study sought to compare the sexual goals of couples affected by PVD to community control couples and to compare the sexual goals of women with PVD to those of their male partners.

 People’s desires to approach pleasure and avoid pain are well established in theories of motivation [8,9]. Such theories distinguish between the independent systems of approach (or attainment) and avoidance (or inhibition), which are activated when individuals adopt self-regulatory actions focused on attaining success and/or averting failure, respectively [10,11,12]. The approach-avoidance distinction, when applied to sexuality, posits that people may engage in sex to attain positive outcomes, such as to show love for a partner (i.e., an approach sexual goal), and to avoid negative outcomes, such as their partner’s disappointment (i.e., an avoidance sexual goal) [5,13, see review by 14]. Sexual goals have been further delineated in their focus on the self (e.g., to feel good about one’s self) versus the partner (e.g., to experience pleasure with a partner) [15]. Although conceptualized as independent systems, it is possible to simultaneously hold both approach and avoidance goals for sex [14,16]. For instance, one might pursue sex both to achieve intimacy and to avert discord with a partner. Indeed, while some studies find a positive correlation between approach and avoidance sexual goals [5,17], others have found no significant association [13]. Importantly, sexual goals have distinct associations with sexual and relationship outcomes; approach sexual goals are associated with enhanced sexual desire, and relationship and sexual satisfaction (while controlling for avoidance goals), and avoidance goals are associated with lower desire and satisfaction (controlling for approach goals) [5,13,17].

 Although other types of goals, such as task persistence and pain avoidance, have been shown to affect a person's ability to manage pain [18,19], the role of goals in vulvovaginal pain has only recently received empirical attention. An epidemiological study found that, despite their pain, more than 90% of affected women engaged in intercourse in the preceding six months [20]. In a qualitative study, Elmerstig, Wijma, and Berterö [4] found that women suffering from pain during sexual intercourse reported engaging in intercourse to achieve intimacy with, and to avoid abandonment by, their partners, suggesting that both approach and avoidance sexual goals—and particularly those that were partner-focused—affected women's decisions to persist with painful intercourse. Further, Rosen and colleagues [5] found that in a sample of women with PVD and their partners, women’s higher approach sexual goals were associated with their higher relationship and sexual satisfaction, whereas women’s higher avoidance sexual goals were associated with women’s lower sexual and relationship satisfaction, more depressive symptoms, and lower relationship satisfaction for their partners.

While no studies have directly compared the level of sexual goals in women affected by PVD to those of unaffected women, Brauer and colleagues [3] found that compared to controls, women who experienced pain during intercourse (i.e., they did not have a specific diagnosis), reported persisting with sex for fewer reasons that involved pleasure (conceptually aligned with approach sexual goals) and more reasons that included a sense of obligation or to avoid losing a romantic partner (conceptually aligned with avoidance sexual goals). Further, couples affected by PVD have reported lower sexual rewards and higher sexual costs compared to control couples [21]. Fears of partner-loss or disappointment, and feeling obliged to meet partners’ sexual needs, have also figured prominently into the sexual goals of women with vulvo-vaginal pain in qualitative studies [4,7]. Together, these findings suggest that partner-focused sexual goals may be especially relevant for women with PVD, and that they may endorse lower approach sexual goals and higher avoidance sexual goals compared to control women. Given that partners of women with PVD are also negatively impacted by the pain [22] and that romantic partners tend to adopt similar goals (see [23] for a review of goal contagion research), it is possible that partners of women with PVD may report lower approach and higher avoidance sexual goals compared to partners of control women. Finally, although research with community couples typically finds no gender differences in sexual goals [13], in the context of PVD, whereby women bear the burden of pain, it is plausible that women may endorse higher avoidance sexual goals and lower approach goals than their partners. Uncovering differences in sexual goals will provide insight into an important motivational factor that could help account for the negative sexual and relational consequences observed in couples struggling with this condition. An enhanced understanding of how the sexual goals of couples affected by PVD differ from control couples may also support sexual goals as targets for interventions to improve sexual and relational functioning in couples coping with PVD.

**Aims**

 The aim of this study was to compare the sexual goals of women with PVD and their partners to those of a control group of community women and their partners. This study also sought to determine whether there are differences in sexual goals between women with PVD and their partners. We predicted that (1) women with PVD would have lower approach sexual goals and higher avoidance sexual goals compared to control women. The same pattern was expected when comparing partners of women with PVD to control partners; (2) women with PVD would have lower approach sexual goals and higher avoidance sexual goals when compared to their partners. Consistent with prior research [13,17], we expected no differences between control women and their partners in approach or avoidance sexual goals.

**Methods**

*Participants and Procedure*

 The studies were approved by the authors’ institutional research ethics boards. Both the PVD and control couples were drawn from samples who participated in larger studies examining interpersonal factors in couples coping with PVD or in community couples, respectively [24,25]. Data for the current study were drawn from the baseline assessment sessions only. Participant and couple characteristics are presented in Table 1.

 **PVD sample.** Women with PVD and their partners were recruited from two cities (*blinded*). Couples were recruited from poster, print, and online advertisements (*n* = 209; 63%), via participation in previous studies in the authors' laboratories (*n* = 43; 13%), physician referral (*n* = 53; 16%), and word of mouth (*n* = 27; 8%). Women with PVD were first screened for eligibility with a structured telephone interview conducted by a research assistant. Participants were eligible if they experienced pain during intercourse that was subjectively distressing, occurred on at least 80% of intercourse attempts, lasted for at least six months, and was limited to activities involving pressure to the vestibule. Women had to be between the ages of 18 and 45 years and premenopausal, while partners had to be over the age of 18. Couples must have had at least 4 in-person contacts per week, been together at least three months, and have engaged in sexual activity at least once per month during the previous three months. Sexual activity was defined broadly and included non-penetrative activities. Women attended a gynecological examination for diagnosis by a standardized cotton-swab test [26], which included a minimum average pain rating of 4 on a scale of 0 (*no pain*) to 10 (*worst pain ever*) in one or more locations of the vestibule during the gynecological exam. Women were excluded if they had an active vulvo-vaginal infection previously diagnosed by a physician, self-reported infection, or pregnancy. Of the 332 women who were eligible after initial screening, 223 women and their partners agreed to participate. However, 62 couples were excluded after initial screening, resulting in a final sample size of 161 couples (see Figure 1 for details). Of the participating couples, 159 were in a mixed-sex relationship and two were in a same-sex relationship. Further descriptive characteristics of the study sample (e.g., level of sexual satisfaction, sexual function, mood, and relationship satisfaction) can be found in prior publications (see [*blinded*, *blinded*]).Women and their partners attended a laboratory-based session where they provided informed consent and independently completed the study measures. Women were compensated $30 ($10 for their initial visit and $20 for the gynecological exam) and partners were compensated $10.

 **Control Sample**. Control couples were comprised of a convenience sample that was recruited at (*blinded*). To be eligible, participants were required to be English-speaking couples over the age of 18 who were in a relationship for at least three years, and were married or living together. Eligible couples provided informed consent and were invited to complete a survey independently from each other about aspects of their relationship, including their approach and avoidance sexual goals. Of the 212 community couples who began the survey, 40 provided incomplete data, resulting in a final sample size of 172 couples. Couples who participated in the study were awarded a small gift for their time (e.g., a pen or notebook with a University logo). All couples were in mixed-sex relationships.

**Measures**

 ***Sexual goals*.** Interpersonal sexual goals were measured using 10 items previously used in research on sexual motivation [5,27,28]. Only items reflecting partner-focused goals influencing the decision to engage in sex—as used in prior research [5,6,29]—were retained (see Table 1). Participants indicated the importance of five approach sexual goal items in motivating their decision to have sex with their partner (e.g., “to promote intimacy in my relationship” and “to experience pleasure with my partner”), and five avoidance goal items (e.g., “to prevent my partner from becoming upset” and “to prevent my partner from falling out of love with me”). Items were rated on a 7-point scale (1 = *not at all important* to 7 = *extremely important*). Items for both approach and avoidance sexual goals were averaged; higher averages for each subscale indicated a greater tendency to be motivated by that sexual goal. Previous research supports the reliability and validity of this measure [13,17]. An approach sexual goal item (“*to please my partner*”) was removed to improve the internal consistency of the measure for women with PVD. An exploratory factor analysis using principle axis factoring and a promax rotation revealed that this item did not load onto the approach subscale as expected for either the women with PVD (factor loading of .11) or partners of women with PVD (factor loading of .38). Conceptually, this item differs from other approach sexual goals by focusing more on the individual pleasure of the partner rather than the shared pleasure of the couple as the motive for pursuing sex, which may explain why it failed to properly load with the other approach sexual goal items. All other items loaded onto the approach and avoidance sexual goals subscales, as expected, for both women with PVD and their partners. For approach sexual goals, Cronbach's alpha was .79 for women and .81 for partners in the PVD sample, and .77 for women and .73 for partners in the control sample. For avoidance sexual goals, Cronbach's alpha was .88 for women and .90 for partners in the PVD sample, and .86 for women and .86 for partners in the control sample.

**Data Analysis**

Statistical analyses were conducted with SPSS (version 23.0; SPSS, Inc., Chicago, IL, USA). We used a 2 (gender) X 2 (group) mixed multivariate analysis of variance (MANOVA) with gender as a within-subjects factor was used to compare the groups, followed by univariate analyses of variance (ANOVAs) and mean comparisons (*t*-tests) for any observed group effects. Effect size estimates were made using partial eta squared (ηp2). Chi-square tests (χ2) were used to measure differences in the categorical demographic variables between the two groups, including relationships type and annual income bracket. Student’s *t*-tests were used to compare age and relationship duration between groups. Data reduction for demographic variables, such as combined annual income and relationship type, involved combining response options among couples and binning the results into categories. For example, participants selected their annual income from among 11 income brackets (e.g., 1 = *$0 – 9,999*; 2 = *$10,000 - 19,999*;… and 11= *above $100,000*). Incomes were then combined among partners and put into the following three annual income brackets: $0 – 39,999; $40,000 – 59,999, and above $60,000. A similar procedure was used for relationship type, which was treated as nominal categorical data. Chi-square tests were then used to compare these variables between the PVD and control samples. When significant differences were observed, these variables were controlled for in the analyses.

**Results**

Women with PVD were significantly younger than control women, *t*(331) = 10.54, *p* < .001, and partners of women with PVD were significantly younger than control partners, *t*(331) = 9.77, *p* < .001. The PVD sample had been in a relationship for a shorter period, *t*(331) = 10.53, *p* < .001, was less likely to be married, ᵡ2(3, *N* = 333) = 83.56, *p* < .001, and more likely to report an annual income below $40,000.00, ᵡ2(2, *N* = 333) = 28.33, *p* < .001, compared to the control sample (see Table 2). Therefore, age, relationship length, relationship type, and level of income were controlled for in the analyses. The means and standard deviations for approach and avoidance sexual goals are reported in Table 3, separately for the PVD and control samples.

 There was a significant multivariate effect for group, *F*(2, 325) = 14.23, *p* < .001, ηp2 = .08, and for the group by gender interaction, *F*(2, 325) = 8.82, *p* < .001, ηp2 = .05. The main effects for gender, *F*(2, 325) = 0.10, *p* = .91, ηp2 = .00; women’s age, *F*(2, 325) = 0.15, *p* =.86, ηp2 = .00; partners’ age, *F*(2, 325) = 0.31, *p* =.73, ηp2 = .00; relationship length, *F*(2, 325) = 0.54, *p* =.59, ηp2 = .00; relationship type, *F*(2, 325) = 0.54, *p* =.59, ηp2 = .00; and income level, *F*(2, 325) = 0.41, *p* =.66, ηp2 = .00 were not significant, nor were there any significant interactions between gender and any of the following: age, relationship length, relationship type, and income level.

Results of the follow-up ANOVA for the group effect showed that, overall, couples affected by PVD endorsed lower approach sexual goals, *F*(1, 328) = 21.75, *p* < .001, ηp2 = 0.07, and higher avoidance sexual goals, *F*(1, 328) = 4.59, *p* < .05, ηp2 = 0.01, compared to control couples (see Table 3). These effects are considered moderate and small, respectively [30]. The follow-up ANOVA for the gender by group interaction effect was significant for both approach sexual goals, *F*(1, 328) = 13.01, *p* < .001, ηp2 = 0.04 and avoidance sexual goals, *F*(1, 328) = 5.65, *p* < .05, ηp2 = 0.02, with effects falling between the small to medium range [30] (see Table 4). Pairwise mean comparisons revealed that women with PVD reported lower approach sexual goals when compared both to control women, *t*(331) = 5.91, *p* < .001,Cohen’s *d*= 0.65, and to their own partners, *t*(320) = 4.25, *p* < .001, Cohen’s *d* = 0.48, and higher avoidance sexual goals when compared both to control women, *t*(331) = 3.44, p < .001, Cohen’s *d* = 0.38, and to their own partners, *t*(320) = 3.44, *p* < .01, Cohen’s *d* = 0.36. According to Cohen [31], effects sizes are considered large at 0.80, moderate at 0.50, and small at 0.20. No significant differences in approach and avoidance sexual goals were found between partners of women with PVD and control partners, nor between control women and control partners. In sum, women with PVD reported lower approach sexual goals and higher avoidance sexual goals compared to both control women and their own partners.

**Discussion**

Using an established motivational model [8,9], the current study sought to compare the approach and avoidance sexual goals of couples affected by PVD to those of community control couples. Overall, couples affected by PVD reported lower approach and higher avoidance sexual goals compared to control couples. However, upon closer examination, only women with PVD (and not their partners) reported lower approach and higher avoidance sexual goals compared to controls. Further, women with PVD reported lower approach and higher avoidance sexual goals compared to their partners. Findings are consistent with interpersonal conceptualizations of pain [32,33], and underscore sexual motivation as an important interpersonal factor that differs between couples with PVD and community control couples. As such, sexual motivation should be considered in biopsychosocial conceptualizations and treatment of this condition.

In support of our hypothesis, women with PVD reported higher avoidance sexual goals than control women. These results are in line with those of Brauer and colleagues [3], who found that women experiencing pain during intercourse reported more avoidance motives for intercourse, such as to prevent the loss of their partner or feeling pressured to have sex with their partner, than women without this pain. It is possible that, compared to controls, women with PVD are more motivated by avoidance sexual goals due to the experience of pain. Qualitative studies have found that women who experience pain during intercourse report feelings of shame and guilt [34]. Correspondingly, women with PVD have reported both emotional distress and damage to their relationship due to the pain [35]. Together, these findings suggest that the experience of PVD-related pain may contribute to increased relational strain, possibly accounting for the observed differences, such that women with PVD are more likely to engage in sex to avoid further stress, conflict, or guilt. Finally, women with PVD may be more attuned to negative interpersonal or pain-related cues than control couples [36], which could also contribute to stronger avoidance sexual goals.

 In line with Rosen and colleagues [6], avoidance sexual goals were higher for women with PVD than for their partners, likely because it is the woman with PVD who ultimately experiences the pain and suffers more extensive consequences. Indeed, while couples affected by PVD have reported more sexual costs (i.e., physical or mental effort, pain, or negative affect as a result of a sexual exchange with a partner) compared to unaffected couples, women with PVD reported even higher sexual costs than their partners [21]. In contrast, no differences in approach and avoidance sexual goals were found between partners of women with PVD and partners of control women, suggesting that PVD is not significantly associated with partners’ motives for having sex. An opposite picture might emerge when examining avoidance sexual goals for *not* initiating sex. That is, while both partners in couples affected by PVD may avoid initiating sex due to the pain, partners of women with PVD may experience a greater burden related to fears of being rejected or causing pain to their partner [37]. Thus, partners of women with PVD may report higher avoidance goals for *not* engaging in sex, compared to women with PVD. Couples’ sexual goals for *not* engaging in sex and the implications of these goals are understudied and should be explored in future research.

Although overall, couples affected by PVD reported lower approach sexual goals compared to control couples, only the approach sexual goals of women with PVD were significantly lower than those of control women. Women with PVD also had significantly lower approach goals than their partners. Again, this is likely due to the fact that it is the women with PVD who must endure the pain and not her partner. However, approach sexual goals were still moderately high in women with PVD and were higher than their avoidance goals (*M* approach sexual goals = 5.50; *M* avoidance sexual goals = 3.98, on a 7-point scale), suggesting that despite the presence of pain, women with PVD may still pursue sex in pursuit of approach goals. This result is consistent with other PVD research which has found that certain aspects of the relationship are less affected by the pain problem. For example, Rosen and colleagues [21] found that both women with PVD and their male partners evaluated their sexual relationship as highly rewarding (i.e., pleasurable and positive) and to the same extent as control couples. It follows that perceiving a high level of sexual rewards may help women with PVD stay motivated to pursue sex for intimacy and connectedness, even in the presence of pain. There are many negative sexual, psychological, and relational consequences associated with PVD [38]. Thus, it is notable that even though women with PVD are struggling with a distressing condition, they are still able to appreciate, and seek out, positive aspects of their sexual relationship. However, it is also possible that the study methods may have precluded the participation of more distressed couples, and biased the PVD sample towards those in which women were predisposed to be more approach-oriented in their sexual relationships.

The current study empirically documented differences in sexual goals between couples affected by PVD and community couples. Finding that the sexual goals of both members of the couple with PVD differed from controls, though ultimately it was the women with PVD whose goals were significantly different, further elucidates the scope of the impact of PVD on intimate relationships and supports the movement towards relationship-oriented designs in PVD research and treatment [39,40]. Some limitations should also be acknowledged. First, the correlational design of the study limits confidence that the results were due to a causal link between PVD and sexual motivation. Second, despite efforts to select a control sample similar to the PVD sample, there remained significant differences in age, relationship length, relationship type, and income level, which were controlled for in the analyses. There may have been differences in other variables that were not assessed in the current study. Third, the comparison group was recruited in the context of a study focusing on interpersonal factors in community couples, which precluded a systematic screening for vulvovaginal pain. Given that the lifetime prevalence estimates of PVD ranges from 7% to 8% in reproductive-aged women [1] it is possible that some women in the comparison sample also had PVD. Fourth, although similar to prior samples [41] the samples were comprised primarily of Caucasian couples in mixed-sex relationships, which may limit the external validity of the current findings.

 In conclusion, results are in line with previous research recommending sexual goals as targets for psychological interventions to help couples cope with PVD [5]. Recent findings suggest that sexual motivation is dynamic, and potentially open to intervention. For example, in community couples, increasing the salience of approach sexual goals improved sexual satisfaction [29]. Motivational interventions have also shown promise in improving pain and coping in chronic pain populations [42,43]. With this in mind, clinicians could strive to help couples with PVD become aware of their sexual motives, with the aim of bolstering approach sexual goals and reducing avoidance sexual goals. The size of the effects observed in the current study suggest that interventions targeting sexual goals may be maximally beneficial when used in combination with other empirically supported targets (e.g., cognitive biases, intimacy; [44,45,46]) and in the context of cognitive-behavioral or acceptance-based treatments. Still, it is possible that couples who are able to shift their focus toward approach sexual goals and away from avoidance sexual goals may adjust better to PVD and experience fewer consequences as a result.

Conflict of Interest: The authors report no conflicts of interest.

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Figure 1: Flow chart of PVD couples excluded from the study.

|  |  |
| --- | --- |
| 223 couples agreed to participate  |  |
|  | Excluded due to pregnancy (*n* = 7)  |
| Eligible couples (*n =* 216) |  |
|  | Excluded because no PVD diagnosis (*n* = 11); due to infection (*n* = 1); due to pain ratings below 4/10 (*n* = 2) |
| Eligible couples (*n =* 202) |  |
|  | Withdrew while undergoing eligibility screening (*n* = 30); excluded due to relationship change or incomplete data (*n* = 11) |
| Eligible couples (*n =* 161) |  |

**Table 1**

*Items Assessing Approach and Avoidance Sexual Goals*

|  |  |
| --- | --- |
| Approach Sexual Goals | Avoidance Sexual Goals |
| To please my partner.\* | To prevent my partner from falling out of love with me.  |
| To promote intimacy in my relationship. | To prevent my partner from losing interest in me. |
| To express love for my partner. | To avoid having to decline my partner’s request. |
| To experience pleasure with my partner. | To prevent my partner from becoming upset. |
| To add excitement to my relationship. | To avoid conflict in my relationship. |

*Note:* Participants were asked to rate the importance of the above items in why they typically engage in sex with their partner, from 1 = *not at all important* to 7 = *extremely important*.

\* Item removed for analysis due to low internal consistency and poor factor loading for women with PVD.

**Table 2**

*Sample characteristics*

|  |  |  |  |
| --- | --- | --- | --- |
|  | PVD *N* = 161 | Controls*N* = 172 | *\*p*  |
| Age (years), mean (SD) |  |  |  |
|  Women | 26.53 (5.60)  | 35.27 (9.21)  | <.001 |
|  PartnersCombined annual income, *n* (%) | 28.26 (7.00)  | 37.83 (10.61)  | <.001<.001 |
|  $0-39,999 | 62 (38.50) | 23 (13.40) |  |
|  $40,000-59,999 | 28 (17.40) | 35 (20.34) |  |
|  >$60,000 | 71 (44.10) | 114 (66.30) |  |
| Relationship type, *n* (%) |  |  | <.001 |
|  Live apart | 33 (20.50) | 11 (6.40) |  |
|  Cohabitate | 71 (44.10) | 26 (15.10) |  |
|  Married | 35 (21.7) | 123 (71.50) |  |
|  Other | 22 (13.70) | 12 (7.00) |  |
| Relationship Duration (years), mean(SD)  | 4.76 (3.55)  | 12.37 (8.74)  | <.001 |
| \*Student’s *t*-test or chi-square test |  |  |  |

**Table 3**

*Mean, standard deviations for approach and avoidance sexual goals for couples affected by PVD and pain-free control couples.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Variable | Group | *M* | *SD* | *F* | ηp2 |
| Approach | PVD | 5.79 | 0.77 | 21.75\*\* | 0.07 |
|  | Control | 6.12 | 0.61 |  |  |
| Avoidance | PVD | 3.63 | 1.34 | 4.59\* | 0.01 |
|  | Control | 3.32 | 1.20 |  |  |

*Note. N=* 161 couples with PVD and172 control couples. Approach and avoidance sexual goal scores had a possible range of 1 to 7.

\**p*<.05; \*\**p*<.001

**Table 4**

*Mean, standard deviations, follow-up ANOVAs, and simple effects analysis for approach and avoidance sexual goals in women affected by PVD and their partners and control couples.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Women | Partners | Follow-up ANOVA |
| Variable/Group | *M* | *SD* | *M* | *SD* | *F* | ηp2 |
| Approach |  |  |  |  |  |  |
|  | PVD | 5.50ab | 1.12 | 5.98a | 0.95 | 13.01\*\* | .04 |
|  | Control | 6.21b | 1.11 | 6.10 | 0.94 |  |  |
| Avoidance  |  |  |  |  |  |  |
|  | PVD | 3.98de  | 1.84 | 3.31d | 1.85 | 5.65\* | .02 |
|  | Control | 3.29e | 1.82 | 3.30 | 1.84 |  |  |

*Note*. For the outcome variables, means with the same subscript indicate a significant difference of *p* < .05; *N=* 161 couples with PVD and172 control couples; \**p*<.05; \*\**p*<.001