


A Longitudinal Examination of Common Dyadic Coping and Sexual Distress in New Parent Couples during the Transition to Parenthood

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New parents experience significant disruption to their sexual relationships such as lower desire and sexual frequency relative to pre-pregnancy. Little is known about the sexual distress new parents feel related to these changes, how sexual distress evolves over time, or how coping with stress relates to this distress. New parent couples who engage in more adaptive, joint coping with mutual stressors—common dyadic coping (CDC)—may be better able to manage distress related to their sexuality and thus, experience less sexual distress at 3-months postpartum and experience more marked improvement over time. In 99 first-time parent couples, we examined the link between CDC measured at 3-months postpartum and trajectories of sexual distress across 3-, 6-, and 12-months postpartum. Analyses used dyadic latent growth curve modeling informed by the actor-partner interdependence model. Mothers' sexual distress at 3-months postpartum was clinically elevated and higher than their partner's. Mothers' sexual distress declined significantly over time, whereas partners' sexual distress remained low and stable. An individual's higher perceptions of CDC was significantly associated with their own (but not their partner's) lower sexual distress at 3-months postpartum. No significant associations were found between CDC and change in sexual distress over time. How new parents jointly cope with stressors early in the postpartum period may lessen the distress they have about their sexuality at a time when most couples have just resumed sexual activity. Results identify CDC as a possible novel target for interventions aimed at helping couples manage sexual distress during the transition to parenthood.

Keywords: *Sexual Distress; Postpartum; Common Dyadic Coping; Transition to Parenthood*

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During the transition to parenthood, couples are met with a myriad of new personal and relational stressors. The postpartum period, defined as the first year after birth, is a vulnerable stage fraught with hormonal and physical changes, sleep deprivation, and changed roles and responsibilities. The stress of navigating this transition can have a significant impact on new parents' sexual relationship. While 78–90% of couples resume sexual activity by 3-months postpartum (McDonald, Woolhouse, & Brown, 2017), sexual problems, such as reduced frequency of sexual activity and impaired sexual function (i.e., sexual desire, arousal, satisfaction, and pain), are common (McBride & Kwee, 2017). Over the first year postpartum, between 41–87% of new mothers and 22–45% of new fathers report problems with sexual function (McBride & Kwee, 2017; Saotome, Yonezawa, & Sukanuma, 2018), and 36% of mothers and 46% of fathers describe themselves as dissatisfied with their sex lives (Ahlborg, Dahlöf, & Hallberg, 2005). New parents' sexual function generally improves over the first year after the birth of a baby but does not necessarily return to prepregnancy levels (Jawed-Wessel & Sevic, 2017). While many couples find the postpartum changes to their sexual lives concerning (Schlagintweit, Bailey, & Rosen, 2016), little is known about how sexual distress evolves over time or how coping with stress relates to this distress. Defined as negative feelings about one's sexuality, such as worry, frustration, guilt, embarrassment, and feelings of inadequacy (DeRogatis, Clayton, Lewis-D'Agostino, Wunderlich, & Fu, 2008), sexual distress is a distinct and important component of sexual well-being (Stephenson & Meston, 2010a).

One factor relevant to the degree of sexual distress may be common dyadic coping (CDC), that is, the way couples jointly cope with the stress of a new baby. CDC may be particularly important for fostering feelings of trust, closeness, and intimacy—factors which contribute significantly to the experience of sexual distress (Stephenson & Meston, 2010b). The aim of the current study was to examine the links between CDC at 3-months postpartum and both sexual distress at 3-months postpartum and the trajectories of sexual distress (i.e., 3- to 12-months postpartum) in first-time mothers and their partners.

Sexual Distress in the Postpartum Period

Almost all research to date on sexuality in the transition to parenthood has focused on sexual function. An outcome that is virtually absent from the literature for this period is sexual distress, which is surprising given that it is required for a clinical diagnosis of sexual dysfunction (American Psychiatric Association, 2013). Sexual distress is common in the general population, reported by 19–24% of women (Bancroft, Loftus, & Long, 2003; Hendrickx, Gijs, & Enzlin, 2016) and 10–15% of men (Hendrickx et al., 2016; Mitchell et al., 2013) and may be heightened during the transition to parenthood due to known changes in the sexual relationship (McBride & Kwee, 2017). Importantly, sexual distress is a key indicator for help-seeking behaviors related to sexual problems (Evangelia et al., 2010), and is thus suggestive of who may be most in need of clinical attention.

Both members of a couple may undergo changes to their sexuality during the transition to parenthood, such as reduced sexual frequency and desire, negative body image, the onset of pain with sexual activity, and lack of energy and time for sexual activity (McBride & Kwee, 2017). These changes may contribute to negative feelings about their sex life. In a cross-sectional study of couples who were sampled between 3- and 12-months postpartum, 90% of respondents endorsed more than 10 sexual concerns (Schlagintweit et al., 2016). Further, new parents have reported that these changes were unexpected and that they felt unprepared to cope with them, which is likely to heighten sexual distress (Condon, Boyce, &

Corkindale, 2004; Olsson, Lundqvist, Faxelid, & Nissen, 2005). Although research on postpartum sexual distress specifically is scarce, the few studies in this area suggest that it is indeed prevalent. In a cross-sectional study, Schwenck, Dawson, Muise, and Rosen (2020) found that new parent couples reported higher sexual distress at each of 3-, 6-, and 12-months postpartum compared to community couples. Further, a recent longitudinal study following 203 new parent couples from mid-pregnancy to 12-months postpartum revealed that mothers reported consistently higher sexual distress than their partners over time. In 24% of couples, mothers' sexual distress was clinically elevated across the postpartum period (Rosen, Dawson, Leonhardt, Vannier, & Impett, 2020). While these recent studies suggest that sexual distress is heightened and common for couples transitioning to parenthood, neither examined if new mothers' and partners' distress influence one another over time, and no studies have examined factors that may relate to couples' sexual distress during this period.

Feelings of sexual distress do not occur in isolation, and are highly amenable to the relational context (Stephenson & Meston, 2010b, 2015). In community samples, women reported greater sexual distress when they believed their sexual problems led to lower satisfaction in their partners (Stephenson & Meston, 2015). Such findings highlight the dyadic nature of sexual distress and are particularly relevant in the postpartum period given that mothers typically report lower sexual desire than partners (Rosen, Bailey, & Muise, 2018). Existing studies are mostly cross-sectional, limiting our understanding of how sexual distress evolves over this time for each member of the couple. It is possible that sexual distress may improve over time as couples adapt to their new roles and responsibilities and as their sexual function improves.

Further, it is unclear what factors are associated with new parents' sexual distress. Most research on postpartum sexuality has focused on the impact of biomedical factors (e.g., breastfeeding and mode of delivery), however, these have been inconsistently associated with sexual outcomes (McBride & Kwee, 2017). Emerging research suggests that interpersonal factors (e.g., empathy toward one's partner and relationship satisfaction) may be just as, or more important, for couples' postpartum sexuality than biomedical factors (Hipp, Kane Low, & van Anders, 2012). The interpersonal factors explored to date have still focused on the individual. Instead, the way couples *jointly* cope with the stress of a new baby may be especially important for the distress they feel about their sexuality.

Dyadic Coping and Sexual Distress

The stress associated with the birth of a new baby affects both members of a couple, as do changes to the sexual relationship. Thus, *dyadic* approaches to coping with stress (i.e., coping strategies that involve both partners) may be particularly important for couples' sexual distress in the postpartum period. One such dyadic approach is CDC, a form of coping that is relevant to couples experiencing a shared stressor. CDC is distinct from general partner support in that it reflects a shared effort to cope, as opposed to unidirectional support provided from one partner to the other (Bodenmann, 1997). According to the Systemic Transactional Model (STM), CDC is defined as a process whereby couples facing a "we" stressor that affects both members of the couple (e.g., the birth of a new baby) engage in joint efforts to re-establish the well-being of both members of the couple individually and of the relationship as a whole (Bodenmann, 2005). The transactional nature of the STM highlights the interdependence between partners' stress and coping processes (Bodenmann, 2005).

Past research examining dyadic coping in couples has found differences between individuals' perceptions of the couple's coping (Falconier, Jackson, Hilpert, & Bodenmann, 2015) as well as unique effects of each individual's perception on their own and their

partner's outcomes (Ernst et al., 2017; Molgora, Fenaroli, et al., 2019). Such findings highlight the importance of measuring dyadic coping from both members of the couple separately, while also accounting for their interdependence via a dyadic approach. Examples of CDC include joint efforts to problem solve, seek information, or share feelings (Bodenmann, 2005). For new parents, this coping may reflect talking to each other about parenting stress, helping one another reframe the stress of a new baby by reflecting on the joy of parenthood, and making joint efforts to prioritize emotional and physical intimacy as a couple, separate from the baby. When individual members of a couple report higher CDC, this refers to the individuals' own perception that the couple engages in joint efforts to cope with stressors more frequently. The STM suggests a temporal sequence of stress communication in couples; specifically, responding to a shared stressor by engaging in joint coping efforts (i.e., CDC), facilitates feelings of trust, commitment, and closeness for both members of a couple (Bodenmann, Atkins, Schär, & Poffet, 2010), and in turn, improved relational outcomes. By facilitating enhanced intimacy, CDC may be related to less concern and worry about negative changes to new parents' sex lives, resulting in lower sexual distress for both members of the couple as they re-establish their sexual relationship over the first year postpartum. Indeed, feelings of intimacy are associated with lower sexual distress in community samples (Stephenson & Meston, 2010b).

Most dyadic coping research to date has focused on the links with relationship outcomes. Falconier et al. (2015) meta-analyzed the results of 57 studies and found a moderate correlation between overall dyadic coping and relationship satisfaction for both members of couples. CDC is more robustly linked with the outcomes of both partners than individual coping efforts (Herzberg, 2013; Papp & Witt, 2010). In pregnancy, there is cross-sectional evidence to suggest that when individuals perceived higher CDC, they and their partners reported greater relationship adjustment (Molgora, Acquati, Acquati, Fenaroli, & Saita, 2019). Much less is known about the association between dyadic coping and couples' sexual outcomes, which is surprising given the inherent link between CDC and sexuality (e.g., joint efforts for emotional and physical intimacy). In a sample of 103 female undergraduate students who were in committed romantic relationships and who were experiencing stress, Bodenmann et al., (2010) found that higher reported overall dyadic coping was positively related to their own sexual satisfaction and frequency of orgasm, and was associated with a 55% increase in sexual activity. Another cross-sectional study of 198 couples found that stressors internal to the couple (e.g., partners' divergent needs or difficulties affecting one member of a couple, such as mothers' biological changes after childbirth), and stress due to critical life events (e.g., the transition to parenthood) were linked with more sexual problems in men and women. Conversely, stressors external to the couple (e.g., job stress and financial stress) were not associated with sexual problems (Bodenmann, Ledermann, Blattner, & Galluzzo, 2006). Taken together, these findings suggest that the perceived ability to cope with shared stressors during the major life event of becoming parents for the first time may be associated with less sexual distress.

Findings examining the link between an individual's own reported dyadic coping and their partner's sexual outcomes have been more mixed. There are preliminary data in married couples to suggest that higher dyadic coping reported by each member of the couple buffers the negative effect of sexual dissatisfaction on relationship satisfaction for both partners (Gasbarrini et al., 2015). However, in a sample of parent couples with a child undergoing cancer treatment, fathers' own report of CDC was associated with their own sexual adjustment, but not mothers' (Van Schoors et al., 2019). To our knowledge, the existing studies linking dyadic coping and sexual outcomes are outside of the postpartum context, have focused mostly on overall dyadic coping as opposed to CDC specifically, and have not examined the association between dyadic coping and sexual distress.

Furthermore, the association between an individual's own reported CDC and their partner's sexual outcomes remains unclear.

Taken together, while the STM suggests a link between CDC and couples' sexual distress, we are unaware of any existing literature examining its association with sexual distress. Specifically, higher perceived CDC by new mothers and their partners at 3-months postpartum, a time when most couples resume sexual activity amidst significant stress (McBride & Kwee, 2017), may lessen *both* partners' distress about their sexual relationship by facilitating feelings of trust, closeness, and intimacy. Engaging in CDC to jointly cope with the stress of having a new baby early on in the postpartum period may set the stage for reducing sexual distress in both members of the couple at 3-months postpartum and across the first year of parenthood.

The Current Study

The objective of the current study was to examine the link between CDC measured at 3-months postpartum, to sexual distress intercepts (i.e., at 3-months postpartum), and sexual distress slopes (i.e., change over 3-, 6-, and 12-months postpartum) of first-time mothers and their partners. The associations between partners' predictors and outcomes were organized within an actor-partner interdependence model (APIM), which includes *actor* effects (i.e., the relationship between one's own predictor and one's own outcomes) and *partner* effects (i.e., the relationship between one's own predictor and a partner's outcomes). We had four main hypotheses: (a) mothers and partners would experience high levels of sexual distress at 3-months postpartum (i.e., above validated clinical cutoff scores), with mothers reporting higher distress than their partners; (b) mothers' and partners' sexual distress would decline significantly over the first year postpartum, with mothers showing greater decline; (c) mothers' and partners' greater CDC at 3-months postpartum would be negatively associated with their own and their partner's levels of sexual distress at 3-months postpartum; and (d) mothers' and partners' greater CDC at 3-months postpartum would be associated with greater improvement in their own and their partner's sexual distress over time.

METHOD

Participants

First-time expectant mothers were recruited as part of a larger, longitudinal study of women's sexuality over the transition to parenthood. Women were eligible to participate if they were over 18 years of age and between 18 and 24 weeks pregnant with an uncomplicated singleton pregnancy, as the presence of complications (e.g., gestational diabetes, preeclampsia, history of complicated birth(s), etc.) is associated with additional strain on perinatal adjustment (Wright, Belanger, & Dulude, 2000). If present, medical/psychiatric conditions had to be well-managed, as determined via a self-assessment question posed to the participant by a research assistant in the initial screening interview. In addition, mothers had to be fluent in English and have access to a personal email account to complete the study measures. The current study was presented as a "couples addition" sub-study of the larger project. For the current study, mothers were required to be in a relationship for at least 6 months and have a partner (over the age of 18) willing to participate. Partners of eligible mothers were invited to participate when they were between 2- and 4-months postpartum. Couples in mixed- and same-sex relationships were eligible. A total of 202 mothers and their partners were approached to participate in the sub-study, and 116 agreed to take part. Reasons for nonparticipation included women not interested ($n = 54$), partners not interested ($n = 27$), and women no longer in a relationship ($n = 5$).

Couples were also excluded if both members did not complete the initial (i.e., 3-month) survey ($n = 17$). Of the participating couples, 99 mothers and 99 partners completed the baseline survey at 3-months postpartum. A total of 98 mothers (99% retention rate) and 93 partners (94% retention rate) completed the 6-month survey, and 98 mothers (99% retention rate) and 93 partners (94% retention rate) completed the 12-month survey. Thus, 99 couples were retained for analysis. Women reported on their own sociodemographics upon recruitment, while partners reported on their own sociodemographics during the first time point (i.e., 3-months postpartum). Data on childbirth were extracted from mothers' medical records. All mothers identified as female. A total of 97 (98%) partners reported that they were male, 1 (1%) reported they were female, and 1 (1%) indicated they were two-spirit. Full sociodemographic characteristics of the sample are presented in Table 1.

Procedure

Participants for the larger study were recruited from the IWK Health Centre (Halifax, NS, Canada) diagnostic imaging clinic. Potentially eligible women were identified by a research assistant prior to their routine 20-week anatomical ultrasound. At their appointment, research staff provided information about the study, and if mothers were interested and eligible, obtained written informed consent. Between 2- and 4-months postpartum, enrolled mothers were contacted via email to participate in a couples' sub-study and were asked to invite their partner to participate. Partners provided their electronic consent at the beginning of the first survey. All surveys were completed online using Qualtrics Research Suite online survey software. Survey links were emailed to mothers and partners to complete at 3-, 6-, and 12-months postpartum and expired after 4 weeks. Strategies to enhance retention were employed including email and telephone reminders and financial incentives (Dawson, Vaillancourt-Morel, Pierce, & Rosen, 2020). Mothers and partners received \$15 CAD and \$10 CAD online gift cards, respectively, upon completion of each survey (mothers' surveys were longer given that they were also completing measures for the larger study). This study was approved by the IWK Health Centre Research Ethics Board.

Measures

Sociodemographic information

At enrollment (i.e., 20-week ultrasound), women reported on their own age, sex, sexual orientation, ethnicity/culture, relationship status, relationship length, and shared annual household income. Partners self-reported their own age, sex, sexual orientation, and ethnicity/culture when enrolled at 3-months postpartum.

Sexual distress

Sexual distress in mothers and partners was assessed at each time point using the Sexual Distress Scale-Revised (SDS-R; DeRogatis et al., 2008), which is validated for use in both women (DeRogatis et al., 2008) and men (Santos-Iglesias, Mohamed, Danko, & Walker, 2018). The SDS-R is comprised of 13 items in a single factor and has strong psychometric properties (DeRogatis et al., 2008). Participants are asked to rate how often a series of feelings and problems related to their sex life bothered them or caused distress over the last month. Questions are rated on a 5-point Likert scale ranging from never (0) to always (4). Total scores range from 0 to 52 with higher scores indicating greater sexual distress. Scores ≥ 11 are indicative of clinically significant sexual distress in women (DeRogatis et al., 2008). The clinical cutoff score for men has been suggested to be higher than

TABLE 1
Demographics

	Mothers <i>M</i> ± <i>SD</i> or <i>N</i> (%)	Partners <i>M</i> ± <i>SD</i> or <i>N</i> (%)
Age (years)	29.46 ± 3.68	31.44 ± 4.16
Sexual Orientation		
Heterosexual	93 (93.9%)	95 (96.0%)
Bisexual	4 (4.0%)	2 (2.0%)
Other ^a	2 (2.0%)	2 (2.0%)
Ethnicity/Culture		
English/French Canadian	86 (86.8%)	82 (82.8%)
First Nations Canadian	2 (2.0%)	1 (1.0%)
African Canadian	1 (1.0%)	2 (2.0%)
Western/Eastern European	—	4 (4.0%)
Asian American/Asian	4 (4.0%)	2 (2.0%)
American	2 (2.0%)	—
Middle-eastern	1 (1.0%)	2 (2.0%)
Other ^c	3 (3.0%)	6 (6.1%)
Relationship Status		
Dating	1 (1.0%)	
Cohabiting (i.e., living with a partner)	7 (7.1%)	
Engaged	5 (5.1%)	
Married/Common-law	85 (85.8%)	
Other ^b	1 (1.0%)	
Relationship Length (months)	81.14 ± 43.36	
Shared Annual Income		
\$0–\$39,999	6 (6.0%)	
\$40,000–\$79,999	25 (25.3%)	
>\$80,000	68 (68.7%)	
Type of Birth		
Vaginal delivery	49 (49.5%)	
Instrumental Delivery (forceps)	6 (6.1%)	
Instrumental Delivery (vacuum extraction)	13 (13.1%)	
Caesarean section	26 (26.3%)	
Sexual Function ^d	24.10 ± 6.60	61.89 ± 6.52
Couples' frequency of sexual activity ^e	9.33 (6.41)	

^aOther self-identified sexual orientations included the following: gay, unlabeled, pansexual.

^bOther relationship types included the following: "dating more than one partner".

^cOther ethnicities included the following: Biracial, British, Caribbean, Celtic, Central European, Hispanic/Latino/Latina, Inuit, Scandinavian, Scottish Canadian.

^dSexual function was measured by the Female Sexual Function Inventory (FSFI) for mothers and female partners and the International Index of Erectile Function (IIEF) for male partners. Values are reported for mothers who were sexually active in the previous 4 weeks ($n = 68$) and male partners who were sexually active in the previous 4 weeks ($n = 66$). Possible scores on the FSFI ranged from 7.2 to 36 (mothers who were not sexually active in the previous 4 weeks did not get a total score). Possible scores on the IIEF ranged from 5 to 75. For both measures, higher scores indicate better sexual function. The sexual function scores of 1 female partner and 1 two-spirit partner are not reported to preserve confidentiality of individual data.

^eAt 3-months postpartum mothers reported on the frequency with which they engaged in six different partnered sexual activities in the past 4 weeks on a scale from 0 (never) to 6 (multiple times per day). Possible scores ranged from 0 to 36 with higher scores indicating more frequent and varied sexual activity.

for women at ≥ 19.5 ; however, much less research has been conducted with men so more caution is warranted in using a cutoff (Santos-Iglesias et al., 2018). Internal consistency in our sample was excellent at each time point for mothers (Cronbach's $\alpha = 0.92$ – 0.94) and partners (Cronbach's $\alpha = 0.91$ – 0.93).

Common dyadic coping

The Common Dyadic Coping (CDC) subscale of the Dyadic Coping Inventory (DCI; Bodenmann, 2008) was used to assess the joint efforts that mothers and partners perceive engaging in to cope with shared stress postpartum. The DCI overall, and the CDC subscale specifically, are psychometrically strong (Levesque, Lafontaine, Caron, & Fitzpatrick, 2014). The CDC subscale asks respondents to indicate how often they engage in a series of activities as a couple to manage stress on a 5-point Likert scale ranging from 1 (very rarely) to 5 (very often). Example items include, “We engage in a serious discussion about the problem and think through what has to be done” and “We help one another to put the problem in perspective and see it in a new light”. Total scores range from 5 to 25 with higher scores indicating perceptions of greater CDC. Internal consistency in our sample at 3-months postpartum was good and similar to the validation samples (Levesque et al., 2014) for mothers (Cronbach’s $\alpha = 0.83$) and partners (Cronbach’s $\alpha = 0.78$).

Data Analysis

Descriptive statistics were used to characterize the sample and were calculated using the Statistical Package for the Social Sciences (SPSS V. 25.0, SPSS Inc., Chicago, IL). All other analyses were conducted with Mplus software (version 8.2; Muthén & Muthén, 1998–2017). Dyadic latent growth curve models (LGCM) were used within a structural equation model (SEM; Kenny, Kashy, & Cook, 2006) to estimate the latent intercept for sexual distress at 3-months postpartum and average change across time (i.e., slope). Given the dyadic nature of the data, an actor–partner interdependence framework (Kenny et al., 2006) was employed to account for changes in both partners’ variables within the same model and to assess the covariance (i.e., interdependence) between the growth factors (i.e., intercepts and slopes). A full information maximum likelihood approach (Muthén & Muthén, 1998–2017) was used to account for missing data, which allowed us to retain in the analyses all couples who provided data for at least one of the three postpartum time points. Overall model fit was assessed based on a range of indices including a nonsignificant chi-square test, the comparative fit index (CFI) greater than 0.95, the Tucker–Lewis Index (TLI) greater than 0.95, the root mean square of error approximation (RMSEA) less than .06, and the standardized root mean square residual (SRMR) below 0.08 (Kline, 2016).

RESULTS

Unconditional Dyadic Latent Growth Curve Model

An unconditional dyadic LGCM was estimated to establish the pattern of change in sexual distress in mothers and partners from 3- to 12-months postpartum, including associations between mothers’ and partners’ intercepts and slopes (see Table S1 for descriptive statistics for the study variables). The model provided good fit indices: $\chi^2(7) = 6.29$, $p = .51$; CFI = 1.00; TLI = 1.01; RMSEA = 0.00 [CI = 0.00–0.12]; SRMR = 0.04. Mothers’ mean intercept of 13.92 ($SE = 0.95$, $p < .001$) was above the clinical cutoff, suggesting that at 3-months postpartum mothers were experiencing clinically elevated distress about their sex life. Mothers’ mean intercept was significantly greater than their partners’ intercept of 10.85 ($SE = 0.77$, $p < .001$), Wald $\chi^2(1) = 6.92$, $p < .01$, which was below clinical cutoffs. Random estimates of the intercept for mothers (63.91, $SE = 13.51$, $p < .001$) and partners (51.15, $SE = 9.06$, $p < .001$) were significant, suggesting variability in levels of sexual distress at 3-months postpartum. Sexual distress declined significantly over time for mothers -0.33 ($SE = 0.11$, $p < .01$), but remained stable for partners, -0.02

($SE = 0.07, p = .73$). Random estimates of the slopes were not significant for mothers 0.32 ($SE = 0.36, p = .37$) or partners 0.12 ($SE = 0.21, p = .58$), indicating that all mothers showed similar declines in sexual distress and all partners showed similar stability in their sexual distress over time. The degree to which sexual distress changed postpartum was significantly stronger for mothers compared to partners, Wald $\chi^2(1) = 6.44, p < .05$. See Figure 1 for the trajectories of sexual distress for mothers and partners.

To test the interdependence of sexual distress within couples, we examined the covariance between mothers' and partners' sexual distress intercepts and slopes. The covariance between mothers' sexual distress intercept and their own slope ($-2.77, SE = 1.52, p = .07$) and partners' sexual distress intercept and their own slope ($-0.12, SE = 0.80, p = .88$) were not significant, indicating that one's own sexual distress at 3 months was unrelated to their own change in sexual distress over time. Additionally, mothers' own sexual distress intercept was not related to their partners' sexual distress intercept ($6.01, SE = 7.30, p = .41$) or slope ($0.09, SE = 0.65, p = .89$). Similarly, partners' sexual distress intercept and mothers' sexual distress slope were not related ($0.29, SE = 0.83, p = .73$). These results suggest that one's own sexual distress at 3 months was unrelated to a partner's level of sexual distress at 3 months and rate of change in sexual distress postpartum.

Conditional Dyadic Latent Growth Model

To examine the contribution of CDC to sexual distress at 3-months postpartum and trajectories of sexual distress (i.e., across 3-, 6-, and 12-months postpartum), mothers' and partners' reported CDC scores at 3-months postpartum were included in a dyadic conditional LGCM. The model provided good fit indices: $\chi^2(11) = 7.98, p = .72$; CFI = 1.00; TLI = 1.03; RMSEA = 0.00 [CI = 0.00 – 0.08]; SRMR = 0.03. Mothers' ($M = 18.20, SD = 14.66, Range = 9-25$) and partners' ($M = 17.60, SD = 13.71, Range = 10-25$) self-reported CDC at

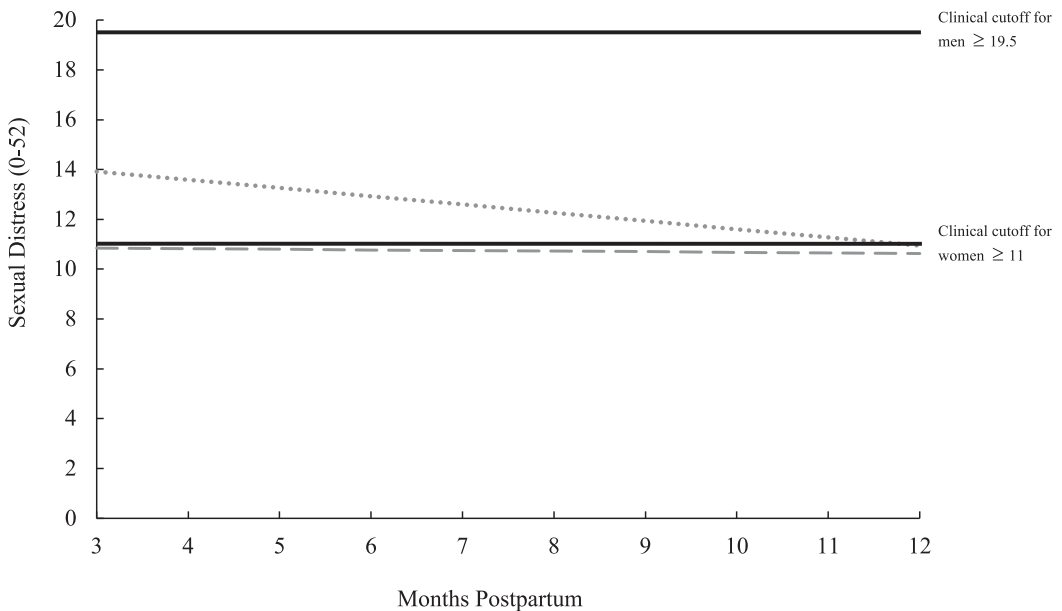


FIGURE 1. Trajectories of Sexual Distress from 3- to 12-Months Postpartum for Mothers and Partners

Note. The standard clinical cutoff value for men was used for all partners ($N = 99; n = 97$ were male).

3-months postpartum were significantly correlated $r(94) = .37, p < .001$; Table S2). Further, mothers' and partners' own reports of higher CDC significantly predicted lower levels of their own sexual distress at 3-months postpartum (Mothers': $-0.57, SE = 0.26, p < .05$, Partners': $-0.67, SE = 0.21, p = .001$). Specifically, for every 1 unit increase in mothers' reported CDC at 3-months postpartum, there was a 0.57 unit reduction in their sexual distress at 3-months postpartum, and for every 1 unit increase in partners' reported CDC, there was a 0.67 unit reduction in their sexual distress at 3-months postpartum. The strength of the effect of CDC on mothers' and partner's own sexual distress intercepts was similar for mothers and partners, Wald $\chi^2(1) = 0.09, p = .76$. Mothers' reported CDC at 3 months was also not related to their partner's levels of sexual distress at 3-months postpartum ($-0.01, SE = 0.21, p = .96$) and partners' reported CDC was not related to mothers' levels of sexual distress at 3-months postpartum ($-0.28, SE = 0.27, p = .29$). There were no significant relationships between CDC and change in sexual distress for mothers or partners. Mothers' reported CDC was not related to their own ($0.001, SE = 0.03, p = .98$) or their partner's ($-0.02, SE = 0.02, p = .30$) slope, and partners' reported CDC was not related to their own ($0.03, SE = 0.02, p = .08$) or mothers' slope ($-0.03, SE = 0.03, p = .29$).

DISCUSSION

The purpose of this study was to examine the links between common dyadic coping (CDC) at 3-months postpartum and sexual distress at 3-months postpartum as well as change in sexual distress over time in a sample of first-time parent couples. We found that mothers' sexual distress was clinically elevated and higher than their partner's at 3-months postpartum. Mothers' sexual distress declined significantly, from above to below clinically elevated levels, from 3- to 12-months postpartum, while partners' sexual distress remained low and stable over time. An individual's higher perceptions of CDC (i.e., the couple's joint efforts to cope with stress) were significantly associated with their own (but not their partner's) lower sexual distress at 3-months postpartum. No significant associations were found between CDC and change in sexual distress over time for mothers nor partners.

Prior studies on postpartum sexuality have largely ignored the sexual distress experienced by new mothers and their partners, as well as couples' dyadic (versus individual) methods of coping in the transition to parenthood. This study advances our understanding of how sexual distress changes over time after the birth of a new baby for both mothers and partners and the interdependence of their sexual distress over time. In line with the Systemic Transactional Model (Bodenmann, 2005), new parents who perceive that they are coping collaboratively with their partner to deal with the novel stressors of parenthood, may have less negative feelings about their sexuality in the postpartum period.

In the current study, only mothers' (but not partners') levels of sexual distress were above the clinical cutoff at 3-months postpartum (a score of 11 or higher for women and a score of 19.5 or higher for men on the SDS-R). Although the primary focus of our paper was not to examine the reasons why mothers and their partners were experiencing sexual distress, the finding that mothers experienced higher sexual distress than their partners may be explained by the myriad of changes to sexuality that are unique to women who give birth. Hormonal fluctuations, changes to body image, breastfeeding, and vaginal trauma are linked to decreased desire and arousal and increased pain during intercourse in new mothers, which in turn, can be associated with sexual distress (McBride & Kwee, 2017; Rosen et al., 2009). On average, while partners' levels of sexual distress at 3-months postpartum were below clinical cutoffs for men, the LGCM revealed that there was significant variability in both mothers' and partners' levels of sexual distress at this time point.

This variability points to the possibility that some partners in our sample may have been experiencing elevated levels of sexual distress, and some mothers may not have been distressed by their sexual relationship in the postpartum period. It is worth noting that the cutoff score for men is much higher than for women, based on a preliminary validation paper that requires replication (Santos-Iglesias et al., 2018). However, the partner's average sexual distress would not be deemed clinically elevated relative to the more stringent clinical cutoff for women either.

The clinically elevated levels of sexual distress experienced by mothers at 3-months postpartum suggest that this may be an important topic to address in postpartum care, although future research is needed to examine how mothers can best manage their distress. New mothers infrequently discuss sexual problems with their clinicians (Barrett et al., 2000), but when they do, the conversations typically focus on contraception and safe return to sexual activity (DeMaria et al., 2019). Current research supports the use of a single item from the SDS-R ("In the past 30 days, how often did you feel distressed about your sex life?") to screen women for sexual distress (Carpenter et al., 2015). This screener offers a practical, efficient method to identify mothers and partners in the clinical setting who may be experiencing sexual distress, regardless of the origin of that distress, and require further attention and intervention.

Consistent with our hypothesis, mothers' sexual distress improved significantly over time, and by 12-months postpartum was no longer above the clinical cutoff. This finding is in line with past research, which found less pronounced differences in sexual distress between new parents at 12-months postpartum and control couples, compared to 3-months postpartum (Schwenck et al., 2020). The clinical cutoff reflects a score that best distinguishes women with and without sexual dysfunction. As such, the degree of change in sexual distress in our study from above to below the clinical cutoff, although relatively small, may be clinically meaningful. Given that sexual distress is a strong determinant of treatment-seeking behavior (Evangelia et al., 2010), it is also possible that this degree of change would correspond to a difference in who may be likely to seek treatment for their sexual difficulties. Although we saw significant decline in sexual distress over time, examination of those who exceeded clinical cutoffs revealed that at 3-months postpartum, 56% of mothers and 13% of partners exceeded their respective clinical cutoffs for sexual distress, whereas by 12-months postpartum 48% of mothers and 14% of partners exceeded the clinical cutoffs. This trajectory may be reassuring for new mothers experiencing distress about their sex life after childbirth. That said, clinical cutoff scores are somewhat arbitrary and the movement of sexual distress scores from above to below the cutoff may still only reflect small changes that could be subtle to new mothers. It is also notable that the proportions of mothers and partners who exceeded the clinical cutoffs were relatively similar at 3- and 12-months postpartum, suggesting that, overall, the level of concerns and worries about sexuality remained elevated during this period. Mothers may need to be followed longer to see larger reductions in sexual distress as the psychological and biological changes associated with their sexuality are still in play during the first 12 months after birth. Indeed, given that CDC was not associated with how new mothers' sexual distress improved from 3- to 12-months postpartum, other factors may be stronger determinants, including improvements in physical function after childbirth (e.g., recovery from vaginal trauma or surgery), as well as other aspects of their life (e.g., improved sleep and role adjustment) that were interfering with their sexuality.

In contrast, partners' sexual distress appeared to remain low and stable between 3- to 12-months postpartum, in line with a recent study (Rosen et al., 2020). These findings may be attributable to the fact that partners' sexuality is impacted to a lesser degree compared to mothers that gave birth (Saotome et al., 2018), and thus, may be less distressing. Partners may also view the disruption to their sexual relationship as normative given the

significant physical and emotional changes that the mother endured. Finally, new fathers report feeling empathic and understanding toward their partner about changes to their sexual relationship (MacAdam, Huuva, & Berterö, 2011), which, may be linked to low sexual distress at this time.

The main goal of our study was to examine whether the way in which couples cope together postpartum was linked with their sexual distress. In partial support of our hypothesis, mothers' and partners' higher CDC was associated with their own lower sexual distress at 3-months postpartum. These findings are in line with theory (Bodenmann, 2005), and past research linking relational closeness with lower sexual distress (Stephenson & Meston, 2010b). When new parents believe that they and their partner are engaging in more joint coping strategies, they may have greater feelings of intimacy and trust, and consequently be less distressed about their sexual relationship. However, contrary to our prediction, mothers' and partners' CDC were not linked to the other parent's sexual distress. There is robust evidence for the association between one's own perceived CDC and both one's own and a partner's relational outcomes (Austin & Falconier, 2013; Falconier, 2013; Zemp, Milek, Cummings, & Bodenmann, 2017), including new parents' marital adjustment (Molgora, Acquati, et al., 2019; Rauch-Anderegg, Kuhn, Milek, Halford, & Bodenmann, 2020). However, our findings are in line with the limited past research that has found an association between one's own perceived dyadic coping and one's own sexual satisfaction, but not a partner's sexual adjustment (Van Schoors et al., 2019). Our study adds to the small but growing body of literature on dyadic coping and sexual outcomes suggesting that the effects of CDC on one's own sexuality may be stronger than the effects on one's partner. Although CDC is inherently a relational concept focused on how couples work *together* to manage stress, it was still assessed as an individual's perception of that coping. Moreover, sexual distress is primarily an intraindividual construct based on how individuals feel about their *own* sexuality. Thus, one's perception of dyadic coping may be more strongly linked to one's *own* sexual distress.

While higher CDC at 3-months postpartum was related to a lower sexual distress intercept for mothers and partners (i.e., at 3-months postpartum), the level of CDC at 3-months postpartum was not associated with how sexual distress changed over 3-, 6-, and 12-months postpartum. Early in the postpartum period (e.g., 3-months postpartum) is a critical window for couples to be navigating and adjusting to changes in their sexuality given that the vast majority have resumed sexual activity by this time (McDonald et al., 2017). This is a vulnerable period for new parents who are coping with the acute physical and psychological stressors brought on by childbirth and new parenthood, and may explain why we observed the strongest effect of CDC on sexual distress during this time. Indeed, there may be other factors that influence sexual distress and thus make it more or less likely that couples need to use dyadic coping as time progresses. For instance, due to improvements in stressors (e.g., role adjustment and more sleep) for both members of the couple, CDC may become less relevant to how sexual distress changes over time (Burnham, Goodlin-Jones, Gaylor, & Anders, 2002; Elek, Hudson, & Bouffard, 2003). It is possible that mothers' and partners' perceived CDC at 6- and 12-months postpartum would take into account the other changes that are occurring in their lives and how they are coping over time and may therefore be associated with changes in their sexual distress. However, due to our sample size, we were unable to examine how the evolution of CDC over time is related to changes in sexual distress.

Strengths and Limitations

This study has numerous strengths, including its longitudinal dyadic design, use of validated measures, and novel focus on sexual distress, an understudied aspect of postpartum sexuality. However, there are limitations which must be noted. The results are reflective of the experiences of a homogenous sample of primarily White, heterosexual, married couples with relatively high household income. While these demographics are representative of the population served by the clinic from which the sample was recruited, the generalizability of the results to more diverse populations (e.g., ethnic minorities, non-Western cultures, and same-sex couples) is limited. Our sample may also have been subject to enrollment bias, in that couples who chose to participate may have had more positive relationships than those who chose not to participate (Wittenborn, Dolbin-MacNab, & Keiley, 2013). Our analyses focused on the postpartum period only and we did not control for baseline levels of sexual distress (e.g., in pregnancy or prepregnancy) or other aspects of prepartum relationship functioning. Further, while the clinical cutoff values we used for sexual distress have been validated in the general population, they have not been validated in postpartum samples specifically, and should be interpreted with caution. Finally, we did not examine trajectories of sexual distress beyond 12-months postpartum, nor other factors that may be implicated in new parents' sexual distress and CDC (e.g., sexual function, fatigue, body image, depression, and relationship satisfaction), which should be explored in future research.

CONCLUSIONS

In conclusion, this study is among the first to investigate the sexual distress experienced by new mothers and their partners over the first year postpartum. Sexual distress is high for new mothers early in the postpartum period but declines, whereas sexual distress starts lower and remains stable over time for partners. An enhanced understanding of the trajectories of sexual distress for mothers and partners will allow clinicians to communicate realistic expectations about postpartum changes to sexuality, and to identify new parents who may need clinical support. This study also highlights that new parents' joint efforts to cope with stressors early on in the postpartum period are associated with less distress about their sexual relationship. These findings point to CDC as a potential novel therapeutic target for couples transitioning to parenthood, which may help new mothers and their partners navigate changes to their sexual relationship early on in the postpartum period.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Table S1. Descriptive Statistics for the Study Variables for Mothers and Partners

Table S2. Correlations among Study Variables