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Self-compassion and Compassionate Love are Positively Associated with Sexual and Relational Well-being Among Expectant and New Parent Couples

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Abstract

Pregnancy and the postpartum period can be a challenging time for many couples' relationships. Outside of pregnancy and the postpartum period, being more attentive and sensitive to one's own suffering (i.e., high in self-compassion) and showing love that centers on another person's well-being (i.e., compassionate love) has been linked with greater sexual and relationship satisfaction and lower sexual distress. Both self-compassion and compassionate love may benefit couples during the perinatal period by facilitating more adaptive coping and greater responsiveness to one's own and one's partner's needs. The goal of this study was to examine associations between self-compassion and compassionate love and sexual and relationship satisfaction and sexual distress in two samples of (1) expectant (n = 102) and (2) new parent (n = 102) couples. During pregnancy, self-compassion and compassionate love were linked with higher relationship and sexual satisfaction and lower sexual distress. In the postpartum, higher self-compassion and compassionate love were associated with greater relationship satisfaction, but were less consistently linked with sexual satisfaction and sexual distress. Consistent with theory, self-compassion and compassionate love may allow expectant and new parent couples to adjust to the demands of new parenthood more easily, with benefits for their sexual and relationship wellbeing. Given our data and the established benefits of self-compassion and compassionate love for facilitating adjustment during stressful life events, educating couples about the importance of fostering self-compassion and compassionate love during pregnancy, and after the baby is born, may cultivate resilience which, in turn, may promote stronger relationships.

Keywords: compassion; perinatal; couples; sexual well-being; relationship satisfaction

Self-compassion and compassionate love are positively associated with expectant and new parent couples sexual and relational well-being

Introduction

The perinatal period—pregnancy and up to 12-months postpartum—is a vulnerable time for couples' romantic and sexual relationships likely due to myriad biological, psychological, and interpersonal changes inherent to this transition (for a review see Fitzpatrick et al., 2021). Outside of the perinatal period, being high in self-compassion—being attentive, open, and sensitive to one's own suffering—is associated with higher relationship and sexual satisfaction and lower sexual distress (e.g., Michael et al., 2021; Neff & Beretvas, 2013; Sadiq et al., 2022; Santerre-Baillargeon et al., 2018). Given that couples navigate changes to their relationship during the perinatal period together, compassion that incorporates an interpersonal perspective may also be relevant. Compassionate love—a caring, altruistic love that centers on another person's well-being, especially during periods of difficulty or suffering—is linked with higher relationship and sexual satisfaction outside of the perinatal period (e.g., Neto & Wilks, 2017; Reis et al., 2014), but has not been examined in the perinatal period nor have links with sexual distress been investigated. Both self-compassion and compassionate love may benefit relationship and sexual outcomes during the perinatal period by facilitating more adaptive coping and greater responsiveness to one's own and one's partner's needs during this period of adjustment. Thus, the overarching goal of the current study was to examine links between self-compassion and compassionate love with expectant and new parent couples' relationship satisfaction, sexual satisfaction, and sexual distress, during two times of known vulnerability—pregnancy and the postpartum period.

Cross-sectional and longitudinal research of expectant and new parent couples find that both gestational/birthing parents[1] and their partners experience changes to their relationship and sexual satisfaction that onset in pregnancy and often persist throughout the postpartum period (e.g., Leonhardt et al., 2022; Rosen et al., 2021; Schwenck et al., 2020). This period is also a vulnerable time for how couples interpret these changes, with one and sometimes both members of the couple reporting fluctuating levels of worries or concerns about their sexuality—sexual distress (Dawson et al., 2021; Schwenck et al., 2020; Tavares et al., 2022). Importantly, there is significant heterogeneity with respect to the degree to which relationships and sexuality change. Indeed, research supports that changes to relationship satisfaction, sexual satisfaction, and sexual distress in the perinatal period are not the same for everyone (Ahlborg et al., 2008; Belsky & Rovine, 1990; Leonhardt et al., 2022; Rosen et al., 2021; Shapiro et al., 2000; Tavares et al., 2022). While some couples experience marked declines that persist well after the baby is born, other couples manage to maintain relatively high or at least stable levels of relationship and sexual satisfaction, and low levels of sexual distress.

Given variability within- and between-couples with respect to changes to romantic and sexual relationships, it begs the question: what might be associated with these changes? While previous research has focused on psychosocial risk factors for relational and sexual problems during the perinatal period (for a review, see Fitzpatrick et al., 2021), more recent research has examined potential protective factors. For example, how new parent couples jointly cope with shared stressors is associated with greater relationship and sexual satisfaction (Schwenck et al., 2022) and lower sexual distress (Schwenck et al., 2022; Tutelman et al., 2022). Moreover,

[1]We use the terms "gestational parent" to describe pregnant persons and "birthing parent" to describe persons who gave birth. We use the terms "non-gestational parent" or "non-birthing parent" to refer to the partner who is not pregnant and did not give birth, respectively. We use these terms to be inclusive and capture gender diversity among both parents in our samples.

having a partner who understands and is responsive to one's sexual needs during the perinatal period (i.e., a partner who is higher in dyadic empathy and sexual communal strength, respectively) is associated with both parents' higher relationship and sexual satisfaction (Muise et al., 2017; Rosen et al., 2017). Coping, dyadic empathy, and responsiveness to sexual needs during periods of difficulty are core components of self-compassion and compassionate love; however, associations between self-compassion and compassionate love and relationship and sexual outcomes have not been directly examined during the transition to parenthood.

Self-compassion and Relationship and Sexual Outcomes

Self-compassion is one intrapersonal factor associated with more adaptive coping, greater empathy, and greater responsiveness to one's own and one's partner's needs, especially during times of suffering or adjustment (Lathren et al., 2021). The three components of self-compassion include: self-kindness, which involves self-soothing responses to distress; mindfulness, which involves a balanced and non-judgmental response to negative emotions; and common humanity, which acknowledges that all people experience difficulties and emotional distress, which fosters a sense of connection (Lathren et al., 2021; Neff & Beretvas, 2013). Theoretical models of self-compassion propose that self-compassion exerts its benefits in romantic relationships through more effective emotion regulation and stress management, and that this might promote resiliency during vulnerable times. Indeed, it is thought that self-compassion fosters greater feelings of connection between partners, which might include a stronger sexual connection (Lathren et al., 2021; Neff, 2023; Neff & Beretvas, 2013). Self-compassion is also associated with more effective and open communication about individual health and sexual difficulties (Raque-Bogdan & Hoffman, 2015; Schellekens et al., 2017), which could also lend itself to a stronger romantic and sexual connection between both members of the couple. Given the stressors inherent to both

pregnancy and adjusting to new parenthood after the baby is born, self-compassion may be relevant to couples' relationship and sexual outcomes.

There is emerging evidence from community samples that self-compassion is linked with relationship and sexual outcomes. Cross-sectional studies sampling individuals experiencing health difficulties (e.g., coping with cancer, infertility) have found that higher self-compassion is associated with greater relationship and sexual satisfaction, and lower sexual distress (Michael et al., 2021; Sadiq et al., 2022). In cross-sectional and daily experience studies with community couples, individuals' own higher self-compassion is linked with their own and their partner's higher relationship satisfaction (Neff & Beretvas, 2013) and their own higher sexual satisfaction (Ferreira et al., 2020). In a dyadic study sampling couples in which one partner had a sexual dysfunction (i.e., pain during vaginal penetration), higher self-compassion among the partner without sexual dysfunction was associated with lower sexual distress for both members of the couple (Santerre-Baillargeon et al., 2018). These individual and dyadic studies demonstrate intra- and interpersonal benefits of self-compassion for both relationship and sexual outcomes.

Self-compassion is also associated with stronger relationship outcomes during pregnancy. In the only study to our knowledge, higher levels of self-compassion among gestational parents and their partners (who were not necessarily first-time parents) were each linked with higher emotional intimacy (a couple level variable capturing closeness, trust, warmth, and affection in the relationship; (Huynh et al., 2022). Inconsistent with other research outside of pregnancy, self-compassion was not significantly associated with reports of sexual quality (i.e., sexual satisfaction, presence/absence of negative emotions during sex, presence/absence of sexual difficulties). The discrepant findings with other research may be due to methodological differences, given that the quality of the sexual relationship was assessed via an in-person

interview and rated by the interviewer rather than based on the couples' own reports. This study also did not employ a dyadic analytic approach, which prevented an examination of how self-compassion was linked with one's own and one's partner's relationship and sexual outcomes. To our knowledge, no studies have examined links between self-compassion and relationship and sexual satisfaction and sexual distress in the postpartum period. However, based on theory and research sampling other groups who are experiencing sexual challenges, we might expect that being higher in self-compassion postpartum would be linked with higher relationship and sexual satisfaction and lower sexual distress for oneself and one's partner.

Compassionate Love and Relationship and Sexual Outcomes

Similar to self-compassion, compassion for one's partner is also relevant for relationship and sexual outcomes. Compassionate love includes actions (e.g., showing affection) and attitudes (e.g., valuing the other person), which can be directed toward a romantic partner, with a specific focus on caring, supporting, and understanding the experience of that person, especially during challenges or suffering (Fehr et al., 2014). Theory suggests that compassionate love has strong intra- and interpersonal effects, in part because it feels good to both express and receive this type of love (Underwood, 2009). As such, compassionate love may buffer against the ups and downs of adapting to new relationship stressors inherent to pregnancy and the postpartum, which in turn may explain variability in couples' relationship and sexual outcomes during this time (Alves et al., 2019; Kuersten-Hogan & McHale, 2021).

Most research on compassionate love has sampled newlywed, mixed-gender couples, finding positive links with various relationship outcomes including social support, marital efficacy (i.e., the ability to manage stressors) during conflict, marital stability, emotional empathy, and relationship satisfaction and commitment (Collins et al., 2014; Fehr et al., 2014;

Neff & Karney, 2005; Neto & Neto, 2022; Reis et al., 2014). One dyadic daily experience study found that—for both women and men—on days when individuals reported engaging in more daily acts of compassionate love (e.g., I voluntarily did something special for my partner) relative to their average across all days, they and their partner reported greater relationship satisfaction that day (Reis et al., 2014). Thus, outside of the perinatal period, there is strong evidence that compassionate love is linked with better relationship satisfaction cross-sectionally and longitudinally for both members of the couple.

Very little research has examined links between compassionate love and sexual outcomes, despite evidence that relational and sexual outcomes bidirectionally influence one another (Byers, 2005). In line with equity and exchange theories, giving and receiving compassionate love may contribute to greater relational and possibly sexual satisfaction because expressing compassionate love is perceived as having a partner who is highly responsive to one's needs (Fehr et al., 2014). One cross-sectional study sampling individuals across the lifespan (i.e., young adults, middle-age adults, and elderly adults) found positive associations between compassionate love and sexual satisfaction across each group studied (Neto & Wilks, 2017). No studies to our knowledge have examined links with sexual distress. Given that pregnancy and postpartum are associated with novel and distressing sexual concerns for both members of the couple (Allsop et al., 2022; Schlagintweit et al., 2016), it follows that those higher in compassionate love may be more attune to their partner's sexual difficulties and concerns. This compassion may contribute to more empathic and supportive responses to sexual difficulties, thereby contributing to lower levels of sexual distress.

The Current Study

The perinatal period introduces unique challenges to couples' romantic and sexual relationships that they navigate individually and together. Outside of this period, evidence supports the benefits of self-compassion and compassionate love for couples' relationship satisfaction, with emerging evidence for links with sexual satisfaction and distress. Given that the perinatal period is often characterized by significant stress and adjustment for both partners, responding in a compassionate way to oneself and one's partner, may be especially relevant for understanding sexual and relational adjustment during this time. Indeed, examining these factors in the perinatal context may uncover a novel factor that could help couples better navigate this vulnerable period. The goal of the current study was to examine associations between self-compassion and compassionate love with relationship satisfaction, sexual satisfaction, and sexual distress in two independent samples of pregnant and postpartum couples. Given the importance of identifying protective factors that shape relationship and sexual outcomes in the perinatal period, we hypothesized that a person's own higher levels of self-compassion and compassionate love would be associated with both their own and their partners' higher relationship satisfaction, higher sexual satisfaction, and lower sexual distress.

Method

Participants and Procedure

We simultaneously recruited 116 expectant couples at any stage of pregnancy and 131 new parent couples any time before 12-months postpartum in Canada (70.6%) and the United States (29.4%) from December 2020 to August 2021. To be included in either sample, participants had to be 18 years or older, fluent in English, in a committed romantic relationship with their partner for at least six-months and have access to a personal e-mail account. Given that parents of multiples are at a greater risk of postpartum depression (Choi et al., 2009), which is

associated with poorer sexual well-being (Dawson et al., 2021, 2022), couples were required to have or have had a singleton pregnancy and no other children currently residing in the home. Although one member of the couple had to be the biological gestational or birthing parent, our study was otherwise inclusive to couples of all bodies, sexual orientations, and genders. Couples were not eligible to participate if one member of the couple self-reported an unmanaged medical or psychiatric illness, or if either partner were pregnant (postpartum sample only).

Interested participants completed an online screening survey to determine eligibility. The individual completing the eligibility screening survey provided their partner's contact information. If the couple was deemed eligible, we approached both members of the couple via email to participate in the study. Upon enrollment, couple members were individually sent an anonymized link to a single online Qualtrics survey where they provided informed consent prior to beginning the questionnaires. Participants were instructed to complete their survey independently from their partner. Our research team encouraged participation in the study through e-mail reminders if the survey was not completed after one, two, and three weeks. After four weeks, the survey link expired, and couples were no longer eligible to participate. Both partners were required to complete the survey to be included in our analyses. All procedures were approved by the Research Ethics Board at the IWK Health Center in Halifax, Nova Scotia.

We withdrew couples from either dataset if one or both partners did not complete the survey ($N_{pregnant}$ = 14; $N_{postpartum}$ = 26), failed two out of three data quality checks, which instructed participants to select a certain response to confirm they were paying attention (e.g., This is an attention check. Please select the option "Does not apply"; $N_{postpartum}$ = 2), or if their survey responses indicated that they were ineligible for the study ($N_{postpartum}$ = 1). Our final samples included 102 pregnant (M = 28.3 weeks pregnant; range 8-40 weeks, SD = 7.8 weeks)

and 102 postpartum (*M* = 24.8 weeks postpartum; range 2-56 weeks, *SD* = 14.1 weeks) couples. We individually compensated participants with the equivalent of $10 CAD in Amazon gift cards upon survey completion.

Measures

Sociodemographic Information. Participants reported their age, geographic location, ethnicity, gender, sexual orientation, household income, relationship status and duration, and employment status (see Table 1).

Self-compassion. We assessed self-compassion using 6 items from the Self-compassion Scale-Short Form (SCS-SF; Raes et al., 2011). Items on the SCS-SF were rated on a 5-point Likert scale from 1 (almost never) to 5 (almost always) and capture how often individuals behavee or thought in ways that demonstrate self-compassion (e.g., "when something upsets me, I try to keep my emotions in balance") in the past 4 weeks. Scores on the 6 items were summed to create a total score ranging from 6 to 30 with higher scores indicating greater self-compassion. Scores for three different subscales with 2 items each were also calculated including self-kindness, mindfulness, and common humanity. Scores for each subscale range from 2 to 10. The SCS-SF was validated in a sample of cisgender men and women (Raes et al., 2011), and demonstrated excellent internal consistency in the present study's pregnancy ($\alpha_{\text{gestational parent}}$ = .86, $\alpha_{\text{non-gestational parent}}$ = .84) and postpartum ($\alpha_{\text{birthing parent}}$ = .93, $\alpha_{\text{non-birthing parent}}$ = .93) samples.

Compassionate Love. We assessed compassionate love using the 9-item Compassionate Love Scale for Humanity-Short Form (CLS-H-SF; Chiesi et al., 2020). Items were adapted for the present study to reflect compassionate love for one's romantic partner rather than towards vulnerable strangers. Items were rated on a 7-point Likert scale from 1 (not at all true) to 7 (very true) and evaluate the degree to which individuals felt and demonstrated compassion or altruistic

love toward their romantic partner (e.g., “I feel a selfless caring toward my partner”). Mean scores were calculated for each participant with higher scores indicating greater compassionate love in the past 4 weeks. The CLS-H-SF was originally validated in a sample of both cisgender men and women (Chiesi et al., 2020). In the present study, the CLS-H-SF demonstrated good to excellent internal consistency in both the pregnancy ($\alpha_{\text{gestational parent}} = .89$, $\alpha_{\text{non-gestational parent}} = .93$) and postpartum ($\alpha_{\text{birthing parent}} = .82$, $\alpha_{\text{non-birthing parent}} = .81$) samples.

Relationship Satisfaction. We assessed relationship satisfaction during the past 4 weeks using the 4-item Couples Satisfaction Index (CSI-4; Funk & Rogge, 2007). Items on the CSI-4 were rated on a 5- or 6-point Likert scale depending on the item and capture how individuals felt about their relationship (e.g., happiness, satisfaction). Scores on the 4 items were summed to create a total score ranging from 0 to 21 with higher scores indicating higher relationship satisfaction. The CSI-4 has been used reliably in samples of cisgender men and women (Funk & Rogge, 2007), women in same-sex relationships (Minten & Dykeman, 2019), and couples in pregnancy and postpartum (Sened et al., 2020). For the present study, scores on the CSI-4 demonstrated strong internal consistency in both the pregnancy ($\alpha_{\text{gestational parent}} = .83$, $\alpha_{\text{non-gestational parent}} = .88$) and postpartum ($\alpha_{\text{birthing parent}} = .91$, $\alpha_{\text{non-birthing parent}} = .91$) samples.

Sexual Satisfaction. We assessed sexual satisfaction in the past 4 weeks using the validated Global Measure of Sexual Satisfaction (GMSEX; Lawrance & Byers, 1995). The GMSEX included five bipolar items rated on a 7-point Likert scale (e.g., very negative/very positive). Items on the GMSEX were summed to create a total score ranging from 5 to 35, with higher scores signifying greater sexual satisfaction. The GMSEX has been validated in samples of cisgender adults in heterosexual (Lawrance & Byers, 1995) and same-gender/sex relationships (Calvillo et al., 2020), and couples in pregnancy and the postpartum (Rosen et al., 2021;

Schwenck et al., 2020). For this study, the GMSEX demonstrated excellent internal consistency in both the pregnancy ($\alpha_{\text{gestational parent}} = .91$, $\alpha_{\text{non-gestational parent}} = .92$) and postpartum samples ($\alpha_{\text{birthing parent}} = .93$, $\alpha_{\text{non-birthing parent}} = .95$).

Sexual Distress. We assessed sexual distress during the past 4 weeks using the 13-item Sexual Distress Scale-Revised (SDS-R; DeRogatis et al., 2008). This measure captured the extent to which individuals felt bothered or distressed about sexual problems. Items on the SDS-R were rated on a 5-point Likert scale and range from 0 (never) to 4 (always). Scores for each participant were summed to create a total score ranging from 0 to 52, with higher scores reflecting higher sexual distress. The SDS-R has been validated in cisgender women (DeRogatis et al., 2008) and men (Santos-Iglesias et al., 2018) and has been used reliably in previous samples of first-time parent couples (Rossi et al., 2022; Schwenck et al., 2020). For the present study, scores on the SDS-R demonstrated excellent internal consistency in both the pregnancy ($\alpha_{\text{gestational parent}} = .96$, $\alpha_{\text{non-gestational parent}} = .94$) and postpartum ($\alpha_{\text{birthing parent}} = .94$, $\alpha_{\text{non-birthing parent}} = .90$) samples.

Data Analysis

All data processing and analyses for the present study were conducted in SPSS 28.0. Missing data were not imputed for the current study, as participants with missing data ($n = 2$) were missing more than 10% of the affected measures. All variables met normality assumptions. Our analyses were informed by the Actor Partner Interdependence Model (APIM) (Cook & Kenny, 2005) with self-compassion and compassionate love as the independent variables, relationship satisfaction, sexual satisfaction, and sexual distress as the dependent variables, and partner role (e.g., gestational or non-gestational parent; birthing or non-birthing parent) as the distinguishing variable. These analyses allowed us to evaluate associations between individuals'

self-compassion and compassionate love with their own relationship and sexual outcomes (i.e., actor effects) as well as their partner's relationship and sexual outcomes (i.e., partner effects). Separate models were run for self-compassion and compassionate love with each of the three outcome variables (i.e., relationship satisfaction, sexual satisfaction, and sexual distress), and separately for the pregnancy and postpartum sample. Thus, a total of 6 models were run in each sample, 3 for self-compassion and 3 for compassionate love. All syntax and output are available on the Open Science Framework (https://osf.io/hjdkv/).

Results

Self-compassion

All results are presented in Tables 2 (pregnancy) and 3 (postpartum). Higher self-compassion among gestational parents and their partners were associated with their own higher relationship satisfaction, sexual satisfaction, and lower sexual distress in pregnancy. Gestational parent's higher self-compassion was linked with their partner's higher relationship satisfaction, but not their sexual satisfaction or sexual distress. Partner's higher self-compassion was linked with the gestational parent's higher relationship satisfaction and sexual satisfaction, but not their sexual distress.

In the postpartum sample, higher self-compassion was associated with one's own higher relationship satisfaction, but not their own sexual satisfaction or sexual distress. When birthing parents reported higher self-compassion, their partner's reported greater relationship satisfaction. No other partner effects were observed for any of the outcomes. Associations for the three self-compassion subscales are included as supplemental analyses (see Supplemental Tables 1 and 2). The pattern of results were largely consistent with those reported for the total self-compassion score.

Compassionate Love

In our pregnant sample, higher compassionate love was associated with both partner's own higher relationship satisfaction and sexual satisfaction, and the gestational parent's lower sexual distress. Individuals' higher compassionate love was also linked with their partner's higher relationship satisfaction, and gestational parents higher compassionate love was linked with their partner's higher sexual satisfaction. No partner effects were observed for sexual distress. In the postpartum sample, higher compassionate love was associated with one's own higher relationship and sexual satisfaction, but not sexual distress. No significant partner effects were observed.

Discussion

In our dyadic study of two separate samples—pregnant and postpartum couples—we examined associations between self-compassion and compassionate love with couples' relationship satisfaction, sexual satisfaction, and sexual distress. In general, individuals' greater self-compassion and compassionate love were mainly associated with their own higher sexual satisfaction and lower sexual distress in pregnancy and with their own higher sexual satisfaction in the postpartum period, suggesting more of an intrapersonal benefit for sexual outcomes. We saw both intra- and interpersonal benefits of self-compassion and compassionate love for relationship satisfaction—that is, greater compassion was linked to both own and partner higher relationship satisfaction. These data extend theories of self-compassion and compassionate love to the understanding of sexual in addition to relational outcomes during the perinatal period. Consistent with theory and prior research outside of the perinatal period, our findings add to the burgeoning body of literature examining protective factors during the perinatal period. Specifically, that self-compassion and compassionate love may be important protective factors

for expectant and new parent couples as they navigate relational and sexual challenges (Leonhardt et al., 2022; Michael et al., 2021; Muise et al., 2017; Neff & Beretvas, 2013; Rosen et al., 2017, 2020; Sadiq et al., 2022; Santerre-Baillargeon et al., 2018; Schwenck et al., 2022; Tutelman et al., 2022).

Building upon previous research outside of the perinatal period, self-compassion was associated with greater sexual satisfaction, but only for pregnant couples. Specifically, when gestational parents reported being more compassionate toward themselves, they reported feeling more sexually satisfied in pregnancy. In addition, when non-gestational parents were high in self-compassion in pregnancy, both they and the gestational parent reported higher sexual satisfaction. Interestingly, these findings differ from Huynh et al. (2022) who did not observe benefits of self-compassion for pregnant couples' sexual quality, though sexual quality was assessed via an interview and rated by the interviewer rather than the couples themselves. However, previous research sampling non-pregnant individuals has established the intrapersonal benefits of self-compassion for sexual satisfaction (Michael et al., 2021; Sadiq et al., 2022). The one dyadic study sampling community couples found that greater self-compassion among partners who are men was associated with their own and their woman partner's higher sexual satisfaction (Ferreira et al., 2020). Pregnancy is associated with body changes for both partners (Fitzpatrick et al., 2022), with body dissatisfaction being linked to lower sexual satisfaction. It is possible that by being self-compassionate about these and other changes (e.g., showing kindness and being non-judgemental toward the self, seeing it as a common experience for everyone in pregnancy) might reduce negative cognitions and promote more positive evaluations of the changing sexual relationship—that is greater sexual satisfaction. Given that the gestational parent is the person undergoing the most significant changes to their sexuality during pregnancy

(Dawson et al., 2021; Rosen et al., 2021; Schwenck et al., 2020), it is possible that having a partner who makes them feel less alone in their experience (i.e., being high in common humanity), may serve to strengthen the emotional connection and foster intimacy between partners, contributing to higher levels of sexual satisfaction for not just themselves but also the gestational parent.

To our knowledge, this is the first dyadic study to examine links between compassionate love and sexual satisfaction. Caring for your partner and showing compassion when they are in need, that is, being higher in compassionate love, was associated with one's own higher sexual satisfaction in pregnancy and the postpartum. In the pregnant sample, we also saw that when gestational parents were higher in compassionate love, their partners reported greater sexual satisfaction. Compassionate love is positively associated with perceiving that your partner is responsive to your needs (Fehr et al., 2014) and previous research has demonstrated links between perceived partner responsiveness and sexual satisfaction among first-time birthing parents (Rosen et al., 2020). Being high in compassionate love may allow partners to not only be more responsive to one another's needs, but also to provide emotional and instrumental support that in turn strengthen a couples' sexual connection. This result adds to a growing body of research demonstrating the protective benefits of being more understanding of one another's needs and responding in empathic ways for sexual satisfaction during the perinatal period (Muise et al., 2017; Rosen et al., 2017, 2020).

We also examined for the first time, whether self-compassion and compassionate love might be linked to couples' sexual distress in pregnancy and the postpartum, given that the perinatal period is associated with increases in sexual concerns, which many couples experience as distressing (Allsop et al., 2022; Dawson et al., 2022; Schlagintweit et al., 2016). In pregnancy

only, being higher in self-compassion was associated with one's own lower sexual distress. With respect to compassionate love, when gestational parents were higher in compassionate love they reported lower sexual distress in pregnancy, but no effects were observed in the postpartum or for partner's sexual distress. Indeed, pregnancy is a time of heightened sexual distress for gestational parents in particular (Vannier & Rosen, 2017). Our findings suggest that gestational parents who respond to their own distress with sensitivity and understanding may fare better than those who are lower in self-compassion and compassionate love. The absence of partner effects for sexual distress, might be in part due to other intra- and interpersonal factors being more relevant to understanding sexual distress. Indeed, intrapersonal factors like postpartum depression and anxiety (Asselmann et al., 2016; Dawson et al., 2020, 2021, 2022), stress (Leavitt et al., 2017; Maas et al., 2018; Tavares et al., 2019), and fatigue (Dawson et al., 2020), as well as interpersonal factors like dyadic coping (Schwenck et al., 2022; Tutelman et al., 2022) may be better predictors of sexual distress in the postpartum. The lack of effects in the postpartum sample, in particular, may be because sexual distress tends to decline (i.e., improve) across the postpartum period and as such we may have lacked power to detect small effects if they do exist (Dawson et al., 2021; Rosen et al., 2021).

Replicating previous research in community couples and extending it to perinatal samples, we found that self-compassion and compassionate love were each linked with relationship satisfaction for oneself and for one's partner. Indeed, we found that when individuals were higher in self-compassion, that is being attentive, open, and sensitive to their own difficulties, they and their partners reported greater relationship satisfaction in pregnancy and the postpartum period. For compassionate love, we saw similar patterns for pregnant couples, however, for postpartum couples, being higher in compassionate love was only linked

with their own higher relationship satisfaction. It is possible that self-compassion and compassionate love exert their benefits during the relational challenges of pregnancy and the postpartum period by helping couples more effectively manage emotions and stressors associated with this adjustment, as well as responding to one another through supportive and caring acts (Fehr et al., 2014; Lathren et al., 2021; Neff & Beretvas, 2013; Reis et al., 2014). Consistent with interpersonal theories of intimacy (Laurenceau et al., 1998) and one study of pregnant couples (Huynh et al., 2022), self-compassion and compassionate love may help couples maintain intimacy, which translates into feeling more satisfied with their relationship.

Our patterns of results were relatively consistent for both the gestational/birthing parent and their partners; however, what did differ is the overall pattern of effects as a function of sample (i.e., pregnant vs. postpartum). While pregnancy may be associated with novel relational and sexual challenges, we might expect even more stressors to be present after the baby is born (Doss & Rhoades, 2017; Vismara et al., 2016). As such, we might have expected to see stronger associations between self-compassion and compassionate love and our outcomes in the postpartum, yet we saw a larger number of effects within our pregnant sample. The most parsimonious explanation for this difference may relate to other factors specific to the postpartum period (e.g., fatigue, reduced time with one's partner relative to caring for the baby) being stronger contributors to sexual and relationship outcomes during this time period. Another possibility is that we know sexual and relational outcomes tend to decline in pregnancy and improve, on average, across the postpartum period (Leonhardt et al., 2022; Rosen et al., 2021; Schwenck et al., 2020); thus, although the study was cross-sectional we may have been capturing couples at different stages of sexual and relationship change, which may have influenced the results.

Limitations

Although our study increased understanding of the links between self-compassion and compassionate love for sexual and relationship well-being during pregnancy and the postpartum, our study is not without limitations. One strength of the current study is the recruitment of two separate samples of pregnant and postpartum couples; however, our study was also cross-sectional, thus we cannot draw conclusions regarding causality. Future dyadic studies should sample couples over the course of their transition to parenthood, to examine temporal associations and to establish if self-compassion and compassionate love buffer against expected declines in relationship and sexual outcomes. Despite efforts to recruit a diverse sample via the use of inclusive advertising (e.g., images of sex/gender diverse couples), targeted advertising in online groups for sex/gender diverse expectant and new parents, and paid Facebook ads to recruit geographically and socioeconomically diverse couples, most couples reported being in mixed-gender/sex relationships (97%), were White (77%), and of high socioeconomic status (70%). As such these findings may not generalize to couples with minoritized and marginalized identities. There is strong evidence to support that identity and social categorization influence individuals' and couples' experience of the transition to parenthood (Chan et al., 2021; Mehra et al., 2020; Owais et al., 2020), and other evidence supporting that self-compassion may buffer against some adverse effects of minority stress (Vigna et al., 2018). Indeed, sex and gender-diverse couples may experience different stressors (e.g., homophobia and transphobia, stigma related to their sexuality, gender, and relationship) while navigating hetero- and cisnormative healthcare systems during their transition to parenthood (Röndahl et al., 2009). As such, we might observe different effects (e.g., stronger) among sex and gender-diverse couples, similar to findings linking self-compassion with other aspects of mental health (Carvalho & Guimar, 2022). Indeed, future

research should intentionally recruit more diverse samples to provide findings that are more generalizable in line with recent recommendations (Lowik et al., 2022).

Conclusions

In sum, our data reveal for the first time the links between self-compassion and compassionate love for pregnant and new parent couples' relationship and sexual satisfaction and to some extent sexual distress. This new knowledge of protective factors may be especially relevant for prevention and intervention efforts with expectant and new parent couples. For example, clinicians could assess self-compassion and compassionate love when seeing individuals or couples in pregnancy or in the postpartum to examine whether these would be relevant targets to help couples navigate challenges to their relationship. Consistent with theory, interventions (e.g., compassion-focused therapy) focused on fostering self-compassion and compassionate love may allow couples to adjust to the demands of new parenthood more easily through more effective emotion regulation, problem solving, and greater awareness of their own and their partner's needs. Given our data and the established benefits of self-compassion and compassionate love for facilitating adjustment during stressful life events (Michael et al., 2021; Neff & Beretvas, 2013; Sadiq et al., 2022; Santerre-Baillargeon et al., 2018), educating and teaching couples the importance of fostering self-compassion and compassionate love before conception, during pregnancy, and after the baby is born may cultivate resilience, which in turn may promote stronger relationships.

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Table 1.

Sociodemographic descriptives for the pregnancy (N = 102 couples) and postpartum (N = 102 couples) samples

	Pregnancy sample		**Postpartum sample**	
	Gestational parents *M* ± *SD* or *N (%)*	Non-gestational parents *M* ± *SD* or *N (%)*	Birthing parents *M* ± *SD* or *N (%)*	Non-birthing parents *M* ± *SD* or *N (%)*
Age (years)	30.39 ± 4.09	31.82 ± 4.06	30.26 ± 4.06	31.44 ± 4.18
Weeks pregnant or postpartum	28.3 ± 7.8		24.8 ± 14.1	
Gender				
Woman	100 (97.1%)	2 (2.0%)	101 (99.0%)	-
Man	-	99 (96.0%)	-	102 (100.0%)
Genderqueer	3 (2.9%)	2 (2.0%)	1 (1.0%)	-
Non-binary	-	1 (1.0%)	-	-
Sexual Orientation				
Heterosexual	83 (81.4%)	93 (91.2%)	90 (88.2%)	96 (94.1%)
Lesbian	-	1 (1.0%)		
Bisexual	13 (12.7%)	3 (2.9%)	8 (7.8%)	3 (2.9%)
Pansexual	2 (2.0%)	2 (2%)	3 (2.9%)	1 (1.0%)
Asexual	1 (1.0%)	1 (1.0%)	1 (1.0%)	2 (2.0%)
Queer	2 (2.0%)	-	-	-
Questioning	1 (1.0%)	2 (2.0%)	-	-
Ethnicity/Culture				
Indigenous	-	-	-	2 (2.0%)
White	76 (74.5%)	79 (77.5%)	80 (78.4%)	78 (76.5%)
East Asian	3 (2.9%)	1 (1.0%)	5 (4.9%)	3 (2.9%)
Hispanic	1 (1.0%)	1 (1.0%)	6 (5.9%)	4 (3.9%)
Latina/Latino/Latinx	2 (2.0%)	2 (2.0%)	3 (3.0%)	2 (2.0%)
African American/Black	3 (2.9%)	6 (5.9%)	3 (2.9%)	5 (4.9%)
South Asian	6 (5.9%)	4 (3.9%)	1 (1.0%)	2 (2.0%)
Southeast Asian	2 (2.0%)	3 (2.9%)	3 (2.9%)	1 (1.0%)
Biracial/Multiracial	8 (7.8%)	2 (2.0%)	3 (2.9%)	4 (3.9%)
Middle Eastern/Central Asian	1 (1.0%)	1 (1.0%)	1 (1.0%)	1 (1.0%)
Something else†	-	2 (2.0%)	-	-
Relationship Status				
Married	82 (80.4%)		86 (84.3%)	
Common-law	10 (9.8%)		11 (10.8%)	
Engaged	6 (5.9%)		3 (2.9%)	
Living together	4 (3.9%)		2 (2.0%)	
Relationship Length (years)	6.83 ± 4.68		7.17 ± 3.35	
Shared Annual Income				
$0-$39,999	8 (7.8%)		8 (7.8%)	
$40,000-$79,999	20 (19.7%)		25 (24.5%)	
>$80,000	74 (72.5%)		69 (67.6%)	
Self-compassion Total Score	20.51 ± 4.70	20.84 ± 4.87	18.75 ± 4.68	20.47 ± 4.68
Self-kindness Subscale	6.59 ± 1.77	6.42 ± 1.79	6.17 ± 1.80	6.26 ± 1.90
Mindfulness Subscale	7.37 ±1.66	7.66 ± 1.80	6.53 ± 1.82	7.86 ± 1.69
Common Humanity Subscale	6.55 ± 1.95	6.76 ± 2.06	6.05 ± 1.91	6.35 ± 2.04
Compassionate Love	6.46 ± 0.59	6.21 ± 0.83	6.09 ± 0.88	5.89 ± 0.90

Note. The total *N* for our gender variable exceeds the total study *N* (i.e., 204 couples) as participants were allowed to select as many options as they felt applied to them. Thus, participants who selected more than

one gender are captured in more than one cell. †Participant response(s) for ethnicity: Southern European

Table 2. *Associations between self-compassion and compassionate love and relationship satisfaction, sexual satisfaction, and sexual distress in pregnant couples.*

	Self-Compassion Total						***Compassionate Love***					
	b	*SE*	df	*t*	*p*	95% CI	*b*	*SE*	df	*t*	*p*	95% CI
Relationship Satisfaction												
Actor effects												
Gestational parents	**0.12**	**0.05**	**99**	**2.20**	**.03**	**0.01, 0.22**	**1.39**	**0.43**	**99**	**3.26**	**.002**	**0.55, 2.24**
Partners	**0.22**	**0.06**	**99**	**3.81**	**<.001**	**0.11, 0.34**	**2.12**	**0.31**	**99**	**6.89**	**<.001**	**1.51, 2.73**
Partner effects												
Gestational parents	**0.19**	**0.05**	**99**	**3.76**	**<.001**	**0.09, 0.29**	**0.87**	**0.31**	**99**	**2.84**	**.006**	**0.26, 1.47**
Partners	**0.17**	**0.06**	**99**	**2.83**	**.006**	**0.05, 0.29**	**0.88**	**0.43**	**99**	**2.05**	**.04**	**0.03, 1.73**
Sexual Satisfaction												
Actor effects												
Gestational parents	**0.32**	**0.13**	**99**	**2.46**	**.02**	**0.06, 0.57**	**2.95**	**1.09**	**99**	**2.70**	**.008**	**0.77, 5.12**
Partners	**0.46**	**0.12**	**99**	**3.91**	**<.001**	**0.23, 0.69**	**1.53**	**0.72**	**99**	**2.11**	**.04**	**0.09, 2.97**
Partner effects												
Gestational parents	**0.39**	**0.12**	**99**	**3.14**	**.002**	**0.14, 0.64**	0.76	0.78	99	0.97	.33	-0.79, 2.31
Partners	0.13	0.12	99	1.04	.30	-0.11, 0.37	**2.26**	**1.01**	**99**	**2.24**	**.03**	**0.26, 4.27**
Sexual Distress												
Actor effects												
Gestational parents	**-0.75**	**0.24**	**99**	**-3.09**	**.003**	**-1.24, -0.27**	**-4.65**	**2.03**	**99**	**-2.30**	**.02**	**-8.67, -0.64**
Partners	**-0.58**	**0.18**	**99**	**-3.27**	**.001**	**-0.93, -0.23**	-1.10	1.10	99	-1.00	.32	-3.29, 1.08
Partner effects												
Gestational parents	-0.41	0.24	99	-1.74	.09	-0.88, 0.06	-2.43	1.45	99	-1.68	.10	-5.31, 0.44
Partners	-0.07	0.18	99	-0.39	.70	-0.43, 0.29	-2.59	1.54	99	-1.68	.10	-5.65, 0.46

Note. Significant associations ($p < .05$) are bolded.

Table 3. *Associations between self-compassion and compassionate love and relationship satisfaction, sexual satisfaction, and sexual distress in postpartum couples.*

	Self-Compassion Total						***Compassionate Love***					
	b	*SE*	df	*t*	*p*	95% CI	*b*	*SE*	df	*t*	*p*	95% CI
Relationship Satisfaction												
Actor effects												
Gestational parents	**0.21**	**0.07**	**98**	**2.98**	**.004**	**0.07, 0.35**	**2.25**	**0.32**	**98**	**7.11**	**<.001**	**1.62, 2.88**
Partners	**0.15**	**0.07**	**98**	**2.15**	**.03**	**0.01, 0.30**	**2.01**	**0.34**	**98**	**5.90**	**<.001**	**1.34, 2.69**
Partner effects												
Gestational parents	0.14	0.07	98	1.96	.05	0.00, 0.28	0.51	0.31	98	1.62	.12	-0.11, 1.12
Partners	**0.19**	**0.07**	**98**	**2.73**	**.008**	**0.05, 0.34**	0.45	0.35	98	1.29	.20	-0.24, 1.14
Sexual Satisfaction												
Actor effects												
Gestational parents	0.05	0.16	97	0.32	.75	-0.26, 0.36	**1.88**	**0.86**	**99**	**2.17**	**.03**	**0.16, 3.59**
Partners	0.34	0.18	98	1.88	.06	-0.02, 0.70	**1.99**	**0.97**	**98**	**2.05**	**.04**	**0.06, 3.93**
Partner effects												
Gestational parents	0.20	0.16	97	1.26	.21	-0.11, 0.51	0.34	0.83	97	0.41	.68	-1.30, 1.99
Partners	0.03	0.18	98	0.18	.86	-0.33, 0.39	0.16	0.99	98	0.16	.87	-1.81, 2.13
Sexual Distress												
Actor effects												
Gestational parents	-0.37	0.24	98	-1.52	.13	-0.86, 0.12	-1.61	1.35	98	-1.19	.24	-4.28, 1.07
Partners	-0.28	0.18	98	-1.57	.12	-0.64, 0.07	-1.41	0.98	98	-1.44	.15	-3.37, 0.54
Partner effects												
Gestational parents	-0.09	0.25	98	-0.35	.73	-0.57, 0.40	-0.16	1.32	98	-0.13	.90	-2.79, 2.46
Partners	-0.28	0.18	98	-1.56	.12	-0.63, 0.08	0.15	1.00	98	0.15	.88	-1.83, 2.14

Note. Significant associations ($p < .05$) are bolded.