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You Just Don't Get It: The Role of Perceived Partner Responsiveness in the Link Between Cumulative Childhood Interpersonal Trauma and Postpartum Sexual Satisfaction

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ABSTRACT

After childbirth, couples often experience a decline in sexual satisfaction, with interpersonal trauma survivors being particularly vulnerable. In fact, increasing evidence links cumulative childhood interpersonal trauma (CCIT) with reduced sexual well-being in adulthood. However, little is known about the influence of CCIT on postpartum sexual satisfaction and the underlying mechanisms, while childbirth is a stressful period that may reactivate traumatic memories and disrupt intimacy. Perceived partner responsiveness could serve as an explanatory mechanism, as it has been associated with sexual satisfaction in CCIT survivors. Using a dyadic approach, this study aimed to examine the role of perceived partner responsiveness in the association between CCIT and postpartum sexual satisfaction in couples who recently welcomed a child. A randomly selected community sample of 473 Canadian parental couples completed online self-reported questionnaires assessing CCIT, perceived partner responsiveness, and sexual satisfaction. Path analyses guided by the Actor-Partner Interdependence Model revealed that CCIT was associated with lower sexual satisfaction through lower perceived partner responsiveness in both mothers and fathers. Moreover, significant dyadic indirect effects confirmed partners' interinfluences on outcomes. Results highlight the importance of targeting both partners' perceived partner responsiveness in interventions aiming to enhance postpartum sexual satisfaction among parents who have experienced CCIT.

Introduction

Although the birth of a child is generally a joyful event, couples may face significant challenges during this period as they navigate substantial changes both individually and in their relationship (Delicate et al., 2018). Among these challenges, those related to sexuality are common, with both partners often experiencing difficulties in sexual desire and satisfaction (Fitzpatrick et al., 2021). Sexual satisfaction, defined as the subjective and emotional evaluation of the positive and negative aspects of one's sexual relationship (Lawrance & Byers, 1995), is a key component of psychological and relational well-being (see Sánchez-Fuentes et al., 2014). Maintaining a satisfying sexual relationship is one of the main determinants of relationship satisfaction (Joel et al., 2020), and this holds true during the postpartum period (Nezhad & Goodarzi, 2011). Therefore, the resumption of a satisfying sexual life during this time is an important dimension of postpartum recovery.

Postpartum Sexual Satisfaction

The postpartum period (i.e., up to 12 months after the birth of a child) is associated with decreases in both the frequency of sexual intercourse and sexual satisfaction for both partners (Behzadipour et al., 2021; Schwartz & Young, 2009). Most literature on postpartum sexual well-being has focused primarily on mothers (e.g., Dawson et al., 2020; Delgado-Pérez et al., 2022; McBride & Kwee, 2017; Rahmani et al., 2023; Wood et al., 2022), with limited research on fathers. Ahlborg al.'s (2005) study with first-time parents suggested that fathers may experience higher levels of sexual dissatisfaction compared to mothers after childbirth. Conversely, Schwenck et al. (2020) found that mothers reported significantly lower sexual satisfaction than fathers three months after childbirth. In a recent dyadic study, Bourque-Morel et al. (2025) found that both partners reported increases in sexual satisfaction from pregnancy to 12 months postpartum. Another dyadic and longitudinal study led by Rosen et al. (2021) revealed that mothers' sexual satisfaction remained low but stable over time, while their partners' satisfaction continually declined up to 12 months postpartum. Taken together, these findings highlight potential gender differences in how women who give birth and their partners navigate sexuality during the postpartum period.

To date, most studies have examined sexual satisfaction from an individual perspective, assessing each partner separately without considering how one partner's experience may influence the other's (Byers & Wang, 2004). Even when both

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partners were included, limited attention was given to the interdependence of factors influencing sexual satisfaction between partners, despite the inherently relational nature of sexual dynamics. A dyadic approach offers a more nuanced understanding of how partners' experiences mutually influence one another, which is especially relevant during the postpartum period, when couples must renegotiate their intimacy.

According to the biopsychosocial theory of sexual well-being (McBride & Kwee, 2017), the year following the birth of a child is a particularly vulnerable period for declines in sexual satisfaction, given the biological, psychological, and relational changes that occur. Factors such as increased stress, postpartum depression, fatigue, and changes in family roles have been increasingly studied in relation to sexual well-being during this time (Tavares et al., 2023). Mothers may also face additional physical changes (e.g., perineal trauma and breastfeeding) that further affect their experience of sexuality and satisfaction (see Korzeniewski et al., 2021). Recent evidence suggests that psychosocial factors, such as relationship satisfaction, may exert a greater influence on sexual well-being than biological factors such as breastfeeding (Dawson et al., 2020). Despite these recent efforts to identify psychosocial factors linked to sexual satisfaction during the postpartum period (e.g., attachment insecurities; Bourque-Morel et al., 2025), childhood interpersonal trauma has rarely been investigated in the context of postpartum sexuality.

Childhood Interpersonal Trauma and Postpartum Sexual Satisfaction

Childhood interpersonal trauma refers to any act or omission causing harm to a child within an interpersonal context (Briere & Scott, 2015). It includes neglect, physical or psychological abuse, sexual abuse, witnessing interparental violence, and peer bullying experienced before the age of 18 (Espelage et al., 2016; Finkelhor et al., 2007). Childhood interpersonal trauma has been associated with a wide range of negative outcomes in adulthood (see Dugal et al., 2016). Trauma research shows that experiencing various forms of trauma, regardless of their severity or frequency, is related to more severe and long-lasting symptoms (Bolduc et al., 2018; Godbout et al., 2023; Hodges et al., 2013; Hughes et al., 2017). This phenomenon has been labeled as cumulative childhood interpersonal trauma (CCIT; Finkelhor et al., 2007).

Beyond its well-documented links to psychological and relational difficulties, CCIT has been shown to negatively affect sexual well-being, particularly sexual satisfaction in adulthood. Previous research has documented associations between CCIT and lower sexual satisfaction in community and clinical samples (Bigras et al., 2017; Dugal et al., 2023; Dussault et al., 2022; Godbout et al., 2020). Partners of individuals with a history of CCIT may also encounter sexual dissatisfaction (Vaillancourt-Morel, Bussières, et al., 2023). To date, however, no study has explored these associations in the context of postpartum couples. Parents with a history of trauma, especially CCIT, tend to face greater individual and relational challenges when adjusting to parenthood (Garon-Bissonnette et al., 2022; MacIntosh & Ménard, 2021; Morissette Harvey et al., 2024). MacIntosh et al. (2020) further noted that sexual difficulties among CCIT survivors may surface during major life transitions, such as childbirth. The arrival of a child can be a stressful event that reactivates traumatic memories and disrupts intimacy within the couple (Chamberlain et al., 2019), placing this population at a double risk of sexual dissatisfaction: first, due to their history of CCIT, and second, because the postpartum period itself heightens vulnerability to sexual difficulties.

The lack of empirical data on this issue limits the evidence base needed to inform assessment and treatment for parental couples presenting with lower sexual satisfaction following childbirth. For this population, experts recommend a comprehensive sexual history of both partners, including their experiences of child sexual abuse, to better understand their current sexual difficulties (Rosen & Byers, 2020). More broadly, sex therapy scholars advocate for the systematic assessment of CCIT in each client (MacIntosh et al., 2020). In light of these clinical recommendations and the limited empirical work conducted with postpartum couples, further research is needed to examine factors associated with sexual satisfaction after childbirth, particularly by examining the role of CCIT and the mechanisms underlying this association. Identifying the processes through which CCIT contributes to lower sexual satisfaction can guide clinical practice by clarifying therapeutic targets and informing interventions with couple. Given its established associations with CCIT (Vaillancourt-Morel et al., 2019, 2023) and with mothers' postpartum sexual satisfaction (Rosen et al., 2020), perceived partner responsiveness may specifically serve as a key explanatory mechanism linking CCIT to couples' sexual satisfaction during this period.

CCIT, Perceived Partner Responsiveness and Postpartum Sexual Satisfaction

According to the Interpersonal Process Model of Intimacy (Reis & Shaver, 1988), a key component in the development and maintenance of intimacy is perceived partner responsiveness. This process is described through three main dimensions (Reis & Le, 2023). The first is understanding, the sense that one's partner truly knowns and grasps who they are. The second is validation, referring to the belief that the partner values and respects one's abilities, traits and perspectives. The third is caring, defined as the perception that one's partner is attentive and willing to meet one's needs, for instance by offering support during stressful times or making sacrifices. When individuals perceive their partner as being responsive, they tend to be more emotionally expressive (Ruan et al., 2020), more trusting toward their partner (Jesslyn & Dewi, 2020) and report greater relationship satisfaction (see Arican-Dinc & Gable, 2023).

Research suggests that perceived partner responsiveness also affects the sexual domain (Birnbaum, 2023). For example, a study conducted among women suffering from genito-pelvic pain and their partners indicated that the higher their own and their partner's levels of perceived partner responsiveness, the more sexually satisfied the women were, but this link was not observed in their partners (Bergeron et al., 2021). A recent study also found a bidirectional association between perceived intimacy (including perceived partner responsiveness) and sexual satisfaction in couples over time (Beaulieu et al.,

2022). In a longitudinal and daily diary study conducted among community couples, a person's greater daily intimacy, including perceived partner responsiveness, was associated with their own greater sexual satisfaction 12 months later, but not with their partner's (Bergeron et al., 2024). Moreover, few studies have investigated the association between perceived partner responsiveness and postpartum sexual satisfaction. Rosen et al. (2020) observed that mothers' perceptions of partner responsiveness predicted higher sexual satisfaction up to 12 months postpartum. Delgado-Pérez et al. (2022) documented strategies used by mothers to adapt to the changes that appear in their first sexual relations after childbirth. Closeness, support, and understanding were found to be useful strategies to cope with these changes, as well as to improve intimacy in their relationships. Therefore, perceiving responsiveness in a partner appears to play a crucial role for sexual well-being during the postpartum period, but additional research is needed to confirm this in fathers. To enhance couples' postpartum sexual satisfaction, it is crucial to identify factors that may shape partners' perceptions of each other's responsiveness and foster interactions where both feel understood, validated, and cared for during this period of adjustment.

The intimacy model of Reis and Shaver (1988) further suggests that perceived responsiveness is filtered through prior relational experiences (Reis, 2017). Perceptions of others are often shaped by cognitive biases (Kenny & Acitelli, 2001), which can distort how partner's responsiveness is perceived. These biases may be influenced by experiences of CCIT, potentially altering how partner responsiveness is interpreted. Although this question remains underexplored, two recent studies support this hypothesis. Vaillancourt-Morel, Rosen, et al. (2023) found that individuals who reported more childhood maltreatment reported lower perceived partner responsiveness over 35 days. Another study conducted by Vaillancourt-Morel et al. (2019) revealed that higher levels of childhood maltreatment – including emotional, physical and sexual abuse, as well as emotional and physical neglect – were associated with lower levels of perceived partner responsiveness, which in turn correlated with lower sexual satisfaction (Vaillancourt-Morel et al., 2019). However, these studies did not account for the cumulative interpersonal traumatic experiences outside of the caregiving system, such as bullying or exposure to violence between parents, which have also been linked to adult sexual difficulties (Morozov & Boislard, 2022; Voisin et al., 2014). Moreover, no study has investigated this model in couples during the postpartum period. As outlined above, parents with a history of CCIT may face an even greater risk of sexual dissatisfaction after childbirth. The interplay between CCIT, perceived partner responsiveness, and sexual satisfaction may function differently in this population, given the unique adjustments that couples are required to make during the postpartum period.

Building on the conceptual framework proposed by Reis and Shaver (1988, 2017), which emphasizes the role of prior relational experiences in shaping perceived responsiveness, and on empirical evidence highlighting perceived partner responsiveness in the association between childhood trauma and sexual satisfaction, a process-oriented framework was adopted in the present work with couples after childbirth. Thus, perceived partner responsiveness was examined as an explanatory relational process linking early interpersonal trauma and postpartum sexual satisfaction. This perspective further supports the focus on perceived partner responsiveness as a clinically relevant and modifiable target, given its strong links with sexual satisfaction and its amenability to change within couple-based interventions.

The Current Study

This study aimed to examine the indirect role of perceived partner responsiveness in the association between CCIT and sexual satisfaction in couples after childbirth. Using a dyadic perspective considering both partners, indirect effects can be represented by four pathways: actor-actor, actor-partner, partner-partner, and partner-actor (Ledermann et al., 2011). Based on previous studies, it was expected that a parent's level of CCIT would be negatively associated with their own level of perceived partner responsiveness, which, in turn, would be associated with their own lower sexual satisfaction (*actor-actor indirect effect*). It was also expected that a parent's level of CCIT would be negatively associated with their own level of perceived partner responsiveness, which, in turn, would be associated with their partner's lower sexual satisfaction (*actor-partner indirect effect*). Additionally, it was expected that a parent's level of CCIT would be negatively associated with their partner's level of perceived partner responsiveness, which, in turn, would be associated with the parent's own lower sexual satisfaction (*partner-partner indirect effect*). Finally, it was expected that a parent's level of CCIT would be negatively associated with their partner's level of perceived partner responsiveness, which, in turn, would be associated with the partner's lower sexual satisfaction (*partner-actor indirect effect*).

Given the mixed findings on gender differences during the postpartum period, this study also aimed to explore whether these effects differed between individuals who identified as mothers and fathers. Based on the literature on postpartum sexual satisfaction in both groups, we expected the dyads to be distinguishable, such that potential significant differences would emerge in how CCIT relates to perceived partner responsiveness and sexual satisfaction among mothers and fathers.

Method

Participants

A total of 646 eligible couples were recruited and completed the questionnaires, but only couples who reported having engaged in sexual activity since childbirth (i.e., kissing, caressing, oral, vaginal or anal penetration) were kept in the analyses. This resulted in a final sample of 473 mixed-gender parental couples ($n = 946$). As each couple included one parent who identified as a mother and had carried the child and one who identified as a father, we refer to participants as mothers and fathers, alternating with the term "parents" when referring

to both. For sociodemographic information on participants, see Table 1.

Procedure

Participants were recruited through a collaboration with the Quebec Parental Insurance Plan and the authorization of the *Commission d'Accès à l'Information*. Contact information (including names, phone numbers, and e-mail addresses) of parents from various regions of Quebec was randomly selected and shared with the research team. Research assistants reached out to parents by e-mail or phone to verify their eligibility and invite them to participate. To qualify for the study, parents had to meet the following criteria: 1) be 18 years of age or older, 2) be a parent of a child aged six months or younger, 3) be in a couple relationship and cohabitating with the other parent, 4) speak and understand French or English, 5) one of the parents must have given birth to the child in Quebec, and 6) both parents must agree to participate in the study. The decision to include a criterion requiring that one partner had carried the child was made to account for the specific challenges associated with giving birth. Although same-gender couples were eligible to participate in the study, this criterion significantly limited their inclusion. Given their very small number ($n = 9$) and the study's secondary objective of examining gender differences, these couples were not included in the present analyses.

Parents who consented to participate in the study were invited to take part in a confidential online survey focused on the well-being of parental couples. Each parent received a personalized code to access and complete the online questionnaire, which was hosted on the Qualtrics platform. Participation took approximately 40 minutes, and all participants provided informed consent before being included in the study. A financial compensation of CAN$20 per person (or $40 per couple) in the form of gift cards (e.g., Amazon) was provided following their participation. Ethical approval for this project was obtained from the institutional research ethics committee of the University of Quebec in Montreal.

Measures

Each member of the couple completed a questionnaire to assess socio-demographic characteristics, including age, gender, place of birth, spoken language, level of education, annual income, and occupation. Additional questions were asked about the couple's relationship, such as marital status, duration of relationship, number of children, and age of newborn.

Table 1. Sociodemographic characteristics.

	Mothers		Fathers	
Characteristics	*n*	%	*n*	%
Birthplace				
Canada	399	84.4	384	81.4
Africa	16	3.4	24	5.1
Europe	30	6.4	27	5.7
South America	7	1.5	10	2.1
Asia	9	1.9	8	1.7
Other	12	2.5	19	4
Level of education completed				
Primary school	9	1.9	19	4
High school	56	11.8	70	14.8
CEGEP (college)/professional diploma	182	38.5	207	43.8
Undergraduate	146	30.9	115	24.3
Graduate	80	16.9	62	13.1
Yearly income (CAN$)				
$19,000 or less	55	11.7	15	3.2
$20,000 – $39 999	126	26.8	51	10.8
$40,000 – $59 999	150	31.9	163	34.5
$60,000 – $79 999	83	17.7	130	27.5
$80,000 and more	56	11.9	113	23.9
Relationship status				
Common-law	335	71	336	71
Married	133	28.2	135	28.5
Number of children				
First child	228	48.5	232	49.4
2 children	145	30.9	140	29.8
3 and more	97	20.5	98	20.8
Breastfeeding vs. formula-feeding method				
Breast only	160	45.7	153	43.1
Breast milk bottle-feeding only	15	4.3	15	4.2
Breast and bottle (breast milk or formula)	82	23.4	87	24.5
Exclusively bottle-fed (formula)	89	25.4	90	25.4
	M	*SD*	*M*	*SD*
Infant's age in months	2.69	1.59	3.03	1.78
Relationship duration in years	7.08	4.10	7.13	4.07
Age in years	30.61	4.59	32.83	5.57

Notes. *M* = mean. *SD* = standard deviation.

Cumulative Childhood Interpersonal Trauma

Participants' experience of CCIT was measured by the Cumulative Childhood Trauma Questionnaire (CCTQ; Godbout et al., 2017). The CCTQ consists of 24 items assessing eight forms of interpersonal trauma experienced before the age of 18: 1) sexual abuse, 2) physical violence, 3) psychological violence, 4) physical neglect, 5) psychological neglect, 6) exposure to physical violence between parents, 7) exposure to psychological violence between parents, and 8) peer bullying. Sexual abuse in childhood was operationalized according to the criminal code of Canada, asking whether the individual experienced unwanted sexual acts before the age of 18, or unwanted sexual acts before the age of 16 with an adult at least five years older or in a position of authority. A dichotomous score was created to differentiate between the presence (1) and absence (0) of sexual abuse. The other seven forms of interpersonal trauma were measured using a 7-point Likert scale (0 = *never* to 6 = *every day*) indicating the frequency of each type of trauma experienced before the age of 18, during a typical year. Dichotomous scores were created for these seven forms of trauma to differentiate between the presence (1) and absence (0) of each trauma. A CCIT score was produced by summing the eight dichotomous scores for each form of trauma, allowing for the assessment of trauma accumulation ranging from 0 to 8. Cronbach's α indicated high internal consistency in the current sample for both parents: .89, corresponding to alphas from previous studies (Bigras et al., 2017; Godbout et al., 2020).

Perceived Partner Responsiveness

Perceived partner responsiveness was assessed using the *Perceived Partner Responsiveness* subscale from the daily measure developed by Laurenceau et al. (2005), which is based on the Interpersonal Process Model of Intimacy (Reis & Shaver, 1988). This questionnaire consists of four items measured with a 7-point Likert scale (1 = *not at all*, 7 = *a lot*). Partners were asked to rate, in general, how much they feel their partner validates, understands, accepts, and cares about them in their relationship. Examples items are "*How much do you feel your partner understands you?*" and "*How much do you feel cared for by your partner?*." Items were summed to produce a total score ranging from 4 to 28, with a higher score indicating a higher level of perceived partner responsiveness. This subscale demonstrated good internal consistency (Cronbach's alpha of 0.91 for women and 0.92 for their partners; Bois et al., 2013) and good construct validity (Laurenceau et al., 2005) in other studies. In this study, the measure exhibited very good internal consistency, with α = 0.90 for mothers and 0.91 for fathers.

Sexual Satisfaction

The Global Measure of Sexual Satisfaction (GMSEX; Lawrance & Byers, 1995) was used to measure five dimensions of sexual satisfaction rated on a 7-point bipolar scale. Participants answered the following question: *For each continuum, please indicate the number which best describes your sexuality with your partner*. The dimensions were good-bad, pleasant-unpleasant, positive-negative, satisfying-unsatisfying, and valuable-worthless. Items were summed to produce a global score of sexual satisfaction ranging from 5 to 35, with higher scores reflecting greater satisfaction. Following the recommendations of the instrument's authors, participants completed the GMSEX only if they reported having engaged in sexual activity (i.e., kissing, fondling, oral, vaginal, or anal penetration) within the past six months. The GMSEX has good internal consistency (α = 0.96) and convergent validity with other measures of sexual satisfaction (Lawrance & Byers, 1995). In this study, the internal consistency was also strong (α = 0.91 for mothers and 0.88 for fathers).

Data Analytic Strategy

Descriptive statistics and preliminary bivariate correlations were computed using the Statistical Package for Social Sciences (SPSS) version 29. Subsequently, path analyses were conducted to test the hypothesized model using Mplus 8.4 software (Muthén & Muthén, 2015), based on the Actor-Partner Interdependence Model (APIM; Kenny et al., 2006). This analytic methodology allows for the examination of both actor and partner effects. The maximum likelihood estimator (MLR) with standard errors and chi-square statistics was used in all path analyses, as this estimator is robust to nonnormality. Missing data (< 4%) were handled by default using the full information maximum likelihood (FIML). A preliminary APIM was performed to examine direct actor and partner associations between CCIT and sexual satisfaction.

An integrative APIM model was then tested to examine actor and partner indirect associations of perceived partner responsiveness in the association between CCIT and sexual satisfaction, while testing whether these associations differed significantly between mothers and fathers. To do so, all actor and partner associations between variables were progressively constrained to be equal between mothers and fathers. Indices of fit of each constrained model were compared using the rescaled −2 log-likelihood difference test, which is distributed as chi-squared with degrees of freedom equal to the rescaled difference in the number of parameters between the models (Satorra & Bentler, 2010). A nonsignificant chi-square test value ($\Delta\chi^2$) indicates that the constrained model does not significantly alter model fit, meaning the parameters do not differ significantly between mothers and fathers. Adopting a similar model comparison approach, we conducted additional analyses by setting equal constraints on actor and partner paths in the integrative model. This enabled us to compare within-partner associations with cross-partner associations and to observe any potential similarities or differences in effect sizes of actor and partner paths. Several indicators were used to calculate overall goodness of model fit: a nonsignificant χ^2 value, a comparative fit index (CFI) and Tucker-Lewis index (TLI) value of .90 or higher, a root-mean-square error of approximation (RMSEA) value less than .06 and a standardized root-mean-square residual (SRMR) value less than .08 indicate good fit quality (Caron, 2018). Finally, the bootstrap resampling method was used to assess the significance of the indirect effects of perceived partner responsiveness in the final constrained model (Hayes, 2017). This method involves creating 5000 resamples from the original dataset by randomly selecting data for each resample. An indirect effect is considered significant if the resulting bootstrap confidence interval does not include zero (Preacher & Hayes,

2008). To account for potential confounding factors in the measurement of sexual satisfaction, relationship duration, number of children, and breastfeeding vs. formula-feeding method were tested as covariates in the integrative model.

Results

Descriptive Statistics

Prevalence rates for childhood interpersonal trauma across genders are presented in Table 2 and means and standard deviations for all study variables are presented in Table 3. Paired group comparison tests revealed small but significant differences between mothers and fathers on two of the three variables. Mothers reported significantly more exposure to CCIT ($t(466) = 2.87$, $p = .004$) as compared to fathers, while fathers reported significantly greater sexual satisfaction ($t(467) = -2.87$, $p = .004$) than mothers. No significant differences were found on perceived partner responsiveness ($t(455) = -.73$, $p = .463$). Statistically significant bivariate Pearson correlations were observed between all studied variables and across genders (see Table 3).

CCIT and Postpartum Sexual Satisfaction

Path analyses were first performed to examine direct associations between CCIT and sexual satisfaction and revealed significant actor associations for both mothers ($\beta = -.18$, $p < .001$) and fathers ($\beta = -.24$, $p < .001$). One significant partner association was found between fathers' CCIT and mothers' sexual satisfaction ($\beta = -.15$, $p = .009$). These direct associations explained 6.5% of the variance in sexual satisfaction for mothers and 6.2% for fathers.

CCIT, Perceived Partner Responsiveness and Postpartum Sexual Satisfaction

A fully integrative model was tested to examine the associations between CCIT and sexual satisfaction through perceived partner responsiveness. To explore potential gender differences, all actor and partner associations were sequentially constrained to be equal between mothers and fathers. Each constrained model was compared with the saturated baseline model (see Table 5, Supplemental Material). All actor and partner associations could be constrained to be equal between mothers and fathers without significantly decreasing the model fit. Then, we progressively constrained the within-partner associations with the cross-partner associations together to be equal (e.g., setting the path between mother's CCIT and mother's perceived partner responsiveness to be equal to the path between father's CCIT and mother's perceived partner responsiveness), and found that it did not significantly worsen the model fit (see Table 5, Supplemental Material). This result suggests that each parent's level of CCIT equally contributed to their own and their partner's perceived partner responsiveness. However, constraining within-partner and cross-partner associations of CCIT and sexual satisfaction, as well as between perceived partner responsiveness and sexual satisfaction to be equal, worsened model fit ($\Delta\chi^2(20) = 6.12$, $p = .01$; $\Delta\chi^2(20) = 17.29$, $p < .001$). This suggests that a parent's sexual satisfaction is better explained by their own CCIT exposure and their own

Table 2. Prevalence of childhood interpersonal trauma.

	Mothers		Fathers	
Prevalence of childhood interpersonal trauma	*n*	%	*n*	%
Child sexual abuse	89	18.9	39	8.3
Physical abuse	195	41.4	210	44.8
Psychological abuse	171	36.4	128	27.3
Physical neglect	56	11.9	80	17.1
Psychological neglect	340	72.2	298	63.7
Witnessing physical abuse between parents	43	9.1	30	6.4
Witnessing psychological abuse between parents	205	43.6	152	32.4
Bullying by peers	208	44.3	211	45.1
Number of types of childhood interpersonal trauma reported	*n*	%	*n*	%
0	53	11.2	83	17.7
1	92	19.5	93	19.8
2	93	19.7	89	19.0
3	78	16.6	69	14.7
4	65	13.8	57	12.2
5	37	7.9	42	9.0
6	31	6.6	23	4.9
7	12	2.5	10	2.1
8	10	2.1	3	0.6

Table 3. Descriptive statistics and correlations for study variables among mothers and fathers ($n = 473$ couples).

Variable	*M*	*SD*	1	2	3	4	5	6
1.Mothers' CCIT	2.77	1.98	–					
2.Fathers' CCIT	2.45	1.92	.20**	–				
3.Mothers' PPR	23.98	4.12	−.19**	−.15**	–			
4.Fathers' PPR	24.13	4.20	−.18**	−.22**	.41**	–		
5.Mothers' SS	28.02	5.83	−.21**	−.19**	.39**	.24**	–	
6.Fathers' SS	28.82	5.38	−.09*	−.25**	.24**	.37**	. 39**	–

Notes. CCIT = cumulative childhood interpersonal trauma; PPR = perceived partner responsiveness; SS = sexual satisfaction. **$p < .01$. *$p < .05$.

perceived partner responsiveness rather than by their partner's CCIT and perceived partner responsiveness. Fit indicators for the final constrained model revealed a satisfactory adjustment to the data: $\chi^2(7) = 5.826$, $p = .56$, CFI = 1.000, TLI = 1.000, RMSEA = .000, 90% CI [.000, .050], SRMR = .024. We subsequently tested the duration of the relationship, number of children, and breastfeeding vs. formula-feeding method as covariates in the model. The number of children and relationship duration were not significantly associated with sexual satisfaction, and all structural paths remained unchanged with their inclusion. Given that the breastfeeding vs. formula-feeding method was not significantly associated with either parent's sexual satisfaction, and that its inclusion decreased model fit, this covariate was excluded for parsimony. Therefore, only relationship duration and number of children were kept in the final model. This final constrained model showed an excellent adjustment to the data (χ^2 (23) = 22.50, $p = .49$, CFI = 1.000, TLI = 1.000, RMSEA = .000, SRMR = .023) and explained 17% of mothers' and 20.3% of fathers' sexual satisfaction.

As shown in Figure 1, the final model revealed that all actor associations were significant for both parents. A parent's CCIT was negatively associated with their own perceived partner responsiveness, while perceived partner responsiveness was then positively associated with their own sexual satisfaction. Additionally, the direct actor association between a parent's CCIT and their own sexual satisfaction remained significant. Four significant partner associations were also found, with each parent's CCIT being negatively associated with their partner's perceived partner responsiveness, and with each parent's perceived partner responsiveness being positively associated with their partner's sexual satisfaction. Following the inclusion of perceived partner responsiveness, the direct partner association between fathers' CCIT and mothers' sexual satisfaction became nonsignificant.

Hypothesized indirect paths were all confirmed by the results of the bootstrap procedure. A total of eight significant indirect paths were observed in this model and are presented in Table 4 with standardized estimates, 95% confidence intervals and levels of significance. The actor-actor indirect effect was confirmed in both parents, revealing that a parent's CCIT was negatively associated with their own sexual satisfaction through their own lower perceived partner responsiveness. Additionally, all hypothesized partner indirect effects were found in both mothers and fathers. Specifically, the actor-partner indirect effect revealed that a parent's CCIT was negatively associated with their partner's sexual satisfaction through their own lower perceived partner responsiveness. A parent's CCIT was also negatively associated with their own lower sexual satisfaction through their partner's lower perceived partner responsiveness (partner-partner indirect effect). Finally, the partner-actor indirect effect indicated that a parent's greater CCIT was associated, through their partner's lower perceived partner responsiveness, to their partner's lower sexual satisfaction.[1]

Discussion

The months following the arrival of a newborn are a critical period of adjustment for a couple's sexual well-being (Fitzpatrick et al., 2021). Using a dyadic approach, the current study examined the indirect role of perceived partner responsiveness in the association between CCIT and postpartum sexual satisfaction among couples. The findings indicated that one parent's CCIT was related with both their own and their partner's lower sexual satisfaction through lower perceived partner responsiveness. This study contributes to the advancement of empirical knowledge by considering how past traumatic experiences can affect a couple's sexual satisfaction after childbirth and by explaining how perceived partner responsiveness can help better understand this association. The results also provide additional insights by focusing on the dyadic effects within the couple and the cumulative effect of multiple forms of childhood interpersonal trauma.

CCIT and Postpartum Sexual Satisfaction

As expected, results revealed that a parent's CCIT was associated with their own lower sexual satisfaction for both mothers and fathers. This finding is consistent with those of recent studies, which have found that in both clinical and non-clinical populations, survivors of CCIT tend to report less satisfying sexuality in adulthood (Bigras et al., 2017; Dugal et al., 2023; Godbout et al., 2020). Our results suggest that this effect, although accounting for only a limited proportion of the variance, may also be applicable to the context of early parenting.

CCIT, Perceived Partner Responsiveness and Postpartum Sexual Satisfaction

The main findings of this study highlight the role of perceived partner responsiveness as an explanatory mechanism in the association between CCIT and postpartum sexual satisfaction. Consistent with our hypothesis of *actor-actor indirect effects*, the more mothers and fathers reported having experienced childhood interpersonal trauma, the less they perceived responsiveness from their partner, which in turn was linked to their lower sexual satisfaction. These results align with those of Vaillancourt-Morel et al. (2019), who observed in community couples that perceived partner responsiveness acted as a prospective mediator in the relationship between childhood maltreatment and sexual satisfaction. According to the Interpersonal Process Model of Intimacy, perceiving that the other is responsive to one's needs and emotions is one of the conditions for couples to build their intimacy (Reis & Shaver, 1988). However, our findings suggest that experiencing greater levels of CCIT can interfere with this process, making it more difficult for individuals to feel understood and cared during the postpartum period.

On one hand, this may be explained by the central role that parent-child relationships and childhood trauma play in

[1] Although a mediation analysis was our primary objective, we also considered the possibility that perceived partner responsiveness could function as a moderator. We therefore tested all actor and partner interaction terms for both members of the couple, resulting in a total of four possible interaction effects per partner. None of the eight interaction terms reached statistical significance (all p values > .05). Accordingly, the indirect pattern of associations remains the most coherent representation of the observed dyadic relationships.

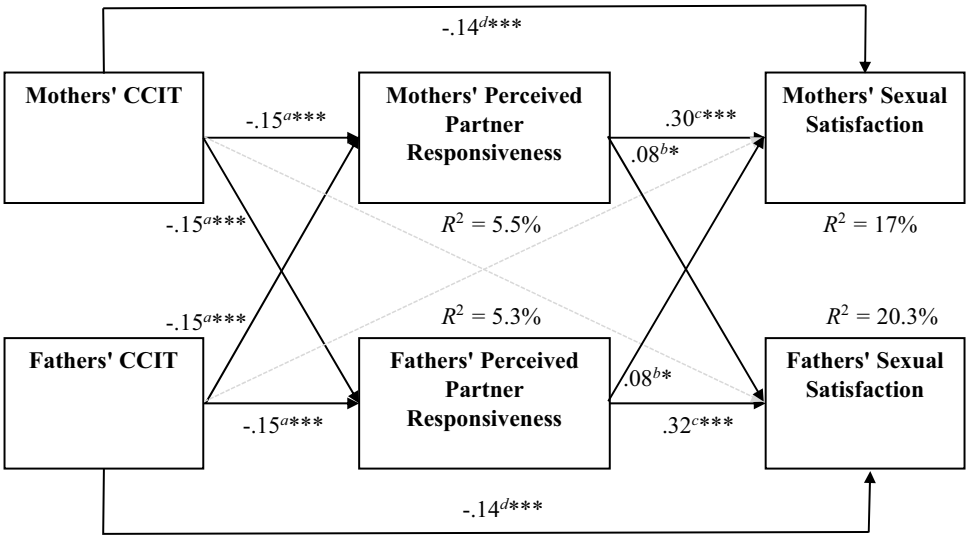

Figure 1. Constrained APIM model of the role of perceived partner responsiveness in the association between CCIT and sexual satisfaction ($n = 473$ couples).
Notes. CCIT = cumulative childhood interpersonal trauma. Significant links are in bold. Pooled standardized estimates are reported for links that were found to be statistically equivalent. Identical subscripts (a, b, c, d) represent links that have been constrained to be equal. ***$p < .001$. **$p < .01$. *$p < .05$.

Table 4. Estimates of significant indirect associations in the constrained APIM model, with 95% confidence intervals and significance levels ($n = 473$ couples).

		95% CI		
	β	*LL*	*UL*	*p*
Actor effects *(actor-actor)*				
Maternal CCIT – maternal PPR – maternal SS	−.046	−.066	−.029	<.001
Paternal CCIT – paternal PPR – paternal SS	−.047	−.068	−.030	<.001
Partner effects *(actor-partner)*				
Maternal CCIT – maternal PPR – paternal SS	−.013	−.026	−.003	.028
Paternal CCIT – paternal PPR – maternal SS	−.012	−.024	−.003	.027
Partner effects *(partner-partner)*				
Maternal CCIT – paternal PPR – maternal SS	−.012	−.025	−.003	.028
Paternal CCIT – maternal PPR – paternal SS	−.013	−.025	−.003	.027
Partner effects *(partner-actor)*				
Maternal CCIT – paternal PPR – paternal SS	−.048	−.070	−.031	<.001
Paternal CCIT – maternal PPR – maternal SS	−.044	−.064	−.028	<.001

Notes. CI = confidence interval; *LL* = lower limit; *UL* = upper limit; CCIT = cumulative childhood interpersonal trauma; PPR = perceived partner responsiveness; SS = sexual satisfaction.

shaping how individuals perceive and interpret others' empathetic responses in adulthood (Cook et al., 2018). Experiencing multiple traumas in childhood can disrupt the development of secure relational patterns, potentially leading to heightened sensitivity or mistrust toward empathetic cues in later relationships. Social learning theory proposes that the contingency between the child's demands and the caregiver's responses leads to a cause-and-effect experience, whereby response patterns are learned and produce generalized expectations in future relationships (Bowlby, 1973; Rotter, 1966). It is possible that abuse, neglect or bullying experienced during childhood create an environment where significant figures may be less responsive, leaving the child feeling misunderstood, invalidated, and unprotected. These response patterns may become internalized and expected in later relationships, forming a filter through which others' behaviors are interpreted (Bowlby, 1973; Reis, 2017). Other studies also observed that trauma survivors tend to report higher levels of distrust in their partner and greater perceived interpersonal threat (Hepp et al., 2021), interpret neutral expressions more negatively (Catalana et al., 2020; Hautle et al., 2023; Pfaltz et al., 2019) and perceive their partner as engaging in more negative exchanges (e.g., felt criticized by their partner; Whisman, 2014). Therefore, CCIT may increase the sensitivity to threat and negative interactions, impairing the ability to accurately perceive a partner's responsiveness. This, in turn, could lead to lower sexual satisfaction during postpartum.

On the other hand, the months following childbirth represent a critical adjustment period for couples, during which mutual responsiveness may be essential to reconnect with intimacy and sexual satisfaction, particularly among those with a history of CCIT. Parents who have experienced CCIT may find it more challenging to express their sexual needs and may require additional sensitivity, patience and support from their partner to reestablish a satisfying sexual connection. For instance, mothers with a trauma history may be particularly

sensitive to signs of invalidation when resuming sexual activity, making partner's understanding especially crucial during this period. This dynamic is consistent with findings showing that women identify support and understanding as key strategies for coping with postpartum changes and improving intimacy in their relationship (Delgado-Pérez et al., 2022). Our results also add novel insights by showing that perceived partner responsiveness is associated with fathers' sexual satisfaction, and not only with the outcomes of mothers. Although fathers do not face the same physical challenges as mothers during the postpartum period (e.g., physical recovery, mood stability; Rahmani et al., 2023), we found that they reported greater sexual satisfaction when perceiving higher responsiveness from their partner. Fathers may find it difficult to adapt to role shifts and to being relegated to a second priority (Rahmani et al., 2023), which may be particularly destabilizing for individuals with a trauma history and difficulties with identity and trust. In such cases, perceiving one's partner as responsive and appreciative may play a vital role in fostering intimacy and sexual fulfillment, whereas low responsiveness may undermine these outcomes.

Furthermore, the dyadic design of this study allowed us to observe significant indirect associations between one parent's CCIT and their partner's sexual satisfaction, partially explained by both their own and their partner's levels of perceived partner responsiveness. These results are consistent with secondary trauma theory (Nelson & Wampler, 2000) and with findings from a recent meta-analysis showing that an individual's childhood trauma exposure is also associated with their partner's experiences, such as lower couple satisfaction and higher psychological distress (Vaillancourt-Morel, Bussières, et al., 2023). Individuals reporting childhood trauma may exhibit deficits in emotion regulation (Kerig, 2020) and empathy (see Zhang et al., 2024). Consequently, survivors may struggle to adequately validate, understand, and care for their partner during this stressful period (e.g., following the birth of a child). As a result, partners may perceive reduced responsiveness from the parent who has experienced CCIT, which can lead to decreased sexual satisfaction. This dynamic may create a cycle in which both mothers and fathers expect a certain level of responsiveness from their partner; when those expectations are not met, they may in turn provide less understanding, care, and validation, ultimately contributing to lower sexual satisfaction for both partners.

Gender Differences

None of the associations examined in this study differed significantly between mothers and fathers, suggesting that the interplay among CCIT, perceived partner responsiveness, and postpartum sexual satisfaction similarly affects both parents. This finding aligns with recent studies showing that the associations between CCIT and adult relational functioning (e.g., parenting alliance, relationship satisfaction) tend to be comparable for mothers and fathers in the months following childbirth (Morissette Harvey et al., 2024; Rassart et al., 2024). This result is nonetheless surprising, given the well-documented differences in how mothers and fathers experience sexuality during this period. Our findings suggest that perceiving partner responsiveness during the postpartum period may be equally important for both genders in relation to CCIT and sexual satisfaction after childbirth. However, differences could potentially emerge in the specific dimensions of responsiveness. Future studies could explore these distinctions by examining the three dimensions of responsiveness separately rather than relying on a global score. It is also possible that gender differences in the structural associations were not detected because postpartum-specific variables (e.g., childbirth-related pain, hormonal changes, breastfeeding-related challenges) were not included in the model. Nevertheless, gender differences did emerge at the mean level, with mothers reporting higher levels of CCIT and fathers reporting greater sexual satisfaction. These results are consistent with prior research showing that mothers typically report lower sexual satisfaction than their partners during the postpartum period (Rosen et al., 2021; Schwenck et al., 2020) and suggest that both parents may experience the postpartum sexual transition differently, even if the underlying relational processes are similar.

Strengths, Limitations and Future Studies

The findings provide valuable insights into the dyadic effects of CCIT on sexual satisfaction through perceived partner responsiveness during a significant period of adult adjustment, specifically the postpartum period. This study extends previous intra-individual studies on trauma and sexuality by using a large, randomly selected population sample of couple parents, and by focusing on those at higher risk of developing sexual difficulties or dissatisfaction.

Despite these strengths, some limitations must be considered. First, all couples in the current sample reported being in a heterosexual relationship. The inclusion criterion requiring that one partner had given birth may have inadvertently limited the participation of LGBTQ+ parents and consequently, restricted the generalizability of the findings to non-heterosexual couples. Specific studies should focus on the reality of couples from the sexual and gender diversity community before generalizing results to these populations. However, because our results revealed no gender differences in the associations tested in the model, conducting separate analyses for mixed-gender and same-gender couples may not be necessary when examining this model among postpartum couples. This suggestion should nonetheless be interpreted with caution, as our sample, although representative of parental couples from Quebec, may not reflect the broader population due to certain sociodemographic characteristics (e.g., higher education levels). Second, although we examined three covariates relevant to postpartum sexual satisfaction (i.e., number of children, relationship duration and breastfeeding vs. formula-feeding method), other factors that may influence parents' sexuality during the postpartum period could be included in future models. For instance, perinatal trauma or other stressful life events (e.g., financial strain) may also have influenced the results obtained. It is also important to consider the sociopolitical context in which this study was conducted. In Quebec, parental leave policies are among the most generous in North America, offering substantial protected time at home and income replacement for both parents. Such

structural support may mitigate stress and facilitate dyadic adjustment in ways that could influence postpartum sexuality, thereby limiting the generalizability of our findings to contexts with less supportive family policies. Third, because our sample included only participants who had resumed sexual activity, future research should examine whether similar models apply to couples who have not yet resumed sexual relations, given that sexual satisfaction may also be relevant outside of active sexual engagement. Fourth, because the data were self-reported, there remains a possibility of social desirability bias or that partners may have shared their responses despite being instructed not to. Future research could combine self-report measures with interviews or observational methods to mitigate such biases. Fifth, given the cross-sectional design of this study, causal inferences cannot be drawn, and the directionality of the associations remains uncertain. The findings should therefore be interpreted with caution, and longitudinal studies are needed to clarify these associations, as alternative models may also be plausible. For example, it is equally plausible that greater sexual satisfaction could lead individuals to perceive their partner as more responsive, rather than perceived responsiveness leading to greater satisfaction. Finally, the model examined in the present study explained between 17% and 20% of the variance in couples' postpartum sexual satisfaction. Other variables that might account for a larger proportion of this variance should be explored, particularly those directly related to the postpartum context (e.g., parental stress, postpartum depression), to better situate sexuality within this specific period of adjustment.

Implications for Research and Intervention

This study underscores the importance of considering both the history of childhood interpersonal trauma and the perception of partner responsiveness to better understand parents' sexual satisfaction during the postpartum period. Given that sexual satisfaction often fluctuates after the arrival of a child (Rosen et al., 2021), interventions during this time may play a pivotal role in supporting couples' sexual well-being. The present findings provide empirical support for assessing all forms of childhood trauma, even in the absence of child sexual abuse, to better understand sexual dissatisfaction during the postpartum period. While this has long been recommended by sex therapy experts (MacIntosh et al., 2020), empirical evidence supporting this recommendation was lacking. Furthermore, perceiving one's partner as responsive appears essential to sexual satisfaction after childbirth, both among couples in general and among those who have survived childhood interpersonal trauma. Clinicians could therefore explore how each partner feels understood, validated, and cared for by the other, and to what extent their experiences diverge from their expectations. Couples might, for example, be invited to share moments since the birth of their child when they felt that their partner was attentive and supportive, as well as instances when they felt inadequate or misunderstood, particularly in the sexual domain. Exploring both partners' contributions to these interactional patterns may foster mutual understanding and, in turn, greater sexual satisfaction. Inspired by cognitive-behavioral couple therapy (Epstein & Zheng, 2017), such work on perceived responsiveness and the reinterpretation of partners' behaviors could help identify concrete strategies to enhance dyadic collaboration, thereby promoting greater mutual satisfaction within the couple's sexual relationship. Future research and clinical interventions should continue to examine how fostering responsiveness within the couple may buffer the long-term impact of childhood trauma on sexual well-being in times of stress and adaptation.

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Data Availability Statement

The data that support the findings of this study are available from the corresponding author, [AP], upon reasonable request.

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