SEXUALLY Speaking

Sexual Changes During and After Pregnancy

Preparing new parents with perspective, evidence, and resources.

While pregnancy and the birth of a baby bring joy to many parents, they may also have significant effects on both sexual function and frequency. Discussing with your patients potential changes in their sex lives can make it easier for them to adapt in a timely and mutually satisfying way.

SEX DURING PREGNANCY

Frequency. Research and anecdotal evidence generally support the truism that couples experience a decline in sexual activity (including manual breast and genital stimulation, oral sex, and sexual intercourse) during pregnancy, with by far the greatest reduction in the third trimester.[1-3] Pauleta and colleagues found that the prepregnancy frequency of intercourse remained the same during the first and second trimesters, only to decrease significantly in the third.[1] In a study of 40 pregnant women in Turkey, Aslan and colleagues found that "sexual interest [was] unchanged or slightly decreased in the first trimester, variable in the second trimester and decreased sharply at the end of the third trimester."[2] This pronounced reduction in women's sexual desire in the third trimester is further supported by a German study of 30 couples that found that solo masturbation in pregnant women remained relatively constant until the last trimester, when it declined significantly.[4] French kissing and male masturbation, however, remained relatively stable throughout the pregnancy period.

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Function. Erol and colleagues found a general decline in female sexual function from the first to the third trimester in 589 healthy pregnant women assessed with the Index of Female Sexual Function questionnaire.[5] The questionnaire assesses for sexual dysfunction in the following areas:

- vaginal discomfort
- vaginal dryness
- decrease in sexual desire
- sexual life dissatisfaction
- orgasmic dysfunction
- diminished clitoral sensation

In assessing sexual function during pregnancy and in the postpartum period, Pauls and colleagues used the Female Sexual Function Index (which assesses desire, arousal, lubrication, orgasm, satisfaction, and pain) and found that declines in desire, arousal, lubrication, and orgasm continued for six months after women gave birth.[3] Such changes in sexual function may be related to other variables of pregnancy, including the woman's levels of nausea and fatigue in the first trimester, the effects of increasing girth in the second and third trimesters, and positive or negative cultural attitudes toward sex in pregnancy in general.

SEX AFTER CHILDBIRTH

While most women will return to their usual level of sexual functioning at about six months after delivery,[6] some will encounter challenges from lingering effects of the pregnancy or birth processes.

Trauma to the pelvic floor. Medical interventions such as episiotomy at the time of delivery can result in trauma to the soft tissue of the perineum. Women who've had a significant perineal laceration, with damage to the skin and muscles of the perineum up to and including a tear in the anal sphincter, are the least likely to resume sexual activity within one year.[7]

Spontaneous perineal lacerations can effect sexual functioning; women with more significant (second, third, or fourth degree) tissue damage report less desire to be held or stroked by their partner than those who experienced superficial (first degree) tears.[8] In a study of 248 primiparous women, those who'd had a cesarean section were more likely to return to prepregnancy sexual activity within six months than those who'd had an episiotomy.[9]

Incontinence. Women who have urinary or fecal incontinence are less likely to resume sexual activity after childbirth.[10] In one study of 50 women, more than 75% had at least occasional urinary incontinence at six months gestation, compared with 34% at six months postpartum.[11] Researchers have found rates of urinary incontinence from 10.5% to 23% one year postpartum.[12, 13]

Incontinence is associated with the use of epidural anesthesia and the length of the second (pushing) stage of labor; those pushing for more than an hour may experience the most incontinence after delivery.[12] In a study of 75 women, anal incontinence was associated with the use of forceps during delivery.[14] There's good evidence that pelvic floor muscle training and exercises can be of benefit in urinary incontinence[15]; however, the evidence for their efficacy in anal incontinence is weaker. It should be easy to understand how leakage of urine or feces can affect a woman's feelings of attractiveness as well as the impact it might have on her sexual partner.

Pelvic pain and dyspareunia may be due to perineal trauma, as discussed earlier, or to vaginal dryness associated with altered hormone levels during breastfeeding.[8] Fear of pain may also decrease arousal and lubrication, in turn leading to more pain during intercourse.[9]

Psychosocial factors. Body image is important to how women see themselves as sexual beings. In a study of 79 new mothers in Australia, women reported feeling fatter and less fit six months after giving birth than they did before pregnancy and also reported a greater discrepancy between their perceived current size and their ideal size after pregnancy than before.[16] The authors suggest that societal expectations may influence women's body image after delivery, with six months postpartum considered the time by which women should have returned to close to their prepregnancy size and shape. Certainly, pictures of new Hollywood moms—who seem to

Using the PLISSIT Model to Talk About Sex with New Parents

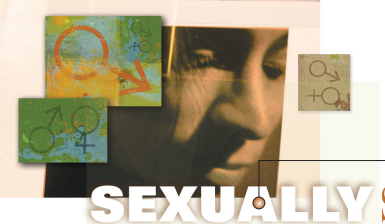
Permission:
All nurses should be able to function at this level—for example, to make a general statement that normalizes the topic.
- Example: "It may feel like you'll never have sex again with a new baby in the house, but it will happen. If you notice anything different, you can talk to your gynecologist about it at your next visit."

Limited Information:
Most nurses should be able to give this kind of information.
- Example: "Many breastfeeding mothers notice some vaginal dryness that can make sex uncomfortable. This is due to hormonal changes and can be treated with a lubricant. You may want to try using one."

Specific Suggestion:
Requires a higher level of expertise on the part of the nurse, who must be able to provide anticipatory guidance on the possible sexual consequences of giving birth or on normal postpartum changes.
- Example: "You had a third-degree tear during delivery that may cause some pain if you try to have intercourse. You may want to wait a while longer before resuming intercourse, or make sure you allow enough time and stimulation for arousal. Some women find that using a lubricant helps, while others avoid intercourse and instead rely on oral and manual stimulation."

Intensive Therapy:
Usually requires a referral to a sex therapist or specially trained counselor.
- Example: "It sounds like you and your partner are really being challenged at this time. Having a new baby can put a lot of strain on a relationship. I think you'd both benefit from seeing one of our social workers who can help you communicate more effectively."

Annon JS. *The behavioral treatment of sexual problems.* Honolulu, HI: Enabling Systems; 1974.



return to their ideal form within weeks—support this belief.

Other factors also play a role. The relationship between first-time parents is irrevocably changed by the new family member. Some women have told me that being a new mother seems discordant with that of being a sexual partner. The demands of new parenthood include sleepless nights, anxiety, and a focus on the baby—all of which divert attention from the sexual aspects of the relationship; this, in turn, can lead to relationship stress. The role of the partner seems to be a determining factor in how quickly a couple resumes sexual activity; if the partner expresses a strong desire for sex, it's more likely to happen.

WHAT CAN NURSES DO?

Nurses have traditionally used *anticipatory guidance* as part of pre- and postnatal education. However with shorter hospital stays for women giving birth, there isn't often enough time to talk about sex—especially when new parents' attention is on a myriad of other concerns such as breastfeeding, bathing, sleep patterns, and comforting the baby. Sexuality may be the last thing on their minds.

Attitudes toward sexuality in pregnancy are often influenced by culture. Ask your patients what they've been taught about sexuality in the perinatal period and keep this in mind when providing guidance. Review your opinions about this subject and remember to hold these in check when advising patients.

A recent study offers insight into what new parents want to know about sexuality during the first year after delivery.[17] At four months postpartum, men and women had similar questions:

- When can we resume intercourse?
- What methods of birth control are appropriate?
- What sexual changes can we expect after having a baby?

At 12 months, couples wanted to know how to deal with the woman's body image issues and how to cope with discrepancies in desire, since men tended to want sex more than their partners. Child-rearing differences also affected the relationship.[17]

Discussion is essential. Not all nurses are comfortable discussing sexual issues with patients; many may feel there isn't enough time to do so, especially with all of their other responsibilities. And if patients don't raise questions, nurses might assume that sexual issues aren't important to them. An example of how to talk to new parents about sexuality is provided in *Using the PLISSIT Model to Talk About Sex with New Parents*.

At the very least, raise the topic of sexuality and let patients know that it can be an issue. Let them know that there's help out there if they encounter difficulties. Most consumer books on pregnancy, childbirth, and parenting include sections on sexuality both during and after pregnancy. Encourage expecting and new parents to revisit these sections. There are also many popular parenting Web sites that provide specific sections, blogs, or columns about sexuality.

Some couples will need more help; in such cases, a referral to a marital or sex therapist may be necessary. For women who've experienced perineal trauma, a referral to a pelvic floor therapist may be helpful in alleviating pain and dealing with the aftermath of damage to the pelvic floor. ▼

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