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Pregnancy, Childbirth, Postpartum Process, and Sexual Health

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Abstract

Sexual health is one of the important parameters in general health evaluations. Sexual problems form the basis of the problems that affect the spouses the most and cause unhappiness. Sexuality is described as a need that is not vital but necessary for the continuation of the species. Contrary to popular belief, sexuality starts from intrauterine life and continues until death. In every period of life, sexual satisfaction and perception of sexuality are expressed differently. The most important periods in a woman's life are pregnancy and childbirth. Hormonal stimuli and physical and mental changes in women greatly impact a woman's general health, relationships, and sexuality. The relationship between pregnancy and sexuality has been full of myths, taboos, and misconceptions throughout history. Studies on the effects of pregnancy, childbirth, and puerperium on sexual life will be beneficial in determining the situation and the needs of the couples in this regard. This review was done to prevent misconceptions about sexual life during pregnancy, childbirth, and puerperium and to reduce the fears and prejudices of couples on this issue.

Key Words: Pregnancy, Childbirth, Postpartum, Sexual Life

Introduction

The World Health Organization (WHO) defines sexual health as a state of physical, emotional, mental, and social well-being related to sexuality and not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relations and the possibility to have enjoyable and safe sexual experiences that are free from coercion, discrimination, and violence. To ensure and maintain sexual health, the sexual rights of all individuals must be respected, protected, and fulfilled (1, 2).

Sexual Life in Pregnancy

The understanding of sexuality during pregnancy is still a primitive belief. Since this primitive belief preserves its characteristic, it continues to be a subject that cannot be asked easily by doctors. Sex during pregnancy was seen as an inconsistent situation by couples, and in the Masters and Johnson study, 77 out of 111 women stated that they were warned to abstain

from sex, especially in the last trimester. The pregnancy period for both spouses is a crisis period in their lives and the transition from being a couple to being a family (3). As a result of physiological, psychological, and anatomical changes, pregnancy affects sexual life (3,4). Sex during pregnancy usually comes to the fore when there is a problem related to pregnancy, and in this case, the first decision is the prohibition of sexuality (3).

Sex during pregnancy is full of false thoughts, myths, and taboos (3, 5). Kitzinger reported that pregnant women have a fear that sexual intercourse during pregnancy may cause premature birth or miscarriage, harm the fetus, initiate labor, or rupture the amniotic sac. In addition, Kitzinger stated that some women exaggerate their body appearance during pregnancy and believe that they are ugly. This belief in pregnant women negatively affected sexuality. During pregnancy, pregnant women struggle with nausea and vomiting, skin discoloration, enlarged breasts, and weight gain, and sleep and eating problems. This process may cause sexuality to be pushed into the background (3).

Cultural Aspect

Throughout history, the view of sexuality during pregnancy has differed according to societies and has been affected by cultural norms (3,6). While sexual intercourse is prohibited during pregnancy in some societies, it is believed that it should continue throughout the pregnancy period in some societies. For example, in the Old Hindu belief, "Semen is necessary for the healthy progress of pregnancy, and sexual intercourse can be made during pregnancy." However, the natives of New Guinea state that "sexual intercourse should not be done from the moment the pregnancy is known until the child walks" (3).

Social and cultural factors can also affect the sexual life of couples during pregnancy. In particular, the education of the couples, whether they have a profession, their marriage duration, and even their ethnic identity, can affect sexual functions during pregnancy. One of the most comprehensive studies on this subject was conducted by Güleroğlu and Gördeles Beşer on approximately 1811 pregnant women. The authors stated that the most important factors on sexual life in pregnant women are advanced gestational age, low education level, marriages lasting more than ten years, unwanted pregnancies, and gestational week. In addition, it has

been shown in this study that structural problems such as back pain, respiratory distress, constipation, and cramps have a negative effect on sexual life during pregnancy (7).

Causes of Changes in Sexual Function during Pregnancy

Sexuality is affected by myths, sexual dysfunctions, and physical and psychological changes (3, 8). Pregnancy and childbirth are a special period in a woman's life that includes important physical, hormonal, psychological, social, and cultural changes that may affect her own sexuality and the health of the couple's sexual relationship (9). The increase in progesterone and estrogen hormones in a pregnant woman contributes to shiny hair, soft and smooth skin, and a more positive feeling for the pregnant woman. This situation can positively affect the view of sexuality. However, changes in the breast and genitals make the pregnant woman sensitive to sexuality. Touching sensitive breasts during sexual intercourse may negatively affect sexual desire. Therefore, special attention should be paid not to use the breasts during sexual intercourse (3, 10).

In the first trimester of pregnancy, it is wrong to think that sexuality is not affected because the woman is not aware that she is pregnant. Although it is different for every woman, there is usually a decrease in the frequency of sexual intercourse in the first trimester. Because major factors such as sleep orientation, breast, and vaginal disorders, eating problems, nausea-vomiting and fatigue may cause sexuality to be pushed into the background (3, 11). In some pregnant women, even their spouses' body or mouth odor may be disgusting. In this case, it can negatively affect the spouses' view of sexuality (3, 12). This reluctance and disgust in women can cause erection problems in men, and they can also experience sexual dysfunction if their partner is no longer attractive. However, this is not an expression of erectile dysfunction. Especially in the second trimester, an increase in sexual desire is observed in expectant mothers who adapt to pregnancy with the major decreasing factors and accept the changes that motherhood will bring to their life. However, in the second trimester, some men may refrain from harming the fetus and may think that the baby's movements are "perceiving them" during sexual intercourse. In this case, it may cause sexuality to be thrown into the background again (3).

Gunher et al. stated that sexual activity is mostly initiated by the male partner before

and during pregnancy. In addition, in the studies of Naim and Bhutto, Gökyıldız and Beji, it was stated that the initiator of sexual intercourse was the male partner. Gunher et al. stated in their studies that, while 91.1% of respondents responded as a male partner who started sexual intercourse before pregnancy, this rate was reported as 95% during pregnancy. Studies have proven that the male partner usually initiates sexual intercourse (13).

In the arousal phase during pregnancy, although there is no sexual stimulation, since there is an increase in secretion due to pregnancy, the moistening of the vagina is higher during pregnancy. This situation can negatively affect sexuality (3).

The orgasm phase during pregnancy is quite variable. Sometimes the pain may be felt at orgasm, and the pain may persist even after intercourse. Pelvic congestion can increase sexual experience and orgasm in some women. In a study conducted by Goodlin et al., 16% of pregnant women stated that they felt uterine contractions during sexual intercourse even if they did not have an orgasm. 77% of the women studied in this study can experience orgasm more quickly in the second and third trimesters due to muscle tension and venous increase. For this reason, there are also women who state that they have orgasms for the first time during pregnancy (3).

In their study, Oruc et al. stated that the state of having an orgasm during sexual intercourse would decrease with the progression of pregnancy. Gunher et al. also stated the rate of orgasm is 70.2% for the first trimester, 75% for the second trimester, and 47.9% for the third trimester. In their study, Goodlin et al. reported that the rate of orgasm increased in the third trimester (Efe, 2006, 41), while Gunher et al. and Oruç et al. stated in their studies that the rate of orgasm decreases with the progression of pregnancy (13). During pregnancy, pregnant women may sometimes experience dissatisfaction due to the long duration of stimulation during the relaxation, that is, resolution, phase after orgasm. Sex during pregnancy can be affected by whether the pregnant woman feels sexy or not. In their study, Reamy and White explained that social norms argue that pregnant women do not look attractive and that there should be no sexual desire and activity during pregnancy. During pregnancy, pregnant women may feel fat, tired, weak, and fragile, and these feelings can negatively affect sexuality during pregnancy (3).

With the enlargement of the uterus in the third trimester, physical complaints that decrease in the second trimester may reappear. Respiratory distress, decreased movement,

stomach problems, milk coming from the breasts, frequent urination, strong uterine contractions during sexual intercourse can cause a decrease in sexual desire. In this case, it can negatively affect sexuality. In addition, the fear of childbirth, which increases with the approaching date of birth, can also affect libido (14).

Khalesi et al. (2018) stated in their study named "The Effect of Pregnancy on the Sexual Function of Couples" that pregnancy can affect sexual satisfaction in men and women. The study determined that the frequency of sexual function reached lower levels at the beginning of pregnancy and in the third trimester. Studies on the subject show that 90% of pregnant women have not had sexual intercourse in the last four weeks of pregnancy. 70% of pregnant women stated that they were not worried about decreasing their sexual desire during pregnancy. Only 11.2% of pregnant women had a positive attitude about sexuality during pregnancy. According to the study results, 68% of the pregnant women never asked health professionals about their sexual problems during pregnancy and did not discuss sexual problems. For men, the fact that their spouses are pregnant is perceived as a transition to fatherhood for them. In other words, the sexual reactions of men are also affected by this process. Several factors affect the quality of couples' sexual intercourse during pregnancy. Fear of hurting a woman inhibits desire and can have an impact on arousal and, therefore, sexual intercourse in men. However, there are not enough studies on the prevalence of sexual dysfunction in the literature (15).

Yeniel and Petri(2013) mentioned in their study called "Pregnancy, Birth and Sexual Function: Perception and Facts" that endocrine and psychomotor factors, anatomical changes during pregnancy and childbirth, and different types of delivery may cause sexual dysfunction in women. They saw Female Sexual Dysfunction (FSD) as one of the most common problems and stated that it affects 40% of women. They stated that they tend to be affected by conditions any physiological, mental, or pathological event in which a woman is involved that affect the life cycle, such as aging, hormonal status, pregnancy, birth, as well as breastfeeding, medical disorders, pelvic floor, mood changes, depression and its treatment (16).

Intercourse Positions During Pregnancy

During pregnancy, the growing abdomen may cause the appropriate intercourse position not to be selected. The most important method in eliminating this factor is to determine the

most comfortable positions of the pregnant woman during sexual intercourse and to continue the sexual intercourse by adding different positions, which will eliminate the problems arising from pregnancy.

Positions where the woman stands on her knees and hands and is on top or side by side are positions that can be easily related during pregnancy. As sexual activity other than vaginal intercourse during pregnancy, massage, masturbation, oral sex, fantasy, and use of sex toys can positively affect the sexual lives of couples (7). It has been questioned in studies as an indicator of sexual desire in masturbation. In the study of Gökyıldız and Beji, the thoughts of pregnant women about masturbation were examined, and 24% of them stated that they cited their spouses as the reason for not masturbating, that it was not natural, or that they did not find it necessary. It was stated that 76% of pregnant women marked the option "pregnant woman does not masturbate." Gunher et al., in their study, stated that only one pregnant woman masturbated both before and during pregnancy. Generally, the response of pregnant women to this issue is limited, and Gunher et al. stated that the reason for their limited response might be that Turkish society sees sexuality as a taboo. They also stated that the frequency of dyspareunia generally increases in the third trimester and that the reason for this may be uterine growth, uterine contractions, and emotional factors (13).

Eryılmaz et al., in their study on the subject of sexuality in pregnant women, stated that 49.2% of pregnant women abstained from sex due to pain during sexual intercourse. Gunher et al., in their study, reported that 67.1% of pregnant women described pain during sexual intercourse. They stated that this rate increased in the third trimester, and 78.6% of them described pain in the last trimester (13).

Although the view towards sexuality in pregnancy is different from each other in the literature, the common and final statement is that sexual intercourse can continue throughout pregnancy unless there is any medical problem. Situations where sexual intercourse should be prohibited during pregnancy are the risk of abortion in the current or previous pregnancy, vaginal bleeding, premature rupture of membranes, infection in the genital area, cervical insufficiency, sexually transmitted infection in the partner. In addition, the belief that sex during pregnancy will harm the fetus or cause infection is wrong. Because the cervical canal is covered with mucus plaque, this does not allow bacteria to enter the uterus, and the fetus lives away

from bacteria. The amniotic sac is resistant to traumas and pressures, so it is not affected by weight during intercourse (3).

The Effect of Delivery Type on Female Sexual Dysfunction

The effect of mode of delivery on sexual functions remains to be the subject of numerous studies. In most of these studies, it has been shown that the mode of delivery can change sexual health. Because the pudendal nerve, which innervates the clitoris, vulva, and perineum, can be damaged by the pressure of the baby's head during vaginal delivery, and hypotonic vaginal muscles due to vaginal prolapse can lead to a decrease in orgasm ability. Although the literature data on interventional births are contradictory, the general opinion is that interventional births have negative effects on sexual functions. More pain was detected during sexual intercourse six months after delivery in pregnant women who had a normal vaginal delivery and had a mediolateral episiotomy. However, no difference was found in terms of sexual functions in the pre-pregnancy and postpartum 6th-month evaluations in the cesarean section group. Shirvani et al. reported that primiparas who gave birth vaginally had a decrease in their sexual pleasure and satisfaction within six months after birth (7).

Another condition in which sexual functions are affected in the postpartum period is obstetric complications such as perineal tears that may occur during childbirth. Perineal tears that occur during childbirth are associated with decreased libido, orgasm, and sexual satisfaction in the postpartum period. While 54% of women without postpartum perineal tears stated that they started the sexual activity in the 6th week postpartum, this rate is 39% in women with 2nd-degree perineal tears and around 25% in women with third and fourth-degree tears. Although most of the studies demonstrated a correlation between perineal damage and time to start sexual activity, Buhling et al. reported that in women with episiotomy and perineal tear, the rate of starting sexual intercourse within 6-8 weeks is 31%, and the rate of starting after eight weeks is 50%. In women without perineal damage, this rate is 30% and 50%, respectively, and they stated that there was no statistical difference between the groups (7).

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Postpartum Female Sexual Functions

The postpartum period is now considered a period when couples gradually get used to their parenting roles and have a chance to return to their prenatal sexual activities. In this period, although female sexual functions are closely related to hormonal, anatomical, psychological, and cultural factors, the relationships between couples and family structure also significantly affect sexual life (7). Various physical, hormonal and psychological changes after childbirth affect the emotional state of the woman. These significantly affect their family life, including the quality of sexual relations (17).

Although it is not possible to rank the importance of these factors among themselves, when evaluated anatomically, perineal trauma causes painful sexual intercourse, causing avoidance of sexual intercourse in the postpartum period or inability to enjoy sexual intercourse. In terms of hormones, the decrease in androgen hormones that occur with the effect of increasing prolactin levels in the postpartum period is considered to be associated with a decrease in sexual desire and arousal. Low estrogen levels in the postpartum period can cause atrophy and decrease in congestion and dryness in the vagina, causing painful sexual intercourse and a decrease in sexual desire and arousal. Another reason for postpartum sexual dysfunctions is the mother's fatigue, insomnia, and inability to find time for sexual intercourse during this period. In addition, another important issue is that psychological factors such as anxiety and depression in the postpartum period can cause a decrease or loss in sexual desire, arousal problems, and difficulty in reaching orgasm due to antidepressant use. Cultural and social characteristics are another factor that affects the time it takes for couples to start sexual activity in the postpartum period. Social and religious beliefs that sexual intercourse is prohibited, especially in the first six weeks after birth, which is called the puerperium period, result in not engaging in sexual activity during this period. Studies conducted in our country also support this statement, and it is reported that the time to start a sexual activity after birth is approximately 30 days and above (7).

A study through a meta-analysis of 59 research studies published in English and German between 1950 and 1996 concluded that 40% of women had problems with their first sexual intercourse after giving birth. More than half of them stated that they had painful experiences during sexual intercourse after giving birth. This study also showed that 57% of women were

dissatisfied with giving their husbands sexual pleasure, and in most cases, the need to satisfy their partners motivated women to continue their sex life after giving birth. The study claimed that sexual activity, both during pregnancy and postpartum, was more intense when women were free from discomforts such as pain and vaginal bleeding. Therefore, the experience of sexuality in the postpartum period is very complex due to changes in biological, psychological, and social factors. It is also important to understand women's perceptions of sexuality in the postpartum period, as both the woman and her partner may experience difficulties. It is very important to understand and consider both physiological changes and transformations in social, psychological, and family environments (18).

Another reason for avoiding sexual intercourse during the postpartum period is the concern that having sexual intercourse while bleeding and discharge continue will increase the risk of infection. The reality in this concern is also supported by studies. Particularly, the mode of delivery, whether episiotomy was applied, and the perineal injury during delivery were associated with the risk of sexual intercourse-related infection during this period. It is known that the breastfeeding period affects female sexual functions. Studies show that breastfeeding can have different effects on the sexual functions of women in the postpartum period. Tenderness in the breasts, milk coming from the breasts during sexual intercourse, the woman's not finding herself sexually attractive, and new pregnancy anxiety are seen as negative factors on sexual functions. Contrary to these findings, there are also studies stating that breastfeeding positively affects female sexuality. Masters and Johnson compared breastfeeding and non-breastfeeding mothers 6th.-8th. weeks of postpartum in terms of their sexual functions and stated that breastfeeding women started sexual intercourse earlier and their sexual desire levels were higher when compared to women who did not breastfeed. They stated that the same situation was observed in mothers who still continued to breastfeed their babies in the 2nd month postpartum. Falicov also stated in a study he conducted in 1973 that the breastfeeding period has positive effects on sexual functions. However, the fact that both studies mentioned were carried out in periods when birth and sexuality were perceived differently socially and culturally brings along the concern of whether the results can be adapted for today. There are also studies stating that breastfeeding does not affect female sexuality. Heidari et al. evaluated

the sexual activity in women during breastfeeding in their study conducted in 2009 and reported that breastfeeding does not affect sexual functions (7).

There are conflicting statements in the literature regarding the time required for sexual functions to return to normal in the postpartum period. Connoly et al. reported that sexual activity returned to normal at the end of the 3rd month in approximately 80% of the women in their study, which they had sexual function evaluation of the women at the postpartum 2nd, 6th, 12th, and 24th weeks. While the complaints of painful sexual intercourse continued in 30% of the women in the 3rd month, only 17% of the women stated that they had painful sexual intercourse as of the end of the 6th month (7).

Similarly, Barrett et al.stated in their study, in which they examined 484 postpartum women, that 89% of women returned to their previous sexual activities at 6th. month postpartum. However, the frequency of sexual dysfunction such as painful sexual intercourse, vaginal laxity, decrease in vaginal lubrication, bleeding, and sexual reluctance increased in the first trimester in these women. Continuing breastfeeding and a history of painful sexual intercourse were stated as the most important risk factors in women who stated that they still had sexual dysfunction at the end of the sixth month (7).

Consultancy

Counseling women during pregnancy, childbirth and the postpartum period is very important. It would be more beneficial to consider the couple together in these processes. Providing counseling services will eliminate false thoughts and taboos and will create an environment where couples can easily ask what they want to ask and learn.

APPENDIX Table:1
Basic Principles in Counseling

• Preventing damage	• Offering options
• Reflecting value	• Listening, allowing her to speak
• Giving correct information	• Handling the couple together
• Giving advice	• Initiating conversation by healthcare personnel
• Asking open-ended questions with a general introduction to the subject	

Conclusion

In the light of all these discussions, literature evidence shows that pregnancy and the postpartum period can negatively affect sexuality. The important thing is to know what the spouses understand regarding sexual intercourse and to inform the couples correctly. By providing the right counseling service to the spouses at the right time during pregnancy, wrong thoughts will be eliminated, and when the right information is added to the wrong thoughts, the pregnancy process will be a process that couples can express with happiness, not with fear. However, although the effect of the mode of delivery on sexual functions is not fully known, there is also evidence stating that it has negative effects. It is very important for us to decide with a multidisciplinary team to prevent the sexual functions of couples from being adversely affected by the mode of delivery, and therefore choosing the most appropriate mode of delivery. The first row in this team should be the pregnant woman. In the postpartum period, couples must be informed about when to start sexual intercourse. It should not be forgotten that pregnancy and childbirth have a significant impact on the overall quality of life and the Quality of Sexual Life.

What the Nurse Should Do During Pregnancy, Childbirth and Postpartum Period

APPENDIX Table:2

Pregnancy Period (19).
• Identification of sexual problems before pregnancy by questioning,
• Counseling about frequent changes in pregnancy,
• Counseling on sexual intercourse during pregnancy,
• Investigation of possible pregnancy depression,
• Perineal massage and pelvic floor exercise should be recommended to help reduce perineal trauma and postpartum pain.
Birth Period
• Vaginal delivery and less invasive obstetric practices that protect the integrity of the perineum,
• Avoiding routine or unnecessary episiotomy during delivery,
• Repair of anal sphincter tear that may occur after birth,
• Repair of perineal tears that may occur during delivery with synthetic absorbable sutures,
• Before discharge, counseling should be provided about postpartum sexual life, perineal pain, and dyspareunia.
Postpartum Period
• Determining the sexual function by questioning and providing consultancy for the elimination

of concerns,
• Informing about the changes related to the parenting process,
• Controlling the wound healing in the perineum in the presence of dyspareunia,
• Questioning the presence of urinary and fecal incontinence,
• Suggesting vaginal lubricants to breastfeeding women,
• Informing couples about alternative sexual positions if necessary,
• Questioning about fatigue and self-care,
• Questioning the couple's fears, priorities, and knowledge,
• Allowing the couple to express their feelings without judging them,
• Advising on sexuality and sexual problems,
• Referral to a specialist, if necessary, is among those required.

(http://www.istanbulsaglik.gov.tr/w/sb/duyurular/belge/dogum_sonrasi.pdf)

While taking the anamnesis, the couples should ask open-ended questions, and information should be gathered about their hidden and explicit sexual needs. This information should be combined with the past anamnesis (20).

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