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Perspective

Restoring sexual functioning and couple bonding following childbirth

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Abstract

Pregnancy and childbirth represent important transitional periods. Sexual concerns and relationship quality following childbirth are often under-addressed. Sexual functioning following childbirth may be influenced by a myriad of factors, inter alia misconceptions, dyadic coping, disparate role expectations, reduced sexual desire, disruption of biological rhythms, lack of contraceptive awareness, mental illness, perineal injuries, fatigue, new born related factors and sociocultural practices. Moreover, post-partum concerns are largely focussed on the mother-baby unit, and there may be overall neglect of the couple. Healthcare professionals need to adopt culturally sensitive and evidence-based interventions to improve sexual functioning and bonding between the new parents and their overall quality of life.

Introduction

Child birth is a time of change. During the first few months following childbirth, new parents encounter a host of new stressors and responsibilities that impact their personal lives and relationships.[1,2] Reaching a dyadic equilibrium can be arduous following this milestone event.[3] Sexuality is an important and often under-addressed facet of the couple's relationship post-partum.[4] When actively enquired about, research suggests that over 80% of new parents endorse sexual concerns, and about half of them experience sexual difficulties within the first year of childbirth.[5,6] Moreover, sexual concerns following childbirth are associated with distress related to the sexual relationship and the couple"s relationship overall.[6] Despite the prevalence and associated distress, this aspect of health is under researched. Moreover, sexuality is influenced by a complex interplay

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of several individual, social, medical and relationship factors. Thus, this narrative review hopes to provide an overview of the impact of childbirth on sexuality, the couple unit, the factors determining sexual functioning, healthcare barriers and suggested interventions to improve sexual functioning in new parents.

The dyad

Parents commonly endorse apprehension regarding the frequency of sexual relations and the appropriate time to resume sexual activity following childbirth. [6] A study of over 200 participants from North America reported the importance of several other factors that may impact sexual activity, such as the mother's perception of her body, disruption of biological activities such as sleeping patterns, and the physical strains of parenting a newborn and recovering from childbirth.[6]Following childbirth, new mothers and fathers may have disparate expectations in parental and couple roles that can be linked to relationship dissatisfaction and can further delude into their sexual relationship. [7,8] Conversely, sexual difficulties can lead to greater relationship dissatisfaction. [9] Post-partum sexual concerns and distress can negatively impact dyadic coping [10], communication [11], couple intimacy [12], and eventually, parenting [13] and child development [14,15]. A study of 820 new parents from a Swedish sample found that both sets of parents were discontent with dyadic sexuality, with mothers reporting fatigue as an important factor that deterred sexual activity.[1,16] Researchers also report an imbalance in the sexual desire reported between mothers and fathers, which can be a critical source of dissatisfaction in their sexual lives.[1,17] The transition to new parenthood has been linked to a decline in marital quality in 40-70% of couples, with the first year following childbirth being the most crucial.[18] The postpartum marital decline is greater than the rate of decline from the time of marriage through the antenatal period.[8] Lack of privacy, parental mental health[19], increased domestic and financial responsibilities[20], reduced amount of quality time spent as a couple unit [21], and myths and misconceptions about sexual concerns can further add to this strain. New parents may be reluctant to report dissatisfaction with their relationships and sexuality due to constraints of time, perceived stigma, and perception of their healthcare provider's inability to help with these issues.[2] New parents may decrease social activities outside of parenthood which can be linked to greater maladjustment.[22] Couples may also postpone sexual activity due to fear of pregnancy and lack of awareness about safe contraceptive methods following childbirth.[23]

The new parents

Pregnancy and childbirth are associated with a significant decline in sexual functioning, and studies have shown that this decline is more evident in the third trimester and three to six months following delivery.[24] This decline may be attributable to fears of precipitating labour [25] and causing fetal injury [26] or due to religious and social beliefs and practices. Antepartum sexual dysfunction and its consequences can undoubtedly extend into the postpartum period. In the period following delivery, the resumption of sexual activity may be influenced by several factors, including parity, lactation, type of delivery, perineal injuries, hormonal fluctuations, and cultural factors. For the new mother, postpartum represents a time for recovery and bonding. [20,27,28] Postpartum, women experience increased emotional and physical strain and generally assume the primary responsibility for childcare.[28,29] Insomnia and sleep deprivation are prevalent in postpartum women and can have important implications for the mother's well being, overall mood, and functioning. [30] Women may experience disturbances in body image, self-identity, grief of their loss of previous self,

fatigue, lowered confidence, and mood fluctuations in the post-partum period. [16,31-34] In extreme cases, post-partum mood disorders and anxiety can challenge the mother's health and infant bonding, may require separation or hospitalization, and lead to disruptions within the family. [35-37] Moreover, treating depression with psychotropics can potentially cause or worsen sexual difficulties. [38,39] An Australian study found that the most prevalent type of sexual dysfunction in post-partum mothers was sexual desire disorder, with over 80% of women reporting low desire. [40] The risk factors identified for female sexual dysfunction in this study included late resumption of intercourse, decreased frequency of intercourse, postpartum depression, and dissatisfaction in the relationship.[40] A study from a clinical sample in Virginia highlighted that new mothers had higher rates of sexual concerns following cesarean deliveries compared to women with vaginal deliveries.[5] Women who experience traumatic labour, perineal tears, episiotomy, and emergency procedures may have increased rates of sexual dysfunction.[41-45] Moreover, the couple's sexual frequency may be determined by embarrassment about incontinence, bodily appearance, weight gain, and dermal changes during pregnancy. [41,46,47] Post-traumatic stress disorder in new parents following negative experiences in labor and quality of care have been shown to impact the couple's relationship and the parent baby bonding. [48,49] Although breast feeding is encouraged for maternal and infant health, lactation is associated with lower estrogen, progesterone, and androgen levels which may negatively affect sexual desire, decrease lubrication and increase breast tenderness.[42] Moreover, several studies have shown that breast feeding mothers are more likely to resume vaginal intercourse later than non-breastfeeding mothers.[50,51] Overall, female sexual dysfunction in the postpartum period is highly prevalent and requires prompt intervention. [52]

Postpartum psychiatric disorders can also affect new fathers.[53] Paternal anxieties may stem from their past parental experiences and the fear of uncertainty in the couple's relationship after childbirth.[3,54] Partners can also feel side-lined when one parent focuses on the child [2], and fathers can have distress related to their role as a parent.[55] Postpartum blues, depression, and bonding difficulties in one partner have been shown to be linked to the Edinburgh postpartum depressive scale scores in the other partner.[56] Therefore, a parent's morbidity may very well be a couple morbidity that affects their overall quality of life. Approximately 10% of fathers experience depression, and this prevalence increases to 25% between three and six months postpartum.[57] Paternal depression has been linked with substance use, poor father infant bonding, and higher rates of relationship dissatisfaction.[58-60] Further more, previous studies have demonstrated that infants of fathers who experienced depression were at an increased risk of developmental delays and behavioural problems. [61,62]

The newborn

The newborn's rhythms and discomfort expression differ greatly from an adult's. Irregular rhythms and crying in the newborn can cause parental stress.[63] Parents may face disparities in the division of responsibilities related to the care of the new born[64], frustration, and sleep deprivation [65]. A new-born with a difficult temperament [66], colic, or repeated health concerns can provoke parental and marital strain[67,68]. Moreover, studies have shown that negative childbirth experiences and sexual dissatisfaction are associated with the development of colic in the baby. [69] One may reasonably expect these difficulties to increase proportionately if there are multiple children to care for. [7] Studies have shown that irregular sleeping patterns in the child and relationship dissatisfaction are important predictors of parental stress. [70]

Culture and healthcare barriers

The post-partum period in India has been given much emphasis across cultures. [71] After childbirth, women are often confined at home with their newborns for a period of 40 days to decrease the risk of infection and ward off the evil eye.[72] In some regions, it is common practice for the woman to return to her mother's home for the initial period of mothering to enjoy quality time with trusted female relatives and forego household responsibilities as she bonds with the newborn.[73,74,75] Most cultural practices are often centered around the mother and baby, with little focus on the bond between the father and the baby and between the couple. Often, fathers only feature in important rituals related to the post-partum period but may be separated from the mother and newborn's chambers if it is considered inauspicious. Moreover, the couple's temporary separation during the initial months after childbirth and the culturally sanctioned practice of sexual abstinence for the first six months can lead to sexual and relationship dissatisfaction. Misinformation and poor attitudes related to contraceptive practices during this time period are rampant.[76-78] Couples may abstain from sexual intercourse due to the fear of pregnancy during lactation. Moreover, co-sleeping with the newborn and lack of privacy from other family members in joint families may contribute to sexual dissatisfaction. Where on the one hand, cultural practices such as increased family support are helpful to the mother's health, they may also lead to a decrease in the time spent as a couple unit for the new parents.

The health system in the post-partum period comprises of the obstetrician- gynaecologist and the paediatrician. The post-partum concerns are largely focussed on the mother baby unit and there may be an overall neglect of the couple. Routine non-judgemental questioning into the sexual lives and relationship satisfaction of the new parents are uncommon and paternal mental health issues and dissatisfaction are often missed. [59]

Measures to restore sexual functioning and couple bonding

Utilizing the evidence from the available literature as a guide, the efforts to restore sexual functioning and bonding between new parents can be approached from a bio-psycho-socio-cultural lens to address this important but overlooked aspect of the period following childbirth. Health care professionals in culturally diverse settings should be aware of the needs and concerns of the couple and adopt culturally sensitive approaches to the assessments and interventions. Exploring the myths and misconceptions about sexual functioning in the postpartum period as well during pregnancy can provide an avenue to discuss sexual difficulties and provide more information. Identifying psychological, child birth related, medical, social and cultural factors that are influencing the sexual functioning in the couple will aid in providing comprehensive care. Appropriate and timely liaison with specialists for the treatment of incontinence, perineal injuries, hormonal fluctuations, contraceptive procedures and methods, newborn health and behavioral concerns and mental health concerns in the new parents may help to address some of these factors. A comprehensive evaluation and brief advice from the couple's primary physician or reproductive assistant may sometimes be sufficient to educate and inform the couple about the various risks and treatment options through the antenatal and postnatal period. If psychological issues are distressing, couple or individual sessions with a trained mental health professional discussing fears, concerns, expectations, frustrations and role transitions may be planned during and after the pregnancy. The sessions may focus on improving communication between the couple, discussing specific changes in behaviors, quality time, co-troubleshooting

common areas of conflicts, sexual and couple expectancies, division of responsibilities, upbringing and cultural practices, boundary setting between and beyond the couple, enhancing physical and non-physical intimacy and improving the overall sexual and couple satisfaction. The treatment of pre-existing or new onset sexual dysfunction can potentially improve the quality of interpersonal relationships, heighten self-esteem and cohesiveness between the new parents. These measures can improve the couple's quality of life, decrease morbidity and also provide a healthier environment for the child. The beginning of a new family translates to the beginnings of the establishments of new units- the couple unit needs to be given as much emphasis in healthcare practices as the parent-child unit.

Available research has been valuable in providing insights into maternal mental health and physical concerns. However, in comparison, there are fewer studies that have explored paternal concerns, couple distress and bonding, cultural mediators, and the newborn's role in the couple unit. Moreover, there is a dearth of research on the intervention measures to mitigate these concerns. Studies in the future may aim to explore the sensitive and vital issue of sexuality in the new parents and discuss specific treatment options for the same.

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