

REVIEW

Human sexuality during pregnancy and the postpartum period

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Abstract: Sexual problems and dysfunctions during pregnancy are often led by the anxiety of hurting the fetus. Males are also afraid of hurting a female and females are afraid of insufficient satisfaction of a male partner. Just 12–14 % of couples deny sexual problems after the childbirth. The main postpartum risk factor for dyspareunia is the extent of a birth injury. Breastfeeding is linked to a low coital activity, low sexual desires and low sexual satisfaction of females and their partners. Breastfeeding females start with a sexual life later; more often suffer from dyspareunia and indicate a lower satisfaction with the sexual intercourse. Further, episiotomy is associated with a higher prevalence of a postpartum dyspareunia. Low interest of antenatal and postnatal care providers in the issues of sexuality is documented. Lack of relevant information is the common reason for avoiding this topic. 76 % of pregnant females would recommend a discussion on sexuality during pregnancy as a topic in an antenatal clinic and almost a half of pregnant women evaluate the information received from health care providers as insufficient (Ref. 48). Full Text (Free, PDF) www.bmj.sk.

Key words: sexuality, pregnancy, delivery, puerperium, sexual dysfunction.

Sexuality of forthcoming and new-blown parents plays an important medical and psychological role. We can see it from two different points of view; firstly as sexual activities of parents influencing the course and the outcome of pregnancy; and secondly as the ongoing pregnancy, childbirth and breastfeeding influencing the quality and the quantity of sexual enjoyment of the couple. Sexuality can be negatively influenced by the pregnancy and the childbirth but there can also be a significant improvement of sexual relationship of the couple.

Genital changes during the pregnancy

Progesterone's dominant role during the first trimester of pregnancy causes some physical and mental changes that alter the female sexuality. Increase excitability and sensibility of breasts; vulvar and vaginal tissue congestion (sometimes linked with the dyspareunia); copious discharge and involuntary urine leakage are the organic changes that can negatively affect the quality of the female sexual life (1–4). Progesterone creates vasodilatation, and thus lowers systemic blood pressure, causes fatigue that, combined with discomfort, reduces sexual excitability. Moreover, the central effect of progesterone produces dysphoria (5, 6).

Due to reduced cellular immunity and elevated estrogens levels there is a higher risk of recurrent and chronic vaginal mycotic infections accompanied by dyspareunia and reduced inter-

est in sexuality during pregnancy. Especially females with in-born or acquired immunodeficiency are prone to these infections (7–9).

Uterus starts to be susceptible to oxytocin produced during the intercourse and especially during orgasm in the later course of the pregnancy resulting in post-orgasmic contractions causing discomfort. Nevertheless, these contractions don't promote neither cervical ripening nor premature labor and usually cease up to 15 minutes in otherwise intact pregnancy (10).

Because of low level of estrogens during 6–8 weeks after the childbirth and during breastfeeding there is a reduced sexual excitability, thinned vaginal wall and orgasms reduced in both frequency and intensity. Breastfeeding women can ejaculate milk during the orgasm. After the ablation these changes regress and some females experience orgasm more intensively than before the pregnancy. 20 % of all females indicate an excessive relaxation of vagina in the period from 3 to 6 months after the childbirth (1, 11).

Sexual interest and initiative

Usually a female interest in sex is not changed during the first trimester of pregnancy or there is just a slight decrease; however, there is a gradual decline in the interest during the rest of pregnancy (11, 12). On the other hand, up to 37 % of females indicate a general increase in the sexual interest during the whole pregnancy (13). Preference in erotic and sexual activities remains unchanged; only the popularity in vaginal stimulation lowers in the third trimester. Interest in sexual activities is still lower 3 month after the childbirth compared to the state before pregnancy (14). Female coital activity during the pregnancy and puerperium is often motivated by the endeavor to sexually satisfy

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the partner and secure a partner's faith (1, 11, 14). No difference in prevalence of postpartum depressive symptoms in homosexual versus heterosexual females was found (15).

Sexual activities

Coital activity lowers during the first trimester; it is variable during the second one and significantly lowers during the third one. Most couples practice intercourse till the seventh month; one quarter to a half of couples practices it during the eighth month and just one third does so during the ninth month. Last sexual intercourse usually occurs during the last month prior to the delivery. About 10 % abstain from the intercourse since the very beginning of a pregnancy. A change of the preferred position can be observed during the whole pregnancy; change from missionary position for side by side position or female-up position. The mean frequency of intercourse varies about 4–5 per month during the second trimester (16–18).

Typical couple starts with sexual life 6–8 weeks after the delivery. 95 % of females have more or less regular sexual intercourse till 3 months after the delivery; whereas 97 % have intercourse after one year. Compared to the state before pregnancy, the sexual activity is significantly lower in the first year after the childbirth. 84–90 % of couples use some mode of contraception, respective to the breastfeeding – the most popular are hormonal contraception and condom (11, 16, 18–20).

Noncoital sexual contacts start approximately 3 weeks after the childbirth, usually prior to the onset of a coital activity. Anal intercourse is practiced by just a minor portion of pregnant women. Prevalence of classical heterosexual activities (coitus, oral intercourse, manual stimulation) and masturbation most often tracks a standard frame – gradual decrease during the course of pregnancy, none or a minimal prevalence during the first three months after the delivery followed by a rise later on. Fellatio is practiced much more often than cunnilingus during the pregnancy and postpartum period (1, 16, 21).

Pleasure of sex and the orgasm

Pleasure of sex is indicated by 76–79 % of all females before pregnancy (7–21 % of women deny pleasure of sex at all). There is a fall to 59 % during the first trimester, followed by an increase to 75–84 % during the second one and a fall again to 40–41 % during the third one. More than half of females indicate pleasure of sexual contacts, 20 % indicate partial pleasure and 24–30 % have no pleasure of sex at all during the first year after the delivery (1, 2, 14, 19, 21, 22).

51–87 % of women reach orgasm in non-pregnant state; 10–26 % of females are anorgasmic for their lifetime. During pregnancy, the findings are controversial – orgasmic ability fluctuates according to the course of pregnancy and is also dissimilar in published papers (19–54 %) (1, 2, 12, 13, 22, 23).

The first orgasm after the childbirth is usually perceived by females at about 7 weeks postpartum; only 20 % of women have orgasm during the very first intercourse after the childbirth; or-

gasmic ability reaches 75 % of females at about 3–6 months postpartum. Preferred methods of reaching the orgasm do not change compared to state before pregnancy – manual or oral stimulation, vaginal intercourse and masturbation (1, 14, 20, 24, 25).

Risks and benefits of sexual activities during the pregnancy

Many studies evaluating the influence of sexual activities on the course of pregnancy and the pregnancy outcome have been performed. Some of them documented the association between the frequency of sexual intercourse and the preterm labor, mainly in the presence of a genital infection (10, 26–29). A low but real risk of cunnilingus during pregnancy should be noted – blow of air to the vagina of a pregnant female can cause the air embolism (30, 31).

Benefits of sexual activities during the pregnancy were not investigated but at least one study proved that the sexual activities and a pleasure are associated with a higher subsequent relationship stability, better emotional background and better communication 4 months and 3 years after the childbirth (1, 32).

Sexual problems and dysfunctions

Epidemiology

30–50 % of couples are afraid of insulting the fetus by a sexual activity during the pregnancy. Males are also afraid of hurting a female and females are afraid of insufficient satisfaction of a male partner (32, 34).

Just 12–14 % of couples deny sexual problems after the childbirth. Many couples are afraid of a sexual comeback. More than a half of females feel pain on the first postpartum intercourse; 41 % indicate a significant dyspareunia even 3 months after the delivery, 22 % indicate the same 6 months postpartum and 19 % indicate this a year postpartum (2, 11, 14, 16, 21). 57 % of females are concerned about their partner's satisfaction. From the long-term point of view, sexual relationship get worse in a third of couples and get better in a quarter of couples after the childbirth (35).

4–28 % of males had extramarital relationship during the pregnancy and early months postpartum, thus putting the couple in the risk of sexually transmitted diseases including HIV infection (35–37).

Etiology of sexual problems and dysfunctions

Occurrence of sexual problems, decrease in sexual activities, interests and enjoyments during the pregnancy, postpartum and breastfeeding are mainly caused by the physiologic changes connected to the pregnancy and the labor. On the other hand, sexual behavior and problems connected to the transition to parenthood are influenced by a mutual interaction of biomedical, psychological and socially marital factors (38–41).

Biomedical factors:

– Exhaustion, fatigue

- Fears of fetus harm
- Dyspareunia
- Back pain
- Low physical attraction of a female

Psychological factors:

- Mental symptoms (depressive mood)
- Pre-pregnancy sexual history
- Negative and ambivalent relation to pregnancy

Relationship factors:

- Low satisfaction with the relationship
- Ambivalent attitude to the partner

The main postpartum risk factor for dyspareunia is the extent of a birth injury – 11 % of females with no birth injury indicate dyspareunia; 15 % of females with a minor birth injury not requiring suture document it; 21 % of females with sutured birth injury suffer from dyspareunia and 40 % of females that underwent episiotomy suffer from dyspareunia (16, 20, 21, 41). The grade of perineal tear is not the only important predictive factor; significant factor is also the extent of a vaginal wall injury that is significantly associated not only with dyspareunia but also with the prevalence of an early urinary incontinence (38). Risk of a postpartum dyspareunia is also increased in an instrumental vaginal delivery (especially forceps delivery). Dyspareunia has a lower prevalence in females after the Caesarean section at 3 months after the delivery; the difference vanishes at 6 months after the childbirth. The Caesarean section as a prevention of sexual dysfunction in the postpartum period couldn't be accepted because of its many complications not only during operation, but also in subsequent pregnancies (42). Females after the Caesarean section indicate an earlier onset of the postpartum sexual life (43–47).

Breastfeeding is linked to a low coital activity, low sexual desires and low sexual satisfaction of females and their partners. Breastfeeding females start with a sexual life later; more often suffer from dyspareunia and indicate a lower satisfaction with the sexual intercourse. The cessation of a breastfeeding has a positive effect on a sexual activity but does not increase the orgasmic ability. A negative influence of breastfeeding is caused by a high level of prolactin which suppresses the production of gonadotrophins and results in hypo-estrogenic state. Next factor is fatigue and change of a view on breast function in both partners (nutritional versus sexual) (1, 2, 20, 21, 35, 48).

It is to be stressed that sexual activity and sexual satisfaction globally decrease with the duration of the relationship in both couples with children and couples without them (1, 23).

Diagnosis of sexual problems and dysfunctions; their prevention and treatment

Episiotomy is associated with a higher prevalence of a postpartum dyspareunia, thus this operation should be used just in strong indications. A routine use should be avoided (1, 46).

Most gynecologists declare that they discuss sexual problems during pregnancy and postpartum with their patients sufficiently. On the other hand, two thirds of females do not remember their gynecologists to do so. 76 % of pregnant females would recommend a discussion on sexuality during pregnancy as a topic in an antenatal clinic. 45 % of pregnant women evaluate the information received from health care providers as insufficient. About a half of pregnant women who discussed the issue of sexuality during pregnancy with their health care provider had had to initiate the dialog; 34 % of them had a bad feeling about it. Antenatal care providers very rarely discuss alternative coital positions or the alternatives to a vaginal intercourse with their clients. 8–10 % of pregnant women abstain from sexual intercourse during pregnancy according to the health care provider recommendation (1, 10, 25, 33).

Many antenatal care providers are dubious in the issues of sexual consulting in pregnancy, especially in a high risk. Quite common is to prohibit sexual intercourse, mainly in the case of vaginal bleeding and the risk of a preterm labor. But there is not a consensus on the length of this abstaining; there is no concrete recommendation in obstetrics textbooks. Dubiousness and lack of information are the common reasons for avoiding this topic. Dialogues on the sexual problems are usually not included in a routine antenatal care; and if so, partner is not a participant in this discussion (1, 10).

Postpartum care in the USA and Europe mainly concentrates on the newborn not on the mother. Health care providers often lack information and experience to consult sexuality in postpartum period. Routine check-up at the end of 6 weeks puerperium is insufficient because just 35–40 % of all females started with sexual life by that time (38, 43). The main topic of sexual consulting at this check-up is contraception (76 %); issues like perineal problems, pain, insufficient lubrication and a loss of sexual desire are usually not discussed, and thus stay concealed in most females (2, 20, 43).

Conclusions

Generally, a significant influence of pregnancy, childbirth and breastfeeding on a quality on the sexual life of a couple is recognized. Decrease in frequency and quality of sexual activities caused by physiologic and mental changes and increase in sexual dysfunctions can cause serious partnership problems, possibly leading even to the disruption of the couple or search for an extramarital sexual relationship.

Low interest of antenatal and postnatal care providers in the issues of sexuality is documented. Lack of relevant information is the common reason for avoiding this topic. Routine check-up after 6 weeks of puerperium is in the view of searching for sexual dysfunctions insufficient; more suitable would be check-up after 3 months when most females (90 %) already started with the sexual intercourse (38, 43). A structured interview is indicated in the search for dyspareunia, eventually for vaginal dryness sensation. Realized organic disorders should be treated immediately (e.g. local estrogens, laser treatment); in case problems persist, sexological and psychological consultations are indicated.

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