

**Women's Experiences of Sexual Intimacy in the Early Postnatal
Period Following Physical Birth Trauma**

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Introduction: Thesis overview

Sexual health and functioning is essential to individuals' quality of life, mental health and well-being. The process of pregnancy and childbirth involves significant physical, emotional, psychological, hormonal, social and cultural changes which can impact on women's individual sexuality and their sexual intimacy within their couple relationship (Johnson, 2011). Despite this, women's postnatal sexual health remains under-researched (World Health Organisation, 2006).

To date, the published literature in the field of postnatal sexual functioning has primarily been conducted with women, within the first twelve months. It has focussed on the frequency and timing of resuming sexual intercourse, and the factors which affect this (Leeman & Rogers, 2012), as opposed to exploring all aspects of sexual intimacy as previously recommended (Von Sydow, 1999). The first paper within this thesis, a systematic review, aimed to review existing literature concerning mothers' experiences of sex and all aspects of sexual intimacy in the first postnatal year, published since this early meta-analysis.

Due to the dominance of quantitative studies exploring postnatal sexual functioning, women's subjective experiences of sexual intimacy have remained relatively absent in the literature (Johnson, 2011; Von Sydow, 1999). The second paper of the thesis therefore gives five women's voices a platform, providing a phenomenological account of their personal experiences of sexual intimacy, in the early postnatal period following physical birth trauma (defined as an episiotomy or a second-degree perineal trauma).

References:

- Johnson, C. E. (2011). Sexual health during pregnancy and the postpartum. *Journal of Sexual Medicine*, 8, 1267–1284.
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CHAPTER 1

SYSTEMATIC LITERATURE REVIEW

Mothers' experiences of sex and sexual intimacy in the first postnatal year: A systematic review

Manuscript prepared for submission to 'Sexual and Relationship Therapy'
(Word limit 6,000 excluding tables, references, figure captions, footnotes or
endnotes)

Mothers' experiences of sex and sexual intimacy in the first postnatal year: A systematic review

Abstract

Background: The transition to parenthood following childbirth can be socially and emotionally significant, impacting on postnatal sexual functioning. This study aimed to conduct a systematic review of the literature on mothers' experiences of sex and sexual intimacy in the first postnatal year, since an early meta-analysis was conducted in 1996.

Method: Systematic review strategies of nine databases were conducted to identify relevant literature. Electronic database were searched for English language, peer-reviewed literature using search terms relating to 'sex', 'intimacy', 'postnatal', 'experience' and 'twelve months' and their quality was systematically assessed.

Results: Thirteen studies meeting the criteria were included. Women typically resumed sexual intercourse during the early postnatal weeks when the prevalence of sexual health problems was high. Women experienced significantly more sexual problems, such as pain and dyspareunia following perineal trauma, yet sexual functioning changes or problems were rarely explored by healthcare professionals.

Conclusion: Consistent with earlier reviews, this review demonstrated the lack of focus on all aspects of sexual intimacy post-natally. The prevalence of postnatal sexual problems following perineal trauma highlights the need for interventions aimed at supporting these women, including healthcare professionals providing information and having discussions with women regarding postnatal sexual changes and possible problems.

Keywords: Postnatal, sex, intimacy, twelve months

Introduction

Sexual health is defined as “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity” (World Health Organisation; WHO, 2006). It is considered “fundamental to the physical and emotional health and well-being of individuals, couples and families, and to the social and economic development of communities and countries” (WHO, 2006). Women’s postnatal health can significantly affect their own physical and mental health (Schytt, Lindmark, & Waldenström, 2005), whilst contributing to the health of their children (Kahn et al., 2002).

Sexuality and sexual relations are central to reproductive and sexual health, yet most sexual activity is not directly associated with reproduction; highlighting individuals’ and couples’ desire to have fulfilling and pleasurable sexual relationships that go beyond reproductive functions (WHO, 2006). Sexual relationships can fluctuate throughout a person’s lifespan, adjusting to age and changes in circumstances, with the transition to parenthood following the first childbirth, being described as an event of major social and emotional significance (Cowan & Cowan, 1988). Despite women’s postnatal mental health having been extensively researched (Chivers, Pittini, Grigoriadis, Villegas, & Ross, 2010; Moel, Buttner, O’Hara, Stuart & Gorman, 2010), their postnatal sexual functioning has been neglected. This may be due to the complexity of the area, as it encompasses diverse behaviours, physiological, psychological, social, cultural, political and spiritual or religious processes and aspects of sex (Abdool, Thakar & Sultan, 2009).

Sex and sexual intimacy may be viewed as natural, healthy and pleasurable aspects of life (Allgeier & Allgeier, 1995; Hyde & DeLamater, 1997), however this has not always been the case and it differs culturally. Despite cultural beliefs evolving and adapting to different eras, sex remains a focus of cultural norms and restrictions, and can still be a topic accompanied with disgust and embarrassment for many adults (Goldenberg et al., 1999). Such evolutions are echoed within empirical research in this area, as an early meta-content analysis highlighted how the focus of research has reflected the eras in which it was undertaken (Von Sydow, 1999). Specifically, early research of sexual functioning initially focussed on sexual activity during pregnancy, shifting to postnatal sexual functioning over time (Leeman & Rogers, 2012; Von Sydow, 1999).

Key findings highlighted in Von Sydow's (1999) review, included how prevalent postnatal sexual problems were in the literature between 1950 and 1996, despite sex being a highly taboo subject during this time. For instance, only 14% of women recorded having no postnatal sexual problems at all; with 40% of women experiencing problems during their first postnatal sexual intercourse experience, leading to 64% of the 40%, subsequently avoiding it (Von Sydow, 1999). Despite some interesting findings, the validity of them could be questioned as the studies were largely heterogeneous; encompassing diverse sampling, methodology, design, data collection and used non-validated self-report measures.

Since Von Sydow's (1999) meta-analysis, postnatal sexual functioning research has predominantly been conducted solely with women. Often using self-report questionnaires in cohort or cross-sectional study designs, they invariably report

findings on the frequency and timing of resuming sexual intercourse, the experience of perineal pain/dyspareunia, levels of sexual desire, enjoyment and satisfaction (Barrett et al., 1999). Besides changes in family structure and sleep patterns, other factors found to negatively affect postnatal sexual health include: perineal trauma and operative vaginal deliveries, dyspareunia, postnatal depression and breastfeeding. These have again been researched predominantly with women using similar research designs. Postnatal sexual health problems are reportedly common; with 41-83% of women at two to three months post-natally experiencing some sexual dysfunction (Leeman & Rogers, 2012). However, resumption of postnatal sexual activity is rapid, with 52% of women resuming sexual activity by five to six weeks post-natally and 90% by three months post-natally (Rogers, Borders, Leeman & Albers, 2009).

Despite research concerned with the resumption of sexual intercourse and factors which negatively affect this, dominating the postnatal sexual functioning literature, the lack of professional recognition of such difficulties has increasingly been reported (Barrett et al., 2000; Glazener, 1997). Few women are provided with information on postnatal sexual functioning changes, and only a minority of women experiencing postnatal sexual problems were asked about them during postnatal health visits or discussed them with healthcare professionals (Barrett et al., 1999; 2000).

Predominantly, this literature has explored women's postnatal sexual functioning within the first twelve months, focussing on sexual intercourse as opposed to all aspects of sexual intimacy (Von Sydow, 1999). Recommendations from earlier reviews of this

body of literature have highlighted the need to research all aspects of sexual intimacy (Johnson, 2011; Von Sydow, 1999). This systematic review aims to synthesise existing studies exploring mothers' experiences of sex and sexual intimacy in the first postnatal year since the early meta-analysis was conducted by Von Sydow (1999). This would facilitate understanding of mothers' experiences which could not only direct clinical practice but also future research in this area.

Method

Eligibility criteria

This review focuses on studies of mothers' experiences of sex and sexual intimacy in the first postnatal year. Studies were included if:

- English language papers published in peer reviewed journals, as a certain level of quality can be assumed of these studies.
- Published after 1996, as studies up to this date could have been included in the earlier meta-content analysis published by Von Sydow (1999).
- Included either primiparous or multiparous women due to this area being a relatively new research interest.
- Mothers were aged 18 and over due to the stage of their physical growth and development.

Due to arguably being somewhat different in nature, studies that solely investigated postnatal sexual functioning of specialist subgroups of mothers were excluded. For example, mothers who have HIV, depression, experienced intimate partner violence and secondary suturing following that immediately undertaken following childbirth.

Search strategy

Electronic databases PsycINFO, PsycARTICLES, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, Global Health, MEDLINE, MEDLINE with Full Text, University of Liverpool Catalogue, Scopus and Web of Science were searched for English language literature in peer-reviewed journals. The flow of information through the phases of the systematic review is reported using the Preferred Reporting Items for Systematic Reviews (PRISMA) diagram (Figure 1).

Search terms

The search terms aimed to identify relevant literature using combinations of terminology within this research area and were combined using Boolean operators. The first concept related to sexual intimacy, included ‘sex*’ (truncated) or ‘intima*’ (truncated). The second concept related to the postnatal period following childbirth, included ‘postpartum’ or ‘postnatal’. The third concept related to capturing women’s sexual health experiences, included ‘experienc*’ (truncated). The final concept related to the postnatal timeframe, included “12 months” or “first year” or “year” or “twelve months”.

Quality Assessment

The methodological quality of the final 13 papers were assessed using the Newcastle-Ottawa Assessment Scales (NOS; Wells et al., 2000). This quality assessment tool, designed specifically for cohort studies, with an adapted version for cross-sectional studies was selected as the final 13 papers utilised these study designs (see Appendix B). Moreover, the content validity and inter-rater reliability of the NOS has been established. The NOS employs a 'star system' whereby studies are

assessed on three broad perspectives: the selection of the study groups; the comparability of the groups; and the ascertainment of either the exposure or outcome of interest for the studies. Each category received between two to five stars each, totalling a maximum of nine stars for the quality of each cohort study and ten stars for cross-sectional studies as can be seen in Tables 2 and 3 below (Wells et al., 2000).

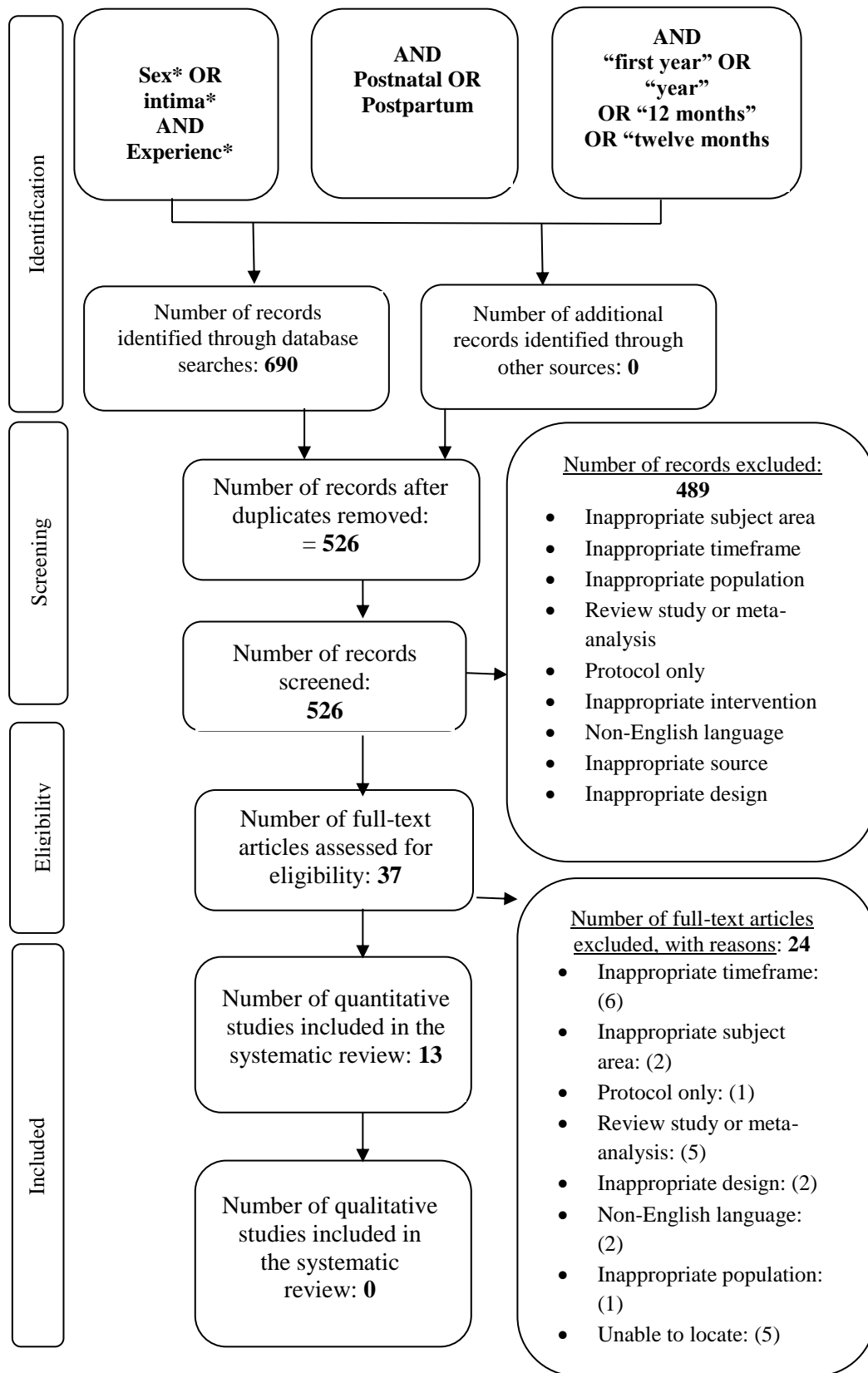
Data Extraction

Data was extracted from the selected studies regarding study design, participants, year the study was conducted, country of origin, evaluation moments, and statistical and descriptive outcomes. These are detailed in Tables 1 and 4.

Results

A total of 690 records were obtained from the electronic search and 164 duplicates were removed. In total, 526 articles were assessed on title and abstract, with 37 being eligible for full-text assessment. Reasons for exclusion are provided in Figure 1. The most common reason for exclusion was having an inappropriate subject area, meaning there was no reference to sex or sexual intimacy; or the articles focused on specialist sub-groups when exploring postnatal sexual functioning such as intimate partner violence, mothers with postnatal depression, adolescents and childhood abuse etc. The full-text of these 37 studies were reviewed, with a further 24 studies being excluded (see Figure 1). The most common exclusion reason was exceeding the twelve months postnatal timeframe.

Figure 1. Flow of information through the phases of the systematic review



Characteristics of included studies

The characteristics of the 13 included studies are detailed in Table 1. Baseline evaluation moments, involved a total of 6,909 participants; 5,995 of whom completed all final evaluation moment questionnaires. The studies involved women of mixed parity; five studies including only primiparous women, three including women of mixed parity (either primiparous or multiparous), one including only nulliparous women and for four, parity was not reported. The reported mean age of women ranged from 25 to 34 years old, but this was not reported in seven studies, yet two of these required women to be minimum age of 16 to participate. Evaluation moments ranged from six to twelve hours after the birth to up to 12 months post-natally. Two studies evaluation moments exceeded 12 months, thus only their findings up to this time point were included.

Table 1. Characteristics of included studies

Study	Design type	Year conducted	Country	n	Sample	Exclusions (if specified)	Mean age	Evaluation Moments Post-natally (range)	Drop-out Rate (%)
Avery (2000)	Cohort	1989-1990	USA	576	▪ Primiparous breastfeeding women	X ¹	28	▪ 6-24 hours ▪ 1, 3, 6 and 12 months ²	11
Glazener (1997)	Cohort	1990-1991	UK	1249 ³ 1116 ⁴ 438 ⁵	▪ Parity not reported ▪ 20% of women delivered between June 1990-May 1991	X	X	▪ Discharged from hospital ▪ 8 weeks ▪ 12-18 months. ⁶	14
Buhling (2006)	Cohort	1997-1999	Germany	655	▪ Primiparous women ▪ Delivering between May 1997 to May 1999	Stillbirths and births prior to 35 completed weeks	29	▪ 6-30 months	60
Connolly (2005)	Cohort	1993-1994	USA	150 ⁷ 47 ⁸	▪ Nulliparous women ▪ Aged 18+	X	25	▪ Prior to pregnancy ▪ Third trimester ▪ 2, 6, 12 and 24 weeks post-natally	69 ⁹

¹ Each X represents data not provided.

² Those who had not weaned by 12 months were followed every 3 months until complete weaning reported.

³ Completed postnatal experience in hospital questionnaire

⁴ Completed 8 week questionnaire

⁵ Completed the 12-18 month questionnaire

⁶ Only outcomes up to 12 months included due to the inclusion criteria of this review. If unclear, caution was taken and they were not included.

⁷ Number of women who enrolled

⁸ Number of women who completed all questionnaires

⁹ Of the original sample compared to those who completed all questionnaires

Study	Design type	Year conducted	Country	n	Sample	Exclusions (if specified)	Mean age	Evaluation Moments Post-natally (range)	Drop-out Rate (%)
Saurel-Cubizolles (2000)	Cohort	09.1993-07.1994	France & Italy	632 ¹⁰ 723 ¹¹ 589 ¹² 697 ¹³	<ul style="list-style-type: none"> ▪ Mixed parity (primiparous and multiparous) 	Multiple pregnancies/still birth/neonatal death	X	<ul style="list-style-type: none"> ▪ At birth ▪ Infants' 5 and 12 month birthdays 	17 ¹⁴ 12 ¹⁵
Signorello (2001)	Cohort	1996-1997	USA	615	<ul style="list-style-type: none"> ▪ Primiparous women ▪ Birth between August 1996-February 1997 	X	X	<ul style="list-style-type: none"> ▪ Pre-birth ▪ 3 and 6 months 	30
Acele (2011)	Cross-sectional	2007-2008	Turkey	230	<ul style="list-style-type: none"> ▪ Mixed parity (primiparous and multiparous) ▪ Women aged 18-40 	No active sex life/separation from partner/illiterate	27	<ul style="list-style-type: none"> ▪ 8.1 months (2-12 months) 	13
Barrett (1999)	Cross-sectional (pilot)	1996	UK	98	<ul style="list-style-type: none"> ▪ Primiparous women ▪ Live birth between February and March 1996 	X	X	<ul style="list-style-type: none"> ▪ 8-9 months (7-12 months) 	38
Barrett (2000)	Cross-sectional	1997-1998	UK	484	<ul style="list-style-type: none"> ▪ Primiparous women ▪ Live birth between July and December 1996 	X	X	<ul style="list-style-type: none"> ▪ 6 months 	39

¹⁰ Total number who completed all questionnaires in France

¹¹ Total number who completed all questionnaires in Italy

¹² Total number included in the analysis for France (excluding mothers who were pregnant/ recently given birth 12 months after the index delivery)

¹³ Total number included in the analysis for Italy (excluding mothers who were pregnant/ recently given birth 12 months after the index delivery)

¹⁴ Drop-out rate for mothers in France

¹⁵ Drop-out rate for mothers in Italy

Study	Design type	Year conducted	Country	n	Sample	Exclusions (if specified)	Mean age	Evaluation Moments Post-natally (range)	Drop-out Rate (%)
Chivers (2011)	Cross-sectional	X	Canada	77	<ul style="list-style-type: none"> ▪ Parity not reported ▪ Women aged 18+ 	X	34	<ul style="list-style-type: none"> ▪ 13 weeks (3-24 weeks) 	37
Heidari (2009)	Cross-sectional	2008	Iran	456 (258 ¹⁶ 198 ¹⁷)	<ul style="list-style-type: none"> ▪ Mixed parity (primiparous and multiparous) 	X	27	<ul style="list-style-type: none"> ▪ 2-6 months 	39 ¹⁸ 21 ¹⁹
Williams, Herron-Marx & Hicks (2007)	Cross-sectional	X	UK	482 ²⁰	<ul style="list-style-type: none"> ▪ Parity not reported ▪ Aged 16+ 	X	X	<ul style="list-style-type: none"> ▪ 12 months 	77
Williams, Herron-Marx & Knibb (2007)	Cross-sectional	X	UK	482 ²¹	<ul style="list-style-type: none"> ▪ Parity not reported ▪ Aged 16+ 	X	X	<ul style="list-style-type: none"> ▪ 12 months 	77

¹⁶ Total women in the breastfeeding group

¹⁷ Total women in the bottle-feeding group

¹⁸ Drop-out for women in the breastfeeding group

¹⁹ Drop-out for women in the breastfeeding group

²⁰ The same population as the Williams, Herron-Marx & Knibb (2007) study is used, but reports different outcomes so can legitimately be dealt with as separate studies.

²¹ The same population as the Williams, Herron-Marx & Hicks (2007) study is used, but reports different outcomes so can legitimately be dealt with as separate studies.

Quality assessment

Of the 13 studies included in this review, six utilised cohort study designs and seven cross-sectional study designs. The quality assessment results of the included studies can be found in Tables 2 and 3.

Cohort studies

Overall quality scores for the six cohort studies ranged from five to eight out of nine. In relation to the selection of participants, all six studies used convenience/opportunistic sampling methods and so all could only be regarded as somewhat representative of the target population, as opposed to truly representative, thus highlighting potential selection biases. As the sample size used in one of the studies was somewhat small (Connolly, Thorp & Pahel, 2005), highlighting drop-out biases, thus limiting generalizability of findings.

Two of the six studies took measures limiting potential reporting biases by matching women's self-report information to clinical and obstetric medical records, for example their degree of perineal trauma. However, the remaining four studies relied solely on mothers' self-report methods, thus increasing the likelihood of biases existing (Buhling et al., 2006; Signorello, Harlow, Chekos & Repke, 2001). To limit pre-existing sexual intimacy difficulties confounding the results, four studies also recorded pre-pregnancy intimacy experiences (Avery, Duckett, & Frantzich, 2000; Buhling et al., 2006; Connolly, Thorp & Pahel, 2005; Signorello, Harlow, Chekos & Repke, 2001).

All studies employed appropriate follow-up time frames with the final evaluation moments ranging between six to 12 months post-natally. However, variations in the overall quality of outcome across these studies was attributed to either high drop-out rates, inadequate descriptions of participants lost or the over-reliance on self-report outcome measures only and the associated biases. In attempts to reduce reporting biases, only two of the six studies referred to their outcome measures having been pre-evaluated by independent experts in their fields (Avery, Duckett, & Frantzich, 2000; Buhling et al., 2006).

Cross-sectional studies

Of the seven cross-sectional studies, overall quality scores varied between six to nine out of ten. All seven studies used convenience/opportunistic sampling methods and so all could only be regarded as somewhat representative of the target population, as opposed to truly representative, highlighting potential selection biases. Large drop-out rates and smaller sample sizes for two studies (Barrett et al., 1999; Chivers et al., 2011), along with comparisons between respondents and non-respondents only being evident in three of the studies (Barrett et al., 1999; 2000; Williams, Herron-Marx & Hicks, 2007); may further weaken generalizability.

All studies gained quality ratings for providing descriptions of non-validated tools used; with only three studies achieving maximum quality ratings for using validated tools or stipulating how their non-validated tools were pre-evaluative by independent experts (Acele & Karacam, 2011; Chivers et al., 2011; Heidari, Khoei & Asiabar, 2009). Thus biases regarding data collection could exist.

Regarding the outcome quality assessment ratings, all studies employed appropriate statistical analyses. The sole reliance on self-report methods for three studies (Acele & Karacam, 2011; Chivers et al., 2011; Heidari, Khoei & Asiabar, 2009), prevented them achieving maximum ratings according to the NOS (Wells et al., 2000). This should be interpreted with caution however due to the nature of research in this field depending on self-report assessments, whilst studies gaining maximum ratings matched participant information to clinical and obstetric medical records, thus limiting these biases (Barrett et al., 1999; Barrett et al., 2000; Williams, Herron-Marx & Hicks, 2007; Williams, Herron-Marx & Knibb, 2007).

Table 2. Detailed Risk of Bias Results Using the Newcastle-Ottawa for Assessing Quality for Cohort Studies

Study, Year (Reference)	Selection (Maximum 4 stars)			Comparability (Maximum 2 stars)		Outcome (Maximum 3 stars)			Total Score (Max 9 stars)
	Representativeness of the exposed cohort	Selection of the non-exposed cohort	Ascertainment of exposure	Demonstration that outcome of interest was not present at start of study	Comparability of cohorts on the basis of the design or analysis	Assessment of outcome	Was follow-up long enough for outcomes to occur	Adequacy of follow-up of cohort	
Avery (2000)	* ²²	*	- ²³	*	*	-	*	*	6
Glazener (1997)	*	*	-	-	*	-	*	*	5
Buhling (2006)	*	*	*	*	**	*	*	-	8
Connolly (2005)	*	*	-	*	**	*	*	-	7
Saurel-Cubizolles (2000)	*	*	-	-	**	-	*	*	6
Signorello (2001)	*	*	*	*	**	*	*	-	8

²² Each asterisk represents if the individual criterion within the subsection was fulfilled

²³ Each dash represents if the individual criterion within the subsection was not fulfilled

Table 3. Detailed Risk of Bias Results Using the Newcastle-Ottawa for Assessing Quality for Cross-Sectional Studies

Study, Year (Reference)	Selection (Maximum 5 stars)			Ascertainment of the exposure (risk factor)	Comparability (Maximum 2 stars) The subjects in different outcome groups are comparable, based on the study design or analysis. Confounding factors are controlled.	Outcome (Maximum 3 stars)		Total Score (Max 10 stars)
	Representativeness of the sample	Sample Size	Non- respondents			Assessment of the outcome	Statistical test	
Acele (2011)	*	*	-	**	**	*-	*	8
Barrett (1999)	*	-	*	*-	**	**	*	7
Barrett (2000)	*	*	*	*-	**	**	*	9
Chivers (2011)	*	-	-	**	*-	*-	*	6
Heidari (2009)	*	*	-	**	**	*-	*	8
Williams, Herron-Marx & Hicks (2007)	*	*	*	*-	**	**	*	9
Williams, Herron-Marx & Knibb (2007)	*	*	-	*-	**	**	*	8

Overall outcomes

A summary of the descriptive and statistical outcomes of all the included studies can be found in Table 4 (see Appendix C). Key findings are described below:

Resumption and experience of sexual intercourse

Of the eight included studies exploring the resumption of sexual intercourse, the median time sexual intercourse was resumed was between six to seven weeks post-natally. Moreover, 82-90% of women resumed sexual intercourse between six to nine months post-natally, with a minority of women engaging in masturbation only (10%) and others not having engaged in any form of sexual activity, partnered or solitary (13%) (Acele & Karacam, 2011; Chivers et al., 2011; Connolly, Thorp & Pahl, 2005).

Perineal trauma and maternal age were found to be strongest predictors of timing to resume sexual intercourse. Women with an episiotomy, second- and high-degree perineal trauma waited on average 2.1 weeks longer to resume than women with an intact perineum. Similarly, women aged 35 or over waited 2.5 weeks longer to resume than women younger than 25 years old; whilst breastfeeding women also resumed intercourse significantly earlier than non-breastfeeding women (Signorello, Harlow, Chekos & Repke, 2001; Williams, Herron-Marx & Hicks, 2007; Williams, Herron-Marx & Knibb, 2007).

Women experiencing an episiotomy, spontaneous perineal tear or operative delivery, experienced significantly more pain during their first sexual intercourse than those experiencing a spontaneous vaginal delivery without perineal injury or Caesarean

section. No significant differences between modes of delivery and the enjoyment or resumption of sexual intercourse were found (Buhling et al., 2006); but oral sex by their partners significantly declined post-natally (Barrett et al., 1999). Women experienced orgasms around six weeks post-natally (39%), 12 weeks (60%) and at 24 weeks (61%); with orgasms being described as similar to pre-pregnancy or improved by 71-83% of women during this period (Connolly, Thorp & Pahel, 2005).

Prevalence of postnatal problems

Five of the included studies explored the prevalence of postnatal problems. Of those women who resumed sexual intercourse, 17-43% of women experienced at least one problem up to three months post-natally, with this rising to between 36-43% at six months and 80-91% at 12 months post-natally (Acele & Karacam, 2011; Barrett et al., 1999; 2000; Glazener, 1997; Williams, Herron-Marx & Hicks, 2007). Limited information was provided as to the severity or duration of these problems, with only two studies reporting the prevalence of sexual problems pre-natally (38%) and during the course of pregnancy (33%) (Acele & Karacam, 2011; Barrett et al., 2000). Yet, the biggest predictor of experiencing postnatal sexual problems included the presence of sexual problems during pregnancy, an increase in age, having had two or more births, an increase in time following childbirth, and experiencing first or second-degree perineal trauma (Acele & Karacam, 2011; Williams, Herron-Marx & Hicks, 2007).

Postnatal problems such as pain, lack of vaginal lubrication, vaginal looseness/lack of muscle tone and difficult reaching orgasm, increased significantly during the first three months, with this declining by six months post-natally, but not to pre-

pregnancy levels (Barrett et al., 1999; 2000). Despite the high prevalence of women experiencing postnatal sexual problems (80-84%), only 15-19% of women reported them to healthcare professionals (Barrett et al., 1999; 2000).

Perineal pain and trauma

Nine studies reported findings regarding the prevalence of perineal pain. At one week post-natally, 42% of women experienced perineal pain, rising to 62% by three months and decreasing to 10-36% up to twelve months post-natally (Barrett et al., 1999; Barrett et al., 2000; Glazener, 1997; Williams, Herron-Marx & Hicks, 2007). The severity of pain varied depending on the degree of perineal trauma, with mild pain being more frequently reported by women with an intact perineum (51%), compared to women who had experienced second-degree (42%) or high-degree trauma (31%). Severe pain more commonly being reported following a second-degree trauma (14%) compared to a high-degree trauma (10.4%) or an intact perineum (7%) (Signorello, Harlow, Chekos & Repke, 2001).

Perineal trauma was significantly associated with more perineal difficulties (perineal pain, healing incontinence) and sexual difficulties (dyspareunia, lack of lubrication, unwanted leakage of urine or faeces during sexual intercourse, lack of sensation, vagina too tight or lax). Women experiencing a spontaneous tear or an episiotomy reported significantly more perineal difficulties than women with an intact perineum. Moreover, women reported significantly higher levels of perineal difficulties, resuming sexual intercourse significantly later following a forceps vaginal delivery

compared to other modes of birth (Williams, Herron-Marx & Hicks, 2007; Williams, Herron-Marx & Knibb, 2007).

Buhling et al. (2006) found that perineal pain during first intercourse was experienced by 69% of women. Perineal trauma significantly related to pain during the first sexual intercourse in a dose-response manner, with breastfeeding and a history of dyspareunia being additional predictors. Pain during first intercourse was significantly greater for women with perineal lacerations (74% second- and high degree) than women without (58%) (Signorello, Harlow, Chekos & Repke, 2001). At three months post-natally, dyspareunia was significantly related to degree of perineal trauma (33% intact, 48% second-degree, 61% high-degree). Relative to women with intact perineums, women with a second-degree and third or fourth-degree perineal trauma were 80% and 270% retrospectively more likely to report dyspareunia at three months post-natally (Signorello, Harlow, Chekos & Repke, 2001).

Breastfeeding

Two studies reported findings on the effects of breastfeeding on women's sexual functioning. The majority of women (74.6%) did not find breastfeeding interfered with their sexual relationship, whilst a minority of reported it to be a minor (12.4%) or major (3.2%) problem for them. Slightly less women (40.4%) reported feeling sexual aroused whilst breastfeeding, than those who did not (59.4%) (Avery, Duckett, & Frantzich, 2000; Heidari, Khoei & Asiabar, 2009). In relation to their breasts having a dual purpose, slightly more women (39.2%) found this easier than women who experienced some degree of difficulty with it (32.2%) (Avery, Duckett, & Frantzich, 2000). Common effects on sexuality reported by breastfeeding women

included low sexual desire (31.5%), fatigue (38.1%), distorted body style (7.4%) and discharge of milk during intercourse (14.4%); with the latter being more of a ‘turn-off’ (47.5%) compared to those who had a neutral response (24.6%) or who found it a ‘turn-on’ (9.8%) (Avery, Duckett, & Frantzich, 2000; Heidari, Khoei & Asiabar, 2009).

The impact of breastfeeding on postnatal sexual functioning yields inconsistent findings which the included studies continue to reflect. For instance, Glazener (1997) found breastfeeding women were significantly more likely to report a lack of interest in intercourse at eight weeks post-natally than those bottle-feeding; yet Heidari, Khoei and Asiabar (2009) reported breastfeeding women had significantly more intercourse in a month post-natally than bottle-feeding women. Women who breastfed were found to be greater than four times more likely to report dyspareunia compared to non-breastfeeding women (Signorello, Harlow, Chekos & Repke, 2001), with persisting pain during intercourse being significantly associated with breastfeeding at six and twelve months post-natally after controlling for mode of delivery and episiotomy (Barrett et al., 2000; Connolly, Thorp & Pahel, 2005). No significant differences were found between breast and bottle-feeding women’s sexual desire, orgasm, vaginal dryness and dyspareunia post-natally, compared to prenatally (Heidari, Khoei & Asiabar, 2009). Avery, Duckett and Frantzich (2000) however, found women who breastfed more than 26 weeks, were more positive about breast changes, leaking of breasts during sexual arousal and vaginal lubrication during sexual arousal, compared to those breastfeeding for less than 26 weeks.

Professional help and advice

Four included studies provided findings on the information or advice women received about their postnatal sexual health. Only 30% of women reportedly received information about postnatal sexuality from their care provider, with 60% stating that they would have liked this (Chivers et al., 2011). Similarly, 59-69% of women reported health professionals discussed resuming sex after childbirth with them; with the focus of discussions being centred on contraception (93-96%), timing to resume (29-35%) and sexual changes or possible problems (11-18%) (Barrett et al., 1999; 2000). Between 88-91% attended their six week postnatal check, with the majority having vaginal examinations (62-64%); being asked about problems with their perineal/vagina (31-45%), with a minority wanting to ask something but felt they could not (9-11%) (Barrett et al., 1999; 2000).

Depression and other factors

Women experiencing depressive symptoms had a significant lack of interest in intercourse within the first eight weeks post-natally (Glazener, 1997). Moreover they had significantly poorer sexual functioning than women without depressive symptoms, experiencing significantly lower arousal, orgasm and satisfaction; whilst sexually active women with depressive symptoms experienced reduced sexual activity (Chivers et al., 2011).

Tiredness was significantly associated with a lack of interest in sexual intercourse after controlling for depression and breastfeeding (Glazener, 1997). Whilst findings related to parity, found primiparous women were significantly more likely to report painful intercourse and reduced sexual desire at twelve months post-natally than

women who had their second baby (Saurel-Cubizolles, Romito, Lelong & Ancel, 2000).

Discussion

Due to postnatal sexual functioning being an evolving body of literature, this review aimed to summarise and critique existing research into mothers' experiences of sex and sexual intimacy in the first postnatal year, since the publication of an early meta-analysis (Von Sydow, 1999). Despite Von Sydow (1999) recommending future research to explore all aspects of sexual intimacy as opposed to sexual intercourse, the included studies reported findings on postnatal sexual health and functioning as opposed to all aspects of sexual intimacy. This highlights its absence in the literature, reinforcing the need for research to explore all aspects of sexual intimacy. Many interesting and valuable results have been described from the included studies, with fundamental findings being discussed herein.

Firstly, women resumed sexual intercourse promptly during the early postnatal weeks despite the prevalence of postnatal sexual health problems being high during this period, increasing throughout the postnatal period (Acele & Karacam, 2011; Barrett et al., 1999; 2000; Glazener, 1997). Problems included pain, lack of vaginal lubrication, vaginal looseness/lack of muscle tone and difficulty reaching orgasm, which despite declining over time, did not return to pre-pregnancy levels (Barrett et al., 1999; 2000). These findings reflect conclusions drawn from an early meta-analysis that postnatal sexual problems persist over months or years, even following perineal trauma being healed (Von Sydow, 1999). Yet, only a minority of studies assessed for pre-existing sexual problems, thus caution is needed when interpreting

these results, particularly since the presence of sexual problems during pregnancy was one of the largest predictors of experiencing postnatal sexual problems (Acele & Karacam, 2011; Williams, Herron-Marx & Hicks, 2007).

A second finding was the significant impact perineal trauma has on women's postnatal sexual functioning. Not only did experiencing an episiotomy, second- and high-degree perineal trauma significantly delay women resuming sexual intercourse, but they experienced significantly more perineal problems and pain during their first sexual intercourse in a dose-response manner up to three months post-natally. Alarming, women's dyspareunia at three months post-natally significantly increased by 80% following a second-degree trauma and 270% following a third or fourth-degree perineal trauma (Signorello, Harlow, Chekos & Repke, 2001; Williams, Herron-Marx & Hicks, 2007; Williams, Herron-Marx & Knibb, 2007). This exemplifies the serious influence experiencing perineal trauma has on women's postnatal sexual functioning, given that 70% of women completing the national survey of women's experiences of maternity care 2014, experienced either an episiotomy or a minor tear requiring stitches (Redshaw & Henderson, 2015).

A third finding, was despite sexual functioning problems being highly prevalent and the significant impact of perineal trauma, few women received information or advice from healthcare professionals regarding this, despite them reporting this would have been valued (Chivers et al., 2011). Instead, discussions were centred on contraception and timing to resume, with postnatal sexual functioning changes or difficulties rarely being explored (Barrett et al., 1999; 2000).

This raises questions as to what barriers prevent women seeking support from healthcare professionals regarding their postnatal sexual functioning, and why this aspect of women's lives is neglected by healthcare professionals, given postnatal sexual problems being highly prevalent and how quick women resume sexual intercourse. It has been questioned whether this is due to the difficulties people have discussing sex and sexual intimacy, them historically being considered 'taboo subjects' often accompanied with disgust and embarrassment (Goldenberg et al., 1999). Alternatively, it may be due to increased availability and accessibility of additional sources of information, from postnatal support groups and online; or whether healthcare professional's lack of awareness or training in asking about it also plays a role (Bhugra & Colombini, 2013; Leeman & Rogers, 2012). Regardless, it indicates the need for future research to explore these questions further.

Strengths and limitations

Overall, a number of key strengths to this systematic review exist. A reproducible protocol exists (see Appendix D), and a comprehensive search strategy was employed, yielding key papers in the area. The process of the review was rigorous and objective when locating the included studies, an approach intended to reduce the potential for subjectivity. However, a number of limitations of the review also exist. Despite the objective process of locating studies and using standardised quality assessment tools, the underlying quality assessment process of them is somewhat subjective in nature. The quality assessments were not independently assessed by a second reviewer which could have reduced such subjective biases; however, no papers were excluded on the basis of their methodological quality. Caution is needed when interpreting the results, due to the diversity in methodological quality and

heterogeneity of the studies, as they often involved women of mixed parity and relied on single questions or non-validated self-report questionnaires to assess postnatal sexual functioning, neglecting all aspects of sexual intimacy. Moreover, pre-existing sexual functioning problems were rarely considered. Combined, these methodological issues make it difficult to draw firm conclusions from; however, the issues are reflected in this body of literature and have been mentioned elsewhere (Abdool, Thakar & Sultan, 2009; Handa, 2006; Leemman & Rogers, 2012; Von Sydow, 1999).

Implications for future research

Due to the methodological issues described, there is a continued need for further research in this area. The findings from this review appear to be consistent with findings emphasised in an earlier meta-analysis (Von Sydow, 1999), including similar methodological issues. Moreover, as women's postnatal functioning has a significant effect on their own physical and mental health, and their partner's and children's (Kahn et. al., 2002), it is essential for further research within this area to be conducted, involving both quantitative and qualitative methods.

Quantitative research needs to recognise the methodological issues and limitations highlighted across within the evidence base, accounting for them in future research designs. Primarily, this means expanding the focus of postnatal sexual functioning research from sexual intercourse, to all aspects of sexual intimacy, consistent with previous recommendations (Von Sydow, 1999). Future research needs to assess for the presence of sexual problems during pregnancy, given it being one of the largest predictors of them existing post-natally (Acele & Karacam, 2011; Williams, Herron-

Marx & Hicks, 2007). Furthermore, methodological quality would be improved if validated postnatal sexual health assessment tools were used and confounding factors such as parity, age, breastfeeding and depression were controlled for. Prospective longitudinal study designs could be used to understand the long-term effects of childbirth on postnatal sexual functioning.

Consideration or exploration of psychological issues relevant to women's postnatal sexual functioning, such as their attitudes surrounding postnatal sexual intimacy, appraisals of breastfeeding and even the role of body image and the quality of the relationship with their partner, also appears to have been neglected. This illustrates the need for future research to explore the role of these issues in women's postnatal sexual functioning. Lastly, due to the absence of qualitative research located through the process of undertaking this review, and in line with earlier recommendations from Von Sydow (1999), there is a need for more qualitative research in this area. This would provide a platform and a voice for mothers and their partners, in attempts to better understand their subjective experiences of sexual intimacy during the postnatal period.

Implications for clinical practice

This review adds to the growing body of evidence in postnatal sexual functioning, highlighting key findings pertinent for clinical practice in the area. In particular, it illustrates how quickly women resume sexual intercourse after childbirth, but equally how common it is for women to experience a range of postnatal sexual problems and their associated risk factors.

Perineal trauma was found to be one of the biggest predictors of timing to resume sexual intercourse, including whether women experience postnatal sexual health problems (Acele & Karacam, 2011; Signorello, Harlow, Chekos & Repke, 2001; Williams, Herron-Marx & Hicks, 2007; Williams, Herron-Marx & Knibb, 2007). As perineal trauma is commonly experienced by women following childbirth (Redshaw & Henderson, 2015), there is an importance for interventions to support these women, particularly considering sexual health problems can persist for months or years following perineal trauma healing (Von Sydow, 1999).

This review continued to add weight to previous findings that women receive little information and advice post-natally, regarding sexual functioning changes or problems they may encounter during this period, despite reports they would value this (Barrett et al., 1999; 2000). Instead, discussions have centred on contraception or timing to resume intercourse, with many women describing they wanted to ask something, but felt they could not (Barrett et al., 1999; 2000). Clinically this highlights the importance of healthcare professionals providing women with this information, and routinely enquiring about their postnatal sexual functioning during health visits. Providing teaching and training to healthcare professionals regarding the latest empirical findings would also better equip them in disseminating this information to women.

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CHAPTER 2

EMPIRICAL PAPER

**Women's Experiences of Sexual Intimacy in the Early Postnatal
Period Following Physical Birth Trauma**

Manuscript prepared for submission to 'Sexual and Relationship Therapy'
(Word limit 6,000 excluding tables, references, figure captions, footnotes or
endnotes)

Women's Experiences of Sexual Intimacy in the Early Postnatal Period Following Physical Birth Trauma

Abstract

Background: Sexual relations are fundamental to physical and emotional well-being. The present study aimed to explore women's experiences of sexual intimacy in the early postnatal period following physical birth trauma (defined as either a second-degree tear or an episiotomy), considering any sexual intimacy difficulties and their reasons for and/or barriers to seeking support for these.

Method: Individual semi-structured interviews were conducted with five participants, and analysed using Interpretative Phenomenological Analysis (IPA).

Results: Five master themes captured the women's experiences; 'Identity struggle: The old 'normal' versus accepting a new normal', 'Intimacy losses versus intimacy gains', 'The silent struggle', 'Change in relational identity: Transitioning from sexual to parental' and 'The missing chapter of the postnatal story'.

Conclusion: The accounts uncovered how the women's bodies, identities and lives had been physically, emotionally and sexually transformed, from a sexual dyad to a parental triad. Their hidden fears of sex causing pain and trauma remained unexpressed and unanswered, due to the absence of postnatal discussions, and a void of information on sexual intimacy or the consequences of physical birth trauma. The clinical implications are discussed with regards to supporting health care professionals to initiate such discussions, through delivering training, consultation, supervision and service evaluations.

Keywords: Sexual intimacy, postnatal, birth trauma, qualitative research

Introduction

Women's postnatal mental health has been extensively researched (Chivers et al., 2010; Moel et al., 2010). However, their postnatal sexual health remains under-researched, despite sexual relations being fundamental to the physical and emotional health and well-being of individuals, couples and families (World Health Organisation; WHO, 2006).

Focussing on sexual intercourse has dominated research into postnatal sexual health, whilst exploring all aspects of sexual intimacy, remains neglected (Johnson, 2011; Von Sydow, 1999). Particular attention has been given to the timing and frequency of resuming intercourse, along with the prevalence of perineal pain, dyspareunia (pain during or after sexual intercourse), and women's levels of sexual desire, enjoyment and satisfaction (Barrett et al., 1999; Leeman & Rogers, 2012).

Childbirth involves significant physical, hormonal, psychological, social and cultural changes which can impact on a woman's postnatal sexual health and intimacy. The resumption of sexual intercourse is rapid, with women resuming sex between six to seven weeks post-natally, and 82% having resumed by twelve weeks post-natally (Connolly, Thorp & Pahel, 2005; Trutnovsky, Haas, Lang & Petru, 2006). During these early postnatal weeks there is a high prevalence of sexual health problems, which increases over time with up to 91% of women experiencing some sexual problem at twelve months post-natally (Acele & Karacam, 2011; Barrett et al., 1999; 2000; Glazener, 1997). Consistent with previous research that these problems may persist for years, despite the absence of any significant physical trauma, emphasises

the importance of researching subjective experiences and the underlying psychological processes (Von Sydow, 1999).

Positive associations between levels of perineal trauma and perineal pain are further reported. At three months post-natally, reports of dyspareunia significantly increased by 80% following second-degree trauma and 270% following third-degree or fourth-degree trauma (Signorello, Harlow, Chekos & Repke, 2001). Findings from breastfeeding studies report negative effects include; reduced sexual activity due to low sexual desire, fatigue, changes in breasts and lactating when aroused (Avery, Duckett, & Frantzich, 2000; Heidari, Khoei & Asiabar, 2009).

The lack of professional recognition of postnatal sexual health difficulties has increasingly been reported (Barrett et al., 1999; 2000; Glazener, 1997). Post-natally, women frequently receive information on contraception, yet very few are provided with information on sexual health changes or difficulties they may encounter, with a minority initiating discussions with healthcare professional when in need of help or advice (Barrett et al., 1999; 2000; Glazener, 1997).

However, limitations within these studies do exist. Research has primarily focussed on the quantitative analysis of postnatal sexual activities, predominantly sexual intercourse; often using single questions or non-validated self-report questionnaires. Some have neglected to consider pre-existing sexual health difficulties or associated psychological issues relevant to women's postnatal sexual intimacy (Acele & Karacam, 2011; Barrett et al., 1999; 2000).

Given the subjective nature of women's sexual experiences, their accounts have also been neglected in this body of literature. The need to explore women's subjective experiences of all aspects of sexual intimacy has previously been highlighted (Von Sydow, 1999). However, only a small number of international studies have been conducted, which also have raised methodological questions regarding their quality, yet yielded some insightful findings.

In particular, Woolhouse, McDonald and Brown (2012) explored women's experiences of changes in their postnatal sexual relationship, sexuality and intimacy. Findings illustrated a number of psychosocial factors affecting women's sexual intimacy, including tiredness, changing lifestyles and gender roles, emotional connections with children, and body image issues. Their changes in sexual intimacy included reduced sexual desire, loss of feeling sexual, and loss of sexual intimacy despite feeling physically and emotionally close to their partners. The factors assisting their transition to parenthood, included teamwork, time together as a couple and agreeing on priorities. These findings supported previous research that similarly highlighted the impact women's body image, change in priorities and conflicts of relational sexual desires, had on postnatal sexual intimacy, with reassurance mediating this transition (Ahlborg & Strandmark, 2006; Olsson, Lundqvist, Faxelid & Nissen, 2005; Trutnovsky, Haas, Lang & Petru, 2006).

Despite some interesting findings, caution is needed interpreting these results as their research designs could be methodologically critiqued. In particular, the samples used were arguably heterogeneous, including women of mixed parity, birth methods and relationship status. They were also culturally diverse, with women sharing their

experiences up to 3.5 years following their childbirth experience. The current study therefore aimed to take these limitations into consideration by having clear aims and objectives, involving strict inclusion and exclusion criteria to ensure homogeneity.

Aims and objectives

The current study aimed to: (i) explore women's experiences of sexual intimacy within their couple relationship, between three and six months post-natally, following physical birth trauma. The term physical birth trauma was used to conceptualise perineal trauma of either an episiotomy or a second-degree perineal tear. Sexual intimacy includes both penetrative and non-penetrative pleasuring activities, comprising of physical, emotional and sexually intimate experiences.

Other aims were to: (ii) explore how experiencing physical birth trauma impacted on sexual intimacy; (iii) explore whether they experienced any sexual intimacy difficulties; (vi) explore reasons for and/or barriers to, seeking support for any sexual intimacy difficulties; (v) explore their experiences of participating in the research.

Method

Design

Qualitative methodology aided the exploration of research aims. Individual semi-structured interviews were conducted with five participants, and analysed using Interpretative Phenomenological Analysis (IPA). IPA attempts to understand how people make sense of their lived experiences, and its philosophical underpinnings are grounded in phenomenology, hermeneutics and ideography (Smith, Flowers & Larkin, 2009) (Appendix E).

Research Approval

The study gained approval from the Division of Clinical Psychology Research Committee (Appendix F), and the National Research Ethics Service (14/NW/0235) (Appendix G) for ethical approval and research governance.

Participants

Sampling procedures

A purposive sampling method was employed to identify five participants. Between four to ten participants are recommended for doctoral IPA research (Smith, Flowers & Larkin, 2009). The sample size was informed by these recommendations and the data richness. To ensure homogeneity all participants satisfied the research inclusion and exclusion criteria as detailed in Table 1.

Table 1. Participant inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none">▪ First time mothers who had a live birth▪ Aged 18 years or older▪ In a co-habiting couple relationships with the father of the infant▪ Vaginal physical birth trauma: A second-degree tear or an episiotomy	<ul style="list-style-type: none">▪ Third or fourth degree perineal tear▪ Under the care of the perinatal mental health team▪ Involved in child and/or adult safeguarding procedures▪ Women whose babies had been in the neonatal unit for more than seven days▪ Reported history of intimate partner violence between them and the father of the infant▪ Additional vaginal corrective surgery other than that which is undertaken immediately following childbirth

Participant sample

Five white British women aged between 28 and 37 were recruited for this study. See Table 2 below for participant characteristics.

Table 2. Participant characteristics

Pseudonym [age]	Type of perineal trauma	Mode of birth	Postnatal timing of interview (months)	Infant age (weeks)	Maternity leave (months)	Method of feeding
Rachel [30]	Second-degree tear	Vaginal	4	17	5.5	Breast
Janet [28]	Second-degree tear	Vaginal	3	12	12	Breast
Jane [34]	Episiotomy	Forceps	3.5	14	11	Bottle
Jessica [32]	Second-degree tear	Vaginal	3	12	9	Bottle
Catherine [37]	Episiotomy	Forceps	6	26	9	Breast/ Bottle

Participants were recruited through regional health visiting services and a local children's centre. A Participant Information Sheet (Appendix H) informed participants about the research, distributed by health visitors during routine postnatal visits. The researcher presented the research at regional meetings and postnatal support groups in a local children's centre. Recruitment posters were also displayed in regional children's centres (Appendix I). Four of the participants were recruited via health visitors and one via the children's centre.

Procedure

Participants contacted the researcher through completing a participant contact details form (Appendix J), via their health visitor, if they wished to participate. This was

returned to the researcher via the research lead for the trust, in line with information governance requirements.

If agreeable to participate, interviews were undertaken at their home address or local health visiting service. Participants had opportunities to ask questions before signing the consent form (Appendix K) and completing a demographic questionnaire (Appendix L).

The first two interviews were considered pilot interviews, assessing the quality of the topic guide. As the first two participants spoke of the impact of their physical birth trauma on their sexual intimacy, an additional question two was added, to ensure this was explored in subsequent interviews.

Interview procedure

Interviews lasted between 45-100 minutes and were conducted using a topic guide (see Appendix M), which was not rigidly adhered to allow natural exploration of the area. Non-directive probing questions were used to prompt further reflections and greater depth of information. Following the interview participants were debriefed and given a further support information sheet, thanking their participation and detailing a self-help contact details (see Appendix N).

Interviews were digitally recorded and transcribed verbatim. The transcribed interviews were listened to and edited accordingly to ensure consistency in transcription style. To protect participant confidentiality, pseudonyms were used in this paper and supporting quotes were selected accordingly.

Data analysis

The iterative and systematic analytic process followed the procedures recommended by Smith, Flowers and Larkin (2009). Transcripts were repeatedly read to become immersed within the data, before descriptive, linguistic and conceptual comments were noted. These were reviewed and transformed into emergent themes; before connections between them were clustered into superordinate themes (Appendix O and P). Subsequent transcripts were analysed the same way, each being viewed independently. Any emerging ideas from previous transcripts were 'bracketed', to remain true to IPA's idiographic commitment, allowing new themes to emerge (Smith, Flowers & Larkin, 2009). Convergent and divergent themes and connections across the whole sample were compared and clustered into higher-order master themes and their constituent sub-themes. A table of these were then created (Appendix Q).

Quality and validity

To ensure the quality and validity of the analysis, transcripts and analyses at each stage of the analytic procedure were shared with both research supervisors, whom reviewed and supported the final analysis. The researcher kept a reflexive journal of reflections throughout the research process, acknowledging their fore-conceptions and ensuring that they did not influence their interpretations (see Appendix R for the position of the researcher).

Results

The aim was to explore women's experiences of sexual intimacy in the early postnatal period following physical birth trauma, in a small, selected sample.

Following analysis, five master themes emerged, comprising between one to three constituent sub-themes (Table 3).

Table 3. Table of master themes and constituent sub-themes

Master Themes	Constituent Sub-themes
1. Identity struggle: The old 'normal' versus accepting a new normal	<ul style="list-style-type: none"> • The transformed body: Semi-functional and asexual • The body in transition • Re-adjusting to 'another chapter': A new normal, a new way of life
2. Intimacy losses versus intimacy gains	<ul style="list-style-type: none"> • Sexual expectations, obligations and disconnections • Emotional and physical connectedness: A substitute for sexual intimacy
3. The silent struggle	<ul style="list-style-type: none"> • Sexually paralysing re-traumatisation: Fears of sex and pain and trauma • Uncovered and unprotected self: Self rejection versus partner's acceptance
4. Change in relational identity: Transitioning from sexual to parental	<ul style="list-style-type: none"> • Life's new hierarchy Promoting the baby, demoting the self and sexual intimacy
5. The missing chapter of the postnatal story	<ul style="list-style-type: none"> • The elephant in the room: Breaking the taboo in a vacuum of information • The damaging professional etiquette • The unknown power of 'therapeutic' encounters

1. Identity struggle: The old 'normal' versus accepting a new normal

This first master theme reflects changes in the women's identities after having been physically, emotionally and sexually transformed by pregnancy. Finding themselves in a transitional place of uncertainty between their old (pre-pregnancy) sense of normality, and the prospect of a new normality, provokes an identity struggle; arising from disliking their current identity whilst upholding an unrealistic ideal identity.

The transformed body: Semi-functional and asexual

The women spoke of the “*toll of what your body goes through*” (Rachel) during pregnancy, transforming the body physically, emotionally and sexually. For some this created a loss of identity, from a sexual to an asexual self, generating a sense of self-dissatisfaction of their current identity; “*my body’s changed at the minute, I don’t really feel like as sexy as I did before so I don’t really feel...like I wana be that intimate*” (Rachel).

Following transformations there was a sense their bodies became functional, creating and breastfeeding the baby, yet for some, their bodies were semi-functioning, due to postnatal pain and problems experienced. Rachel offers a powerful account of the transformation of her breasts from objects of sexual pleasure to purely functional feeding machines.

My breasts have enlarged quite a lot like with being pregnant...then with breastfeeding...where like before like your breasts are sorta sexual things, they’re not now, it’s just a like feeding source for like my child (Rachel).

Sexually embarrassed that her transformed breasts lactating during intercourse, illustrated a discomfort with her ‘new’ breasts, unable to accept their dual functions, and ultimately deterring sexually intimacy; “*you hear they can leak sometimes, like if you’re having intercourse an I don’t really want that cos I’ll feel like embarrassed and it’ll just like ruin the moment*” (Rachel).

The body in transition

Most women made reference to their bodies being left in a transitional place after being transformed. Their accounts describe this as “*in-between*” stage (Sarah) or a place of “*limbo*” (Rachel), between their pre and post-pregnancy bodies.

You're in limbo sorta thing cos you still need to buy like new clothes cos you obviously not in your pregnancy clothes but you're not like back in your normal clothes and you need something in-between (Rachel).

Being in limbo uncovered a sense of uncertainty and unpredictability regarding what future changes lay ahead. For some, uncertainty brought hope that transition is temporary, and the prospect of future changes conveyed a sense of “*seeing light at the end of the tunnel*” (Catherine; Rachel).

For Sarah, being in limbo was accompanied by frustrations and hidden resentment directed interpersonally towards her partner; “*I kept thinkin'...you've got no idea, all your clothes still fit yer*” (Sarah). Yet Rachel's frustrations were intra-personally directed at the body, for its betrayal at not having transitioned back to her unrealistic identity; “*when people say like they do fit in their old jeans...it's like annoying cos it's like 'why does she do that? Why can't my body do that?'*” (Rachel).

Re-adjusting to 'another chapter': A new normal, a new way of life

Whilst some women desired to return back to pre-pregnancy ‘normality’, others accepted that their bodies and lives were permanently transformed; letting go of their

old lives and sense of normality, whilst welcoming and embracing a new normal and a new life chapter.

You...kinda mourn for your life before...I don't mean...you didn't have your baby 'cos you'd never change it but...you do think oh my God what did we do with our time before an...I just think...it's just another chapter in your life
(Catherine).

Catherine reflects on her old life with her partner, mourning its loss and marking the end of one life chapter as a dyad, yet embracing the next life chapter as a triad. The women's accounts unearthed a sense of unity with their partners which further facilitated their adjustment to this new chapter as a triad.

As Janet's body transformed, so did her sense of normality. Her acceptance of these transformations, led to her creation of a new normal, facilitating her adjustment to this next life chapter; *"getting back to normal...is getting used to the fact that things are going to be different and that I might have some discharge for the rest of me life now"* (Janet).

2. Intimacy losses versus intimacy gains

This second master theme is associated with the sexual intimacy changes these women experienced following physically trauma, and how these are substituted by emotional and physical intimacy gains.

Sexual expectations, obligations and disconnections

Following physical birth trauma, all women shared a degree of sexual disconnection within their relationships, in relation to their sexual expectations or experiences.

There was a collective sense that sex was more important to their partners. Whether their partner's resuming sex expectations were overtly or covertly expressed, they left the women feeling "*mean*", "*guilty*" and "*unfair*" (Rachel) for sexually depriving them. This created a sense of sexual obligation for them to sexually satisfy their partners, regardless of their own sexual desires, causing inequalities and sexual disconnections.

If he's like...in the mood an'...well I'm not, I'm tired or...I've got things to do...then I will yer know do things for him [other sexually pleasuring activities], for him...to get a bit of pleasure...not for me 'cos I just basically am not in the mood (Catherine).

Sexual disconnections existed in Rachel and Janet's relationships, experiencing losses of sexual intimacy, defined as "*non-existent*" (Rachel; Janet). Both accounts uncovered psychological barriers to them not feeling mentally ready for sexually intimacy; "*the barriers I've put up in my head are stopping me from doing it*" (Rachel). These were due to either self-disliking their current, transformed identity (as detailed in the first master theme); or due to their fears of sex causing pain and trauma (as detailed in the third master theme).

Emotional and physical connectedness: A substitute for sexual intimacy

Despite all the women experiencing varying degrees of sexual disconnections, they all articulated a continued physical and emotional connectedness with their partners.

Most women expressed an enhanced emotional connectedness, following creating a life together; “*sharing a love for somebody*” (Sarah), and experiencing a major life transition, thus feeling “*happier*” (Jane), “*complete*” and “*fulfilled*” (Jane; Rachel). Catherine expressed how the baby creates an everlasting connection between them and ultimately a deeper emotional connection.

It gives you that a stronger bond because...both realise that...there's somethin' more important now an' erm yer know whatever happens you will always have that in common (Catherine).

All the women described their physical (i.e. non-sexual) intimacy remaining unchanged; “*it's still the same really and it always has been...nothin's really changed*” (Jane), providing a sense of security and a greater love.

Overwhelmingly, all women expressed having a continued or enhanced emotional closeness with their partners; “*I still feel close to him*” (Jane) or “*the intensity of everything is more*” (Janet). Regardless of being sexually intimate or not, the women's physical and emotional connectedness acted as a substitution for their sexual intimacy, either in its entirety or due to reductions in frequency.

Rachel labelled this emotional connectedness a relational “*comfort blanket*”, providing her with a sense of safety and security that their relationship hasn’t weakened in any way, despite the absence of sexual intimacy.

It’s like the emotional side to it...cos that’s still there an that’s still strong...it’s like a comfort blanket I suppose that we’ve got that element of it an it’s not just all about the sex (Rachel).

3. The silent struggle

The third master theme uncovers a silent struggle, unearthing women’s silent fears that sex will cause pain and trauma, ultimately becoming sexually paralysing. The hidden impact of the trauma and the women’s uncovered and unprotected selves become exposed and vulnerable to their own rejection.

Sexually paralysing re-traumatisation: Fears of sex and pain and trauma

All women offered powerful accounts of their fears that sex would cause pain and trauma, sexually paralysing them by delaying or preventing intercourse. Janet and Catherine compared their fears of painful sex to when they were ‘virgins’, expecting sex would “*hurt like it did the first time I ever had sex*” (Janet).

It’s like going back to when...you were a virgin and you’ve never had sex...that’s what it felt like...I was just expecting it to hurt basically...that was my fear not so much being intimate...just the fear of pain (Catherine).

Feeling like 'virgins', denotes a comparison to a time when fears of the unknown dominated; not knowing what sex would feel like or how much pain it might cause. Unable to overcome these fears, Janet felt unable to be sexually intimate; whilst Catherine overcame her fears with time.

All women expressed fears of sex causing them harm or subsequent perineal trauma. Some of Rachel's fears included; *"if we do have sex will it be painful, erm, will it split sorta again"*, *"I think the tear's going to like rip again"* or *"reopen"* or *"it might start bleeding or something"*. Likewise for Janet these included a *"fear that you could somehow re-tear it"* or that her partner could *"injure"* her. Despite being unable to get these fears out of their minds, the women largely kept them hidden from their partners, undertaking a silent struggle, which caused a form of sexual paralysis.

Uncovered and unprotected self: Self rejection versus partner's acceptance

All the women expressed feeling exposed and vulnerable to their partners' negative judgements following the physical birth trauma. For Jane, having an episiotomy was her *"worst fear"* come true, one which was accompanied with self-contempt and disgust; *"I just think it's horrible, it just sounds horrible an' erm I just didn't wanna look"*. Jane's avoidance at viewing her perineum was shared by other women, symbolic acts of self-rejection with these fears being projected onto their partners.

I think things have probably changed for him as well...if something about that doesn't pop into his head at some point I'd be surprised (Janet).

The physical birth trauma had disabling effects, unable to sit, stand or walk, they were left feeling “*vulnerable*”, “*helpless*” (Catherine) and dependent on their partners. Increased reliance on partners meant they were exposed to things they would not usually have been exposed to. Catherine defined this as “*showing other sides of yourself*” and “*baring your soul*”, a sense of being truly exposed and uncovering a vulnerability to her partners’ judgements. Despite fears of negative evaluation from their partners, they felt a sense of acceptance from them, which they found reassuring and “*freeing*” (Catherine).

4. Change in relational identity: Transitioning from sexual to parental

This fourth master theme portrays women’s accounts of how their baby’s arrival transformed their lives and priorities. Life’s new hierarchy of needs was introduced; transforming their relational identities from a sexual dyad to a parental triad.

Life’s new hierarchy: Promoting the baby, demoting the self and sexual intimacy

Before [baby’s name], your priority is yourself really and your partner that’s it...

...but with a baby being here, obviously your priority is that child, there’s no other priority like, they’re the first priority an you come after that (Rachel)

Rachel’s account captures what was overwhelming expressed by all women; since their baby’s arrival there is no other priority; life’s priorities have been transformed. These new priorities meant that “*everything revolves around the baby*” (Catherine),

at the expense of their own needs. The changed priorities left them questioning who they are; *“I need to remind myself that I am myself”* (Janet), with their own and relational sexual needs being lost in the process of transformation from a sexual dyad to a parental triad.

Catherine refers to a *“pecking order”* of priorities, illustrating how the baby has been promoted to the top, whilst theirs and their partner’s needs (including sexual needs), are demoted, even below life’s other competing responsibilities.

You just go down the peckin’ order an’ I think probably the man even more so erm because people know that it’s the mum that bears the brunt of the care and still got housework an’ everythin’ like that (Catherine).

When there was time for sexual intimacy, the women expressed a shared sense of being too tired for sex; *“you just don’t get the time erm an’ then when you do you’re just both so tired”* (Catherine), with the need for sleep being a greater priority than their sexual needs; *“whenever I’m in bed I wana sleep, that’s pretty much what happens”* (Janet).

The baby’s wakeful demands were another barrier to their sexual intimacy. For Janet this contributed to her not being sexually intimate with her partner; *“it is more that we don’t have time for it rather than we don’t want to though”*. Whereas those who were sexually intimate found that it had become less frequent for the same reason.

Equally, when their babies were sleeping, their physical presence still posed a psychological barrier to being sexually intimate. Fears of their baby’s waking during

intimacy created a sense of obligation to immediately attend to them, generating an anticipation of guilt over abandoning intimacy with their partner.

Alternatively, the awake baby posed an even greater psychological barrier to sexual intimacy, an innocent spectator to a usually private and intimate act. This created a “*strange*” (Janet) and “*weird*” (Rachel) anticipated experience for them, a sense that being intimate in the baby’s presence would be morally wrong, generating feelings of shame and guilt, and ultimately avoiding of sexual intimacy. This further illustrates the promotion of the baby’s needs whilst sexual intimacy is demoted, transforming the sexual dyad to a parental triad.

5. The missing chapter of the postnatal story

This final master theme represents a hidden postnatal experience; with the discovery that no one talks about sexual intimacy or the effects of physical birth trauma post-natally. In their quest for answers, women exposed a vacuum of information on these issues, encountering potentially damaging professional practices during this unfamiliar chapter of their lives. Breaking the taboo, women seek solace in the support and advice of their closest friends, finding powerful “therapeutic” encounters which remain concealed by the taboo.

The elephant in the room: Breaking the taboo in a vacuum of information

Some women described how healthcare professionals and other mothers rarely talk about postnatal sexual intimacy, or the after-effects of physical birth trauma; “*no-one has ever talked about it after, what happens after or anything like that*” (Janet). As

many mothers face these issues, they become the elephant in the room which no one talks about.

Catherine's account of this research being introduced to a baby group revealed an unspoken etiquette of acceptable and unacceptable discussion topics, which women welcomed breaking when they perceived a sense of permission (a 'green light').

People'll talk about the length of their labour, the yer know oh I had gas an' air, I had an epidural...nobody said...oh yeah I had stitches...I really struggled with that afterwards. It wasn't until after you'd been in an' said oh this is what I'm doin'...one of the girls made a comment (laugh) 'oh I was like a patchwork quilt'...an' we were all laughin' about it an' then people started to talk about it...it was almost like somebody had come in an' said yeah that's okay now you can all talk...it's almost like you've given yer the green light to talk about it (Catherine).

Collectively searching for answers via friends or other sources, their questions remained unanswered. The existence of a vacuum of information on these issues was exposed, leaving women wanting information on; *"postnatal issues such as intimacy and sexual health or any concerns"* (Catherine) and *"explanations about what a tear would mean and what it could mean afterwards"* (Janet).

The damaging professional etiquette

Some women described some of the professionals' practices they found damaging during the postnatal period.

She was stitching me up and I said 'how long will it take to heal?' and her response was 'is it because you wanna have sex?' I just find that incredible, I had had him two minutes before and then I suppose there are people who that might be their first thought but it wasn't mine (Janet).

The midwife's misguided assumptions of Janet's question caused her frustration due to the insensitivity of its timing. Taking place in the presence of her partner, this was exemplified, potentially creating a sense of pressure from her partner to resume sex sooner.

Receiving information on contraception featured in most women's accounts; but more prominently in Janet's as she described the dominance of contraception and breastfeeding post-natally. She recalled receiving "*ten leaflets on contraception*" and "*about fifty leaflets for breastfeeding*" which she perceived as additional pressures to resume sex and to breastfeed.

Catherine's time pressured encounters with healthcare professional left her feeling "*fobbed off*", as she perceived services to be "*stretched*". These encounters hindered the likelihood of her seeking professional's advice in relation to her sexual intimacy, holding the support from friends in higher regard.

The unknown power of 'therapeutic' encounters

The women's accounts of seeking support from friends revealed these to be positive and normalising encounters, providing a sense of "relief", "reassurance" (Catherine) and giving them "a little boost" (Rachel).

Janet recalled the positive impact (a normalising experience) these conversations had in the presence of her partner, him becoming aware that other women feel the same and 'not just' her.

She...said... 'I can't even imagine what it would be like for you because I only had a C-section and I didn't want him near me'...which made me feel better and I think it made my husband feel a bit better because he knows it's not just me (laugh) (Janet).

Women found participating in the research a positive "therapeutic" (Catherine) experience, facilitating personal "realisations" (Janet). Yet the therapeutic nature of these encounters remains unknown, due to this unspoken etiquette that exists of acceptable and unacceptable postnatal discussions.

Discussion

The study explored women's experiences of sexual intimacy in the early postnatal period, following physical birth trauma (a term used to conceptualise perineal trauma of either an episiotomy or a second-degree perineal tear).

The analysis revealed five master themes: *'Identity struggle: The old 'normal' versus accepting a new normal'*, *'Intimacy losses versus intimacy gains'*, *'The silent struggle'*, *'Change in relational identity: Transitioning from sexual to parental'* and *'The missing chapter of the postnatal story'*.

Participants offered personal accounts of how the transition to parenthood had transformed their bodies, identities and lives, physically, emotionally and sexually, following a physically traumatic birth. These transformations extended to their intimacy, expressing a continued sense of emotional and physical connectedness, yet sexual disconnectedness. This, and the newly promoted needs of the baby, transformed their relational identities from a sexual dyad to a parental triad, with their own and sexual intimate needs being demoted. Hidden fears of sex causing pain and trauma remained unexpressed and unanswered, due to the unspoken etiquette of acceptable and unacceptable postnatal discussions and a vacuum of information.

'Identity struggle: The old 'normal' versus accepting a new normal'

Participants' accounts uncovered the existence of an identity struggle when their bodies had been transformed by pregnancy. For some, upholding an unrealistic ideal identity created a sense of frustration and self-dissatisfaction of their new body, thus rejecting it, yet others accepted it facilitating their adjustment to motherhood.

This identity struggle reflects research that women consider their new transformed bodies to be a negative aspect of pregnancy (Woolhouse, McDonald & Brown, 2012). A perceived lack of control and permanency of transformations strengthened their self-dislike and sense of betrayal by the body, due to their preconceived socially

constructed expectations of the postnatal body (Olsson, Lundqvist, Faxelid & Nissen, 2005). Yet, some women had an increased sense of empowerment and respect for their new transformed bodies (Woolhouse, McDonald & Brown, 2012).

Comparisons can be drawn between women's accounts of their transformed breasts becoming functional and asexual, to findings from Olsson, Lundqvist, Faxelid and Nissen's (2005), whereby women compared themselves to 'a mother cow, not a desirable woman', reducing their sexual desire. These add weight to findings that approximately a third of women have difficulty with the dual purpose of their breasts (Avery, Duckett, & Frantzich, 2000).

'Intimacy losses versus intimacy gains'

Following physically traumatic childbirths, women expressed sexual disconnections within their relationship, experiencing a loss or reduced sexual intimacy, which has previously been reported (Woolhouse, McDonald & Brown, 2012). Following an episiotomy or second-degree trauma, women resume intercourse later (Signorello, Harlow, Chekos & Repke, 2001).

The women's sense of sexual obligation to satisfy their partners sexually, regardless of their own sexual desires, are increasingly being reported elsewhere (Trutnovsky, Haas, Lang & Petru, 2006; Woolhouse, McDonald & Brown, 2012). Ahlborg, Dahlof and Hallberg (2005) attribute this imbalance of sexual needs as one of the key sources of relationship dissatisfaction. Ahlborg, Dahlof and Hallberg (2005) further reported women's continued sense of emotional and physical connectedness to their partners, substituted their sexual intimacy.

Changes in women's love and sense of connectedness within their relationship can be conceptualised by Sternberg's (1986) triangular theory of love. Their pre-pregnancy love can be understood as consummate love, representing an ideal relationship comprised of a strong sense of intimacy, passion and commitment. The postnatal substitution of sexual intimacy means their love may be conceptualised as a companion love, whereby deep affection and commitment remain with an absence of passion (sexual intimacy) (Sternberg, 1986).

'The silent struggle'

The women's anxieties about intravaginal changes following perineal trauma has been found elsewhere (Olsson, Lundqvist, Faxelid & Nissen, 2005). Specifically, following an episiotomy or spontaneous perineal tear, women experience significantly more perineal difficulties (such as pain, healing, incontinence) (Williams, Herron-Marx & Hicks, 2007).

The women's fears of sex causing pain and trauma, leading to their subsequent avoidance of looking at their perineum or resuming sex, may be conceptualised by Vlaeyen and Linton's (2000) 'fear-avoidance' model. Using this as a framework to understand their experiences, their perineal pain creates pain-related fear, ultimately leading to avoidance behaviours including avoiding sex or looking at their perineums, thus maintaining a cycle of increasing fear and avoidance (Vlaeyen & Linton, 2000).

'Change in relational identity: Transitioning from sexual to parental'

Women's accounts of how their priorities and their relational identities have been transformed from a sexual dyad to a parental triad, is supported by empirical research. In particular, women experience a sense of loss of freedom, spontaneity and the loss of time for oneself or together with their partners (Woolhouse, McDonald & Brown, 2012). Tiredness and limited time for intimacy frequently arose in the literature as consequences of these changed priorities, with sleep being prioritised over sexual intimacy (Ahlborg & Strandmark, 2006; Olsson, Lundqvist, Faxelid & Nissen, 2005).

The overwhelming sense of love and attachment women felt towards their babies, can be explained drawing upon Bowlby's (1969) theory of attachment. These intense emotional connections have been found to compensate for intimacy with their partners (Trutnovsky, Haas, Lang & Petru, 2006), whilst terminating intercourse should their baby awaken, creates a sense of anxiety (Olsson, Lundqvist, Faxelid & Nissen, 2005). These findings are supported by the present study and link closely with attachment theory, whereby the mother is available and responsive to their baby's needs to provide a sense of comfort and security (Bowlby, 1969).

'The missing chapter of the postnatal story'

The women's accounts uncovered an absence of postnatal discussions and a void of information on sexual intimacy or the consequences of physical birth trauma, which is increasingly being highlighted in the literature (Avery, Duckett, & Frantzich, 2000; Barrett et al., 1999; 2000).

Similarly, the neglectful and damaging encounters with healthcare professionals; including the dominance of contraceptive information have been reflected elsewhere (Barrett et al., 1999; 2000; Olsson, Lundqvist, Faxelid & Nissen, 2005). Women's expressed appreciation of discussing feelings, reduced sexual desire and sexual intimacy as opposed to contraception (Olsson, Lundqvist, Faxelid & Nissen, 2005), are also findings which are supported by the present study.

Strengths and limitations

To the best of my knowledge, no published study exists in this field exploring women's experiences of sexual intimacy following physical birth trauma. This study therefore hopes to create an understanding of a select sample of women's subjective experiences, giving them a voice in the literature where it has remained relatively absent.

The use of IPA as a method of analysis is considered a strength, given its commitment to the interpretation of participants' meaning-making (Smith, Flowers & Larkin, 2009). A homogenous sample allowed for the in-depth analysis of the participant's lived experiences, with all five master themes featuring in each of their experiences. Despite the small, selected sample, they provided convergences and divergences of the phenomenon in question (Smith, Flowers & Larkin, 2009).

The researcher's reflexive position throughout, has ensured any preconceptions have been 'bracketed off', whilst ensuring interpretations were grounded in participants' accounts, reflective in the quotations used. The position of the researcher as a 29 year

old female may have also facilitated participants' openness to talk about their personal and sensitive research area.

Recruitment challenges were encountered which may be due to a number of reasons, ultimately resulting a small, select sample. Similarly, recruitment biases may have been present due to the participants being invited to participate, thus appealing to particular kinds of people. Due to the idiographic commitment of IPA, the findings of the study are not generalizable, yet it is important to consider the theoretical transferability of the links between the analysis, the position of the researcher and the existing literature (Smith, Flowers & Larkin, 2009).

Clinical Implications

The prevalence of physical birth trauma as explored in this study is high. The national survey of women's experience of maternity care 2014 reported that 70% of women experienced either an episiotomy or a minor tear requiring stitches (Redshaw & Henderson, 2015). The exposed vacuum of information on postnatal sexual intimacy and the after effects of perineal trauma highlights the significance of providing sufficient postnatal after care. This may involve providing information to women and their partners around what to expect physically, emotionally and sexually, which could be incorporated into brief information leaflets routinely distributed and discussed.

Women's fears of sex causing pain and trauma, leading to their subsequent avoidance of looking at their perineums or being sexually intimate, suggests a need for intervention. Interventions could support women to look at their perineums in the

early postnatal period, to break this ‘fear-avoidance’ cycle sooner, ultimately improving their mental health (Vlaeyen & Linton, 2000).

The need for healthcare professionals to initiate open dialogues with women about their sexual intimacy highlights implications for clinical psychologists. These include seeking to understand what information and support is provided to healthcare professionals to assist them with initiating these discussions, identifying any barriers and formulating and delivering interventions aimed at overcoming them. This could be achieved by disseminating research findings through teaching or training, providing support through consultation or supervision and service development projects evaluating service interventions (see Appendix T for dissemination plans).

Due to the impact having a child can have on relationships and subsequent mental health, sexuality and sexual health should be routinely explored during psychological assessment, regardless of the nature of their presenting difficulties.

Future research

As far as known, this is the first study in this field exploring women’s experiences of sexual intimacy following physical birth trauma, thus further replications are required. These should explore sexual intimacy following more severe perineal tears and other methods of delivery at different postnatal points of time. It would be valuable to understand the subjective experiences of male and same sex partners or single parents during this transition from diverse ethnic and cultural backgrounds. Research into health care professionals’ knowledge and experience of postnatal sexual intimacy would be of value, given its absence for the women of this study.

This would provide an insight into some of the underlying psychological processes involved in postnatal sexual intimacy across ethnically and culturally diverse populations, which could be used to direct larger research designs.

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