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SEXUAL LIFE AFTER CHILDBIRTH  
AND  
ASPECTS OF MIDWIVES' COUNSELLING AT THE  
POSTNATAL CHECK-UP

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## ABSTRACT

The overall aim of this thesis was to explore and describe how sexual life after childbirth is communicated, addressed and reflected upon among new mothers, fathers and midwives and the impact of leaving first and minor second degree tears after childbirth unsutured.

**Specific aims** were to compare two groups of women with minor lacerations (first and second degree) after a vaginal delivery, with respect to the healing process and experience when the lacerations were sutured or left to heal spontaneously (**I**); to elucidate women's experience of their sexual life after childbirth (**II**); to describe fathers' reflections about sexual life 3-6 months after the birth of their child (**III**); to describe midwives' reflections on counselling women at their postnatal checkups, with a special focus on sexuality (**IV**).

**Methods:** Study **I**: A randomised controlled trial (RCT) with 80 term pregnant primiparas with minor perineal lacerations of first and second degree, were randomised in to nonsutured (experimental group) and the control group (sutured) in the study after childbirth in 1997-1998. A follow up examination was performed at 2-3 days and 8 weeks after delivery, with observation protocols and questionnaires and at 6 months after delivery with only a questionnaire. Study **II**: Twenty-seven women participated in six focus group discussion (FGDs), 3-24 months post delivery. Study **III**: Five men participated in two FGD and five interviews that were tape recorded and transcribed verbatim. Study **IV**: Thirty-two midwives participated in five FGDs. The discussions were tape recorded and transcribed verbatim. Descriptive statistics were used to analyse quantitative data (study **I**) and content analysis were applied to qualitative data (study **II-IV**).

**Results:** Study **I**: Minor lacerations (first and second degree) could be left to heal spontaneously or sutured according to the choice of the woman. The lacerations healed within the same time frame and with similar amount of discomfort but the type of pain differed. Sixteen percent of the women in the sutured group, but non in the nonsutured group ( $p=0,0385$ ), considered that the laceration had had a negative influence on the breastfeeding. Study **II**: Women's thoughts about sexual life after childbirth were represented by four themes; stresses of family life alters sex pattern, discordance of sexual desire with the partner, body image after childbirth and reassurance. The women did not feel comfortable with the physical changes that had taken place and their body image and that as well as fatigue affected sexual desire after childbirth. Study **III**: Men's thoughts about sexual life after childbirth were represented by one overarching theme; "transition to fatherhood brings sexual life to a crossroads" and three categories; "struggling between stereotypes and personal perceptions of male sexuality during the transition to fatherhood"; "new frames for negotiating sex" and "a need to feel safe and at ease with sex in the new family situation". To get sexual life working, issues as getting involved in the care of the baby and the household and getting in tune with their partners had to be resolved in regard to sexual desire. Tiredness and lack of time due to the baby altered sexual activity and made men prioritise sleep rather than to have sex. Study **IV**: Midwives' reflections on counselling women at their postnatal visit were represented by two themes, the first "Balancing between personal perceptions of the woman's needs and health system restrictions" with two categories; "Forming a picture of the woman coming for the postnatal visit guided the counselling" and "Lack of knowledge and time-limits restricted the counselling about sexual life after childbirth". The second theme; "Strategies for counselling about sexual life after childbirth", included another two categories, "Task-oriented approach in counselling about sexual life after childbirth" and "Getting in tune to approach the topic of sexual life after childbirth". The midwives tried to identify distinctive features related to the woman's childbirth experience. The strategies used to individualise the visit depended on the context and how the midwife understood the woman's problems (**IV**).

**Conclusions:** The results of this theses suggest that midwives and other health care providers should invite/initiate discussions on sexuality during pregnancy and postnatally. The midwives' own cultural and gender reference points influence their approach toward the mothers and fathers when counselling. Midwives need to be aware of the diversities within female and male sexuality, develop their knowledge around what factors that influences the view and 'norms' about sexuality and gain insight into there own values and assumptions about sexuality. Counselling about health requires a positive and respectful approach to sexuality and sexual relationships

**Keywords:** nonsutured, perineal lacerations, childbirth, sexual desire, postnatal visit, sexual life, midwifery care, counselling, focus group discussion, content analyse

## LIST OF PUBLICATIONS

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## LIST OF ABBREVIATIONS

ABC	Alternative Birth Center
ANC	Antenatal Clinic
CHC	Child Health Clinic
EPDS	Edinburgh Postnatal Depression Scale
FGD	Focus Group Discussion
PND	Postnatal Depression
RCT	Randomised Controlled Trial
WHO	World Health Organisation

## LIST OF DEFINITIONS

Antenatal	The period before childbirth
Dyspareunia	Painful sexual intercourse
Multipara/s	Women who had given birth before
Postnatal	The first 28 completed days after the birth of the infant, referring to the infant (WHO, 1998).
Postpartum/ Puerperium	The time after childbirth (The word postpartum refers to the period shortly after the birth of the placenta (WHO 1998). There is no official definition of the postpartum period but traditionally and culturally it has been supposed to end six weeks after childbirth.
Postnatal visit	The visit that the mother does at the midwife or doctor 6-12 weeks after childbirth, equal to Postnatal check-up.
Primipara/s	First-time mother/s
Sexuality	Se'xus – originates from Latin and is the wording of the behaviour connected with reproduction and the human sexuality includes different needs and behaviour-pattern.

## PREFACE

The origin of this thesis can be traced back to the 1990s when I noticed that postnatal women I met often complained about their stitches after childbirth. Many women told me how the quality of their lives was affected at this very special time in life, and how difficult it was to establish breastfeeding, enjoy time with their babies, and try to re-establish their sex life when the pain and discomfort of stitches made it hard to feel comfortable and at ease. To my knowledge there are no studies about when to suture or not. However, the midwives at the Alternative Birth Centre (ABC) clinic in Stockholm saw good results when they left small perineal lacerations to heal spontaneously. Therefore some colleagues and I decided to perform a study where one group's small perineal lacerations were unsutured and another group's lacerations were sutured (Study I). One of the questions in the six-month follow-up questionnaire was when the mothers first had sexual intercourse after childbirth. We did not ask any other question about sex after childbirth, for example, whether or not the woman felt worried about being sutured or if the laceration played any role for her or her partner. Luckily, there was a place for comments in the six-month questionnaire, and most of the participants took advantage of this. All these comments made me curious about what influenced sexual life after childbirth and what made couples start having sex again. I also asked myself if, how, and when midwives can support, encourage, and empower women and their partners to re-establish their sexual life after childbirth. The next three studies in this thesis were conducted in order to gain a deeper understanding of new mothers' and fathers' thoughts about sexual life after childbirth and also of how midwives think they can best help the mother or the couple achieve this end.



# 1 INTRODUCTION

Having a baby is a powerful experience, and most parents feel especially overwhelmed during the child's first year. The expectations on and experiences of the sexual relationship and the transition to parenthood differ for most people around the world and depend on social and cultural values. Transition to parenthood can increase marital conflict and decrease sexual desire with an end result of reduced marital satisfaction (1). Developing coping strategies for this new situation and the needs during this period in life through support from family, friends, or health professionals can facilitate the transition to parenthood (1).

The core of the midwifery profession is caring for women and their families, and it embraces sexual and reproductive health care during the life cycle and includes the care of the newborn child. Midwives' knowledge, skills, and behaviour put them in a good position to prepare and support women and their families during the early days of parenthood. The role of the Swedish midwife is regulated by the Swedish National Board of Health and Welfare. The regulation points out that midwives should respect the integrity of women and their families when they work with childbearing families and adolescents' sexual and reproductive health (2). The ethical code of midwives "acknowledges women as persons with human rights, seeks justice for all people and equality in access to health care. It is based on mutual relationships of respect, trust, and the dignity of all members of society" (3).

The present thesis aims to contribute to this field of knowledge by examining different aspects of the postpartum visit, including the perspectives of the woman, her partner, and the midwife.

## 2 BACKGROUND

### 2.1 SEXUALITY

*Sexuality* is a central and lifelong aspect of being human, and it encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors (4).

When sexuality underwent medicalisation in the nineteenth century, power over sexuality was transferred from the church to the clinic (5). According to Foucault, something called sexuality was installed in terms of biomedicine and the biology of reproduction. A gradual progression away from the social body towards the physical body of sensation and pleasure paved the way for individualisation of sexuality that is, decoupling sexuality from family obligations.

The World Health Organization (WHO) defined sexual health as “the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love” (6).

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected, and fulfilled (4, 7).

According to Levine, sexual health has much more to do with health than with illness (8).

## **2.2 MATERNITY CARE AND SAFE MOTHERHOOD**

The care for new mothers, their infants, and their families varies around the world, and this care depends on economic conditions as well as cultural and religious values. The lack of postpartum care ignores the fact that the majority of maternal deaths and disabilities occur during the postpartum period. Every day 1500 women die due to complications in pregnancy or childbirth, each day 10 000 babies die within the first month of life, and an equal number are stillborn. Skilled care around the time of birth would greatly reduce the number of these deaths. The physiological and psychological health of the mother and her family is an important issue for all health care professionals, for example, midwives. The WHO Department of Making Pregnancy Safer (MPS) helps to improve maternal health; assists countries to ensure skilled care before, during, and after pregnancy and childbirth; and strengthens national health systems. The main goal is to reduce newborn and maternal mortality significantly by 2015 (9).

There are various social and psychological factors in women's lives that affect their health. Women's health can be discussed with the aid of biomedical, social, and cultural models and in its historical context. Their health cannot be separated from their roles, responsibilities, and status in the family, community, and society (10).

## **2.3 MATERNITY CARE IN SWEDEN**

The Swedish National Board of Health and Welfare issued national guidelines for maternity care for the first time in 1935, and a new version was formulated in 2008 by obstetricians and midwives (11). From the 1950s onwards, all pregnant women have been offered free pregnancy check-ups at antenatal health clinics. The primary goal of antenatal health care is to decrease perinatal mortality. Since 1981, the goal was expanded to promote health in mothers and babies and to reduce morbidity (12). To reach this goal, the care provided should be individualised with a focus on both the physical and emotional health of the mother and infant.

Antenatal health services reach nearly all women, and 97% of women make regular visits to the antenatal clinics during pregnancy. Pregnant women are usually cared for by a midwife, preferably the same midwife throughout the pregnancy, at a

community-based antenatal clinic (ANC). In uncomplicated cases, women have six to nine prenatal visits. The ANCs are staffed mainly by midwives, with access to doctors on a regular basis when needed, and the care is characterised by high continuity. The woman's partner is invited to the ANC visits as well as to the antenatal family classes, which include the following themes: pregnancy, childbirth, early parenthood, personal development, partner relationship, and psychoprophylaxis (13). Antenatal care in Sweden is well accepted by women, and the majority are pleased with the number of visits. The women also value continuity of midwifery care during pregnancy (14). However, some women are dissatisfied that midwives had not been supportive and had not paid attention to their partners' needs (15).

Primiparas, women with medical complications, and women with fear of childbirth have more visits than specified in the standard schedule for normal pregnancies (16). Women who are more psychologically vulnerable – often single, not fully employed, or foreign-born – are less likely to attend antenatal health care. This can lead to suboptimal care and poorer utilisation of the health care system (17). Some authors suggest that perinatal health care could be improved by better access to interpreters and by transcultural understanding and experience (18, 19). However, even if health providers and midwives find it useful to 'know' about customs of different ethnic groups – as if all of them have specific behaviours – health providers might come to view culture as static and homogenous. Furthermore, this 'knowledge' can have the consequence of distinguishing between 'us' and 'the others,' that is, focussing on differences (20, 21). To meet basic needs of foreign-born woman without mastery of Swedish, the Swedish parliament has passed a bill providing this group of women the legal right to an interpreter, free of charge, when they visit a health clinic (22). However, clinical experience shows that a woman often brings her husband or a relative to interpret for her instead. The idea of woman-centred care has made inroads into the organisation of maternity care, but economic restrictions make it difficult to realise. The design of maternity services often clash with the welfare state interests, professional limits, and changing consumer interests surrounding pregnancy and childbirth (23).

Postnatal care is provided by midwives and child health nurses. Before leaving the maternity ward, the woman is routinely informed to contact the ANC for a postnatal check-up as well as the child health clinic (CHC). The CHC is a part of the Swedish

health care system with responsibility for health promotion and maintenance of infants from birth up to school age. The intention is that midwives from the ANC and nurses from the CHC work together to make a smooth transition from the ANC to the CHC for the family.

The postnatal visit, which takes place at the ANC approximately 2-3 months after childbirth, is attended by 65-85% of new mothers (24). The lowest attendance is found among foreign-born women, and the highest attendance is found among women living in the provinces (24).

A woman who had an uncomplicated delivery is offered two visits within the maternal health care system. The first visit is within 7 days, and the second is within 12 weeks postpartum; the scheduled time for the visit is 30-60 minutes. It is recommended that the timing of the postpartum visit is individualised to reflect the woman's needs.

According to guidelines, the postpartum visit should include a physical, emotional, and social assessment of both mother and child. The physical assessment includes blood pressure measurement, haemoglobin (Hb), the woman's weight, check-up of uterine involution, a vaginal examination to check the healing process, and performance of pelvic floor contractions. The emotional and social assessment usually includes revision of the birth experience, and a talk about early parenthood. The purpose of the postnatal visit is also to counsel on contraceptives and breastfeeding (11).

Beake et al.(2005) have shown that women value reassurance that they are doing fine and an awareness and response if they are not (25). Women need to trust the midwife as a person and trust her professional competence (19, 26, 27) when giving reassurance, making examinations, normalising, and working in partnership with the woman. The feeling of trust in the midwife is described by women as important, and it will affect the woman's encounter (28).

Beginning recently, midwives also screen for postpartum depression at some ANCs; but in most cases, if done, postpartum depression screening is performed at the CHC. There is an increased risk of depression among mothers during the postpartum period compared with other phases in life. Risk factors that have been identified include

history of depression, poor relationship with the partner, and high scores on the life event scale (29). O'Hara and Swain (1996) found that socioeconomic difficulties and lack of support from friends and family appear to increase the risk of a new mother's depression after childbirth (30). Postnatal depression is common, is found in 7-13% of all mothers in Sweden (31, 32), and might restrict sexual life (33). Sexual health problems are common after childbirth in both depressed and nondepressed mothers; however, nondepressed mothers are more likely to have resumed sexual intercourse at six months, and they also report fewer sexual health problems than depressed mothers (34).

## **2.4 SEXUALITY AROUND CHILDBIRTH**

Sexual intimacy appears positively related to loving relationship satisfaction and stability (35), but it is important to note that sexuality can be viewed differently by women and men. It has been discussed that for many women, intimacy is a way to sexuality and for many men, sexuality is a way to intimacy (36). This view is established during childhood and adolescence (37).

Sexuality has normal fluctuations during different phases in life, and childbirth is one of those phases. In a German review of 59 studies from the United States and many countries in Europe (not including Scandinavia), sexuality during pregnancy and after childbirth was analysed. This review showed that sexual interest and activity tends to be reduced for several months after delivery (38). Factors related to reduced sexual interest and activity are adjustment to parenthood, marital satisfaction, depression, fatigue, dyspareunia, and breastfeeding (39). When to resume sexual intercourse after childbirth is likely to be influenced by time, geographical location, and cultural patterns. A national Swedish sample found that couples had their first sexual intercourse two months after childbirth (40), which is in line with other studies (38, 41, 42). Investigators have described both positive and negative effects of breastfeeding on postpartum sexual activity (43-47). Overall, women perceived that breastfeeding had a slightly negative impact on sexuality, but it did not greatly affect the woman's sexual relationship with her partner (48). A multitude of evidence says that lacerations during delivery can cause sexual dysfunction (43, 44) and suggests that lacerations occurring during delivery influence whether or not the women will resume sexual intercourse within six months of the baby's birth (40). An American

study among women with different types of lacerations after a vaginal delivery showed that women with an intact perineum or a first-degree laceration experienced considerably less painful sexual intercourse. They also showed more sexual satisfaction and better orgasms than those with major lacerations (49). Although caesarean section protects from perineal trauma (50), it does not necessarily lead to better sexual life after childbirth (51). Barrett et al. (2005) clearly showed that women who deliver by caesarean section are not exempt from experiencing sexual problems after childbirth. Wiklund et al. (2007) found no difference in re-establishing sexual life after childbirth between women requesting caesarean section in the absence of obstetric indication and women planning a vaginal birth (52). In general sexual function of men was not affected by their partner's parity and mode of delivery and an elective caesarean section would not provide additional benefit to men's experience of the sexual life (53).

Basson (2005) discussed the fact that biological factors, such as fatigue, depression, and reduced sex hormone levels, as well as contextual factors, such as becoming a new parent, can negatively affect sexual arousal and desire and result in sexual problems (54).

## **2.5 SUTURING**

Obstetric perineal lacerations have occurred during childbirth throughout the ages. Various methods and materials have been used by midwives and doctors to repair perineal lacerations. However, appropriate and effective management is a continuing problem, and there is a great variety in practice in the way perineal trauma is assessed. Suturing perineal lacerations has been the predominant method to stop heavy bleeding from a laceration and to realign the tissues to facilitate the healing process. Many clinicians and researchers question the practice of leaving some first- and second-degree lacerations to heal spontaneously, while others question the necessity of suturing all lacerations after a vaginal birth. Normally in Sweden, the extent of the trauma is first assessed by the midwife who attends the birth. If she is unsure of the extent of the laceration or if a third- or fourth-degree laceration has occurred, a senior midwife or an obstetrician is consulted. The Swedish midwife is in charge of suturing first- and second-degree lacerations.

### *Prevalence*

Perineal trauma and its repair is an aspect of childbirth that affects millions of women throughout the world. The rates of perineal trauma vary according to individual practice and policy of staff and institutions all over the world. International studies, where episiotomies are more common than in Sweden, report perineal injury in about 85% of the women (55), and a study from Sweden reports that 78% will tear and 47.1% will have a second-degree perineal laceration (56).

### *Classification of perineal trauma*

First-degree spontaneous tears involve the perineal skin only; second-degree involve the perineal muscles and skin; third-degree include injury to the anal sphincter complex (3a <50% of the external anal sphincter torn, 3b >50% of the external sphincter torn, 3c = injury to the external and internal anal sphincter); and fourth-degree include injury to the perineum involving the anal sphincter complex and anal epithelium (57).

### *Episiotomies*

Episiotomy is a surgical incision of the perineum made to increase the diameter of the vulva outlet. The tissues involved are the same as in a second-degree tear (58).

Episiotomy became common practice without scientific evidence of its beneficial effects and has been liberally used in most countries in the thorough belief that it would prevent perineal lacerations, infant morbidity, and future gynaecological problems (59, 60). The use of episiotomy has been challenged within medicine, and a number of reviews of the literature have been published summarising the evidence and supporting the restrictive use of episiotomy (61, 62). In Sweden the rate of episiotomy is 7% (63). A great variation in episiotomy rates by hospitals in Sweden has been observed by other authors (64). A German study showed that episiotomy at a perineal tear presumed to be imminent did not have any advantage with respect to pelvic floor function and should be avoided (65). Ejegård et al. (2008) found that episiotomy can affect a woman's sex life through the second year postpartum with more frequent pain and vaginal dryness during sexual intercourse (66).

### *Suture material and technique*

A Cochrane systematic review of eight RCTs involving 3642 women has found that absorbable synthetic material, when compared to catgut suture material, is associated



with less short-term morbidity but there is no clear difference in terms of long-term pain and dyspareunia (67). The most commonly used suture material today is an absorbable material, and the structure could be either a monofilament (essentially one strand) or a multifilament (several small strands braided together).

A continuous suturing technique for perineal closure is associated with less short-term pain, compared to interrupted methods. If this technique is used for all layers (vagina, perineal muscles, and skin), the pain reduction is even greater than if it is used for skin closure only (68). Some health care providers prefer the interrupted approach, because it is perceived to facilitate a more anatomic repair (69). Studies evaluating two-layered perineal repair, leaving the perineal skin unsutured, have also been conducted (70, 71). This technique shows less suture removal and less perineal pain. More women exposed to this technique resume pain-free sexual intercourse earlier than those having their perineal skin sutured. Suture techniques for third- and fourth-degree tears will not be discussed here.

#### *Statement of problem, Study I*

The routine to leave minor lacerations (first and second degree) unsutured varies by hospitals in Sweden (Personal communication with maternity clinics in Sweden, 2008). The evidence for leaving first- and second-degree lacerations are inconsistent (58, 72). The first part of this study compares the healing process after unsutured and sutured lacerations in labia, vagina, and perineum after vaginal birth.

## **2.6 GENDER ROLES AND TRANSITION TO PARENTHOOD**

Rubin (1975) explains that sex refers to biological differences between men and women, while gender refers to social, cultural, and historical constructions of femininity and masculinity (73). Gender relations describe male and female characteristics that are socially constructed and are related to how we are expected to think and act as men and women because of these social constructs, not just or not even primarily because of our biological differences (74). The major biological difference between women and men is that fertilisation occurs in the woman's body. Because of this, in most societies, women are expected to bear children, be good mothers, be the primary caregivers, and see this as their fundamental role in life (75). Gender roles often dictate who is supposed to be passive or aggressive in sexual

relationships and who is supposed to initiate sexual activity (37). Hirdman (2007) discusses the meaning of sexuality in constructing and shaping masculinity (76). Cultural and social norms define the behaviours and thoughts regarding femininity and masculinity in any society (77). Understanding gender differences contributes to a more complete picture of how sexual relationships are formed and negotiated (78).

Traditional sex roles are strengthened during parenthood, because motherhood usually starts by staying at home with the baby (79). In many families, the ideal of parenthood conflicts with the actual experience (80-82). Expectations relating to the sharing of childcare and household matters influence marital satisfaction. Actual roles often involve conflict and disagreement about practical arrangements and division of time (1), and women are especially dissatisfied with unequal division of housework (83). In many Swedish families the traditional gender roles are preserved (84). According to Swedish statistics, men do a third of what their partners do in terms of household work, even when both of them have full-time jobs. Men tend to be more children-oriented and play more with their children, but they engage less in organising matters concerning the children and are less motivated to do housework (85). The families negotiate to solve everyday problems, the couples argue, and sexuality becomes a weapon in the struggle where the women often subordinate themselves (79).

When partners become parents, different aspects of family life are affected. Communication patterns and family roles form the quality of the relationship between the child and each parent according to a model developed by Cowan and Cowan (2000). The relationship to friends, work, childcare, and grandparents develops a new meaning in forms of stress or support during the transition to parenthood (1).

#### *Statement of problem, Studies II-IV*

Sex after childbirth has been researched relatively often, but there is still a lack of knowledge about how women and men think about their sexual lives after childbirth. There are few studies concerning midwives' skills and counselling on this topic. The second part of this thesis was conducted to elucidate women's and men's thoughts about sexual life after childbirth as well as the midwives' knowledge, skills, and behaviour when counselling on these issues.

### 3 AIMS

The overall aim of this thesis is to explore and describe how sexual life after childbirth is communicated, addressed, and reflected upon among mothers, fathers, and midwives as well as the impact of leaving first- and minor second-degree tears after childbirth unsutured.

The specific aims are

- to compare two groups of women with minor lacerations (first and second degree) after a vaginal delivery, with respect to the healing process and experience when the lacerations were sutured or left to heal spontaneously (I)
- to elucidate mothers' experiences of their sexual life after childbirth (II)
- to describe fathers' reflections about their sexual life 3-6 months after the birth of their child (III)
- to describe midwives' reflections on counselling women at their postnatal check-ups, with a special focus on sexuality (IV)

## 4 SUBJECTS AND METHODS

Four studies are included in this thesis. A randomised controlled trial (RCT) was conducted to test not suturing versus suturing after a small specified perineal laceration (study **I**). Two studies, one on women's and one on men's view about sexual life after childbirth, were conducted using a qualitative approach (studies **II** and **III**). A fourth study describing the midwife's perspective on counselling at the postpartum check-up was performed using a qualitative approach (study **IV**).

There have been several efforts to develop evidence hierarchies that rank studies according to the strength of evidence they provide, where RCT is a superior design in determining whether an intervention does more harm than good despite its limitations (86, 87).

Qualitative nursing research methods have been used mainly in social science research (88) but are now also widely used in health research (89). The data collection methods used in the qualitative studies included focus group discussions (FGDs) and interviews. Qualitative research looks into the meaning of social phenomena understandable by the study subjects themselves (90), and it seeks to explore and answer questions such as what, how, and why (91).

### 4.1 SETTING

This study was conducted in the greater Stockholm area, which includes mainly an urban population but also a smaller rural population. The women in studies **I** and **II** and the men in study **III** were recruited from a hospital in the northern part of Stockholm with two labour wards and with a total of 8 500 deliveries per year. Most of the women who give birth at this hospital are healthy and well educated. Most of the women in study **II** were native born with the exception of a group of women who were second-generation immigrants and spoke fluent Swedish. They were recruited from the south of Stockholm.

The midwives were recruited from all prenatal clinics in greater Stockholm, which take care of women from different social and cultural backgrounds (study **IV**).

## 4.2 STUDY DESIGN

This research programme embraces four different data collections and two different study designs. An overview of the studies is presented in Table 1.

Table 1. Design, study group, data collection, and analysis of the studies in the thesis

Study	Type of study	Study group	Data collection	Data analysis
I 1997-98	Experimental design with RCT	40+38 women	Observation protocols and questionnaires	Statistical analysis m, SD, Student's <i>t</i> -test, chi-square
II 2001-03	Descriptive qualitative	27 mothers 3-24 months after childbirth	6 FGDs with field notes	Content analysis
III 2006	Descriptive qualitative	10 fathers 3-6 months after childbirth	2 FGDs and 5 interviews, tape recorded and transcribed verbatim	Content analysis
IV 2005-07	Descriptive qualitative	32 midwives	5 FGDs, tape recorded and transcribed verbatim	Content analysis

### *Questionnaires (Study I)*

Obstetric data was collected from the birth record. Three different questionnaires were developed to be distributed on three different occasions to assess discomfort and pain retrospectively at each occasion. Discomfort was described as a burning sensation, pulling or stinging pain, and soreness. The wordings were given in the questionnaire, and the women chose the words that best described their discomfort. The first questionnaire included background data, discomfort, kind of discomfort, and anaesthetics. The second and third questionnaires included the same questions and

some additional questions (see Appendix I).

#### *Observation protocol (Study I)*

The observation protocol was developed to assess the healing process, oedema, haematoma, bleeding, and infection. A midwife assessed the healing process twice, by filling out an observation protocol. The observations were the same at both occasions with some additional response-alternatives for the laceration in the perineum (see Appendix II).

The instruments were tested for face validity by a group of women and an expert panel of midwives. A few questions were altered in the questionnaire but not in the protocol.

#### *Focus group discussions (Studies II-III)*

A focus group discussion can be defined as an in-depth, open-ended group discussion that explores a specific set of issues on a predefined and limited topic and consists of 4-12 participants (92, 93). The idea behind the focus group method is that group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one-to-one interview (92, 94). Different aims of a focus group discussion (FGD) create different demands for sampling and for procedures. Thus, like most other qualitative methods, FGDs depend on purposive sampling, and the kind of people included in the study depends on the research question. It is essential to invite people who have some experience of the research questions and who are prepared to share their experiences and thoughts with the group. Small group interviews, with only 2-3 participants, can also be conducted (88, 92). FGDs last approximately 1-2 hours and are summarised in the end to make sure that there have been no misunderstandings. The issues brought up in an FGD might be used as a starting point in the next FGD (92, 95). During the process of the FGDs, fewer and fewer topics will come up and finally the research group concludes that saturation of the topic has been reached (96), and data collection ends. Facilitating and conducting an FGD requires skills in listening, probing, and making decisions about when to move on to the next topic. The moderator is responsible for the flow of the discussion and the interviews and also ensures that no one dominates the conversations (94, 95). Kreuger (1994) recommends an interview guide prepared beforehand with opening, introductory, transition, key, and ending questions (95). The FGDs are often tape

recorded or detailed notes are made (92, 95).

We considered FGDs to be an appropriate method to explore women's, men's, and midwives' views on sexual life after childbirth. For many people sexuality is still a taboo topic. The FGDs with women became an opportunity to debate, contradict, and affirm their opinions about a range of gender-based social issues that arise during the postpartum period. In contrast, some men found the matter too personal to discuss in a group setting and were therefore offered individual interviews.

#### *Individual interviews (study III)*

To respond to the needs of the men who preferred an individual interview, interviews were performed. The same interview guide as in the FGDs was used. The interviews gave us more in-depth knowledge, and they were a good complement to the FGDs.

### **4.3 STUDY I**

#### *Recruitment of sample*

Women were informed about the study at the ANC, both verbally and in writing, by the antenatal midwife. When the women arrived at the delivery ward, they were informed again about the study. They were told that if they were willing to participate, they would be randomised after childbirth if they got a perineal laceration that corresponded to the inclusion criteria (see below). Participants were also informed that they could terminate their participation at any time. For study I, a consecutive sample of 80 women with a specified type of laceration were randomised either to have their minor perineal laceration sutured or to leave it to heal unsutured.

#### *Inclusion criteria study I*

To be included in the study the women had to be primiparous, have a spontaneous labour at term (37-42 weeks of gestation), have mastery of the Swedish language, be non-smokers at least during pregnancy, and give birth to a healthy child. Further, the laceration as assessed by the midwife had to correspond to the following description:

- Labia minora: laceration should not bleed; the labia should not be ripped apart.
- Vagina: laceration should not bleed and the edges should come together well; the mucus should not be completely separated from the bottom of the vagina.
- Perineum: laceration should not bleed; laceration should come together well; the depth and length of the laceration should not exceed 2x2 cm.

### *Procedure*

Ten specially trained midwives carried out the suturing procedure according to the following instructions:

*Technique:* Interrupted suture technique in labia, vagina, and perineum. Continuous subcuticular technique in the skin

*Material:* Absorbable synthetic suture material (polyglycolic acid) in all layers

*Anaesthesia:* Pudendal block and/or Xylocaine spray

When the midwife had checked that the inclusion criteria were met, the woman was asked if she still agreed to participate. The midwife left the woman and her partner alone so she could decide if she wanted to participate or not. The experimental group's lacerations were left to heal spontaneously, and the control group's lacerations were sutured.

### *Dropouts*

Five of the women were excluded because they had not understood they had to follow the outcome of the randomisation. They still thought they had a choice. Another two had to be excluded because non-absorbable suture material was used, which was not acceptable for the study. Thus 40 women participated in the experimental group and 38 in the control group.



### *Data collection*

Data for study I were collected from January 1996 through June 1997. Eighty opaque envelopes containing study protocols were assigned either to suture the laceration or to leave the laceration unsutured. All 80 envelopes were sealed, thoroughly mixed, and numbered sequentially before being placed in a box. The box was placed at the delivery ward in the midwife's office. The midwife picked up the top envelope when the woman had given her consent to participate. Each woman was allocated according to the randomisation procedure.

Follow-up examinations were performed on three different occasions: at 2-3 days, on the maternity ward; at 8 weeks, when performing the regular postnatal visit at the ANC; and at 6 months, by means of a questionnaire that was sent home to the women. Women were retrospectively asked about their discomfort or pain on all three occasions. At the first two follow-up examinations the midwife assessed the laceration with respect to healing, oedema, haematoma, bleeding, and infection. The midwife who made the assessment was not blind to which treatment the woman had received. Blinding was not possible because, at least at the first check-up, the midwife could easily observe whether suturing had or had not been performed.

### *Data analysis*

Descriptive statistics were used, mean (m) and standard deviation (SD), for background data. For comparisons between the two groups, Student's *t*-test for unpaired groups was used for interval data and chi-square analyses for category data. Software programs used for the statistical analyses were Statistical Package SPSS No. 11 for Windows (97).

## **4.4 STUDY II**

### *Recruitment of samples*

In order to select information-rich respondents who would feel comfortable elucidating the questions under study, purposeful sampling was practised and a voluntary, homogeneous sample was selected for focus group discussions (94).

The women in study **II** were identified by the antenatal midwife. The midwife approached women who she perceived would be likely to agree to participate and discuss this topic in a group. Moreover, the women had to be willing to openly share their thoughts and experiences with the group. The participants had to be Swedish-speaking and should have given birth at least three months before the FGD session. The women were approached when they came for the postnatal check-up or if identified later, they were contacted by the midwife. Following consent, the women got a more detailed presentation of the study over the phone by the researchers. Written information and an invitation were sent to the women. A total of 27 women participated in 6 FGDs, 3-7 women in each FGD.

### *Dropouts*

Four women changed their minds and did not participate in an FGD. Three of them dropped out because other things came up that prevented them from coming to the group, and the fourth woman changed her mind about participating in a group discussion.

### *Data collection*

In study **II**, data were collected during 2001-2003. A moderator conducted the FGDs and an observer took detailed notes, as suggested by Kreuger (95). The tape recorder did not work during the first FGD, and the participants of the second FGD preferred that the tape recorder was not used. Detailed notes were thus the basis of data analysis. A discussion guide was used, which was prepared beforehand and posed questions about sexual life after childbirth: had their midwife, friends, or partner brought up questions about desire; what were their perceptions of physical changes in their bodies and their perceptions of their perineal lacerations in relation to their sexual life; and had they received counselling with regard to these topics. The discussions proceeded for 1.5-2 hours and a summary of each FGD was made directly after the session by the moderator, in order to verify with the participants that everything had been correctly understood. A second observer was present at one FGD to find out whether two observers were needed to make proper notes. When compared, the notes were similar and it was concluded that one observer was enough.

### *Data analysis*

The transcribed text from the FGDs and the interviews were analysed using qualitative content analysis inspired by Burnard (1991). In study II the analysis of the data was based on handwritten notes from the FGDs because of technical problems and because the women in subsequent groups felt uncomfortable with the tape recorder. Taking notes has been suggested by Kreuger (95) as an alternative to tape recording. The transcribed text was less detailed, and quotations became fairly short. The data processing was initiated by making a clean copy of the notes using complete sentences, phrases, and quotations after each FGD. Thereafter the text was read and reread by all the authors to become familiar with all of the texts. Meaning units (words, sentences, or paragraphs) related to each other were identified, and authors made comments in the margins when they read the text. Post-it notes were used for notions of what to do with the different parts of the data during the whole process. The meaning units were condensed and labelled with a code, and the codes were assigned different colours. This was done to develop some manageable classification or coding scheme. The whole context was considered when condensing and coding. The codes were compared and sorted into exclusive categories based on similarities. Three of the authors (AO, EN, ML) in study II worked with the analysis and developed coding schemes independently. We then compared and discussed similarities and differences.

The process of analysis involved moving back and forth between the text, the codes, and the categories. Our effort was to uncover categories and themes and to make careful judgements about what was significant and meaningful in the data. At the end of the process, an interpretation of the underlying meaning was formulated into a theme by the authors.

## **4.5 STUDY III**

### ***Recruitment of samples***

Men were invited to participate in study III while they still were at the maternity ward. Before leaving the maternity ward, a midwife at the maternity ward or the researcher informed the men about the study, both in writing and verbally. They were asked to participate in an FGD approximately three to six months after childbirth. It

was found that some men preferred individual interviews over group discussions. A total of 27 men agreed to participate in either FGDs or individual interviews when asked at the maternity ward. In case of no-shows, which are common in studies like this (group discussions of a taboo subject), we overbooked each FGD. In the end, 10 men participated: there were two groups, made up of 3 and 2 men, and 5 individual interviews.

### *Dropouts*

When the invitation was sent out, between three and six months after childbirth, six men answered that they had changed their minds, did not have time, and/or wanted to be with their families. The others agreed to participate and were booked for three different FGDs, and those who had agreed to participate in an interview were booked for one. On the day of the FGD some of the men phoned to say they could not come and were rebooked, and some did not show up and did not leave a message. They were contacted and were rebooked if they were still willing. Seventeen men withdrew from the study. This left two small groups of 2 and 3 participants. The participants found it pleasant and felt at ease in their small groups.

### *Data collection*

In study **III**, data were collected from May through December of 2006. The FGDs and the individual interviews were tape recorded which is considered more reasonable than taking notes (88). A discussion guide was used, which was prepared beforehand and posed questions about sexual life after childbirth: had their midwife, friends, or partner brought up questions about desire; what were their perceptions of physical changes in their partner's bodies and their perceptions of her perineal lacerations in relation to their sexual life; and had they received counselling with regard to these topics. The discussions and interviews lasted between 35 and 60 minutes. The FGDs and interviews were conducted by a man (MB), who was not a member of the research team but was a male facilitator working with an all-male forum for expectant fathers and fatherhood classes. He was perceived as using the same language as the participants and was regarded as "one of the blokes," making him easy to talk to. A male observer (AB) took notes on two occasions. A summary of the discussions was made directly after the session by the moderator, in order to verify that everything had been correctly understood.

### *Data analysis*

The transcribed text from the FGDs and the interviews was analysed using qualitative content analysis inspired by Graneheim and Lundman (98). The audiotapes were listened to, and the text transcribed as being the most feasible data collection for interviews (87, 88). The transcribed text was detailed and when writing quotes, they became more substantial.

The text was read and reread by all the authors to become familiar with all of the texts. Meaning units (words, sentences, or paragraphs) related to each other were identified, and authors made comments in the margins when they read the text. Post-it notes were used for notions of what to do with the different parts of the data during the whole process. The meaning units were condensed and labelled with a code. This was done to develop some manageable classification or coding scheme. The whole context was considered when condensing and coding. The codes were compared and sorted into exclusive categories based on similarities. Three of the authors (AO, EN, ER) worked with the analysis and developed coding schemes independently. We then compared and discussed similarities and differences. The process of analysis involved moving back and forth between the text, the codes, and the categories. Our efforts at uncovering categories and themes and making careful judgements about what is significant and meaningful in data was to see that the data have been appropriately arranged in the category system, that the category system fits the data, and that the data have been properly fitted into it. At the end of the process, an interpretation of the underlying meaning was formulated into a theme by the authors.

## **4.6 STUDY IV**

### *Recruitment and sample*

In study **IV** all midwives working at ANCs in the greater Stockholm area were invited to participate in an FGD about postpartum counselling with a special focus on sexual life after childbirth. First all the ANC co-ordinators were informed about the study, to confirm that it was appropriate in time and did not collide with other ongoing studies. It was important to recruit those who perceived that they had experience related to the research question and were willing to talk freely about the

topic (92). Five FGDs were held with 6-8 participants in each group, for a total of 32 midwives.

### *Dropouts*

Of the 269 invited, 140 midwives responded to a questionnaire with background data, and 41 were willing to participate in an FGD. Two reminders were sent out. In the end 32 accepted to participate. The nine who dropped out were unable to attend due to personal or organisational problems and time constraints (Table 2).

*Table 2. Characteristics of study population (n=140) in study IV*

	<b>Non-participants</b> n=108	<b>Participants</b> n=32
Age in years Mean (SD)	50.3 (± 8.1)	49.2 (± 7.8)
Missing (freq)	1	0
Years in the profession Mean (SD)	20.5 (± 10.2)	20.3 (± 9.9)
Missing (freq)	5	0
Years working with prenatal care Mean (SD)	11 (± 9.5)	9.4 (± 7.7)
Missing (freq)	8	0
Have received additional sexology education (freq)	52	13
Missing (freq)	3	0
Comfortable when talking about sexual life at the postnatal visit Mean (SD) <sup>1</sup>	8.5 (± 1.4)	8.0 (± 1.8)
Missing (freq)	5	0
I think I give adequate information about sexual life after childbirth at the postnatal visit Mean (SD) <sup>2</sup>	7.6 (± 1.9)	7.5 (± 1.9)
Missing (freq)	18	0

<sup>1</sup> VAS end points: very uncomfortable vs. very comfortable (0-10)

<sup>2</sup> VAS end points: do not correspond vs. correspond completely (0-10)

### ***Data collection***

The data for study IV were collected during 2005-2007. The FGDs were tape recorded, which is considered more reasonable than taking notes (88), and an observer also took notes. The same questions were discussed in the FGDs, but now from the counsellor's perspective using an interview guide prepared beforehand. The

discussions proceeded for 1.5-2 hours. A summary of each FGD was made directly after the session by the moderator, in order to verify with the participants that everything had been correctly understood.

### ***Data analysis***

The transcribed text from the FGDs was analysed in the same way as study **III**. The audiotapes were listened to and the text transcribed. Thereafter the text was read and reread by all the authors to become familiar with all of the texts. Meaning units related to each other were identified, and authors made comments in the margins when they read the text. Post-it notes were used for notions of what to do with the different parts of the data during the whole process. The meaning units were condensed and labelled with a code. The whole context was considered when condensing and coding. The codes were compared and sorted into exclusive categories based on similarities. Three of the authors (AO, EN, ER) worked with the analysis and developed coding schemes independently. We then compared and discussed similarities and differences. The process of analysis involved moving back and forth between the text, the codes, and the categories. The analysis followed the same procedure and rigor as in study **III**.

## **4.7 ETHICAL CONSIDERATIONS**

All studies in this thesis were approved by the Regional Ethics Committee in Stockholm (Study **I**: Dnr 95-283; Study **II** Dnr 01-325; Study **III** and **IV**: Dnr 05/1460-32). The participants were informed about the purpose of the study both in writing and verbally and gave their verbal (**II** and **III**) or written (**I** and **IV**) consent. Moreover they were informed about confidentiality and that they were free to terminate their participation at any time. Confidentiality is a problem that cannot be assured in FGDs; we tried to manage this for studies **II** and **III** but, as stated, it was impossible for study **IV**.

Study **I**: The intervention included not suturing specified perineal lacerations. This treatment was supported by clinical experience but had never been exposed to trial. The ethical consideration concerned whether it was ethically acceptable to expose women to this non-intervention treatment. The best way to find out the answer while

at the same time exposing the women to as little harm as possible was deemed to be a randomised controlled trial with very strict inclusion criteria and a procedure with a sufficient number of participants. The women were well informed at several occasions and were given enough time to decide whether or not to participate in the study (see above).

During the FGDs and interviews (studies **II-IV**), sensitive issues that might evoke strong feelings were dealt with. This was taken into consideration by tactful handling of the focus groups, including a contract that required the participants to leave the information received from other participants in the group. After the sessions, all participants were offered time for further discussions and were offered help to establish contact with a health professional if needed.

Study **II**: Most of the women valued the opportunity to express their views and postpartum experiences about re-establishing their sexual life after childbirth and their postpartum visit to the ANC.

Study **III**: When the men were invited to participate in the FGD, still being at maternity ward, they appreciated being invited. One can assume that at that point most of the men were happy and felt well. Most men declined to participate because they felt uncomfortable talking about personal issues in a group or argued that they did not prioritise this. This was both an ethical and scientific problem. Due to this, we offered both FGDs and individual interviews to make men feel more at ease and also to improve data collection. We also chose to have a male moderator, hoping to increase the men's comfort level when talking about sexuality.

Study **IV**: It was impossible to establish anonymity among the midwives, but it was a voluntary sample and they were informed that the participants were from ANCs in Stockholm before consenting to participate (99).



## 5 RESULTS

### 5.1 STUDY I

The main finding of this study was that minor lacerations (first and second degree) could be left to heal spontaneously or sutured according to the choice of the woman. The lacerations healed within the same time frame and with a similar amount of discomfort.

No significant differences were found between the groups regarding background data, such as age, duration of labour, postpartum bleeding, and birth weight. The primary birth position was upright; more than 70% of the women in the study used kneeling or standing positions when giving birth. More women in the unsutured group used alternative anaesthetics or non-medical pain relief, but the difference was not significant. Nitrous oxide and epidural block were used to the same extent in both groups.

The lacerations were divided into different groups, according to their types and combinations (Fig. 1). In the unsutured group, 73% of the women sustained labial tears, compared to 50% in the sutured group. Also, 23% of the women in the unsutured group complained about a burning sensation, compared to 11% in the sutured group, which might be due to more labial lacerations in the unsutured group. The difference was not significant.

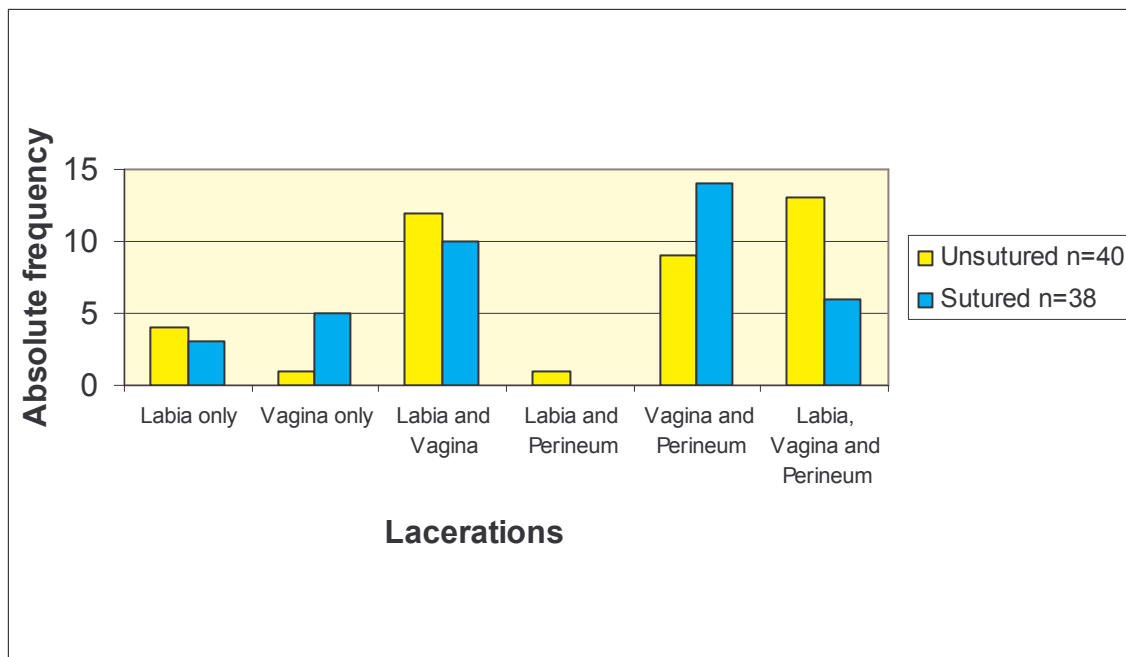


Figure 1. Types of lacerations

### Healing

The follow-up at 2-3 days showed that most of the lacerations in the labia minora and vagina were healing well. In the unsutured group the midwife could see an open wound when holding the edges apart in 2 cases. Gaping edges of the perineal lacerations were found in 5 women in the unsutured group and 4 women in the sutured group. No infection or bleeding was identified.

The follow-up at 8 weeks showed that nearly all lacerations had healed well (Fig. 2). Regarding the vaginal healing, 1 oblique healing in the sutured group was found. In the unsutured group, 5 of the women showed a mucus flap near the introitus and the corresponding figure in the sutured group was 4 women. Perineal lacerations with asymmetry were found in 2 women in the sutured group, although no such asymmetry was observed at the first check-up for this group. No asymmetry was found in the unsutured group, although 1 woman had shown asymmetry at the first check-up.

No statistically significant differences were found in the healing of the lacerations.

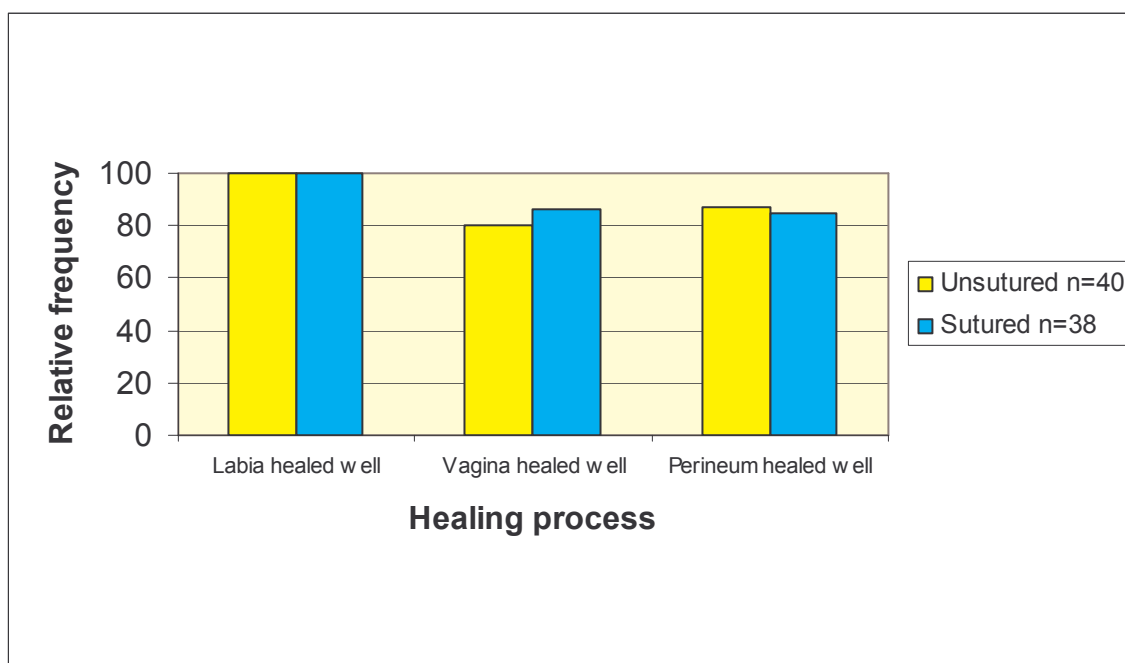


Figure 2. Healing process at 8 weeks

#### *Discomfort*

Nearly half of all women in both groups had no subjective discomfort or pain at all (50%/45%). The discomfort was not related to any particular birth position, duration of second stage, birth weight, or anaesthesia. Discomfort was reported up to 12 weeks in 8% of the unsutured group and in 13% of the sutured group. At the 8-week check-up, 11% of the sutured group used analgesia for perineal pain, while none of the unsutured group did.

#### *Sexual intercourse*

Six months after childbirth, almost all women had had sexual intercourse (90%/89%) at least once. A little more than 10% in each group said that the laceration influenced their experience of intercourse. Comments like “tight/narrow” and “painful/sore” were made in both groups in the six-month questionnaire, and most of the women had feelings of vaginal dryness and stiffness.

#### *Breastfeeding*

One woman in the unsutured group had a breast reduction performed before pregnancy and did not breastfeed at all. There were no significant differences in the duration of breastfeeding, and nearly all women breastfed at the 8-week check-up (95%/100%). None of the women in the unsutured group thought the laceration

negatively influenced breastfeeding, but 16% of the sutured group thought so ( $p=0.0385$ ).

#### *Comments made at the six-month questionnaire*

Most comments from both groups of women were about discomfort or changes of sensitivity during sexual intercourse. In the unsutured group, comments like “flabby, loose, and unattractive” and “wound healed slowly” were made. One woman stated that “it was a relief not to have been sutured” and another said “it feels different, but it is not caused by the laceration.” Women in the sutured group complained about stitches and made comments like “feel like the stitches were still there” and “it is difficult to sit.”

## **5.2 STUDY II**

The findings in the study on women’s thoughts about sexual life after childbirth were represented by four themes: stresses of family life alter sex pattern, discordance of sexual desire, body image after childbirth, and reassurance.

#### *Stresses of family life alter sex pattern*

Fatigue and lack of time due to the baby altered sexual activity and made women prioritise sleep over sex. They needed to have time of their own, however they also emphasised that it was important to spend time with their partner. Many women expressed that the physical changes, as well as the transition to parenthood, would require more time to find normality again.

#### *Discordance of sexual desire*

The women talked about decreased sexual desire after childbirth, probably due to lack of time, fatigue, breast-feeding, and maybe vaginal lacerations. They thought that the child satisfied their need for intimacy and that their partners felt more sexual desire following the delivery than they did themselves. Most partners agreed to postpone or refrain from having intercourse but some insisted on having sex. To balance this situation the women said that they agreed to have intercourse even though they felt no sexual desire. But at the same time, the women expressed that there was a threshold they needed to cross in order to recover their sexual life. A common feeling was that

if one waits too long, it would be more difficult; and many women stated that communication and the possibility to discuss the issue were vital in determining whether or not conflicts and future problems would occur.

### *Body image*

The women were keen to observe changes to their body image following childbirth. Some women expressed anxiety about the permanence of these changes and mentioned plastic surgery as a way to circumvent unwanted body changes. Women were anxious about the vagina, which seemed to be big and loose. In contrast some women felt that they had gained better knowledge of their bodies following birth and could more easily find their pelvic floor muscles to reach sexual satisfaction. These women regarded the changes following childbirth as being true life conditions. The dual purpose of breasts was difficult for the majority of the women, and their breasts were no longer related to sex in the same way as before. Some of the women who had sutured perineal lacerations were particularly anxious about what would happen to their sexual life.

### *Reassurance*

The women said that their partner did not confirm their own dissatisfaction with their body image and that they were more concerned about the size of their vagina than their partners were. The men tried to reassure the women but the women did not believe them.

The postpartum visit was perceived to be an important visit. The women wanted to be reassured by the midwife that their body had returned to normal, and some of the women thought that the visit had encouraged them to resume their sexual life. However, the women thought this visit was too short and would have liked to talk more about feelings and their decreased libido and less about contraceptives. They would have appreciated another visit at 4-5 months, to discuss sexuality and contraceptives.

## **5.3 STUDY III**

The findings in the study on men's experiences and thoughts about sexual life after childbirth were represented by one overarching theme: transition to fatherhood brings sexual life to a crossroads. This theme contained three categories: struggling between

stereotypes and personal perceptions of male sexuality during the transition to fatherhood, new frames for negotiating sex, and a need to feel safe and at ease with sex in the new family situation.

*Struggling between stereotypes and personal perceptions of male sexuality during the transition to fatherhood*

The men in this study thought that media stressed the importance of sex, mostly penetrating sex, too much. They questioned the male role described in the media, suggesting that men cannot manage without sex. The men in this study questioned the stereotypical picture of sex and asked themselves where the distinction is between sex and no sex. The participants considered sexual desire as an individual matter. They also thought it differed both between and within couples. In some couples the woman might be perceived as having more sexual desire than the man.

For most of the men, sexuality and intercourse had not been in focus during pregnancy and after childbirth. It had been replaced by focus on the baby, although the men stated a need for closeness and touch in the relationship. The men expressed that they were prepared to postpone sexual intercourse after the birth of their infant for some time. Most of them expressed that they would do that for the time needed, at least six months and maybe up to a year.

*New frames for negotiating sex*

Becoming a father and the transition to fatherhood brought about a new meaning and a new focus that changed daily life fundamentally. This also changed the previous couple relationship, where some of the fathers described feeling left out and feeling competition with the baby. The men expressed different ways of handling the situation, some by escaping the home to work or to take part in sports. Others tried to enter the mother-child dyad.

Most of the men in this study said that the women were largely responsible for the household matters and that the women felt distressed over the time and strength required by the baby. Some men thought these new responsibilities diminished the woman's sexual desire. Some men also thought that women prioritised a clean and tidy home and sleep over sex. Fatigue was also a reason for the men to postpone sex; the need for sleep outweighed the desire for sex for most of the participants. Another

reason to postpone intercourse was waiting for the lacerations to heal. The men had experienced that their partner needed to be reassured that she had healed well and that sex felt the same as before childbirth. Despite the woman's worries about not being fit, the men considered the alterations to be a minor problem in the sexual relationship and most of them did not sense any differences during intercourse. In general, fathers thought that communication about sexual life was essential in the relationship, and keeping a sense of humour was a good way to handle the situation. They expressed that it was important to wait until their partner was ready, although they also expressed the importance of getting started again. The participants expressed different views about when it was time to resume sexual life and intercourse again. Some men stressed a fear of postponing sex too long, because it might be difficult to get started again.

#### *A need to feel safe and at ease with sex in the new family situation*

It was expressed by all participants that the postpartum visit focussed mainly on the woman and the baby and less on the relationship and on sexual life after childbirth. The men in our study expressed that they needed to be reassured that the transition to fatherhood takes time and that they needed to get accurate information about the changes that might occur in the sexual relationship after childbirth.

## **5.4 STUDY IV**

The findings in the study about midwives' reflections on counselling women at their postnatal visit were represented by two themes. The first theme, balancing between personal perceptions of the woman's needs and health system restrictions, comprised two categories: forming a picture of the woman coming for the postnatal visit guided the counselling, and lack of knowledge and time restricted the counselling about sexual life after childbirth. The second theme, strategies for counselling about sexual life after childbirth, included another two categories: task-oriented approach in counselling about sexual life after childbirth, and getting in tune to approach the topic of sexual life after childbirth. The midwives said they tried to identify distinctive features related to the woman's childbirth experience. The strategies used to individualise the visit depended on the context and how the midwife understood the woman's problems. The midwives considered the postnatal visit important to "round-up" the pregnancy and end the relationship for the time being.

*Forming a picture of the woman coming for the postnatal visit guided the counselling*

The midwives in the FGD expressed that they formed four different pictures of the woman coming for the postnatal visit. The first one was a picture of a healthy mother with no related problems regarding the birth at the time of the visit. The midwives felt they had sufficient knowledge and time for the visit. The second was a mother with a complicated delivery or a traumatic birth experience who needed a careful review of the birth and a physical examination. The midwives thought it was often inappropriate to initiate a conversation about sexual life and there was no time. The third was a mother with some psychological issues, such as marital problems, discordance of sexual desire with her partner, and/or problems with the transition to motherhood. The midwives perceived that these mothers needed more attention, some even needed a referral to a psychotherapist. Some midwives felt that they did not have enough time or knowledge to counsel these mothers about marital and sexual issues. The fourth picture was that of a woman who had communication difficulties. Most of these encounters were with foreign-born women who had not mastered the Swedish language. Some midwives felt that language difficulties and lack of knowledge about cultural diversity constrained their way of counselling about sexual life.

*Lack of knowledge and time restricted the counselling about sexual life after childbirth*

The midwives felt restricted by the health care system when trying to individualise each woman's visit. Time limitations made it more difficult for the midwives to talk about sexual issues at the postnatal check-up. The encounters with foreign-born women often included an interpreter, which required more time and effort from the midwives. Language difficulties and lack of knowledge about cultural diversity constrained their ways of counselling, especially about sexual life. The midwives also expressed a lack of knowledge in sexology and found no possibility for additional education in sexology.

The midwives in the FGDs expressed that they were probing about sexual life after childbirth but that it was important not to put pressure on the woman to talk about sex during the postnatal visit. Two strategies were developed.



*Task-oriented approach in counselling about sexual life after childbirth.*

The task-oriented strategy focussed on examinations, observations, and various tasks to solve the most obvious and concrete needs of the woman, mainly related to the healing process. Using a task-oriented approach meant that the midwife objectified the woman and followed a “chart” on what was included in the visit, rather than adapt to the woman’s individual needs. The tasks often included a vaginal examination and instructions on how to do pelvic floor contractions. Performing a vaginal examination provided a good opportunity to talk about sexual issues and about whether the woman had tried to have sexual intercourse. Midwives described that they often insisted on vaginal examinations when they met a foreign-born woman, and they also asked more direct questions about the woman’s sexual life. Due to language difficulties, a more task-oriented approach was seen as a good way to give instructions about pelvic floor contractions and a good way to reassure themselves about the healing process and the woman’s well-being. When the women themselves asked directly about sexual issues, practical advice was given and most midwives felt comfortable doing so. Another way to approach sexual life after childbirth was by probing about the relationship and the transition to motherhood. However, there was not always enough time to delve into the problems, and midwives often provided general advice. The midwives in the FGDs said that there is a time when it is not acceptable to refrain from sex after childbirth, even though they stressed that this point differs enormously between couples. When clients reached this point, midwives even instructed the women to try to reclaim their sexual life, rather than simply waiting for desire to come.

*Getting in tune to approach the topic of sexual life after childbirth.*

This strategy was a more careful and flexible way to “get in tune.” This approach included attentive listening. When applying this strategy, it was important not to put too much effort on giving advice, but rather to reassure the woman that it takes time to regain strength, vigour, and sexual desire and to choose the right words in expressing this. Other important ways to “get in tune” were to empower and support the woman to take care of herself and to turn down an invitation for sexual intercourse if she did not wish it. “Getting in tune” often meant that the midwives rescheduled the postnatal visit and individualised the visit according to the woman’s needs. This could be done because the midwife knew the woman beforehand and had identified her needs.

## 6 DISCUSSION

### 6.1 METHODOLOGY CONSIDERATIONS

Both quantitative and qualitative data were integrated into this thesis. Using an integrated approach can provide insight into a multidimensional reality (87). Doing an RCT and then exploring one of the questions using qualitative research methods has provided a more holistic view of a couple's sexual life after childbirth and how counselling about sexual life after childbirth can be approached.

#### Study I

To improve validity and consistency of the questionnaires and observation protocols used in the study, they were tested for face validity on a group of mothers and a group of midwives. The questionnaires and protocols were well understood. Furthermore, the inclusion criteria as well as the stitching procedure were very specific, in order to minimise any bias in the intervention (87). The strict inclusion criteria underpinned the strength of the research design. Ten specially trained midwives carefully supervised the study, which also enhanced internal validity (87).

Still it was observed that questions could have been clearer, for example, the questions about pain should have distinguished between pain derived from general dryness and pain resulting from the laceration. Memory deficits might make it difficult to assess sensations such as pain and discomfort retrospectively. The REEDA scale is an instrument devised to evaluate postpartum healing of the perineum. This scale assesses more components than were used in the present study, such as ecchymosis of the perineal area and discharge from the episiotomy (100, 101). Our instrument was easy to use and it is unclear whether the more detailed information gained from the REEDA scale would have added anything to study I.

Participating in a study brings about special attention, which might influence the women's assessments. Being randomised into an experimental group, which was very popular at the time of the data collection, might influence a woman to make a more positive statement about her healing process. Likewise, the midwife who observed the

laceration might have preferences as to the mode of treatment. The structured protocol we used reduced this effect and safeguarded reliability.

### **Studies II, III, IV**

Triangulation is one technique to enhance credibility, where a phenomenon is evaluated from several angles (87, 88, 90, 94). Triangulation can be based on data sources, data collection methods, investigators, and even research methodologies. Triangulation in data sources in this thesis entails collecting data from the interviews of women (study **II**), men (study **III**), and midwives (study **IV**). This was done to evaluate the phenomenon under study: sexual life after childbirth and midwives' counselling. In study **III**, triangulation in data collection methods was used by having focus group discussions as well as interviews. The team was kept together and was continuously involved in all stages of the research.

Peer debriefing (88, 94, 102) and member checks are also techniques to enhance credibility. Bringing back the results from one or two participants of the study can clarify information and confirm the researchers' interpretations (88). In study **II**, some of the participants were encouraged to give honest feedback about interpretive errors and inadequacies in the preliminary analysis. This was done as suggested by Burnard (1991), but we also felt confident with this feedback because data analysis was based on notes taken, rather than audiotape, during the FGDs (103). The preliminary results of our interviews were thus confirmed. Member checks might also induce misleading conclusions of credibility if participants "share some common myths or front" (102) or if they express agreement out of politeness (87). For these reasons, we decided not to use member checks in studies **III** and **IV**. Indeed, audiotape seemed to be a more reliable source of data documentation than notes, which also made member checks superfluous.

Transferability refers to the extent to which findings from data can be transferred to other settings (87). It is therefore important for the researcher to provide a description of the context that is detailed enough for the reader to make his or her own decision about transferability (102). The participants in study **III** were recruited from a homogenous and privileged area, and most participants were middle class and well educated. This could decrease the transferability to other less-privileged settings,

because similar study groups might not be so common.

Dependability refers to the researcher's ability to account for the changed conditions of the phenomenon studied throughout the process (94). During our research process, researchers kept notes about impressions, decisions, and new questions that arose, in order to achieve dependability and confirmability. To minimise inconsistencies and to achieve clear documentation, there was an open dialogue that allowed other researchers to follow the research process.

In studies **II-IV** we used purposeful sampling because it was important to select information-rich cases. In study **III** we had an extremely homogeneous sample, all middle-class and well-educated men. The participants might have been more aware of what is socially desirable than many other men. This might have influenced their ways of talking about the transition to parenthood, sex, and communication about sexuality, as suggested by Janssen et al. (104). The dropout rate was high, which is common in studies about sexuality. It was difficult to recruit fathers for FGDs, because they did not want to talk about "such personal matters" with others in a group, maybe out of respect for the partners. It seemed that men preferred individual interviews to FGDs. However, those who decided to participate were comfortable discussing topics related to sexuality after childbirth. When the men were actually contacted for the FGD or interview, several men who had agreed to participate did not show up or cancelled the interview. It is possible that the interview felt like an intrusion into their privacy. Discussing their sexual life 3-6 months after childbirth might have felt problematic and possibly even dangerous. Many couples might have problems in their sexual lives at this point (39, 105), and if this creates stress for the couple, the man is more likely to drop out of a study like this (106). In many health care situations, men with traditional masculine beliefs are less likely to get health care (107). Men are often hesitant to discuss sexual problems with their clinicians, and many men view any form of seeking care as a sign of weakness (35).

In study **III** the FGDs and interviews were conducted by a male facilitator (MB) who was experienced with groups of men, in order to create a good interview situation. A male observer (AB) took notes on two occasions. An experienced male facilitator for the interviews was thought to make the interviewees feel more at ease to talk about the study topic. In an Australian study, fathers felt more comfortable discussing male

concerns without fear of embarrassment if the facilitator was “one of the blokes” (108). However, the use of a male facilitator also implies a mutual pre-understanding, which might prevent the interviewer from delving more deeply into the topic compared with an interviewer who is completely naive to the discussion topic. The skills of the interviewer are probably more important than the gender (87, 92, 94).

It was difficult to recruit midwives for study **IV**, mostly due to heavy workload and time constraints. The FGDs were usually conducted after working hours; but when FGDs were offered during working hours, still very few midwives were able to attend. Some midwives might have felt they had little or nothing to contribute, and others might have felt they had no real influence on the situation for themselves or the mothers so they saw no use in attending this FGD.

The use of FGDs in health research has also been criticised. Kaplowitz (2000) has stated that controversial and highly personal issues are poor topics for FGDs. He studied whether socially sensitive issues were more or less likely to be discussed in focus groups versus individual interviews. He found that interviews were 18 times more likely to address socially sensitive issues than focus groups (109). The interviews conducted in study **III** might have therefore enhanced the quality of data.

In spite of the fact that some features are common to many qualitative research designs, there is a wide range of overall approaches. There is not a classification system nor taxonomy for the various approaches, although some authors have categorised quality studies in terms of analysis styles or according to their broad focus. The absence of standard analytic procedures makes it difficult to explain how to conduct the analysis, how to be trustworthy when presenting the findings, and how to replicate studies (87). We were inspired by Burnard (1991) in study **II** and Graneheim and Lundman (2004) in studies **III** and **IV** when analysing our results (98, 103).

Burnard (1991) suggests that thematisation should be done at an early stage of the analysis. This suited us better when we had field notes. There is already a certain level of reflection when taking notes, in other words, one makes a choice (albeit unconscious and subjective) about what to write (103). Graneheim and Lundman (2004) suggest the researcher should be more particular in creating codes, categories, and main categories. The tape-recorded transcribed interviews generated more data to

be analysed. It was therefore possible to make deeper analyses – manifest as well as latent – as suggested by Graneheim and Lundman. Otherwise the differences are in the terminology for the steps in the analyses (98). Burnard talks about validity (peer debriefing and member checks); while Graneheim and Lundman use the word trustworthiness, which encompasses credibility, dependability, and transferability (98).

## **6.2 RESULT DISCUSSION**

The main finding of this thesis was that transition to parenthood involved adaptations and it changed the view many women and men had of the meaning of sexuality and sexual life after childbirth. The first study in this thesis showed that minor perineal lacerations after childbirth, both sutured or unsutured, healed well and did not influence the time point for first intercourse after childbirth. Both women and men experienced uncertainty about maternal and paternal roles, and discordance of sexual desire emerged. These results have implications for midwives' counselling. The midwives identified four images of women to guide them through their approach to counselling about sexual life after birth. They chose strategies for counselling the women based on several factors, including the attitudes, knowledge, and economic constraints at their clinics.

Study I, on suturing versus not suturing of first- and minor second-degree tears after a vaginal delivery, was the first RCT in this field to our knowledge. During the time of this study, the natural childbirth movement was strong in Sweden (110). Midwives left small lacerations to heal spontaneously, without any evidence that this was the best solution to bring about less pain and shorten the time interval for resuming sexual life. Study I showed that small lacerations, whether unsutured or sutured, did not affect the time point for first sexual intercourse after childbirth. The women with unsutured lacerations expressed relief at not having stitches.

A recent study in Sweden has shown that, women have their first intercourse after childbirth at mean three months postpartum (40). Postpartum sexual activity can be affected by larger perineal laceration, and it has been shown that women with third- and fourth-degree lacerations resume sexual intercourse later than women without any or with only small lacerations (40, 111). Connolly et al. (2005) reported that

women resumed painless intercourse by six weeks and also that after six months painful sexual intercourse was not associated with route of delivery, perineal trauma, or breastfeeding (44).

In study I women with unsutured lacerations had less discomfort of the laceration during breastfeeding than women with sutured lacerations, when asked 6 months after childbirth.

Study I showed that superficial labial or perineal tears (first-degree) and small second-degree tears (not bleeding and the edges of the laceration coming together well) do not require suturing. These results are consistent with Leeman et al.(2007), who found no significant differences between sutured and unsutured lacerations in women regarding healing and pain. Although, women in both studies with sutured lacerations reported increased analgesic use compared to women with unsutured lacerations (112). In contrast to the results in study I, Fleming et al. (2003) showed poorer healing and more gaping edges of the unsutured lacerations (72). This is probably because the lacerations in their study were not well defined, implying that larger and asymmetric lacerations were left unsutured. The second check-up in that study was performed 6 weeks after childbirth, compared to 8 weeks in study I, which might explain the suboptimal healing process. Indeed, a second-degree tear can vary in length and depth. In study I the lacerations were all well defined in size, which strengthens the rigor of the sample selection.

There is no debate about suturing deep vaginal, perineal, or rectal lacerations. It is standard management to suture them; however, management of minor lacerations of the skin and mucosa is an area of discussion (70, 71, 113, 114). Lacerations in the labia minora on both sides present a risk for labial fusion postpartum, which can cause urinary difficulties, dyspareunia, and even inability to have intercourse. This has to be considered when leaving labial lacerations unsutured (115, 116). In study I no labial fusions were identified during the healing process.

The first study in this thesis is characterised by a biomedical view on sexual life after childbirth, trying to seek medical causes primarily within the body and to consider physical symptoms rather than social relations when understanding sexual life after childbirth (117). When interviewing women and men, a more complex and multidimensional picture appeared. This led to integrating more of a sociocultural



view when analysing women's and men's experiences of sexual life after childbirth. Holland has suggested that the medical view is unstable and contradictory (118). Even social and behavioural scientists have difficulty offering a conclusive interpretation of human sexuality around childbirth across cultures and history (119).

New parents' attitudes towards sexual life are influenced by stereotyped pictures promoted by the media, which put unrealistic expectations on sexual life around childbirth. The stereotypes concern transition to parenthood, negotiating sex when there is a discordance of sexual desire, and discordance of the view of the body, especially the female body image.

For the women in study **II** and the men in study **III**, the baby was in focus and the preoccupation with the baby contributed to a decreased sexual desire during the first months after childbirth. Fatigue was expressed by both women and men as the main reason for decreased sexual desire, and sleep was considered essential. This has been described in several studies concerning women (41, 45, 120, 121) and men (122-124). However, the results in studies **II** and **III** show that most of the women and men expressed the importance of their sexual relationship, although not necessarily sexual intercourse.

In study **II** and study **III**, women and men described that a number of issues, such as unfinished tasks and household duties, had to be resolved before the women would show any interest in having sex. However, the women and men approached the situation in different ways. Women negotiated postponing sex for unfinished household duties, while men used participation in household duties and family interaction to negotiate having sex. Being involved in the new family, sharing the housework, and engaging in the care of the baby were the men's ways to approach sex. Most fathers in study **III** expressed ambivalence. On the one hand, they adhered to the male stereotype that fears being subordinate to the wife and family; on the other hand, they truly wanted to share in the everyday life of their new family. It has been shown that it is easier for older than for younger men to integrate the new role of fatherhood (125), and older men take more parental leave than younger men (84).

Subsequent fathers in study **III** thought it was important to get together with other new families for support and to talk about daily hassles. They described how young families in the same situation met and tried to keep a sense of humour about how to



handle life without sex. This has been shown to be a way to normalise life after childbirth (1, 81, 122, 123, 126).

Study **II** showed that maternal preoccupation and closeness to the child satisfied the women's needs for intimacy and decreased their sexual desire. The daily physical contact with the child increased their need to have some time of their own and they felt sexual activity could wait. For most of the men in study **III**, sexual desire was not in focus and the closeness and preoccupation with the child seemed to satisfy them in early parenthood. This finding is inconsistent with Condon et al.,(2004) who described that the men were not prepared to postpone sexual intercourse and that they were somewhat impatient (106). However, some of the men in study **III** expressed a feeling of being left out and some also expressed jealousy of not being part of the family. If the father felt that he was left out or did not want to take part, he tried to get away through work or sports. This escaping behaviour is in line with the results of Ahlborg and Strandmark (123) and Fägerskiöld (126). To be able to communicate well in the new family situation was considered very important by all the participants. From studies **II** and **III** we have found that couples who communicate well and show affection through hugs and caresses experience a kind of balance with their sexual life, even if they do not have sexual intercourse. This has also been shown by Ahlborg (122). Women who felt safe and respected in their relationships were able to negotiate their sexual activity; communication with the partner was a very important aspect of women's sexual activity (127).

Sexual intimacy has been shown to be the primary contributor to sexual desire for women, and this can be diminished through a lack of tenderness, mutuality, respect, communication, and pleasure from sexual touching (128, 129). Another study showed that men's and women's sexual arousal share a number of commonalities (104). The majority of men in this study indicated that an emotional connection with their sexual partner contributed or was central to their sexual arousal (104). However, Hirdman (2007) discusses the meaning of sexuality in shaping masculinity and whether power and control are fundamental aspects of male sexuality. She also discusses why sexuality is accentuated so strongly in today's society, what part media play, and to what extent women themselves play an active role (76). It is widely accepted that women internalise the male sexual norms, that is, they prioritise their male partners' sexual needs over their own (127).

Several women in study II expressed that their breasts had turned into an area restricted to the baby's needs, not to be associated with sexual activity. Study II supports the previous findings by Avery (2000) where approximately one third of women reported some degree of difficulty with their dual-purpose breasts (48). Rowland (2005) showed a strong relationship between breastfeeding and delaying the resumption of sexual intercourse (47). However, the men in study III did not express any difficulties with their women's breasts having dual purposes; in fact, they were pleased that the breasts had enlarged and described the breasts as fantastic. In another study, fathers' attitudes towards breastfeeding are described as ambiguous (126). There are great inconsistencies in studies on breastfeeding and its influence on the couple's sexual relationship (45, 48, 130).

It seems there is – in any cultural setting – a specific time when couples are expected to resume sexual life after childbirth. It is a clinical experience that health professionals often inform women and their partners that sexual intercourse can be resumed 6-8 weeks after childbirth or after the postnatal visit. This advice is not supported by current research and is probably outdated (124). Some couples are ready to resume sexual intercourse before the postnatal visit and others are not. The importance of individual needs and situations has to be in focus, permitting open discussions when advice is offered around sexual life after childbirth. The men in study III expressed that it was important for the man not to impose himself on the woman but still to facilitate the re-establishment of their sexual life. In this situation, there might be a fine balance between consent and coercion. Most of the women in study II described a threshold they felt they had to cross in order to resume sexual intercourse. Some women in the FGDs stated that they experienced undue pressure to resume sexual intercourse before they were physically or psychologically ready, while others were just waiting for the postnatal check-up. Waiting for the postnatal visit has been described as being a reason to postpone sexual intercourse for both women (42) and men (124). Mutual desire, physical health, and social and cultural expectations were all factors that influenced a couple's sexual life as parents.

The women in study II expressed that they were stressed about their body image after childbirth and had difficulties accepting their bodily changes after childbirth. They were unhappy about the traces childbirth and breastfeeding left and did not feel

satisfied with their bodies. In order to recover, they considered not only diet and physical training, but also plastic surgery. The commercial ideals were obvious. Studies have concluded that women with a more positive body image reported more sexual activity and overall satisfaction with themselves (131, 132). However, social pressures prescribe a different set of requirements for the female body than for the male body (118).

The men in study **III** were concerned about their partners' perceptions of their bodies but could not really understand the women's preoccupation with their body image. They did not express any negative views of their partners' bodies. Generally a woman's body is expected to be the object of men's desires, and women put considerable effort into shaping their bodies to meet those desires (118). Thus, gendered patterns create social differences that both women and men define as typical for 'woman' and 'man' (119).

The midwives in study **IV** did not seem to be very sensitive regarding gender, and they tended to describe the women using stereotypical categories. This has also been shown by other authors (133). The midwives formed a picture for themselves of each woman in an attempt to enhance the encounter with the women. Midwives are expected to include a psychosocial perspective in their work, which involves paying attention to the psychological and social conditions of the women and their families (134). This implies that midwives should be able to identify women with psychosocial health problems, but this group of women was not referred to in the midwives' FGDs. In study **IV** midwives identified four different images of the mothers. The first group was healthy women to whom the midwives thought they could provide accurate counselling about sexual issues. The second, third, and fourth groups were women who required more attention and more time at the postnatal visit. Some of the midwives felt they were not able to provide good care to some of the foreign-born women. The reason for this might be due to the midwife's stereotyping of the ethnic origin (135). Indeed it has been shown that in their encounters with foreign-born women, midwives feel that their fear of incompetence and their social and cultural uncertainty are barriers to providing good care (136). This concern was also described by midwives in our study.

The midwives in study **IV** face increasing pressure, due to organisational cutbacks

and shortages, to work in partnership with women and to meet their emotional needs. It has been shown that caregivers' sensitivity can decrease, which leads to feelings of disempowerment, due to time limits, restricted budgets for interpreters, misuses of power, and narrow attitudes (137). This also makes it more difficult to provide sensitive counselling (138). Some midwives in our study felt that they lacked knowledge in sexology. They found it difficult to get to the heart of the matter and to communicate about sexual issues in an appropriate way. This is consistent with Kline, who found that clinicians believed that limited knowledge about postpartum sexual life made counselling more difficult (139). From a biomedical view, pregnancy, childbirth, and breastfeeding belong to reproduction; and these issues are kept separate from sexuality, which is considered a private matter (110). The re-establishment of sexual life after childbirth is a culturally based norm, and the midwife's own cultural and gender reference points influence her approach toward the mothers. The midwife might fail to recognise sexuality as a component in social and power relationships. The power to define and regulate sexuality has shifted from direct and visible kinship and community groups to abstract and invisible large-scale economic and social forces (140).

The midwives in study **IV** found two approaches for counselling about sexual life after childbirth: a task-oriented approach, which focused on tasks to be performed within limited time frames; and a subject-oriented, or "tuning in," approach, which searched for a way to discuss sexual life after childbirth by reassuring the women of their feelings and choices. The midwives had to balance both aspects professionally. The midwives based their behaviour during their encounters with women on their mental picture and the perceived needs of the client. When it was more difficult for the midwife to get a true understanding of the client, she tended to objectify the client more and to become more task-oriented in her encounter. Hunter (2006) stresses that when midwives experience emotional difficulties in their encounters, they use self-protective strategies, such as professional detachment, distancing, and task orientation (138). A task-oriented strategy objectifies the women; however, the midwives were able to cover all the required content of a postpartum visit. If they perceived they did not have much time, they became more instructive and less empathetic, in order to do the specific things they had to do. If she could identify with her client, she became more subject-oriented, leading to more probing and sensitive listening behaviour, trying to "get in tune" with the woman. This approach is also denoted as "caring

about” (141), “being with” (137, 142), “listening to” (143), and using nondirective communication (144). To give advice that is not close to the client’s opinion will make her stop listening and she will not believe, like, or follow the midwife’s suggestions (145). Examples of tuning in include being careful about the choice of words during communication and offering a second visit to women with traumatic experiences. Creating trust and a supportive climate often leads to longer visits than estimated, which means that a midwife's timetable does not work out at the end of the day or that clients might be booked during a coffee break or lunch. Hunter (2004) stated that midwifery is highly emotional work with many work-related dilemmas and conflicts, and he found that the most emotional management is required around interactions with colleagues and “the organisation (146).”

Almost all of the women in study **II** had looked forward to the postnatal visit, but they were ultimately disappointed with both the limited time and with the general disposition of the midwives. Studies have shown that women are prepared to attend the post partum visit but the current content of the visit does not appear to meet the health needs of women after childbirth and should be reviewed (147, 148). Study **III** showed that men also needed information and reassurance that would increase their feeling of connectedness with their new family situation. Men’s anxieties about childbirth might be missed antenatally because most of the attention is given to the women (106). Both the women and men in studies **II** and **III** needed reassurance and information about the transition to parenthood, the relationship, and sexual life after childbirth. They argued that it would have been valuable to discuss these things during pregnancy. It has been suggested in other studies to discuss sexual life at the regular antenatal visits as well as at the family classes (106, 108). The men in study **III** did not feel included in the antenatal visits; the midwives’ main focus was on the woman and the foetus. Far less time was spent on the relationship and on sexual life, which is consistent with other studies (106, 149, 150).

Gender-sensitive theories should provide guidelines for midwifery practice to decrease the potential of exploitation, enhance advocacy, and provide guidelines for changes, including institutional and organisational changes. This direction of theoretical development in women’s health would reflect and incorporate women’s own perspectives and would provide a basis to empower women in their experiences of health and illness (151).

## 7 CONCLUSION AND CLINICAL IMPLICATIONS

The results of this thesis demonstrate that women, men, and midwives are influenced by stereotypes of female and male sexuality after childbirth as presented in media and society. The interviewed women (study **II**) and men (study **III**) felt unsure about how to show care and how to be careful in their sexual relationship after childbirth. They expressed that open and trustful communication was essential.

Furthermore, this thesis shows that women's perception of their body image after childbirth was central to their interest in their sexual relationship, and that the men in study **III** were aware of the women's concerns about the body image but had difficulties understanding. One aspect of body image that the women were preoccupied with was the changes in the vagina and the stitches. Study **I** shows that if careful classification of perineal trauma is done, first-degree and well-defined minor second-degree lacerations can be left to heal without suturing, and spontaneous healing also benefits the comfort level during breastfeeding.

This thesis indicates that many women's sexual interest after childbirth diminishes in favour of other basic needs, such as sleep and maternal preoccupation with the new baby. It seems that the preoccupation with the baby satisfies the new mothers and fathers. The fathers in this study expressed that they put the baby in focus in early parenthood. When men share the care of the baby and household matters, they seem to focus less on the sexual activities in the couple's relationship.

The midwives (study **IV**) used two counselling strategies, one task-oriented and one subject-oriented, "getting in tune" strategy. The task-oriented strategy tends to be used when the midwife lacks time, knowledge, and cultural and gender sensitivity in her counselling. The subject-oriented strategy is used when the midwives perceive they have enough time and when the woman arouses the midwife's empathy, recognition, and understanding. By balancing factual information and adequate observations, the subject-oriented strategies improve the counselling's ethical aspects and quality.

The results of this thesis suggest that midwives and other health care providers should

initiate discussions about sexuality during pregnancy and after the birth. The midwives' own cultural and gender reference points influence their approach toward the mothers and fathers when counselling. Midwives need to be aware of the diversities within female and male sexuality, develop their knowledge around what factors influence the views and norms about sexuality, and gain insight into their own values and assumptions about sexuality. Counselling about health requires a positive and respectful approach toward sexuality and sexual relationships.

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# 10 APPENDIX

## APPENDIX 1

### Questionnaire (48-72 h)

Nr

Date  
Address

Personal Identity Number

Name and

JNR  
weight

Delivery date and time

Child's birth

1) Did you feel any discomfort after birth from the laceration?

48h  6h  24h

Comments:

2) If yes, what kind of discomfort did you have?

	6h	24h	48h
No discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling, stinging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

3) Have you used analgesia for perineal pain?

No  Yes  Once   
2-3   
> 3

Comments:

**Questionnaire (8 weeks)**

**Nr**

Date  
Address

Personal Identity Number

Name and

1) Do you breastfeed?  
at all

Full

Partly

Not

Comments:

2) Have you felt any discomfort after birth from the laceration?

1 week  4 weeks  6-8

weeks

Comments:

3) If yes, what kind of discomfort?

	1 week	4 weeks	6-8
weeks			
No discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling, stinging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

4) Have you used analgesia for perineal pain?

No

Yes

Once

2-3

> 3

Comments:

**Questionnaire (6 months)**

**Nr**

Date  
Address

Personal Identity Number

Name and

1) Do you breastfeed? Full  Partly  Not  
at all

Comments:

2) Did you feel any discomfort after birth from the laceration?  
8 weeks  3 months  4-6  
months

Comments:

3) If yes, what kind of discomfort did you have?

	8 weeks	3 months	4-6 months
No discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling, stinging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

4) Have you had sexual intercourse? No   
Yes

- < 8 weeks
- 3 months
- 4-6 months

Comments:

5) Has the laceration affected your sexual life? No  Yes  Do not know

If yes,  
how?.....

Comments:

6) If you are breastfeeding or have breastfed, has the laceration has affected the breastfeeding experience? No  Yes  Do not know

If yes,  
how?.....

Comments.....

7) Are you satisfied with the healing of the laceration? No  Yes  Do not know

If no,  
why?.....

Comments:

## APPENDIX 2

### Observation protocol – midwives (8 weeks)

Nr

1) If there is a laceration in the labia, how does it look?

Healed

Not healed

A fistula

Comments:

2) If there is a laceration in the vagina, how does it look?

Edges coming together well

Partly healed

Asymmetry (introitus), “mucus flap”

Comments:

3) If there is a laceration in the perineum, how does it look?

Edges coming together well

Edges gaping

Asymmetry

“Mucus flap”

Not properly healed

Comments:

4) Has there been a wound infection?

Yes

No

Comments:

5) Has there been a bleeding complication?

Yes

No

Comments:

1) If there is a laceration in the labia, how does it look?

Healing well

Not healing well

Comments:

2) If there is a laceration in the vagina, how does it look?

Edges coming together well

Haematoma

Asymmetry (introitus)

Open wound

Comments:

3) If there is a laceration in the perineum, how does it look?

Edges coming together well

Gaping

Asymmetry

Open wound

Comments:

4) Any sign of wound infection?

Yes

No

Comments:

5) Has there been a bleeding complication?

Yes

No

Comments: