Samlivet efter fødslen for nybagte forældre

14. modul Bachelorprojekt i jordemoderkundskab, juni 2017

Jordemoderuddannelsen, Professionshøjskolen Metropol

Laura Rohde, 63080515

Vejleder: Signe Bjørnholt Marcussen

Antal anslag: 73.528

"Dette projekteksemplar er ikke rettet eller kommenteret af Jordemoderuddannelsen, Professionshøjskolen Metropol"
I henhold til Bekendtgørelse om prøver og eksamen i erhvervsrettede videregående uddannelsen nr. 714 af 27/06/2012 bekræfter undertegnede med min underskrift, at opgaven er udfærdiget uden uretmæssig hjælp, jf. §17, stk 6.

Laura Rohde
Resume

Projektets hensigt er at undersøge, hvordan henholdsvis nybagte mødre og fædre oplever samlivet efter fødslen med fokus på, hvorledes jordemoderen kan vejlede parrene i at håndtere de mulige udfordringer. Projektet har en humanvidenskabelig tilgang og analysen bygger på fire kvalitative studier. Til forståelse af parrenes oplevelser samt, hvorledes jordemoderen kan facilitere kommunikation med parret om samlivet, er anvendt flere forskellige teoretiske elementer om samliv, seksualitet og kommunikation. Det diskuteres, hvorledes jordemoderen i mødet med parrene kan implementere vejledning om mulige udfordringer. Det konkluderes, at de nybagte forældres oplevelser er mangesidede og at jordemoderen må individualisere vejledningen efter parrenes behov.
Indholdsfortegnelse

1.0 Problemstilling ....................................................................................................................... 6
2.0 Problemformulering .................................................................................................................... 7
  2.1 Afgrænsning af problemformuleringen ................................................................................. 8
3.0 Projektets metode, empiri og teori ......................................................................................... 8
  3.1 Videnskabsteoretisk tilgang ................................................................................................... 8
  3.2 Søgestrategi samt valg af empiri ......................................................................................... 10
  3.3 Præsentation af empiri .......................................................................................................... 13
    3.3.1 MacAdam et al., 2011. Fathers’ experience after having a child: sexuality becomes tailored according to circumstances ............................................................................. 13
    3.3.2 Olsson et al., 2010. Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth ................................................................................ 13
    3.3.3 Olsson et al., 2005. Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth ................................................................................. 14
    3.3.4 Woolhouse et al., 2012. Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood .................................................................................. 14
  3.4 Valg af teori ............................................................................................................................ 15
  3.5 Opsummering af metode ....................................................................................................... 16
4.0 Analyse af samlivet efter fødslen og jordemoderens vejledningsmuligheder ......................... 16
  4.1 Analysestrategi ...................................................................................................................... 16
  4.2 Hvordan oplever henholdsvis nybagte mødre og fædre deres samliv efter fødslen .......... 17
    4.2.1 Seksualitetens nye udtryk ........................................................................................... 17
    4.2.2 Træthed og prioritering ............................................................................................... 18
    4.2.3 Parforholdets roller .................................................................................................... 18
    4.2.4 Kropsforandringer ...................................................................................................... 20
    4.2.5 Bekræftelse fra partner .............................................................................................. 21
  4.3 Hvordan kan jordemoden vejlede parret? ............................................................................. 22
    4.3.1 Bekræftelse fra jordemoderen .................................................................................... 22
    4.3.2 Kommunikation .......................................................................................................... 23
  4.4 Analyseresultater ................................................................................................................... 26
5.0 Diskussion af analyseresultater samt projektets metodik ....................................................... 27
  5.1 PLISSIT-modellen som jordemoderfagligt redskab ............................................................... 27
    5.1.1 Jordemoderkonsultation .............................................................................................. 28
5.1.2 Forældre- og fødselsforberedelse...............................................................29
5.1.3 Efterfødselskonsultation........................................................................29
5.2 Implementering af PLISSIT-modellen i svangreomsorgen..........................30
5.3 Diskussion af empiri, teori samt projektets metode.................................31
  5.3.1 Kritik af empiri.......................................................................................31
  5.3.2 Kritik af teori.........................................................................................33
  5.3.3 Kritik af projektets metode.................................................................33
6.0 Konklusion....................................................................................................35
7.0 Litteraturliste...............................................................................................36
8.0 Bilagsfortegnelse..........................................................................................39
1.0 Problemstilling

I Danmark sker halvdelen af skilsmisser blandt ægtepar med fælles børn inden det yngste barn fylder 10 år, og der er størst skilsmissehyppighed når barnet er 5 år (Danmarks Statistik, u.å.A). I alt endte halvdelen af alle ægteskaber, både med og uden børn, i skilsmisse i 2016 (Danmarks Statistik, u.å.C). Det skal bemærkes, at statistikken ikke tager hensyn til samlevende par, som går fra hinanden, men udelukkende gifte par, der udgør majoriteten af parforhold i Danmark (Danmarks Statistik, u.å.B). I en stor undersøgelse foretaget af Rockwool Fondens Forskningsenhed og Danmarks Statistik, er par uden hjemmeboende børn generelt lidt mere tilfredse med deres forhold end par med børn (Rockwool Fondens Forskningsenhed & Danmarks Statistik, 2015, s.58-59). Så hvorfor går så mange par med små børn fra hinanden?

Ifølge Margareta Bróden (hereafter Brodén) går mange par fra hinanden i barselsperioden (Brodén, 2004, s.73). Brodén beretter, at oplevelsen af at få et barn, er en af de vigtigste og mest livsforandrende begivenheder. Ydermere hævder Brodén, at graviditeten tilbyder udviklingsmuligheder for på det føllesesmæssige plan at forberede parret på at blive forældre, idet parret i svangerskabet er føllesesmæssigt tilgængeligt, hvilket har stor betydning for udviklingen af forældreskabet (Brodén, 2004, s.308). Teorien underbygges af Sundhedsstyrelsen, som i Anbefalinger for Svangreomsorgen fastslår, at det at få et barn, er det mest livsomvæltende begivenhed, både psykologisk, socialt og fysiologisk. Det konstateres, at den psykologiske proces med forældredannelse og tilknytning mellem barn og forældre i høj grad er bestemt af den støtte der ydes i graviditeten og barselsperioden (Sundhedsstyrelsen, 2013, s.187).

I henhold til Anbefalinger for Svangreomsorgen anbefaler Sundhedsstyrelsen, at alle kommende forældre tilbydes fødsels- og forældreforberedelse. Undersøgelser viser, at parret ønsker at beskæftige sig med sociale, føllesesmæssige og psykologiske aspekter af forældrerollen. Det foreslår, at det kommende forældrepar forberedes på udviklingen af forældreskabet, herunder familiedannelse, ændringer i par-relATION og samliv, forældrerollen og moder- og faderfølelser. Men ifølge Sundhedsstyrelsen ved vi stadig kun lidt om, hvilket indhold forberedelsen bør have, for at være tilpasset kommende forældrepar i dag (Sundhedsstyrelsen, 2013, s.147-148).

Ifølge vejledningen om jordemoderens virksomhedsområde er det jordemoderens opgave at vejlede om familieplanlægning og forberede det kommende forældrepar til fødslen, barselsperioden og forældreskabet (Sundhedsstyrelsen, 2001). Jeg har i løbet af min tid som jordemoderstuderende observeret forældre- og fødselsforberedelse på Hvidovre Hospital, Nordsjællands Hospital,
Næstved Sygehus samt hos det private firma Hélt. På Hvidovre Hospital foregår undervisningen i et auditorie, mens det på Nordsjællands Hospital, Næstved Sygehus og hos Hélt foregår på mindre hold. Fælles for alle steder er, at undervisningen primært har indeholdt overordnet information om selve fødslen med fokus på fødslens faser og smertelindring. Informationen om barselsperioden har især fokuseret på amning og pleje af den nyfødte, og i langt mindre grad på parforholdet efter fødslen. Parnene er på alle hold blevet opfordret til at stille spørgsmål og inndrage egne erfaringer og bekymringer. Jeg har imidlertid oplevelsen af, at det for de fleste er svært at snakke om følelsesmæssige aspekter af forældreskabet, og navnlig de mere intime følelser omkring samlivet med partneren både under graviditeten og efter fødslen. Der ligger samtidig meget forældre- og fødselsforberedelse i jordemoderkonsulationerne, men min erfaring er, at der også her primært er fokus på graviditeten og fødslen, mens barselsperioden og parforholdet ikke diskuteres i lige så høj grad. Jeg finder det derfor væsentligt at undersøge, hvordan jordemoderen kan facilitere kommunikationen omkring de mere følsomme emner i barselsperioden.

Jordemoderfaglig omsorg bør ifølge de etiske retningslinjer for jordemødre, tage afsæt i det enkelte forældrepar og deres individuelle ønsker og behov, da det er parrets graviditet, fødsel og barsel jordemoderen varetager. Det er derfor vigtigt, at jordemoderen tager udgangspunkt i parrenes egne oplevelser og erfaringer (Jordemoderforeningen, 2010). Jeg anser det derfor som værende relevant at undersøge, hvordan henholdsvis nybagte mødre og fædre oplever samlivet efter fødslen, således at jordemoderen kan forberede det kommende forældrepar på, at parterne kan opleve det at blive forældre forskelligt. Min tese er, at jordemoderen dermed kan medvirke til, at parrene styrkes i at håndtere de mulige udfordringer, og på den måde forhåbentlig forebygge, at parrene går fra hinanden.

På baggrund af ovenstående, er jeg nået frem til følgende problemformulering:

2.0 Problemformulering

Hvordan oplever henholdsvis nybagte mødre og fædre deres samliv efter fødslen, og hvordan kan jordemoderen med baggrund i denne viden vejlede parret, således at de styrkes i at håndtere mulige udfordringer i samlivet?
2.1 Afgrænsning af problemformuleringen

I projektet afgrænser ”samliv” ikke kun til det seksuelle mellem parret, men bruges i stedet som et bredt begreb, der henviser til det at leve sammen med et andet menneske i et parforhold (Det Danske Sprog- og Litteraturselskab, u.å.). Der findes et utal af familiekonstellationer, og det er svært at sige, hvad der i dag er en normal familie. Ifølge Danmarks Statistik (u.å.) består størstedelen af familier dog af heteroseksuelle par, hvorfor der i dette projekt udelukkende fokuseres på parforhold bestående af en kvinde og en mand. ”Efter fødslen” afgrænser her i projektet fra barnet fødes indtil 3,5 år efter, idet det er den længste periode postpartum at interviewene er foretaget (Woolhouse et al., 2012). Jeg har i projektet valgt at fokusere på både førstegangs- og flergangsforældre, da der ikke skelnes mellem dette i de fremsøgte studier. Når der tales om samliv, parforhold, moderskab og faderskab er der flere perspektiver at anlægge på problemet. Jeg har valgt i dette projekt primært at anlægge et psykologisk perspektiv på problemstillingen, hvorfor jeg ikke har fokus på de samfundsmæssige diskurser.

3.0 Projektets metode, empiri og teori


3.1 Videnskabsteoretisk tilgang


Hermeneutikkens søsterdisciplin er fænomenologien, som er en filosofisk retning, der søger at belyse, hvordan tingene viser sig for det enkelte menneske i forhold til personens livsverdensammenhæng. Fænomenologien er formuleret af Edmund Husserl, og senere hen nuanceret af flere tænkere. Videnskabens tilgang er, at vi altid allerede er i verden, hvilket Husserl kalder *intentionalitet*. Begrebet henviser til, at bevidstheden altid er rette mod noget, hvilket betyder, at videnskaben skal undersøge den umiddelbart levede verden, som er subjektiv for hvert enkelt menneske. Den fænomenologiske tilgang søger ikke efter årsager, men efter sammenhænge ved at analysere de subjektive bevidsthedsfænomener og dermed finde det meningsindhold, som fænomenerne afspejler (Birkler, 2010, s.103-111; Thisted, 2010, s.54-56). Den fænomenologiske tilgang benyttes i projektet, fordi fænomenologien lægger vægt på de oplevelsesmæssige sider af fænomener (Thisted, 2010, s.54), hvilket problemformuleringen spørger til.

Projektets fortolkningsvidenskabelige tilgang leder frem til at undersøge problemformuleringen ved hjælp af den kvalitative metode. Dette er for det første valgt, fordi datamaterialet ved kvalitativ


3.2 Søgestrategi samt valg af empiri

I dette afsnit beskrives den anvendte søgestrategi, og dernæst argumenteres for udvælgelsen af projektets empiri.


Der er på alle databaser foretaget fritekstsøgning, da jeg søger svar på en problemformulering, som opererer inden for det humanvidenskabelige område (Glasdam, 2011, s.37-40). Af samme årsag, har jeg anvendt værktøjet Population Exposure Outcome (herefter PEO) til at fastlægge nøgleord til fritekstsøgningen (University of Suffolk, 2017). Der er søgt med forskellige kombinationer af nøgleordene.

PEO-skema:

<table>
<thead>
<tr>
<th>Population</th>
<th>Exposure</th>
<th>Outcomes for themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Men</td>
<td>- Childbirth</td>
<td>- Intimacy</td>
</tr>
<tr>
<td>- Man</td>
<td>- Puerperium</td>
<td>- Sexuality</td>
</tr>
<tr>
<td>- Father</td>
<td>- Parturition</td>
<td>- Life together</td>
</tr>
<tr>
<td>- Fatherhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Parenthood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Woman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Motherhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Co-parent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Kriterier for inklusion og eksklusion var som følger;

Inklusionskriterier:

- Studier fra moderne vestlige lande, hvis praksis er vurderet sammenlignelig med dansk praksis.
- Engelsk eller skandinavisk sprog.
- Enkeltstudier.
Eksklusionskriterier:

- Studier med fokus på decideret psykiske problemer.
- Meget unge teenage forældre.
- Andre familiekonstellationer end en kvinde og en mand.

Ved læsning af titel og resume blev der i alt fundet 30 relevante artikler (dubletter frataget). Disse blev gennemlæst og reduceret til fire artikler ud fra de beskrevne inklusions- og eksklusionskriterier samt relevans for besvarelsen af problemstillingen. Som dokumentation for og uddybning af den systematiske litteratursøgning henvises til bilag 1, 2 og 3, der indeholder detaljerede tabeller over de enkelte søgninger.

Som kontrol af den systematiske søgning er der ydermere foretaget en kædesøgning via referencer fra andre artikler (Glasdam, 2011, s.37). Herved fremkom yderligere 12 artikler, hvoraf ingen fandtes brugbare. Endelig er søgt supplerende via Google Scholar og Bibliotek.dk, hvor ingen nye artikler fandtes relevante.

De fire relevante artikler fra den systematiske søgning er herefter valideret ved hjælp af Kirsti Malteruds (herefter Malterud) tjekliste til metodekritisk gennemgang af kvalitative artikler og alle fundet egnete til projektet (se bilag 4). Malterud beskriver tjeklisten som værende et arbejdsredskab til kvalitetsvurdering for klinikere. Alle spørgsmål skal dog ikke besvares med ”ja”, for at artiklen kan vurderes god, idet det ifølge Malterud er en illusion at kunne foretage studier, der opfylder alle kriterierne (Malterud, 2013, s.210-218). Alle fire studier blev fundet brugbare, hvorfor disse artikler er projektets primære empiri til besvarelse af problemstillingen:

- MacAdam et al., 2011. Fathers’ experience after having a child: sexuality becomes tailored according to circumstances (Bilag 5)
- Olsson et al., 2010. Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth (Bilag 6)
- Olsson et al., 2005. Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth (Bilag 7)
- Woolhouse et al., 2012. Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood (Bilag 8)
3.3 Præsentation af empiri
I nedenstående afsnit redogøres for den primære empiri, der efter systematisk litteratursøgning er udvalgt til at besvare problemformuleringen.

3.3.1 MacAdam et al., 2011. Fathers’ experience after having a child: sexuality becomes tailored according to circumstances.
Dette er et kvalitativt studie, foretaget fra november 2008 til april 2009 i Sverige, som ønsker at identificere og beskrive mænds oplevelse af seksualitet efter fødslen. 12 mænd, både førstegangs- og flergangsfødre, deltog i et dybdegående semi-struktureret interview, 6-13 måneder efter fødslen af deres barn. Fædrenes udtalelser samles til et centralt tema: Udtrykket af seksualitet accepteres og modificeres til omstændighederne i forhold til at få et barn. Hovedtemaet inddeles ydermere i 4 undertemaer:

- En ny form for nærhed pga. ikke-eksisterende seksualitet umiddelbart efter fødslen.
- Udtrykket af seksualitet påvirkes af konsekvenserne af at tage sig af barnet.
- Udtrykket af kærlighed og omsorg prioriteres over seksuelle aktiviteter.
- Faderens oplevelse af seksualitet er begrænset af gengældelsen fra partneren.

Studiet konkluderer, at udtrykket af seksualitet ændres efter fødslen for at passe ind i det nye liv med barnet. Sundhedsprofessionelle bør give information til både kvinden og manden om seksualitet efter fødslen, og at denne information ikke kun bør omhandle seksuelle aktiviteter, men i lige så høj grad, hvordan udtrykket af seksualitet kan ændre sig. Parrene bør informeres både før og efter fødslen (MacAdam et al., 2011).

3.3.2 Olsson et al., 2010. Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth.
Studiet er et kvalitativt studie, foretaget fra maj til august 2006 i Stockholm i Sverige, hvis mål er at beskrive fædrenes oplevelse af seksuallivet i løbet af de første 6 mdr. efter fødslen. 10 mænd, både førstegangs- og flergangsfødre, deltog i enten fokusgruppe diskussioner (2 grupper med henholdsvis to og tre deltagere) eller i et individuelt semi-struktureret interview (fem deltagere), 3-6 måneder efter fødslen af deres barn. Det overordnede tema, som fremkom af fædrenes udtalelser, var: Overgangen til faderskabet bringer det seksuelle liv til en korsvej. De 3 undertemaer var som følger:
• Kæmper mellem stereotyper og personlig opfattelse af maskulin seksualitet under overgangen til faderskabet.
• Ny rammer for at forhandle sex.
• Et behov for at føle tryghed og i ro i den nye familie situation.

Konklusionen på studiet er at nybagte fædre sætter barnet i fokus og er villig til at udskyde sex, indtil begge parter er klar igen. Informationen skal tilrettelægges således, at den også passer til mænd, for at gøre overgangen til faderskabet nemmere (Olsson et al., 2010).

3.3.3 Olsson et al., 2005. Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth.
Dette er et kvalitativt studie foretaget i Stockholm i Sverige fra 2001-2003. Målet for studiet er at belyse, hvordan nogle kvinder oplever seksuallivet med deres partner efter fødslen. 27 kvinder, både primi- og multipara, deltog i fokusgruppeinterview 3-24 måneder efter fødslen. Ud fra kvindernes udtalelser, fremkom fire temaer:

• Kropsbillede efter fødslen.
• Stress over det nye familieliv ændrer sex mønstrene.
• Uoverensstemmelse med seksuel lyst hos partneren.
• Bekræftelse.

Studiet konkluderer, at kvinderne prioriterer basale nødvendigheder, såsom søvn samt optagethed af barnet, over det seksuelle liv med partneren. Kvinderne har behov for bekræftelse fra sundhedsprofessionelle i forhold til at deres krop, seksualliv og familieliv kan ændre sig efter fødslen (Olsson et al., 2005).

3.3.4 Woolhouse et al., 2012. Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood.
Dette er et kvalitativt studie, der fokuserer på kvinders oplevelse af ændringer i deres seksuelle forhold, seksualitet og intimitet, som et resultat af graviditet, fødsel og det at være forældre. Det er foretaget fra maj til oktober 2009 i Melbourne i Australien. 18 kvinder, både primi- og multipara deltog i individuelle interview 2½-3½ år efter første fødsel. Af studiet fremkom 3 temaer:

• Psykosociale faktorer påvirker sex og intimitet.
Ændringer i seksuelle og intime forhold.
Faktorer der hjælper.

Det konkluderes, at graviditet, fødsel og det at være forældre kan forårsage signifikante ændringer i intime forhold og kvinders syn på sex og seksualitet. Åben dialog omkring de fysiske, følelsesmæssige og sociale udfordringer i overgangen til moderskabet, kan være gavnlig (Woolhouse et al., 2012).

3.4 Valg af teori

I nedenstående afsnit præsenteres projektets teoretiske fundament. Idet der ikke findes et dækkende teoriapparat til at besvare min problemstilling, har jeg valgt at benytte elementer fra flere forskellige teoretiske perspektiver. Disse præsenteres kort her inddelt efter publikation.

Når to bliver til tre: At skabe en familie sammen (2006)

Lisbeth Liebmann (herefter Liebmann) er uddannet psykolog ved Københavns Universitet i 1989 og er specialistgodkendt i psykoterapi og børnepsykologi. Hun har flere forskellige teoretiske baggrunde, herunder psykodynamisk, kognitiv, systemisk og narrativ (Psykologerne i Nordsjælland, u.å.).

Gitte Haag (herefter Haag) er uddannet som psykolog ved Københavns Universitet, og er ydermere specialist i børnepsykologi (Gitte Haag, u.å.).

Fædre og fødsler (1999)

Svend Åge Madsen (herefter Madsen) er udannet psykolog fra Århus Universitet siden 1981 og efterfølgende klinisk specialist og ph.d. (Svend Aage Madsen, u.å.).

Hanne Munck (herefter Munck) er klinisk psykolog og lektor (Madsen, Munck & Tolstrup, 1999).

Marianne Tolstrup (herefter Tolstrup) er jordemoder (Madsen, Munck & Tolstrup, 1999).
Graviditetens muligheder (2004)

Margareta Brodén er børnepsykolog og autoriseret psykoterapeut (Brodén, 2004).

Ventetiden (1996)

Lisbeth F.K. Holter Brudal (herefter Brudal) er psykolog og har udviklet sit eget område indenfor psykologien: Fødselspsykologi (Gyldendal, u.å.).

The Behavioral Treatment of Sexual Problems: Volume 2 Intense Therapy (1975)


3.5 Opsummering af metode

Ud fra min hermeneutiske tilgang har jeg præsenteret min primære empiri til besvarelse af første del af problemstillingen i form af fire studier; to, der fokuserer på kvinders oplevelser, samt to, der fokuserer på mænds oplevelser. Jeg vil således samle elementer fra den første del af problemstillingen ved hjælp af teoretiske elementer fra Liebmann, Haag, Madsen, Munck, Tolstrup, Brodén samt Brudal og efterfølgende bruge og applikere disse i anden del af problemstillingen via Annon’s PLISSIT-model.

4.0 Analyse af samlivet efter fødslen og jordemoderens vejledningsmuligheder

4.1 Analysestrategi

Følgende afsnit indeholder en analyse af projektets empiri op imod det teoretiske fundament. Afsnittet er inddelt i to overordnede afsnit svarende til de to spørgsmål i projektets problemformulering: "Hvordan oplever henholdsvis nybagte mødre og fædre deres samliv efter
fødslen” og ”Hvordan kan jordemoderen vejlede parret”. Problemformuleringen søges besvaret via en analyse af projektets fire udvalgte studier. Studierne er gennemlæst og inddelt i forskellige temaer omhandlende henholdsvis kvindernes og mændenes oplevelse af samlivet efter fødslen. For yderligere indsigt i tematisering af studierne henvises til bilag 9. De fremkomne temaer analyseres med udvalgte teoretiske elementer, som tidligere fremstillet i afsnit 3.4 ”Valg af teori”. De enkelte resultater føres løbende tilbage op imod analysen som helhed, i henhold til den hermeneutiske metode beskrevet i afsnit 3.1 ”Videnskabsteoretisk tilgang”.

4.2 Hvordan oplever henholdsvis nybagte mødre og fædre deres samliv efter fødslen

I dette afsnit benyttes, som tidligere beskrevet i afsnittet ”Begrundelse for valg af teori”, teoretiske elementer fra Liebmann, Haag, Madsen, Munck, Tøstrup, Brodén samt Brudal til analyse af den primære empiri for at besvare første del af problemstillingen.

4.2.1 Seksualitetens nye udtryk

Et gennemgående tema hos både mænd og kvinder er, at seksualiteten efter fødslen har ændret udtryk. Parrene beskriver, at lysten og overskuddet til seksuelle aktiviteter er nedsat. I stedet opstår der en speciel nærhed mellem parrene, som på den måde bliver det nye udtryk for kærlighed og seksualitet. En mand forklarer: ”You can still show affection and still have a form of sexuality with each other without the intercourse part” (MacAdam et al., 2011, s.149). Vilkårene for samlivet er ændret for parrene pga. deres nye forældrerolle, og parrene oplever, at de har mere fokus på at gøre små ting for at glæde partneren i hverdagen (MacAdam et al., 2011). At opretholde et godt fysisk og følelsesmæssigt parforhold er ifølge parrene afhængig af samhørighed og samarbejde med fælles ansvar for det nye liv (Woolhouse et al., 2012). Ifølge Liebmann & Haag påvirker de nye forældreroller samlivet og en gavnlig fremgangsmåde til at styrke parforholdet, er ved at parrene give hinanden omsorg via kærtegn (Liebmann & Haag, 2006, s.264). For nogle kvinder hører fysisk og psykisk intimitet imidlertid sammen, så for disse kvinder betyder den nedsatte sexfrekvens at intimiten i parforholdet som helhed er forringet: ”Because we don’t have sex very often now at all, a lot of the intimacy has gone as well[…]” (Woolhouse et al., 2012, s.188).
4.2.2 Træthed og prioritering
En essentiel faktor for den ændrede sexlyst er træthed. Begge parter oplever trætheden hos sig selv og hos partneren. En mand udtaler: "…you don’t get the time for just being close and sometimes you are tired and don’t have the same vigour and sex-drive I can feel" (MacAdam et al., 2011, s.152). Nogle af symptomerne på stress er ifølge Liebmann & Haag nedtrykthed, manglende sexlyst og mangel på spontanitet (Liebmann & Haag, 2006, s.258). Når barnets behov er opfyldt og husholdningen klar, prioriterer parrene at bruge tiden på at sove i stedet for seksuelle aktiviteter (Woolhouse et al., 2012). Både kvinder og mænd anser ydermere tid alene, med og uden partneren som vigtigt, men beskriver samtidig, at det er svært at finde tid uden børn. For at gøre overgangen til forældreskabet lettere mener kvinderne, at det er vigtigt at blive enige om prioriteringerne (Olsson et al., 2005; Woolhouse et al., 2012; MacAdam et al., 2011). Vigtigheden af at parret arbejder sammen, beskrives af Liebmann & Haag, som understreger, at parforholdet og sexlivet gives de bedste forudsætninger, når parret betragter det som værende et fælles anliggende (Liebmann & Haag, 2006, s.255).

4.2.3 Parforholdets roller
En gennemgribende oplevelse hos både kvinderne og mændene er, at de føler et forventningspres fra flere fronter. Forventningspresset kommer til dels fra samfundet og dels indefra dem selv. Mændene beskriver, at det samfundsmæssige syn på maskulin seksualitet er anderledes, end hvordan de selv opfatter deres seksualitet som nybagte fædre (Olsson et al., 2010). Mens medierne lægger vægt på, at mænd har større sexlyst end kvinder og at seksuelle aktiviteter er det mest betydningsfulde i et forhold, så ser mændene det som en naturlig del af livet, at sexlysten og -frekvensen falder efter at have fået et barn:

Where is the distinction between sex and no sex? Just being physical lying together naked and touching each other in a gentle, loving way? But what the fuck (sigh). In all the newspapers, like this – how often do you have intercourse? It is ups and downs; it is such a fuss around it [seuxal life]. (Olsson et al., 2010, s.720)

Mændene accepterer således ændringer i seksuallivet, som de allerede inden graviditeten havde forventet ville ske. Disse forventninger er ledt på vej af samtaler med venner og partneren samt via
ugeblade. Mændene er ikke i tvivl om, at det seksuelle samliv vil vende tilbage til parrets norm, men de bliver dog stadig overraskede over, hvor lang tid, det tager (Olsson et al., 2010). For kvinderne kommer forventninger i højere grad indefra i form af skyldfølelse overfor partneren og bekymring for parforholdet. De fleste kvinder fortæller, at deres sexlyst er nedsat, men at de føler, at det er deres pligt at opretholde et tilfredsstillende seksualliv for partnerens skyld. Det medfører, at kvinderne i nogle tilfælde lyver om deres sexlyst for ikke at sige nej til partneren: ”It might hurt the partner if you say no (to have sex). You pretend to feel desire and that you are having an orgasm […]” (Olsson et al., 2005, s.385). Den nedsatte sexlyst følges som et nederlag og kvinderne ser det som tabu at snakke om det (Woolhouse et al., 2012).

Ligesom mændene, er kvinderne sikre på, at sexlysten vil vende tilbage med tiden, og det er her det ambivalente forhold til seksuelle aktiviteter opstår. På den ene side har kvinderne ikke lyst, men på den anden side mener de, at sexlysten hurtigere vil vende tilbage, hvis de forsøger uden lyst: ”To touch each other creates desire and the more you touch, the more you desire” (Olsson et al., 2005, s.385). Dette udsagn støttes af Liebmann og Haag, som fremstiller, at jo længere, der går før sexlivet kommer i gang igen, jo sværere bliver det. De mener derfor, at det kan være nødvendigt at planlægge, således at tiden og rummet til seksuelle aktiviteter skabes i en hverdag styret af barnets behov, som besværliggør spontanitet. De understreger samtidig, at der ikke er noget rigtigt eller forkert i forhold til samlivet. Det vigtigste er, at parrets forventninger og behov er afstemt (Liebmann & Haag, 2006, s.263-266).

afstand mellem parterne, som en kvinde udtaler: "I stay up on purpose until he has fallen asleep, in order not to have to say no to sex" (Olsson et al., 2005, s.385).

Woolhouse et al. beskriver, at kvinder, som tidligere har delt ansvaret for husholdningen ligeligt med deres partner, oplever, at der opstår mere stereotype kønsroller efter barnets fødsel, og at dette skaber konflikter i parforholdet. En kvinde fortæller: "There becomes these assumed roles, and that pisses me off[…]" (Woolhouse et al., 2012, s.187). Mændene er enige i, at parterne håndterer den nye hverdag forskelligt og at det har indflydelse på parforholdet. Mændene mener dog, at kvinderne har for meget fokus på praktiske pligter i stedet for at fokusere på forholdet til barnet (Olsson et al., 2010). Ifølge Madsen, Munck & Tolstrup udvikles forældreskabet ud fra de erfaringer, individet har gjort i sin opvækst, samt hvordan man bearbejder erfaringer fra livet og i løbet af graviditeten, fødslen og spædbarnstiden. Det er derfor naturligt, at der er forskel på kvinders og mænds forældreskab i kraft af kønsspecifikke forhold i deres opdragelse (Madsen, Munck & Tolstrup, 1999).

4.2.4 Kropsforandringer
Efter fødslen oplever kvinderne mange fysiske forandringer og for nogle betyder forandringerne, at de ikke længere føler sig attraktive. Kvinderne udtrykker, at forandringerne virker permanente og de føler, at de har mistet kontrollen. Deres tanker omkring deres bryster har ændret sig, eftersom brysterne har ændret form efter graviditeten og ikke længere ses som noget seksuelt appellerende i kraft af amning, og de føler nu, at brysterne tilhører barnet (Olsson et al., 2005; Woolhouse, 2012). Kvinderne er bekymrede over, hvilken betydning fødselsbristninger og vaginale forandringer har på deres samliv med partneren: "I do not feel happy with my body. Pregnancies and babies deplete it. The breasts get smaller and my vagina is not as tight as before" (Olsson et al., 2005, s.383). I modsætning til denne kvinde, føler andre kvinder, at de har fået mere respekt og en større forståelse for deres krop. Disse kvinder accepterer kropsforandringer som en naturlig del af at blive mor (Olsson et al., 2005; Woolhouse, 2012). Mændene er enige i, at anningen betyder, at brysterne nu er forbundet barnets behov, men de oplever det ikke som værende problematisk for samlivet. I stedet anser de kvinders kropsforandringer som smukke (Olsson et al., 2010). Nogle mænd er dog bekymrede for at forvolde kvinden fysisk skade pga. fødselsbristninger (MacAdam et al., 2011). Kvinderne beretter, at partneren ikke giver udtryk for, at være misforståede med kvinders kropsforandringer, men at utilfredsheden med deres krop kommer inde fra kvinderne selv. Nogle
kvinder har imidlertid svært ved at tro på mændene (Olsson et al., 2005). Muligvis er det det ændrede selvbillede, der i virkeligheden er betydningsfuld for kvinderne i forhold til sexlyst. Flere kvinder udtaler, at de har svært ved at forene moderrollen med rollen som Seksuel partner: "[...]conflicting role to be a mother and a nurturer on one side, and a whore in the bedroom[...]")(Woolhouse et al., 2012, s.188). Denne følelse er ifølge Liebmann & Haag ikke ukendt for forældre til små børn, som i hverdagen skal bevare kontrollen og uforbeholdent tilsidesætte egne behov. Men ved det seksuelle samliv drejer det sig derimod om at give slip på kontrollen og sætte egne behov forrest. Det kan være en svær omstilling for parrene, og især for kvinden, der som tidligere nævnt føler stort behov for kontrol af hverdagens praktiske gøremål grundet læfte kønsroller (Liebmann & Haag, 2006, s.257).

4.2.5 Bekræftelse fra partner
Et gennemgående tema for både mænd og kvinder, er behovet for bekræftelse fra deres partner. Kvinderne, har som tidligere nævnt, behov for, at partneren forsikre dem om, at de stadig er tiltrækkende trods kropsforandringerne i forbindelse med graviditeten og fødslen (Olsson et al., 2005). Mændenes behov for bekræftelse har at gøre med det faktum, at de føler sig udenfor symbiosen mellem moderen og barnet. De søger, at de skal konkurrere med barnet om moderens opmærksomhed (Olsson et al., 2010; MacAdam et al., 2011). Mændene reagerer forskelligt på situationen. Nogle trækker sig væk og bruger mere tid på arbejde eller hobbyer, mens andre involverer sig mere for at blive en del af fællesskabet: "I think it is important to be there… if the mother and child becomes one unit, it will be too much 'they' and you will be left out a bit[...]") (Olsson et al., 2010, s.720). Mændene fortæller, at de ikke længere føler sig som første prioritet i deres partners liv, og dette gør dem jaloux. De beskriver, at grunden til denne udelukkelse er, at deres partner er overvældet af den fysiske nærhed med barnet og at barnet nu opfylder kvindernes behov for kærlighed (MacAdam et al., 2011; Olsson et al., 2010). Kvinderne deler denne opfattelse, idet de beskriver, at den følelsesmæssig tilknytning med barnet kan medføre, at intimiteten med manden nedprioriteres (Woolhouse et al., 2012; Olsson et al., 2005). Ifølge Brodén kan det være svært for kvinder at have flere nære relationer og dele deres opmærksomhed. Kvindens optageteth af barnet, kan såre parteneren og resulterer i, at han føler sig udenfor (Brodén, 2004, s.73). Teorien underbygges af Liebmann og Haag, der beretter, at kvindens følelser for barnet er så stærke, at der ikke er plads til parteneren, hvilket gør ham jaloux (Liebmann & Haag, 2006, s.256-257).
Nogle mænd oplever, at det altid er dem, der indleder til seksuelt samvær med parteneren. Det skaffer mændene og leder til, at de har brug for bekræftelse af deres seksualitet som mand. For disse mænd kommer seksuelle aktiviteter til at afhænge af gengældelsen fra parteneren (MacAdam et al., 2011). Liebmann og Haag beretter, at mens de fleste kvinder skal føle sig anerkendt for at have lyst til sex, har mange mænd brug for at have sex for at føle sig anerkendt. Parrene må vide dette om hinanden, ellers opstår der dissonans og utryghed som resulterer i et utilfredsstillende sexliv. Samtidig kan gentagne afvisninger af ønsker om seksuelt samvær eller anden nærhed være meget sårende og føre til, at den afviste part begynder at gøre gengæld. Dette kan skabe en afstand mellem parret og gøre lysten til nærhed og hengivenhed mindre (Liebmann & Haag, 2006, s.257+262).

4.3 Hvordan kan jordemoderen vejlede parret?
I dette afsnit samles elementer fra analysen af første del af problemstillingen til besvarelse af anden del af problemstillingen ved hjælp af Annons teori om PLISSIT-modellen, som tidligere præsenteret i afsnittet ”Begrundelse for valg af teori”.

4.3.1 Bekræftelse fra jordemoderen
I Sverige, hvor studierne af Olsson et al. 2005 & 2010 er foretaget, er der tilbud om et besøg hos jordemoderen ca. 6 uger efter fødslen (Øresunddirekts Informationscenter, u.å.). Til dette besøg, ønsker både mænd og kvinder bekræftelse fra jordemoderen i forhold til overgangen til forældreskabet. Mændene oplever, at der er mere fokus på barnet end på parforholdet og seksualitet. De ville i stedet gerne bekræftes i, at overgangen til faderskabet tager tid og ønsker konkrete eksempler på, hvordan parforholdet ændres efter fødslen: “[...]so that later on we can look at each other and say 'this is exactly what they talked about’” (Olsson et al., 2010, s.722). Desuden mener de, at det er vigtigt at tale om sex på en afslappet måde (Olsson et al., 2010). Kvinderne istemmer behovet for at tale med jordemoden om samlivet efter fødslen, herunder følelser og deres nedsatte sexlyst. Samtidig vil de gerne tale om fysiske ændringer, og dermed bekræftes af en sundhedsprofessionel i, at deres kroppe er vendt tilbage til det normale (Olsson et al., 2005).

Ifølge Brudal har både kvinder og mænd et stort behov for oplysninger omkring seksualitet både før og efter fødslen. Brudal beretter, at par, som før graviditeten har kunnet tale åbent om deres seksuelle samliv, nu kan have svært ved at tale om det under graviditeten og efter fødslen. Det
fastslås, at den primære grund til dette er usikkerhed og uvidenhed, og at det danner grønbund for misforståelser (Brudal, 1996, s.82). Brudal understreger, at de fleste par er uforberedt på, at seksuallivet kan ændre sig efter fødslen og at nogen bliver overrasket, når sexlysten helt forsvinder (Brudal, 1996, s.76). Liebmann & Haag påpeger desuden, at fordi sexlivet fylder mindre efter fødslen, kan de nybagte forældre tvive på om de virkelig elsker hinanden og passer sammen som par (Liebmaan & Haag, 2006, s.265).

4.3.2 Kommunikation

For mændene er kommunikation omkring seksualitet det vigtigste for at opretholde et godt parforhold, uanset om parrene har et aktivt seksualliv eller ej. Mændene mener, at humor er et godt redskab til at holde det afslappet (Olsson et al., 2010). Mændene beretter, at kommunikation er grundlaget for, at opretholde en fælles forståelse i forholdet, og at kommunikation og seksualitet er tæt forbundet: "If the communication doesn’t work, then the sexuality probably doesn’t work and the sex life not especially well either and tenderness and closeness and all that…” (MacAdam et al., 2011, s.153). Kvinderne tilsletter sig mændenes holdning, idet de anser muligheden for at kunne diskutere udfordringer i samlivet på en ordentlig måde uden kritik eller skyldspålæggelse, som værende essentiel for at undgå fremtidige konflikter i parforholdet. (Olsson et al., 2005). Kvinderne mener samtidig, at kommunikation medfører, at parret fører sig forbunds, hvilket gør overgangen til forældreskabet nemmere (Woolhouse et al., 2012). Ifølge Brodén er der kontinuitet mellem graviditeten og tiden efter fødslen (Brodén, 2004, s.60). Brodén konstaterer, at parrets evne til at dele tanker og følelsesmæssige oplevelser under graviditeten, danner fælles basis for forældreskabet og den nye familie (Brodén, 2004, s.73). Ydermere fastslår Liebmann & Haag, at for mange store konflikter påvirker seksuallivet. Parrene kan pga. dårlig kommunikation i skænderier, komme til at bruge intime oplysninger, som de tidligere har delt i fortrolighed, hvilket opleves som tillidsbrud og misbrug af intimiteten (Liebmann & Haag, 2006, s.261-262).

Men som tidligere nævnt, er det ifølge Brudal ikke altid nemt at tale om seksualitet, især ikke under graviditeten eller efter fødslen. Brudal foreslår, at det der kan hjælpe på seksuelle udfordringer, er at læse om andres oplevelser, for at vide, at man ikke er alene. Det understregeres, at der ikke findes noget normalt eller unormalt i forhold til følelser, men at det er vigtigt at have en viden om evt. forandringer både i forhold til humør, madlyst, søvn og seksualitet. Brudal fastslår samtidig, at
selvom parrene læser om samlivsproblemer, er det en anden ting at tale om dem (Brudal, 1996, s.82-85).


Som nævnt i afsnittet ”Bekræftelse fra jordemoderen”, har parrene behov for at få at vide, at det de oplever og føler er okay, for at de ikke føler sig unormale. Ifølge Annon, er mange ikke bekymret over deres egen opførsel, men i stedet af tanken om, at deres oplevelser er forkerte (Annon, 1975, s.250). Idet jordemoderen bekræfter parret i, at deres oplevelser er normale, giver jordemoderen samtidig parret tilladelse til at fortsætte på samme måde som hidtil. Dette beskriver Annon som Permission. Et vigtigt aspekt af denne tilgang er, at det er lige så essentielt at den sundhedsprofessionelle giver parret tilladelse til at lade være med at optage seksuallivet, eller dele heraf, hvis en eller begge parter ikke har lyst (Annon, 1975, s.250-252). Som påpeget i afsnittet ”Parforholdets roller”, ser kvinderne deres nedsatte sexlyst som tabu, og lyver derfor for deres partner i stedet for at tale med ham om det. Ved at jordemoderen giver tilladelse til, at vente med at genoptage sexlivet, er kvindens oplevelse ikke længere tabu, hvorfor parret i stedet kan påbegynde kommunikationen omkring deres seksualliv. Fordelen ved denne tilgang er ifølge Annon, at den kan benyttes i flere forskellige sammenhænge og at den kun kræver lidt forberedelse fra den sundhedsprofessionelle. Samtidig med at tilgangen kan løse allerede eksisterende udfordringer, kan den også forebygge nye udfordringer i at udvikle sig (Annon, 1975, s.253).

2. niveau af PLISSIT modellen er Limited Information, hvor den sundhedsprofessionelle giver parret faktuel information, som er begrænset og tilpasset i forhold til deres seksuelle udfordringer.
Det kan både lede til, at parret fortsætter på samme måde som hidtil, eller at parret ændrer adfærd. Det essentielle er, at den sundhedsprofessionelle sørger for, at parret har sufficient viden til derefter at træffe et frit valg. Samtidig skal den sundhedsprofessionelle sørge for at begrænse information, således at parret kun modtager information, individualiseret efter deres behov (Annon, 1975, s.255-256). Som tidligere nævnt, havde mændene forventet en ændring i seksualivet, men blev overrasket over hvor lang tid tilbagevenden til normalen for parret tager. Mændene rådførte sig med venner og ugeblade, men havde ikke søgt information hos jordemoderen eller anden sundhedsprofessionel: "Prior to the birth you think, 'a few weeks abstinence’, but now when the child is born…it can be half a year" (Olsson et al., 2010, s.720). Det er derfor jordemoderens opgave at informere omkring mulige ændringer i seksualivet efter fødslen, således at parret er forberedt. Ifølge Annon, hører Limited Information ofte sammen med Permission, idet de to tilgange naturligt overlapper hinanden (Annon, 1975, s.256). I afsnittet ”Parforholdets roller” konstateres det, at mændene påvirkes af mediernes holdninger til kønsspecifik seksualitet, selvom de ikke kan genkende oplevelsen hos dem selv. Her kan jordemoderen forsyne manden med specifik information om ændringer i mandens seksualitet efter fødslen. Derved giver jordemoderen samtidig tilladelse til at det, manden føler, er naturligt på trods af samfundets syn på maskulinitet. Annon understreger vigtigheden af, at den sundhedsprofessionelle er opmærksom på, at informationen er afgrænset til parrets specifike udfordringer (Annon, 1975, s.256).

Sidste niveau af den kortvarige terapi, er ifølge Annon Specific Suggestions. Annon fastslår, at den sundhedsprofessionelle først må optage relevant information og dermed kortlægge parrets reelle udfordringer, for at kunne give gavnlige specifikke forslag til parrene. Hvis den sundhedsprofessionelle blot giver løsningsforslag ud fra parrets indledende forklaringer, overses de underlæggende problematikker og dermed gøres parrets udfordringer større (Annon, 1975, s.258). Som tidligere beskrevet, føler mændene sig ofte udenfor symbiosen mellem mor og barn, og trækker sig derfor i nogle tilfælde væk ved at bruge mere tid på andre ting end familien. Kvinden føler sig i forvejen ofte alene med ansvaret omkring den nye familie. Hun føler ikke, at manden anerkender hendes arbejde i hjemmet, hvilket resulterer i, at hendes lyst til sex og nærhed nedsættes yderligere. Manden har brug for at blive bekræftet, ved at kvinden engagerer hans sexlyst, for på den måde at få opmærksomhed og føle sig anerkendt i parforholdet: "I am not usually like this, needing attention in everything I do[…]So I don’t know if it was a counter reaction of feeling left out…” (MacAdam et al., 2011, s.152). Den umiddelbare udfordring for parret er således dissonans i forhold til sexlyst, men den underlæggende problematik er langt mere kompleks. Derfor må

### 4.4 Analyseresultater

I analysen ses at nybagte mødres og fødres oplevelser af samlivet efter fødslen er mangesidede. Seksualiteten i parforholdet ændrer udtryk, således at nærhed mellem parterne er vigtigere end deciderede seksuelle aktiviteter. Sexlysten og sexfrekvensen er nedsat, hvilket træthed, manglende overskud og tidspres hos forældrene er en essentiel grund til. Både kvinderne og mændene er dog overbeviste om, at sexlysten vil vende tilbage, og anser det som vigtigt at kommunikere åbent omkring udfordringerne og dermed forventningsafstemme deres behov.


Manglende kommunikation omkring problematikkerne leder til misforståelser og manglende forståelse for den anden parts situation, hvilket skaber følelsesmæssig afstand mellem parterne. Analysen viser, at både mænd og kvinder ønsker at diskutere og få information fra jordemoderen og andre sundhedsprofessionelle omkring alle disse psykiske og fysiske ændringer og udfordringer for at blive bekræftet i, at parrenes følelser og oplevelser ikke er forkerte eller unormale. Selvom parrene udtrykker, at de er klar over vigtigheden af åben kommunikation i forhold til alle aspekter
af deres samliv, viser analysen, at det kan være svært for parrene at tale sammen under graviditeten og efter fødslen.

Det ses i analysen, at jordemoderen ved at benytte Annons teori om PLISSIT-modellen, kan give tilladelse til, at parrenes psykiske og fysiske oplevelser ikke er unormale. Idet jordemoderen samtidig fremlægger begrænset information om forandringerne, vil parrene ikke længere opfatte deres følelser som tabubelagte. Når jordemoderen dernæst spørger ind til de umiddelbare udfordringer parrene oplever, afklares de mere komplekse underlæggende problematikker, og jordemoderen kan ud fra disse informationer komme med specifikke forslag til, hvordan parrene kan håndtere udfordringerne og indlede kommunikation omkring deres samliv.

5.0 Diskussion af analyseresultater samt projektets metodik

Følgende afsnit diskuterer brugen af PLISSIT-modellen som jordemoderfagligt redskab samt implementeringen af modellen i svangreomsorgen. Efterfølgende diskuteres styrker og svagheder ved projektets empiri, teori og metode.

5.1 PLISSIT-modellen som jordemoderfagligt redskab

Annon har, som tidligere nævnt, udformet PLISSIT-modellen, som er en model til kommunikation om seksuelle udfordringer. Efter at have applikeret PLISSIT-modellen på min empiri, finder jeg det muligt at overføre elementer fra modellen til kommunikation om andre følelsesmæssige udfordringer, parrene oplever i samlivet efter fødslen. Et essentielt spørgsmål omhandlende brugen af PLISSIT-modellen er imidlertid hvorvidt jordemoderen er kompetent til at foranledige kommunikationen med parrene. Ifølge Studieordningen fra 2009 har jeg som jordemoderstuderende haft teoretisk undervisning svarende til 105 ECTS point. Heraf undervisning i psykologi svarende til i alt 5 ECTS point samt undervisning i sexologi svarende til 0,5 ECTS point. Ydermere har jeg haft undervisning i kommunikation, pædagogik og sociologi svarende til i alt 8 ECTS point, som jeg ydermere finder relevant for jordemoderens kvalifikationer indenfor brugen af PLISSIT-modellen (Undervisningsministeriet, 2009). Jeg mener alligevel, at det er vigtigt at jordemoderen tilbydes efteruddannelse indenfor specielt sexologi for at kunne benytte PLISSIT-modellen i svangreomsorgen i Danmark.
Jeg vil herunder diskutere hvordan PLISSIT-modellen kan benyttes i svangreomsorgen. Ifølge analysen ønsker parrene information og bekræftelse fra sundhedsprofessionelle i forhold til samlivet, både før og efter fødslen. Jeg finder, at jordemoderen kan tilbyde parrene sin viden og ekspertise om emnet i flere situationer: i jordemoderkonsultationen, på forældre- og fødselsforberedelseskurser samt til efterfødselskonsultationen. De forskellige omgivelser og vilkår kan hver især bidrage til at favne flest mulige par, hvilket diskuterer enkeltvis herunder. Idet tilbuddene til parrene før og efter fødslen varierer alt efter fødestedernes praksis, vælger jeg her i diskussionen at tage udgangspunkt i praksissen fra Næstved Sygehus, hvor min sidste kliniske praktik fandt sted.

5.1.1 Jordemoderkonsultation
Det er forventeligt, at forskellige par ønsker forskellige omgivelser at diskutere samlivet i. Jeg vil mene, at nogle par vil finde det mest behageligt at tale om problematikker i samlivet i enrum med jordemoderen, idet det for nogle er grænseoverskridende at dele intime oplevelser og følelser med andre par. Disse par vil jordemoderen kunne adressere i jordemoderkonsultationen, hvor alle tre niveauer af den kortvarige terapi i PLISSIT-modellen vil kunne benyttes. Jordemoderen kan eksempelvis benytte modellen til at tale med parrene om forbindelsen mellem seksuelle aktiviteter og følelsen af anerkendelse fra partneren. Analysen viser, at mænd har behov for sex for at føle sig anerkendt, mens kvinder har behov for at føle sig anerkendt for at have lyst til sex. Jordemoderen kan give parrene tilladelse til at have forskellige behov og samtidig begrænset information om denne dissonans i samlivet, således at parrene er forberedt på eventuelle udfordringer efter fødslen. Jordemoderen kan ydermere specifikt foreslå, at parrene taler om betydningen af sexlyst i forhold til anerkendelse og dermed forventningsafstemmer allerede under graviditeten.

Jeg er bevidst om, at jordemoderen har mange tidskrævende opgaver i konsultationen og udfordringen for jordemoderen vil derfor være at finde tid til at indlede en samtale med parrene om deres samliv. Midlertid kan brugen af PLISSIT-modellen ifølge Annon, tilpasses til mængden af tid den sundhedsprofessionelle har med parrene (Annon, 1975, s.259). For at parrene får det optimale ud af brugen af PLISSIT-modellen, kræver det, at begge parter er til stede. Jeg er dog bevidst om at manden ikke altid deltager i jordemoderkonsultationen. I situationer hvor kun kvinden er til stede, må jordemoderen give kvinden tilladelse til at hendes følelser ikke er unormale samt supplere med begrænset information, som hun efterfølgende selv kan videregive til manden.
5.1.2 Fødsels- og forældreforberedelse
Andre par vil derimod have glede af at diskutere forholdets udfordringer i plenum ved fødsels- og forældreforberedelsen, for således selv at høre andre par fortælle om lignende problematikker. Det er her jordemoderens opgave at skabe et rum, hvor parrene føler sig trygge ved at diskutere følelser og oplevelser ved, at jordemoderen giver tilladelse til, at deres følelser ikke er unormale. Jordemoderen har desuden en mulighed for at tilbyde de kommende mødre og fædre, at diskutere i mindre grupper med henholdsvis andre mødre og fædre, ved at kønsopdele kvinderne og mændene under dele af kurset. Hermed kan jordemoderen give deltageret information til hver af grupperne ud fra jordemoderens viden om de respektive køns oplevelser af samlivet.

På Næstved Sygehus foregår kurset på hold á 10-12 par, hvilket betyder, at udfordringen for jordemoderen er, at det ikke er muligt at individualisere informationen eller forslagene efter hvert enkelt af parrenes behov. Brugen af PLISSIT-modellen kan imidlertid ifølge Annon tilpasses til forholdene for mødet med parret (Annon, 1975, s.259). Alternativt kan brugen af niveau to og tre i modellen efterfølgende foregå i jordemoderkonsultationen eller efterfødselskonsultation.

5.1.3 Efterfødselskonsultation

Uanset om parrene har erfaret nogle ændringer i samlivet eller ej, så vil jordemoderen, ved at åbne samtalen om samlivet ved efterfødselskonsultationen forberede parrene på, at sådanne forandringer muligvis sker i løbet af barselsperioden. Samtidig er det min holdning, at jordemoderen således illustrerer over for parrene, at sundhedsprofessionelle generelt er imødekommende over for at

5.2 Implementering af PLISSIT-modellen i svangreomsorgen


Som analysen og ovenstående studie om skilsmisseårsager viser, så er god kommunikation særlig vigtig for tilfredsheden i samlivet og i sidste ende for at undgå skilsmisse. Jeg mener derfor, at det er vigtigt at sundhedsprofessionelle, herunder jordemoderen, vejleder parrene til sufficient kommunikation, og derved forhåbentlig undgå skilsmisse. Som analysen viser, er samlivets udfordringer et fælles anliggende for parrene, som bedst håndteres, når de samarbejder. Jeg finder det derfor essentielt, at jordemoderen opfordrer begge parter til at deltage i både forældre- og fødselsforberedelsen, efterfødselskonsultationen samt en eller flere af jordemoderkonsultationerne i løbet af graviditeten.

I ovenstående afsnit har jeg diskuteret hvordan og i hvilke omgivelser jordemoderen kan benytte PLISSIT-modellen. Ved at jordemoderen, i mødet med parrene både før og efter fødslen, gentagne gange italesætter mulige udfordringer i samlivet, vurderer jeg, at parrene er forberedt på, hvordan samlivet kan udvikle sig. Jordemoderen har samtidig vejledt parrene i vigtigheden af åben

5.3 Diskussion af empiri, teori samt projektets metode

I nedenstående afsnit reflekteres kritik over empiri og teori anvendt i projektet. Efterfølgende diskuteres dele af projektets metode.

5.3.1 Kritik af empiri

Studierne benyttet i projektet er som tidligere beskrevet i afsnit 3.2 metodekritisk gennemgået ud fra Malteruds tjekliste til vurdering af kvalitative artikler. De benyttede studier er som beskrevet fundet valide, idet forfatterne ved at benytte deres beskrevne metode undersøger deres problemstilling i alle studierne (Kvale & Brinkmann, 2010, s.272) En samlet styrke ved empirien er, at dataindsamlingen til studierne er foretaget fra 2001-2009, hvilket gør empirien samtidsrelevant og overførbar til nutidig praksis. Der er imidlertid nogle problematikker ved alle studierne, som herunder diskuteres enkeltvis. Der henvises til bilag 4 for yderligere indsigt i vurderingen af studierne.
Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth (Olsson et al., 2005):


Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood (Woolhouse et al., 2012):

Forfatterne af dette studie, har ligesom Olsson et al., 2005, ikke bekrævet deres egne forforståelser eller perspektiver ved udforslen af studiet. Ydermere præsenteres ingen strategier for resultatvalidering, interviewene er dog optagede og transskriberede. Det beskrives, at deltagerne er blevet udvalgt ved selective sample, hvilket styrker reliabiliteten, men forfatterne diskuterer ikke konsekvenserne af udvalgsstrategien i forhold til alternative valg.

Fathers’ experience after having a child: sexuality becomes tailored according to circumstances (MacAdam et al., 2011):

I dette studie styrkes reliabiliteten ligeledes idet udvalgsstrategien beskrives, imidlertid diskuteres ej heller her konsekvenserne af strategien. Desuden diskuterer forfatterne ikke implikationerne ved undersøgelsesresultaterne.
Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth (Olsson et al., 2010):

Forfatterne bekræver også i dette studie metoden til udvælgelse og rekruttering af deltagere, hvilket styrker reliabiliteten. Deltagerne i studiet har alle en middel- til overklasse baggrund samt en ungdoms- eller videregående uddannelse. Dette giver en limiteret undersøgelsesgruppe, hvorfor resultaterne ikke nødvendigvis er overførbare til alle nybagte fædre.

5.3.2 Kritik af teori

Som tidligere beskrevet i afsnittet ”Valg af teori”, fandtes intet dækkende teoriapparat til bevarelse af projektets problemstilling, hvorfor elementer fra flere forskellige publikationer og forfattere er benyttet til analysen.


5.3.3 Kritik af projektets metode

Den hermeneutiske tilgangs kerne er fortolkning og min egen forforståelse indvirker på denne fortolkning. Jeg har i projektet redegjort for min egen forforståelse, som gennem analysen er blevet bekræftet. Selvom jeg har været opmærksom på min forforståelse, kan denne imidlertid stadig have farvet min fortolkning af citaterne fra studierne.

Jeg har i projektet udelukkende benyttet mig af empiri genereret af andre forfattere. Disse forfattere har i udarbejdelsen af artiklerne analyseret deltagernes udtalelser og udvalgt de citater, som min
analyse bygger på. Således har forfatternes forforståelser, fortolkning og perspektiver antageligvis påvirket mine analyseresultater. Ydermere har jeg ikke adgang til interviewguides, og ved derfor ikke hvilke spørgsmål forfatterne har stillet, eller hvorledes forfatterne har styret interviewenes retning. På baggrund af dette samt den videnskabsteoretiske tilgang, ville det have været relevant at generere egen empiri og herved opnå en dybere forståelse af nybagte mødre og fædres tanker omkring samlivet. Dette blev dog fravalgt grundet projektets begrænsede tidsrum.

Ydermere fremkom ingen danske studier ved min systematiske litteratursøgning, hvorfor jeg har benyttet mig af studier fra Sverige og Australien. Da disse lande er moderne vestlige lande, hvilket jeg anser som argument for at praksis er sammenlignelig med Danmarks, anser jeg projektets resultater for overførbare til den danske svangreomsorg. Det ville imidlertid være interessant, at foretage lignende studier i Danmark, for på den måde at opnå øget viden om emnet på baggrund af den danske fødekultur.

Ud fra empirien er identificeret temaer, som gør sig gældende for henholdsvis nybagte mødres og fædres oplevelser af samlivet efter fødslen, således at meningsindholdet tydeligt er fremkommet. Ifølge Malterud er dette en datastyret analyse (Malterud, 2013, s.95). Da denne fremgangsmåde er benyttet, er projektets begrundelsesform er induktion. Problemstillingen er undersøgt ud fra menneskelig erfaring, altså enkeltobservationer, og herefter sluttet til almene gældende udsagn. Styrken ved induktivismen er at der skabes ny viden, hvilket samtidig er svagheden ved begrundelsesformen, idet den nye viden ikke er sikker, men blot sandsynlig. Dette induktionsproblem må forskeren være bevidst om, når ny viden skabt ud fra afgrænsede observationer overføres til mere generelle forhold (Birkler, 2005, s.66-71).

Som tidligere nævnt i afsnittet ”Videnskabsteoretisk tilgang”, betyder projektets humanvidenskabelige, herunder den hermeneutisk-fænomenologiske tilgang, at virkeligheden som udforskes er subjektivistisk. Jeg har derfor valgt udelukkende at benytte mig af kvalitative undersøgelser, hvilket jeg anser som en styrke til besvarelse af problemstillingen, da denne spørger ind til parrenes subjektive oplevelser. Hvis jeg i stedet havde valgt at benytte kvantitative undersøgelser som empiri, ville min analyse have inddraget mange flere nybagte forældres holdninger. Nuancerne, som jeg vurderer opstår ved citaterne, ville imidlertid blive begrænset. De to metoder kunne ligeledes begge have været anvendt, og dermed suppleret hinanden til besvarelse af problemstillingen.
Jeg har i projektet valgt at anskue de nybagte forældres oplevelser af samlivet efter fødslen ud fra et psykologisk perspektiv, hvorfor jeg har benyttet teoretiske elementer fra psykologer. Hvis jeg i stedet havde valgt f.eks. at anlægge et samfundsmæssigt perspektiv på projektet og dermed diskuteret kønsstereotypernes påvirkning af samlivet, ville mine analyseresultater have været anderledes end de nuværende.

6.0 Konklusion


Nogle af oplevelserne deles således af parterne, mens andre opstår hos enten kvinderne eller mændene. Oplevelserne er komplekse, idet underlæggende problematikker kan give sig til udtryk i seksuelle udfordringer for parrene. Manglende kommunikation leder således til misforståelser og problemer i samlivet. Det konkluderes at de første tre niveauer af PLISSIT-modellen kan benyttes som et jordemoderfagligt redskab til at kommunikere med kommende og nybagte forældrepar omkring samlivets problematikker. Herved giver jordemoderen tilladelse, begrænset information og specifikke forslag individualiseret efter det enkelte pars behov. Modellen er samtidig velegnet til at vejlede parrene i god kommunikation indbyrdes i parforholdet. Det udledes af projektet at modellen kan benyttes både gennem graviditeten i jordemoderkonsultationen og ved fødsels- og forældreforberedelsen samt efter fødslen i efterfødselskonsultationen.
Projektet henvender sig til jordemødre og andre sundhedsprofessionelle, som møder forældreparrene før og efter fødslen, idet det konkluderes at tværprofessionelt samarbejde mellem jordemødre, praktiserende læger og sundhedsplejerske vil skabe en sammenhængende indsats for parrene. Slutteligt konkluderes det at det er nødvendigt at tilføre flere midler til svangreomsorgen, for at sikre at jordemoderen har tilstrækkelig mulighed for og tid til at tage udgangspunkt i det enkelte pars individuelle oplevelser og behov. De ekstra midler skal samtidig benyttes til at sikre, at jordemoderen er sufficient uddannet til at vejlede parrene, således at de styrkes i at håndtere mulige udfordringer i samlivet efter fødslen.

7.0 Litteraturliste


### 8.0 Bilagsfortegnelse

<table>
<thead>
<tr>
<th>Bilag</th>
<th>Titel</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Litteratursøgning på PubMed</td>
</tr>
<tr>
<td>2</td>
<td>Litteratursøgning på CINAHL</td>
</tr>
<tr>
<td>3</td>
<td>Litteratursøgning på PsychInfo</td>
</tr>
<tr>
<td>4</td>
<td>Tjekliste til kritisk læsning af kvalitative studier</td>
</tr>
<tr>
<td>5</td>
<td>Fathers’ experience after having a child: sexuality becomes tailored according to circumstances (MacAdam et al., 2011)</td>
</tr>
<tr>
<td>6</td>
<td>Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth (Olsson et al., 2010)</td>
</tr>
<tr>
<td>7</td>
<td>Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth (Olsson et al., 2005)</td>
</tr>
<tr>
<td>8</td>
<td>Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood (Woolhouse et al., 2012)</td>
</tr>
<tr>
<td>9</td>
<td>Tematisering af studier</td>
</tr>
<tr>
<td>10</td>
<td>PLISSIT-modellen</td>
</tr>
</tbody>
</table>
### Bilag 1 Litteratursøgning på PubMed

Søgning foretaget d. 29. marts 2017

<table>
<thead>
<tr>
<th>Søgning nr.</th>
<th>Søgeord</th>
<th>Hits</th>
<th>Relevante hits ved læsning af titel samt resume</th>
<th>Relevante hits efter gennemlæsning</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Search (childbirth or puerperium or parturition) Sort by: Relevance</td>
<td>176021</td>
<td>-</td>
<td>Olsson et al. 2010, MacAdam et al. 2011, Williamson et al. 2008, Pastore et al. 2007</td>
</tr>
<tr>
<td>#2</td>
<td>Search (men or man) Sort by: Relevance</td>
<td>701150</td>
<td>-</td>
<td>Olsson et al. 2010, MacAdam et al. 2011</td>
</tr>
<tr>
<td>#3</td>
<td>Search (father or fatherhood or parenthood) Sort by: Relevance</td>
<td>41446</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#4</td>
<td>Search (intimacy or sexuality or life together) Sort by: Relevance</td>
<td>284535</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#5</td>
<td>Search ((((((childbirth or puerperium or parturition)) AND (men or man)) AND (father or fatherhood or parenthood)) AND (intimacy or sexuality or life together)) Sort by: Relevance Filters: Publication date from 1997/01/01; Humans</td>
<td>25</td>
<td>Olsson et al. 2010, MacAdam et al. 2011, Williamson et al. 2008, Pastore et al. 2007</td>
<td>Olsson et al. 2010, MacAdam et al. 2011</td>
</tr>
<tr>
<td>#6</td>
<td>Search (intimacy or sexuality or life together) Sort by: Relevance</td>
<td>284535</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#7</td>
<td>Search (woman or women) Sort by: Relevance</td>
<td>1071916</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#8</td>
<td>Search (mother or motherhood or parenthood) Sort by: Relevance</td>
<td>199885</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#9</td>
<td>Search (childbirth or puerperium or parturition) Sort by: Relevance</td>
<td>176021</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Search (intimacy or sexuality or life together) Sort by: Relevance</td>
<td>284535</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------------------------------</td>
<td>--------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>#11</td>
<td>Search (puerperium or parturition or childbirth) Sort by: Relevance</td>
<td>176021</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#12</td>
<td>Search (parenthood or parents or partner or co-parent) Sort by: Relevance</td>
<td>305342</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>#14</td>
<td>Search (((intimacy or sexuality or life together))) AND (childbirth or puerperium or parturition)) AND ((parenthood or parents or partner or co-parent)) Sort by: Relevance Filters: Publication date from 1997/01/01; Humans</td>
<td>381</td>
<td>Woolhouse et al. 2012, Olsson et al. 2010, MacAdam et al. 2011, Olsson et al. 2005,</td>
<td></td>
</tr>
<tr>
<td>Søgning nr.</td>
<td>Søgeord</td>
<td>Hits</td>
<td>Relevante hits ved læsning af titel samt resume</td>
<td>Relevante hits efter gennemlæsning</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>S1</td>
<td>childbirth or puerperium or parturition Search modes - Boolean/Phrase</td>
<td>24,669</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>men or man Search modes - Boolean/Phrase</td>
<td>125,153</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>father or fatherhood or parenthood Search modes - Boolean/Phrase</td>
<td>14,201</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S4</td>
<td>intimacy or sexuality or life together Search modes - Boolean/Phrase</td>
<td>29,169</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5</td>
<td>S1 AND S2 AND S3 AND S4</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S6</td>
<td>S1 AND S2 AND S3 AND S4 Limiters - Published Date: 19970101-20151231</td>
<td>10</td>
<td>Olsson et al. 2010, Williamson et al. 2008</td>
<td>Olsson et al. 2010</td>
</tr>
<tr>
<td>S7</td>
<td>childbirth or puerperium or parturition Search modes - Boolean/Phrase</td>
<td>24,669</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8</td>
<td>intimacy or sexuality or life together Search modes - Boolean/Phrase</td>
<td>29,169</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9</td>
<td>Woman or women Search modes - Boolean/Phrase</td>
<td>266,932</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S10</td>
<td>Mother or motherhood or parenthood Search modes - Boolean/Phrase</td>
<td>65,847</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S11</td>
<td>S7 AND S8 AND S9 AND S10 Search modes - Boolean/Phrase</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Olsson et al. 2010, Van Duong et al. 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Intet dansk bibliotek har materialet)</td>
<td></td>
</tr>
<tr>
<td>S13</td>
<td>intimacy or sexuality or life together Limiters - Published Date: 19970101-20151231</td>
<td>24,237</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S14</td>
<td>childbirth or puerperium or parturition Search modes - Boolean/Phrase</td>
<td>20,499</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S15</td>
<td>parenthood or parents or partner or co-parents Limiters - Published Date: 19970101-20151231 Search modes - Boolean/Phrase</td>
<td>104,270</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S16</td>
<td>S13 AND S14 AND S15 Limiters - Published Date: 19970101-20151231 Search modes - Boolean/Phrase</td>
<td>51</td>
<td>O’Malley et al. 2015, Williamson et al. 2008</td>
<td></td>
</tr>
<tr>
<td>Søgning nr.</td>
<td>Søgning</td>
<td>Hits</td>
<td>Relevante hits ved læsning af titel samt resume</td>
<td>Relevante hits efter gennemlæsning</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>-----------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>S1</td>
<td>childbirth or puerperium or parturition</td>
<td>6,836</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>men or man</td>
<td>202,631</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>father or fatherhood or parenthood</td>
<td>49,059</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S4</td>
<td>intimacy or sexuality or life together</td>
<td>47,224</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S5</td>
<td>S1 AND S2 AND S3 AND S4</td>
<td>9</td>
<td>Olsson et al. 2010, Pastore et al. 2007,</td>
<td>Olsson et al. 2010</td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td>Gianotten et al. 2007 (Intet dansk bibliotek</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>har adgang),</td>
<td></td>
</tr>
<tr>
<td>S6</td>
<td>childbirth or puerperium or parturition</td>
<td>6,836</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S7</td>
<td>intimacy or sexuality or life together</td>
<td>47,224</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S8</td>
<td>Woman or women</td>
<td>292,810</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S9</td>
<td>Mother or motherhood or parenthood</td>
<td>123,437</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td>Barrett et al. 1999, Judicibus et al. 2002,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pastore et al. 2007, Gianotten et al. 2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Intet dansk bibliotek har materialet)</td>
<td></td>
</tr>
<tr>
<td>S11</td>
<td>childbirth or puerperium or parturition</td>
<td>6,836</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S12</td>
<td>intimacy or sexuality or life together</td>
<td>47,224</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| S13 | parenthood or parents or partner or co-parents  
Search modes - Boolean/Phrase | 202,088 |  |
|-----|--------------------------------------------|------|------|
| S14 | S11 AND S12 AND S13  
Limiters - Publication Year: 1997-2016  
Bilag 4 Tjekliste til kritisk læsning af kvalitative studier

<table>
<thead>
<tr>
<th>Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth (Olsson et al., 2005)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sjekkliste for kritisk lesning av kvalitative studier</td>
<td></td>
</tr>
<tr>
<td><strong>Kilde:</strong> Malterud, 2013, s.217-218</td>
<td>JA KOMMENTARER NEJ</td>
</tr>
<tr>
<td>PROBLEMSTILLING</td>
<td></td>
</tr>
<tr>
<td>Er forskningsspørgsmålet relevant?</td>
<td>x Belyse hvordan nogle kvinder oplever deres seksualliv med deres partner efter fødslen.</td>
</tr>
<tr>
<td>Er problemstillingen tilstrekkelig avgrenset og fokusert?</td>
<td>X</td>
</tr>
<tr>
<td>Gir artikkelens tittel et dekkende inntrykk av innholdet?</td>
<td>X</td>
</tr>
<tr>
<td>REFLEKSIVITET</td>
<td></td>
</tr>
<tr>
<td>Har forskeren presentert motiver, bakgrunn, perspektiver og antakelser?</td>
<td>X</td>
</tr>
<tr>
<td>Er konsekvensen av forforståelsen drøftet tilfredsstillende?</td>
<td>X</td>
</tr>
<tr>
<td>METODE OG DESIGN</td>
<td></td>
</tr>
<tr>
<td>Er kvalitative metoder egnet for utforskning av artikkelens problemstilling?</td>
<td>x</td>
</tr>
<tr>
<td>Har forskeren valgt det mest adekvate kvalitative designet?</td>
<td>X Ikke optaget/transskriberet, kun taget noter, som så efterfølgende er blevet godkendt af 5 deltagere fra forskellige grupper.</td>
</tr>
<tr>
<td>DATAINDSAMLING OG UTVALG</td>
<td></td>
</tr>
<tr>
<td>Har forskeren presentert sin utvalgsstrategi (oftest strategisk el. teoretisk, ikke representativ eller tilfeldig)?</td>
<td>x Rekrutteret af jordemoderen, ud fra hvilke kvinder jordemoderen mente, ville have lyst til at diskutere spørgsmål om seksualitet i en gruppe. Inklusionskriterier: Svensk-talende, født mindst 3 mdr. før interviewet.</td>
</tr>
<tr>
<td>Er dette tilfredsstillende begrunnet?</td>
<td>X</td>
</tr>
<tr>
<td>Er dette en utvalgsstrategi som er best mulig egnet til å belyse problemstillingen?</td>
<td>x Anses ikke som værende representativt, da der er valgt kvinder fra uden grund ved ikke at invitere dem til studiet.</td>
</tr>
<tr>
<td>Spørsmål</td>
<td>Svar</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Har forskeren drøftet konsekvensene av sin utvalgsstrategi i forhold til alternative valg?</td>
<td>x</td>
</tr>
<tr>
<td>Presenteres betydningsfulle kjenneretn ved utvalget tilstrekkelig til at leseren kan forstå konteksten for gjennomføring av studien?</td>
<td>x</td>
</tr>
<tr>
<td><strong>TEORETISK REFERANSERAMME</strong></td>
<td></td>
</tr>
<tr>
<td>Presenteres de teoretiske perspektiver som studien bygger på?</td>
<td>X</td>
</tr>
<tr>
<td>Er den teoretiske referanseramme adekvat i forhold til prosjektets problemstilling?</td>
<td>X</td>
</tr>
<tr>
<td>Forklarer forfatteren hvordan teorigrunnlaget har formet analysen?</td>
<td>X</td>
</tr>
<tr>
<td><strong>ANALYSE</strong></td>
<td></td>
</tr>
<tr>
<td>Beskrives prinsipper og prosedyrer for bearbeiding og analyse av data tilstrekkelig til at leseren får innsyn i veien fra rådata til resultater?</td>
<td>x</td>
</tr>
<tr>
<td>Forklarer forfatteren hvordan katagoriene i resultatdelen ble etablert – stammer de fra teorigrunnlaget, eller er de utviklet med bakgrunn i det empiriske materialet?</td>
<td>x</td>
</tr>
<tr>
<td>Forklarer prinsippene for organisering av resultatpresentasjonen?</td>
<td>X</td>
</tr>
<tr>
<td>Presenteres strategier for resultatvalidering (f.eks. alternative fortolkninger, informantvalidering, triangulering) i metodepresentationen eller diskusjonen?</td>
<td>x</td>
</tr>
<tr>
<td><strong>RESULTATER</strong></td>
<td></td>
</tr>
<tr>
<td>Gir resultaterne relevante svar på studiens problemstilling?</td>
<td>4 temaer:</td>
</tr>
<tr>
<td>- Body image after childbirth</td>
<td></td>
</tr>
<tr>
<td>- Stresses of family life alters sex patterns</td>
<td></td>
</tr>
<tr>
<td>- Discordance of sexual desire with the partner</td>
<td></td>
</tr>
<tr>
<td>- Reassurance</td>
<td></td>
</tr>
<tr>
<td>Lærer vi noe nytt ved å lese resultaterne?</td>
<td>X</td>
</tr>
<tr>
<td>Er resultatpresentasjonen en overbevisende framstilling av funn utviklet fra det empiriske materialet som øe annet og noe mer enn forfikerens forforståelse og teoretiske referanseramme?</td>
<td>X</td>
</tr>
<tr>
<td>Brukes sitater på en adekvat måte til å understøtte og berike forskerens sammenfatning av mønstre identifisert og gjenfortalt</td>
<td>X</td>
</tr>
<tr>
<td>Gode citater.</td>
<td></td>
</tr>
<tr>
<td><strong>DISKUSJON</strong></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Drøftes spørgsmål om intern validitet (hva handler egentlig denne studien om)</td>
<td>X</td>
</tr>
<tr>
<td>Drøftes spørgsmål om ekstern validitet (overførbarhet av funn eller begreper)?</td>
<td>x</td>
</tr>
<tr>
<td>Drøftes spørgsmål om refleksivitet (forskerens rolle, perspektiver og posisjoner)?</td>
<td>x</td>
</tr>
<tr>
<td>Finner vi selvkritiske overveielser om konsekvenser av det valgte designet?</td>
<td></td>
</tr>
<tr>
<td>Drøftes studiens begrensninger, samtidig som forskeren tar ansvar for de valgene som er gjort?</td>
<td>Udvalgsmetoden nævnes, men der tages ikke kritisk stilling til problemerne ved metoden.</td>
</tr>
<tr>
<td>Peker forskeren på noen utvalgte implikasjoner av de funn som er presentert?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PRESENTASJON</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Er teksten velorganisert og lettlest?</td>
<td>x</td>
</tr>
<tr>
<td>Kan leseren skjelne mellom informantenes stemmer og forskerens stemme?</td>
<td>x</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>REFERANSER</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Er sentral og spesifikke referanser på feltet tilfredsstillende dekket og presentert?</td>
<td>x</td>
</tr>
</tbody>
</table>
**Problemstilling**

| Er forskningsspørgsmålet relevant? | x | Kvinders oplevelse af ændringer i deres seksuelle forhold, seksualitet og intimitet, som et resultat af graviditet, fødsel og det at være forældre. |
| Er problemstillingen tilstrekkelig avgrenset og fokusert? | x |
| Gir artikkelens tittel et dekkende inntrykk av innholdet? | x |

**Refleksivitet**

| Har forskeren presentert motiver, bakgrunn, perspektiver og antakelser? | X |
| Er konsekvensen av forståelsen drøftet tilfredsstillende? | x |

**Metode og design**

| Er kvalitative metoder egnet for utforskning av artikkelens problemstilling? | x |
| Har forskeren valgt det mest adekvate kvalitative designet? | x |

**Dataindsamling og utvalg**

| Har forskeren presentert sin utvalgsstrategi (oftest strategisk el. teoretisk, ikke representativ eller tilfeldig)? | x | Selective sample for at opnå variation i deltagerne. Inklusionskriterier: Bosiddende i en radius af 20 km fra midt-Melbourne. |
| Er dette tilfredsstillende begrunnet? | x |
| Er dette en utvalgsstrategi som er best mulig egnet til å belyse problemstillingen? | | |
| Har forskeren drøftet konsekvensene av sin utvalgsstrategi i forhold til alternative valg? | x |
| Presenteres betydningsfulle kjennetegn ved utvalget tilstrekkelig til at leseren kan forstå konteksten for gjeninnføring av studien? | x |

**Teoretisk referanseramme**

<p>| Sjekkliste for kritisk lesning av kvalitative studier | | |
| Kilde: Malterud, 2013, s.217-218 | | |</p>
<table>
<thead>
<tr>
<th><strong>Presenteres de teoretiske perspektiver som studien bygger på?</strong></th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Er den teoretiske referanseramme adekvat i forhold til prosjektets problemstilling?</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Forklarer forfatteren hvordan teorigrunnlaget har formet analysen?</strong></td>
<td>x</td>
</tr>
</tbody>
</table>

**ANALYSE**

<table>
<thead>
<tr>
<th><strong>Beskrives prinsipper og prosedyrer for bearbeiding og analyse av data tilstrekkelig til at leseren får innsyn i veien fra rådata til resultater?</strong></th>
<th>x</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Forklarer forfatteren hvordan katagoriene i resultatdelen ble etablert – stammer de fra teorigrunnlaget, eller er de utviklet med bakgrunn i det empiriske materialet?</strong></td>
<td>x  Ud fra det empiriske materiale.</td>
</tr>
<tr>
<td><strong>Forklarer prinsippene for organisering av resultatpresentasjonen?</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Presenteres strategier for resultatvalidering (f.eks. alternative fortolkninger, informantvalidering, triangulering) i metodepresentasjonen eller diskusjonen?</strong></td>
<td>x</td>
</tr>
</tbody>
</table>

**RESULTATER**

|**Gir resultaterne relevante svar på studiens problemstilling?** | 3 temaer:  
- Psychosocial factors affecting sex and intimacy  
- Changes to sexual and intimate relationships  
- Factors that helped |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lærer vi noe nytt ved å lese resultaterne?</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Er resultatpresentasjonen en overbevisende framstilling av funn utviklet fra det empiriske materialet som oe annet og noe mer enn forskerens forforståelse og teoretiske referanseramme?</strong></td>
<td>x</td>
</tr>
<tr>
<td><strong>Brukes sitater på en adekvat måte til å understøtte og berike forskerens sammenfatning av mønstre identifisert og gjenfortalt fra systematisk analyse av materialet?</strong></td>
<td>x  Gode citater.</td>
</tr>
</tbody>
</table>

**DISKUSJON**

<table>
<thead>
<tr>
<th><strong>Drøftes spørgsmål om intern validitet (hva handler egentlig denne studien om)</strong></th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drøftes spørgsmål om ekstern validitet (overførbarhet av funn eller begreper)?</strong></td>
<td>X</td>
</tr>
<tr>
<td>Spørsmål/Forutsetning</td>
<td>Besvakelse</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Drøftes spørgsmål om refleksivitet (forskerens rolle, perspektiver og posisjoner)?</td>
<td>x</td>
</tr>
<tr>
<td>Finner vi selvkritiske overveielser om konsekvenser av det valgte designet?</td>
<td>x</td>
</tr>
<tr>
<td>Drøftes studiens begrensninger, samtidig som forskeren tar ansvar for de valgene som er gjort?</td>
<td>x</td>
</tr>
<tr>
<td>Peker forskeren på noen utvalgte implikasjoner av de funn som er presentert?</td>
<td>x</td>
</tr>
</tbody>
</table>

**PRESENTASJON**

<table>
<thead>
<tr>
<th>Spørsmål/Forutsetning</th>
<th>Besvakelse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Er teksten velorganisert og lettlest?</td>
<td>x</td>
</tr>
<tr>
<td>Kan leseren skjelne mellom informantenes stemmer og forskerens stemme?</td>
<td>x</td>
</tr>
</tbody>
</table>

**REFERANSE**

<table>
<thead>
<tr>
<th>Spørsmål/Forutsetning</th>
<th>Besvakelse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Er sentral og spesifikke referanser på feltet tilfredsstillende dekket og presentert?</td>
<td>x</td>
</tr>
</tbody>
</table>
**Fathers’ experience after having a child: sexuality becomes tailored according to circumstances**  
(MacAdam et al., 2011)

*Sjekkliste for kritisk lesning av kvalitative studier*

*Kilde: Malterud, 2013, s.217-218*

<table>
<thead>
<tr>
<th>JA</th>
<th>KOMMENTARER</th>
<th>NEJ</th>
</tr>
</thead>
</table>

**PROBLEMSTILLING**

Er forskningsspørgsmålet relevant?  
Identificere og beskrive mæns oplevelse af seksualitet efter fødslen.

Er problemstillingen tilstrekkelig avgrenset og fokusert?  

Gir artikkelens tittel et dekkende inntrykk av innholdet?

**REFLEKSIVITET**

Har forskeren presentert motiver, bakgrunn, perspektiver og antakelser?  

Er konsekvensen av forforståelsen drøftet tilfredsstillende?  
Drøftet, men ikke beskrevet for læseren.

**METODE OG DESIGN**

Dybdegående semi-strukteret narrativ intervju. 30-50 min, båndoptaget, transskriberet.

Er kvalitative metoder egnet for utforskning av artikkelens problemstilling?  

Har forskeren valgt det mest adekvate kvalitative designet?  

**DATAINDSAMLING OG UTVALG**


Har forskeren presentert sin utvalgsstrategi (oftest strategisk el. teoretisk, ikke representativ eller tilfeldig)?  

Er dette tilfredsstillende begrunnet?  

Er dette en utvalgsstrategi som er best mulig egnet til å belyse problemstillingen?

Har forskeren drøftet konsekvensene av sin utvalgsstrategi i
forhold til alternative valg?

Presenteres betydningsfulle kjennetegn ved utvalget tilstrekkelig til at leseren kan forstå konteksten for gjennomføring av studien? **X**

**TEORETISK REFERANSERAMME**

Presenteres de teoretiske perspektiver som studien bygger på? **X**

Er den teoretiske referanseramme adekvat i forhold til prosjektets problemstilling? **X**

Forklarer forfatteren hvordan teorigrunnlaget har formet analysen?

**ANALYSE**

Beskrives prinsipper og prosedyrer for bearbeiding og analyse av data tilstrekkelig til at leseren får innsyn i veien fra rådata til resultater? **X**

Forklarer forfatteren hvordan katagoriene i resultatdelen ble etablert – stammer de fra teorigrunnlaget, eller er de utviklet med bakgrunn i det empiriske materialet? **X** Fra det empiriske materialet.

Forklarer prinsippene for organisering av resultatpresentasjonen? **X**

Presenteres strategier for resultatvalidering (f.eks. alternative fortolkninger, informantvalidering, triangulering) i metodepresentasjonen eller diskusjonen? **X**

**RESULTATER**

Gir resultaterne relevante svar på studiens problemstilling? **X**

<table>
<thead>
<tr>
<th>Overordnet tema:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The expression of sexuality was accepted and modified to the circumstances derived from having a child.</td>
</tr>
<tr>
<td>4 undertemaer:</td>
</tr>
<tr>
<td>- A new way of closeness due to non-existing sexuality immediately after birth.</td>
</tr>
<tr>
<td>- An expression of sexuality influenced by the consequences of caring for a child.</td>
</tr>
<tr>
<td>- The expression of love and consideration taking priority over sexual activities.</td>
</tr>
<tr>
<td>- The father’s experience of sexuality being limited by the</td>
</tr>
<tr>
<td>Lærer vi noe nytt ved å lese resultaterne?</td>
</tr>
<tr>
<td>Er resultatpresentasjonen en overbevisende framstilling av funn utviklet fra det empiriske materialet som øe annet og noe mer enn forskerens forståelse og teoretiske referanseramme?</td>
</tr>
<tr>
<td>Brukes sitater på en adekvat måte til å understøtte og berike forskerens sammenfatning av mønstre identifisert og gjenfortalt fra systematisk analyse av materialet?</td>
</tr>
</tbody>
</table>

**DISKUSJON**

| Drøftes spørgsmål om intern validitet (hva handler egentlig denne studien om) | x |
| Drøftes spørgsmål om ekstern validitet (overførbarhet av funn eller begreper)? | x |
| Drøftes spørgsmål om refleksivitet (forskerens rolle, perspektiver og posisjoner)? | Kun interviewerens rolle drøftes. |
| Finner vi selvkritiske overveielser om konsekvenser av det valgte designet? | x |
| Drøftes studiens begrensninger, samtidig som forskeren tar ansvar for de valgene som er gjort? | x |
| Peker forskeren på noen utvalgte implikasjoner av de funn som er presentert? | x |

**PRESENTASJON**

| Er teksten velorganisert og lettlest? | x |
| Kan leseren skjelne mellom informantenes stemmer og forskerens stemme? | x |

**REFERANSER**

| Er sentral og spesifikke referanser på feltet tilfredsstillende dekket og presentert? | x |
###Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth (Olsson et al., 2010)

<table>
<thead>
<tr>
<th>Sjekkliste for kritisk lesning av kvalitative studier</th>
<th>Kilde: Malterud, 2013, s.217-218</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEMSTILLING</strong></td>
<td></td>
</tr>
<tr>
<td>Er forskningsspørgsmålet relevant?</td>
<td>X</td>
</tr>
<tr>
<td>Er problemstillingen tilstrekkelig avgrenset og fokusert?</td>
<td>X</td>
</tr>
<tr>
<td>Gir artikkels tittel et dekkende inntrykk av innholdet?</td>
<td>X</td>
</tr>
<tr>
<td><strong>REFLEKSIVITET</strong></td>
<td></td>
</tr>
<tr>
<td>Har forskeren presentert motiver, bakgrunn, perspektiver og antakelser?</td>
<td></td>
</tr>
<tr>
<td>Er konsekvensen av forforståelsen drøftet tilfredsstillende?</td>
<td></td>
</tr>
<tr>
<td><strong>METODE OG DESIGN</strong></td>
<td></td>
</tr>
<tr>
<td>Er kvalitative metoder egnet for utforskning av artikkels problemstilling?</td>
<td>x</td>
</tr>
<tr>
<td>Har forskeren valgt det mest adekvate kvalitative designet?</td>
<td>Små grupper, måske bedre adækvat med kun individuelle interview.</td>
</tr>
<tr>
<td><strong>DATAINDSAMLING OG UTVALG</strong></td>
<td></td>
</tr>
<tr>
<td>Har forskeren presentert sin utvalgsstrategi (oftest strategisk el. teoretisk, ikke representativ eller tilfeldig)?</td>
<td>x</td>
</tr>
<tr>
<td>Er dette tilfredsstillende begrunnet?</td>
<td>x</td>
</tr>
<tr>
<td>Er dette en utvalgsstrategi som er best mulig egnet til å belyse</td>
<td>Smal gruppe, ikke nødvendigvis repræsentativ.</td>
</tr>
<tr>
<td>Problemstillingen?</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
</tr>
<tr>
<td>Har forskeren drøftet konsekvensene av sin utvalgsstrategi i forhold til alternative valg?</td>
<td>x</td>
</tr>
<tr>
<td>Presenteres betydningsfulle kjenner-tegn ved utvalget tilstrekkelig til at leseren kan forstå konteksten for gjennomføring av studien?</td>
<td>x</td>
</tr>
</tbody>
</table>

**TEORETISK REFERANSERAMME**

|  
|------------------|------|
| Presenteres de teoretiske perspektiver som studien bygger på? | X |
| Er den teoretiske referansemøn adekvat i forhold til prosjektets problemstilling? | X |
| Forklærer forfatteren hvordan teorigrunnlaget har formet analysen? | |

**ANALYSE**

|  
|------------------|------|
| Beskriver prinsipper og prosedyrer for bearbeiding og analyse av data tilstrekkelig til at leseren får innsyn i veien fra rådata til resultater? | X |
| Forklærer forfatteren hvordan katagoriene i resultatdelen ble etablert – stammer de fra teorigrunnlaget, eller er de utviklet med bakgrunn i det empiriske materialet? | X Fra det empiriske materiale. |
| Forklærer prinsippene for organisering av resultatpresentasjonen? | |
| Presenteres strategier for resultatvalidering (f.eks. alternative fortolkninger, informantvalidering, triangulering) i metodepresentasjonen eller diskusjonen? | |

**RESULTATER**

|  
|------------------|------|
| Gir resultaterne relevante svar på studiens problemstilling? |  
| Overordnet tema: Transition to fatherhood brings sexual life to a crossroads. 3 undertemaer:  
- Struggling between stereotypes and personal perceptions of male sexuality during transition to fatherhood.  
- New frames for negotiating sex.  
- A need to feel safe and at ease in the new family situation.  
Indeholder hvilke behov mændene har for implementering i praksis (sidste undertema). |
<table>
<thead>
<tr>
<th>Lærer vi noe nytt ved å lese resultaterne?</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Er resultatpresentasjonen en overbevisende framstilling av funn utviklet fra det empiriske materialet som øe annet og noe mer enn forskerens forforståelse og teoretiske referanseramme?</td>
<td>X</td>
</tr>
<tr>
<td>Brukes sitater på en adekvat måte til å understøtte og berike forskerens sammenfatning av mønstre identifisert og gjenfortalt fra systematisk analyse av materialet?</td>
<td>X Gode citater.</td>
</tr>
</tbody>
</table>

**DISKUSJON**

<table>
<thead>
<tr>
<th>Drøftes spørgsmål om intern validitet (hva handler egentlig denne studien om)</th>
<th>x</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drøftes spørgsmål om ekstern validitet (overførbarhet av funn eller begreper)?</td>
<td>x</td>
</tr>
<tr>
<td>Drøftes spørgsmål om refleksivitet (forskerens rolle, perspektiver og posisjoner)?</td>
<td>x Kun interviewerens rolle drøftes.</td>
</tr>
<tr>
<td>Finner vi selvkritiske overveielser om konsekvenser av det valgte designet?</td>
<td>x</td>
</tr>
<tr>
<td>Drøftes studiens begrensninger, samtidig som forskeren tar ansvar for de valgene som er gjort?</td>
<td>x</td>
</tr>
<tr>
<td>Peker forskeren på noen utvalgte implikasjoner av de funn som er presentert?</td>
<td>x</td>
</tr>
</tbody>
</table>

**PRESENTASJON**

| Er teksten velorganisert og lettlest? | x |
| Kan leseren skjelne mellom informantenes stemmer og forskerens stemme? | x |

**REFERANSER**

| Er sentral og spesifikke referanser på feltet tilfredsstillende dekket og presentert? | x |
Fathers' experiences after having a child: sexuality becomes tailored according to circumstances

Ruth MacAdam, RN, CNM (Midwife) a, Elisabeth Huuva, RN, CNM (Midwife) b, Carina Berterö, RNT, RSc, MScN, PhD (Professor) c, d

a Women's Primary Healthcare Clinic, Örebro, Sweden
b Department of Women's Healthcare Services, Örebro University Hospital, Sweden
c Department of Medical and Health Sciences, Division of Nursing Science, Faculty of Health Sciences, Linköping University, SE-581 85 Linköping, Sweden

ARTICLE INFO

Article history:
Received 8 June 2009
Received in revised form 14 December 2009
Accepted 22 December 2009

Keywords:
Sexuality
Men's experiences
Fatherhood
Interpretive phenomenology

ABSTRACT

Objective: to identify and describe men's experiences of sexuality after having a child.
Design: a qualitative study using an interpretative phenomenological approach for analysing in-depth interviews.
Participants: purposeful sampling was used. 12 men were interviewed six to 13 months after having a child. Informants were men who became fathers for the first time or had already fathered a child.
Setting: a mid-sized town located in the centre of Sweden.
Findings: four themes became apparent: a new way of closeness due to non-existing sexuality immediately after birth, an expression of sexuality influenced by the consequences of caring for a child, the expression of love and consideration taking priority over sexual activities, and the father's expression of sexuality being limited by the lack of reciprocation from the partner.
Key conclusions: after having a child, the expression of sexuality became subjective to the change in circumstances. Sexuality itself was not experienced any differently, but the expression of sexuality for the fathers was modified depending on how the circumstances presented themselves. Sexuality was extended to different avenues of expression where a sense of belonging evolved and a display of love and affection preceded sexual activities.
Implications for practice: it is important that health care professionals are aware of the various avenues of expression after having a child. It is important to not only inform about sexual activities. Fathers should be involved in discussions of circumstances affecting sexuality to be able to prepare accordingly.

© 2009 Elsevier Ltd

Introduction

The life event of becoming a father permanently changes leaving an imprint on all aspects of a man's life to come. The phenomena of fatherhood and its impact on life has gained interest within the research community, looking to understand and explain the transition from man to father. St. John et al. (2004) describes fatherhood as a time marked by altered family dynamics and social adjustments. Individual challenges of balancing the role of father, provider, and partner are influenced and enhanced by social expectations. The renegotiation of roles and the emotions produced by the transition can generate stress and place a strain on the relationship (St. John et al., 2004).

Many studies present findings about the deterioration of satisfaction in their relationship with parents (Dalgas-Pelish, 1993; Byrd, 1998; Ba 1999; Buist et al., 2003; Condon et al., 2004). This in relation to fatherhood can reduce relationship generate ongoing problems (Buist et al., 2003) expressed intimacy (Barclay and Lutton, 1999).

In 1999, von Sydow performed a meta-context subject of sexuality during pregnancy and after found sparse material concerning men. Re available showed that men displayed more sexual interest after pregnancy than the women. Marital quality with intercourse and tenderness pregnancy. The meta-content analysis highli further studies concerning postpartum sexual have mainly concentrated on sexual functioni
Condon et al. 2004; Pastore et al. 2007; Gungor et al. 2008) or sexual activity and satisfaction (Byrd, 1998; Knauth, 2000; Von Sydow, 2001, 2002; Williamson et al., 2008) and mostly included both partners. The study by Pastore et al. (2007) investigated concerns about postpartum sexuality at four months and 12 months post partum among first-time parents. The results confirmed fathers: had several areas of concern relating to sexuality topics which extended beyond the first year of the child's birth. Concerns ranged from when to resume intercourse to the issue of desire discrepancy between the partners. At 12 months post partum, the most common topic left unresolved reflected mismatched desire, with the sexual needs of the fathers being greater than their partners. Other studies reported that men were dissatisfied with their sexual relationship (Knauth, 2000), and that men experienced an overwhelming decline in sexual function which persisted throughout the first year of the child's birth (Condon et al., 2004). How well the couple's relationship and intimacy worked could be linked to the stability and functioning of the relationship prior to having children (Lewis, 1988).

Only one qualitative study concentrating on fatherhood and postpartum sexuality was found in our literature search. William- son et al. (2008) used a qualitative approach to analyze random written responses obtained in a questionnaire for first time fathers at six-weeks post partum. The majority of responses confirmed a decrease in sexual activity due to lack of time and energy, although the limited responses made it difficult to obtain a deeper insight into this. Concentrating on the couples' intimate relationship in first-time parents, Alhberg and Ståndmark (2001) conducted a qualitative study using interviews. Results showed the importance of maintaining communication as a key aspect for preserving a healthy relationship during the transition into parenthood, regardless of level of intimacy. The absence of being able to express wishes and expectations could leave the man feeling like an outsider with a physical and emotional void.

By concentrating on sexual functioning, activity and satisfaction, studies of men's sexuality post partum have not tended to view sexuality using a holistic approach, where the actual experiences of sexuality can be understood. As described by the World Health Organization (WHO), 'sexuality goes beyond the acts of erotic activities. It includes all aspects of being and cannot be isolated from other aspects of a person's life, therefore becomes vital for viewing a person as whole.' It derives from one's sex, gender identities and roles, sexual orientation, eroti- cism, pleasure, intimacy and reproduction... and... experienced in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships' (WHO, 2008). Sheerin and McKenna (2000) analysed the meaning of sexuality and elicited significant characteristics providing a definition of the expressed conditions of sexuality. The foundation of expressing sexuality is manifested by through the ability to communicate the qualities of one's perceived and accepted sexual identity through mediums such as behaviours, feelings and appearance. The recipient acknowledges, interprets and responds to the communica- tion, which produces a sense of qualification (Sheerin and McKenna, 2000).

According to the research presented above, becoming a father can have a great impact on the way in which sexuality is experienced and expressed. The lack of a holistic approach to the concept of sexuality combined with the few qualitative research designs that have been produced, means that men's experiences of sexuality is a relatively unexplored area. To bring some awareness to this uncharted area of interest, the aim of this study was to identify and describe men's experiences of sexuality, six to 13 months after having a child.

**Method**

This study sought to understand the informants lived experience, in a given context, and to elicit men's lived experiences. The interpretive phenomenolog- Heidegger (Benner, 1994) was compatible with the study as it focuses on the participants' world and data from narrative accounts, which are interpreted based on background. In addition, interpretive phenomenology uncovers similarities and distinctions of a phenomenon the informant's own words, in order to convey aw (1994), reflecting our wish of creating awareness of after having a child. From a hermeneutical interpret- ingle, the interpretation of meaning is central. Mear attention to the questions posed in the text to emphasise on the interpreter's prior knowledge of the study (Kvale, 1996).

**Sample**

The study was conducted in a town located in Sweden. Participants were sought via purposeful sampling. It was mainly achieved by individual encounters in settings, for example organized 'father son' play groups. Informative posters were also placed at various locations as primary health clinics, asking for study volume. Approvals from the head of the department were obtained before the distribution of information about inclusion criteria were as follows: (1) the father was 18 years or older; (2) had to be in an ongoing relationship with the mother; (3) able to communicate Swedish or English; (4) willing to openly share information; (5) have a child aged between six and 13 months; and should not be known to the interviewers. To a standing of the phenomena as a whole, the inclusiveness of data dependent upon the number of children that fathered the child. The age of the child was chosen with the family's active participation, and the researcher was able to reach an understanding of the described experiences after having a child, as per the participant's description of the period of adaptation (St. John et al., 2004). A total of 13 men participate, of which 12 were interviewed. One man chose not to take part in the study due to being unable to commit to the study. Six of the men had children previously and six fathers. All men were employed, and three with a visiting work outside of the 12 men were married, the rest cohabite. The median age of the fathers was 33 years old. The study was performed in accordance with the Declaration of Helsinki and Swedish legislation guidelines (Swedish Code of Statutes, 2003; World Declaration of Helsinki, 2008). Participants that they could leave the study at any time, an information was not required to provide in the full at all times as compared with the experiences of their partners.

**Data collection**

Narrative in-depth interviewing stimulates spontaneous stor- ies and is deemed appropriate for the exploratory research of a person's experiences (Kvale, 2007). It allows for the meanings and commonalities of everyday events to develop an understanding.
that can aid people to explore their own view as well as assist the anticipation of future events (Renner, 1994). Each author conducted a pilot interview to enrich their interviewing skills. The men were interviewed between November 2008 and April 2009. The informants were allowed to choose the locations of the interviews as long as privacy could be attained. This was done to enable the participants to feel more relaxed and comfortable in their positions as informants. Interviews were completed at the informant’s home or workplace with only the informant and interviewer present. The purpose of the interview was explained at recruitment and repeated before the start of the interview to verify their understanding and provide answers to additional questions. Informed consent was obtained at the time of the interview.

The informants were interviewed once and interviews were shared equally between authors. In-depth interview techniques were based on methods described by Kvale (2007). All interviews started with obtaining the informant’s demographic details and then followed with an opening question, asking the subject about their experiences on the subject of sexuality after having a child. The informant was allowed to freely, without restrictions, relate his experiences subjectively. Questions were asked to endorse clarification and/or to further explain areas of interest. This was achieved by repeating significant words in the answers provided, using probing questions such as ‘please could you tell me more about this’, or allowing for periods of silence in the interview (Kvale, 2007). Care was taken not to lead the subject and interfere with minimal interruptions. Notes of behaviour, mood, setutations and other relevant information were recorded after each interview as an aid for more accurate interpretation in the analysis stage. Interviews ranged between 30 and 50 minutes and were tape-recorded and transcribed verbatim. According to Kvale (2007), interview studies generally contain among 15 + 10 interviews. On the basis of the length of the interviews, 12 interviews were deemed appropriate for obtaining adequate material but not too profound to conduct proficient analysis. Names of the informants were substituted to ensure confidentiality.

**Data analysis**

The 12 written transcripts were analysed according to Moustakas’ (1994) modified method of phenomenology. Prior to analysis, both authors clarified their own preconceptions, knowledge and attitudes, which can instigate misinterpretation. As the analysis advanced, care was taken to remain true to both method and transcripts, by remaining close to the original text and not constructing meanings out of context (Renner, 1994). As a first step, all transcripts were read multiple times by both authors to achieve a general understanding of the material and reach completeness. The interviews were then read independently to identify and elicit units, which conveyed meanings of the studied phenomenon. After removing repetitive and overlapping statements, meaning unit were clustered into core themes based on subject relevance. Individual textural descriptions were fashioned out of core themes and through imaginative variation and reflection constructed into structural descriptions. Combining all individual textural-structural descriptions into a composite, the universal description of the essence of the experiences representing the group’s experiences as a whole emerged (Moustakas, 1994). Both authors analysed all interviews, separately and together under the direction of senior author. Findings were read by eight of the informants, who confirmed the authors’ findings to accurately represent the meaning of their lived experiences.

**Findings**

The analysis and interpretation from the statements in the transcribed interviews furnished four themes and by inter-relation reflected an essence: the expression of sexuality was accepted and modified to the circumstances derived from having a child. The themes producing a foundation for this structure were: a new way of closeness due to non-existing sexuality immediately after birth, an expression of sexuality influenced by the consequences of caring for a child, the expression of love and consideration taking priority over sexual activities, and the father’s expression of sexuality being limited by the lack of reciprocation from the partner.

**A new way of closeness due to non-existing sexuality immediately after birth**

The initial time after the birth of the child was experienced as a period of survival. All energy and time was directed towards the infant, sleep and taking in new impressions. The fathers believed that sexual activities were brought to a natural halt due to the woman’s physical healing process, and felt no distress or frustration over the lack of expressing sexuality:

> ...well your sex-life doesn’t really bloom after having a child. It creates a situation, you know the woman cannot have sex under a certain time, and may be I did not either...

Intimacy and sensuality were forgotten, in that channelled by the new situation; a new form created a new form of closeness. Many of the fathers bringing a new strength and understanding relationship:

> ...you have a greater understanding for ea are tired or sad, and can provide each other different ways, so in that way it has relationship.

Fathers felt content with solely expressing the family and considered the lack of inti activities to be a natural progression of the giving...

**Expression of sexuality influenced by the consequences of having**

Most fathers experienced a natural return to sexual activities:

> ...[we] matured at the same time, we felt again. It was nothing I felt frustrated over, if not happen and that she did not feel ready, same amount of time...

Some fathers felt nervous and worried about sexual activities. Some fathers felt nervous and worried about sexual activities. A couple of men mentioned their partner’s breasts going through a change, none of them considered it to affect their sexuality in a negative way and one father appreciated his partner’s new curves. One father expressed feeling less attractive as a man as he was not able to care for his appearance as much as he used to before having a baby.
One man, yet to return to having intercourse 10 months after the birth of his son, did express an understanding for his own situation:

...it was a little boring in the beginning, but after a while it becomes as with anything else you don't miss almost either... but it is really not like I feel, I am so horny, I have to go out and find a replacement, it is not like that.

None of the fathers experienced a change in how they perceived their own sexuality and had 'the same feelings and desires' for their partners as they had prior to the birth of their child. However, the fathers did notice a difference in how sexuality was expressed due to new limitations created by adding one more to the family. Sexual acting out became restricted as well as the time for each other, which entailed more planning and 'being less spontaneous'. All men acknowledged time and energy as key factors for limiting the ability of expressing sexuality:

...you don't get the time for just being close and sometimes you are tired and don't have the same vigour and sex-drive I can feel.

Other men expressed difficulties in finding privacy in the home. This tension made sexuality difficult to express and created a frustration over constant interruptions.

All fathers except one expressed a decrease in sexual activity, which varied from almost no change to noticing a major change in the frequency of intercourse. The display of affection did, in most cases, remain stable but two men encountered a compensation for the lack of intercourse with their partner with 'maybe some more kissing and hugging'.

The men related their current state of being able to express sexuality acceptable, but related it to a limited period that, in some cases, proved to be the only reason for accepting the current situation:

With the child becoming more predictable we don't need to worry that he is going to wake up at any time and we get more time for each other and can relax more and then the rest comes naturally, affection, love and sexuality.

Some men also expressed that it was not possible to achieve the same expression of sexuality they had prior to having a baby but this was also not desired, as having a baby was a natural development of their relationship.

Lack of reciprocation from the partner affected the father's expression of sexuality

All fathers accepted the reduced frequency of sexual activities in respect for their partners' transition into motherhood. However, about half of the men experienced difficulties with fulfilling the need for sexual activities after becoming a father, and two of the men experienced this as a new situation after having their second child. Their partners did not reciprocate the fathers' needs for sexual activities. The partner 'can now be as content with cuddling in bed as I am with having sex'. It left the men feeling disappointed and sometimes more eager for confirmation of their sexuality as a man. The fathers also thought that there should be more sensuality and intimacy without leading to sexual activity. They understood the situation of not being able to express sexuality in the same way, but had a hard time accepting the absence of overall sexuality in their partner:

...can't really understand why my partner's desire has to be so much less when mine has not changed.

The men were being active, seeking out opportunities and always initiating the first step; which after a while for some became a tedious and unrewarding task. They always showed consideration for the partner being tired, and that her sex drive would always precede his own needs. By not acting on the needs for affection and intimacy, fathers were being supportive and considerate to their partners needs:

Then she falls asleep on the sofa almost every night, it is hard to shake her to life and tell her we are going to have sex.

The fathers could accept having 'quick sex' when opportunities emerged, but the partner needed more time to get in the mood and relax:

...nagging her and asking if we can do it (sex), often I say it jokingly but at same time it lies some truth behind it. Maybe she finds my nagging annoying.

The fathers believed that they found more opportunities for sexual activities than their partners, and they realised that intimacy sparked the need for further intimacy:

The more sex we have, the more we want it.

Fathers sometimes found the experience 'dreary, purely frustrating and difficult', but deemed it to be a common experience after receiving confirming information from friends. Being content in the relationship as a whole prevented the relationship from falling to pieces, but could yield problems in the future if the situation became permanent.

In most cases, the fathers did not believe the closeness to their partner was influenced by the new addition to the family, although three men noticed a difference in receiving attention and closeness from their partner after having a baby. From being the partner's first priority and focus of attention, they were now competing for attention, feeling jealous and abandoned:

I am not usually like this, needing attention in everything I do, but somehow it felt as: look how nice I made it here. So I don't know if it was a counter reaction of feeling left out...

They believed that caring for the infant now satisfied their partner's need for affection and bodily contact. By feeling pushed aside, the experience of feeling close is diminished and therefore harder to achieve intimacy.

The expression of love and consideration taking priority over sexual activities

Many of the men experienced sexuality as a vital ingredient in their well-being. It made them feel good and provided them with energy, which made it easier to face life's hardships:

...and partly because I need it for, need it to be happy in my relationship and for me to be happy, for day to day life to work and all that, it means much.

The focus of sexuality now prioritised other areas such as love, sensuality and showing consideration instead of sexual activities:

You can still show affection and still have a form of sexuality with each other without the intercourse part.

The experience of closeness, just by 'lying on the sofa watching a movie and falling asleep holding hands, well just holding each other' or 'just hugging' was considered an expression of love and sexuality, and could at times be just as important as having intercourse.
By having less time but more fleeting moments together with their partner, the focus grew to be 'the small things' and sexuality became further associated with maintaining a good relationship as a whole. The well-being that was created by sharing responsibilities in the home could not be set apart from a rewarding sexuality. Fulfilling set obligations and helping out with household chores would create a more positive atmosphere for sexual expression. One father felt as if he was walking on eggshells trying to please his partner:

... thank you for cleaning the kitchen, I don't think that really goes under my definition of sexuality, but it is one part that follows the other.

All fathers stressed the importance of not forgetting to nourish their relationship. For some of them, this knowledge was gained from previous experiences in past relationships. The men strived to nurse their relationships by giving daily compliments, showing affection or just being close. Many fathers considered making food and dining together as an especially important way of providing intimacy and maintaining the quality in the relationship:

We start with good food. We think that is important. Then, we have the time to sit down and talk with each other... see each other...

A vital part of nourishing the relationship was to allow your partner time alone away from home:

If she has been away for a night and comes home, then she is more in love than ever...

Fathers also expressed a connection between communication and sexuality, and most of them considered communication to lay the foundation for a healthy relationship. Communication served as an instrument for sustaining an understanding in the relationship:

If the communication doesn't work, then the sexuality probably doesn't work and the sex life not especially well either and tenerness and closeness and all that...

One father stated that the communication that had created intimacy and closeness with his partner was now suffering after having a baby, as they now only talked about issues related to keeping the family afloat. By not being able to communicate, expressing sexuality became problematic and a feeling of isolation was created. 'is there something wrong with me'.

The essence: sexuality becoming tailored according to circumstances

The structure of the phenomena was experienced as an accepting and limited period in their relationship, where the expression of sexuality became subjective to the new circumstances created by having a child. Sexuality itself was not experienced any differently, and the fundamental need for seeking contact and intimacy sustained, but the expression of sexuality for the fathers became tailored according to how the situation presented itself. The initial expression of sexuality after birth presented itself with conditions of physical and biological restrictions, which transformed sexuality into a phase relying on the feeling of togetherness. Consumed by caring for the baby and making an allowance for their partner's healing process, closeness and affection was conveyed and achieved through a common interest, the baby. Later, circumstances became bordered by psychological and emotional conditions and the expression of sexuality progressed into prioritising love, consideration and showing affection. As the consequences of having a baby resulted in tiredness and sexual activities dependent upon the reciprocation of the partner, nurturing the relationship by means of the 'small things' became vital for sustaining the need for expressing sexuality. The modifications of expressing sexuality were most commonly viewed as a satisfying experience.

Discussion

The goal in the present study was to gain better undersi of how men experienced sexuality after having a baby. Phenomena of sexuality could not be singled out from everyday life, an interpretative phenomenological approach using interviews was deemed appropriate to ensure focus informants' unique lived experiences (Benner, 1994). It previously mentioned, past research on sexuality and fatherhood demonstrates a limitation in quantitative nature or basing qualitative analysis on unexpected written responses in a questionnaire (Williamson et al., 2008). A qualitative approach will greatly restrict expression and understanding of lived experiences. The results from the present study showed that fathers did not encounter a chance in how they experienced sexuality, but did acknowledge a difference in the expression of sexuality according to their individual and unique situations. At edging time and energy as a cause for changing the expression of sexuality was common for all men and this was illustrated in earlier studies (Ahlborg and Strandmark, 2001; St. Johr, 2004; Williamson et al., 2008). The limited time and energy created a focus on understanding each other’s everyday life, and both previous research and this study indicated that a new form of togetherness evolves between the p after having a baby (Preimberg et al., 2008).

Men often expressed diminished sexual activities primarily change in displaying sexuality. These findings are supported by previous studies (Von Sydow et al., 1999; Condon et al., 2004; St. John et al., 2004; Williamson et al.). The men focused other ways of expressing themselves prioritising showing love, affection and consideration. An cited finding was how many fathers emphasised the importance of the time of being together with their partners. This proved to be with an opportunity to notice and communicate with each other in their otherwise busy lives as parents. Expressing the 'small things' such as eating and listening became the foundation for sustaining sexuality by substituting the lack of sexual activities with affection, comradeship and love. Hence, contradictory findings by Ahlborg do not confirm the substitution of sexuality with sensuality also do not utilise a holistic approach to sexuality by focusing on sensuality from sexuality.

Some interviews in this study revealed a mismatched when the partners’ longing for sexual activities diminishes having a baby. The development of a desire discrepancy established in previous research (Pastore et al., 2007; Will et al., 2008) where the partner was afraid of displeasing the other due to their sexual desire for intercourse (Ahlborg). Those findings could explain why the fathers in this research voiced a need for having more intimacy without the requirement for further sexual activities.

Even though the situation at times could create frust with the advancement of a desire discrepancy, all men sympathetically accepted. None of the fathers experienced considerable distress or conflict due to the differences in sexual activity, which is contradictory to Tomlinson’s results of mismatched desires often creating relationship blights. Further, some second-time fathers experienced a discrepancy that did not exist with the first child and did more secure about sexual activities past partum as stated...
Sydow (1999), although this could be supported by Wielgos et al. (2007) who illustrated an inverse relationship between the number of children and the quality of sex life (i.e., more children means less satisfaction with intimacy).

Many of the fathers voiced the importance of communication within the relationship in order to prevent marital problems, and linked communication to a gratifying sexuality. Ahlborg (2004) supports our results stating how well the intimacy works in a relationship is dependent on the quality of communication. However, particular features of this study exemplify other areas of significance extending beyond the simple act of communication. Sexuality becomes marked by various circumstances and how well the expression of sexuality can be tailored accordingly, rather than the communication foretelling the contentment of sexuality.

The importance of integrating fatherhood without giving up one's own person (Premberg et al., 2008), which might explain this study's results of finding time for yourself as well as being together with their partner, developed into an essential part for the fathers' sexuality and well-being, and could re-spark the desire for their partners. Sexuality was often expressed as connected with overall well-being and considered to be an essential element in the fathers' lives. Similar findings can be found in other studies (Knauth, 2000; Pascoe et al., 2007). Most of the fathers were content with their sexuality after having a baby, which was encouraging, but also a reminder that their happiness was related to judging the situation as a transient phenomenon.

Limitation and strengths

Twelve fathers who were fairly homogeneous in terms of age, demographic and socioeconomic status participated in this research although cannot be generalised to all Swedish men. Despite this, the researchers believe that adequate richness was given in the description of the phenomena to 'enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility' (Lincoln and Guba, 1985, p. 316). A strength in the present study was fashioned by the informants being interviewed alone and knowing that their experiences would not be judged against their partners' experiences. This may aid the stimulation of a more candid and open dialogue as sexuality is a complex subject to discuss, and could a person feeling exposed (Tomlinson, 2005). Further, the interviews were conducted by professional female nurse-midwives with many years of combined experience in health-care-related encounters. In the gender aspects of women interviewing men can prove to be beneficial as communication in the male dyad can often be constrained by hierarchical power relationships and protest masculinity (Oliffe and Thorne, 2007): hence, there could also be some advantages as well regarding men-to-men talk. To ensure truthful research techniques, each author conducted a test interview to enhance their proficiency in qualitative interview techniques, and worked in a continued collaboration with an experienced co-author. To aid credibility, eight of the fathers verified that the authors had elicited the true meaning in their lived experiences by taking part of the findings (Lincoln and Guba, 1985).

Conclusion and recommendation

As these findings show, the expression of sexuality is altered in order to adapt to different circumstances, and sexuality is integrated in everyday life and vital to well-being. Providing information about sexuality after having a baby to both partners as part of prenatal care as well as postnatal care seems imperative. Although the subject of sexuality should be extended to different avenues of expression, and placed a holistic approach of sexuality and should re-integrate information about sexual activities, it is important for care professionals focus on explaining the concept can bring to expressing sexuality in a relationship the understanding and help the couple to pre-judge research should take place to explore the variety exist between fathers of different cultures and be

Conflict of interest

This research has not been subjected to any financial or personal interests, which could have influenced the results in this study.

Acknowledgements

The authors wish to thank all the new fathers that made this study possible by readily sharing their intimate thoughts and feelings.

References


Ahlberg, T., Strandmark, M. 2001. The baby was the focus of parents' experiences of their intimate relationship. Scan Carine Science 15, 318–325.


Knauth, D. 2000. Predictors of parental sense of competence for the couple during the transition to parenthood. Research in Nursing Health 23, 495–505.


Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth

Ann Olsson RN, PhD (Lecturer)1, Eva Robertson RN, PhD (Senior Author)2,3, Anders Björklund MDr, PhD (Senior Research Fellow)4 and Eva Nissen RNMTD, PhD (Professor)2,5

1Department of Clinical Sciences, Division of Caring Science, Danderyd Hospital, Karolinska Institutet, Solna, 2Department of Woman and Child Health, Karolinska Institutet, Stockholm, 3Borås University College of Health Science, Borås, 4Department of Clinical Sciences, Division of Obstetrics and Gynecology, Danderyd Hospital, Karolinska Institutet, Solna and 5School of Life Science, University of Skövde, Skövde, Sweden

Scand J Caring Sci; 2010; 24; 716–725

Fatherhood in focus, sexual activity can wait: new fathers’ experience about sexual life after childbirth

Background: Becoming a parent is overwhelming for most men and women and alters the sexual relationship for many couples.

Aim: To describe fathers’ experience about sexual life after childbirth within the first 6 months after childbirth.

Method: A descriptive design, using content analysis with a qualitative approach, based on focus group discussions and one-to-one interviews.

Participants: Eight first-time and two subsequent fathers participated.

Results: Three subthemes were identified: Struggling between stereotypes and personal perceptions of male sexuality during transition to fatherhood; new frames for negotiating sex; a need to feel safe and at ease in the new family situation. The overarching theme emerged as ‘transition to fatherhood brings sexual life to a crossroads’ and guided us to a deeper understanding of the difficulties men experience during the transition to fatherhood. To get sexual life working, a number of issues had to be resolved, such as getting involved in the care of the baby and the household and getting in tune with their partners in regard to sexual desire. The men needed to be reassured and prepared for this new situation by health care professionals.

Conclusions: New fathers in our study put the baby in focus in early parenthood and were prepared to postpone sex until both parties were ready, although they needed reassurance to feel at ease with the new family situation. The fathers’ perceptions of sexual life extended to include all kinds of closeness and touching, and it deviated from the stereotype of male sexuality. This is important information for health care providers and midwives to be aware of for their encounters with men (and women) during the transition to fatherhood, and parenthood and can contribute to caring science with a gender perspective on adjustment of sexual life after childbirth.

Keywords: sexuality, fatherhood, postnatal visit, childbirth.

Submitted 22 September 2008, Accepted 23 November 2009

Introduction

Becoming a parent is overwhelming and stressful for most men and women. Condon et al. (1) found that men demonstrated the highest symptom levels of stress during pregnancy, with a small improvement at 3 months postpartum, and a little change thereafter. These men appeared to be ill-prepared for the impact of parenthood on their lives, especially in terms of the sexual relationship with their partners. Condon et al. found that the peak period of distress was at the first assessment at 23 gestational weeks during pregnancy, and it decreased steadily postpartum. Sexual activity appeared to decline markedly from prepregnancy with only minimal improvement by the end of the first year after childbirth. Physical effects of the birth and tiredness affected sexual activity (2). A couple’s relationship changes when a child is born, and the attention is directed towards the child (3). In a study by Fagerskiold (4), fathers described an altered relationship that involved less time for each other; however, none of the fathers perceived that the relationship had worsened.

A need for counselling fathers-to-be has been identified. Boyce et al. found that insufficient information about pregnancy and childbirth contributed to psychological distress in fathers. Furthermore, their distress was...
associated with a poor marital relationship and a poor social network (5). Deave et al. have found that fathers would have appreciated more information on parenting, relationship changes and their partners' perspectives before becoming parents (6). It has been suggested that discussing sexuality should begin early in the pregnancy, and an ongoing discussion could be incorporated into each prenatal visit (2). The organisation of the health care system, which offers the couple a postnatal visit between 6 and 12 weeks, is likely to influence the point in time when the couple resumes sexual activity (2). Indeed, the fathers also expect the nurse at the child health centre to recognise relational difficulties in the new family and to give advice (4).

In Sweden, fathers are invited to accompany the mothers to the prenatal visits as well as to family classes (7). During pregnancy, 84% of the primiparous women and 11% of the multiparas attended education classes with their partners (8). Fathers are also expected to share the parental leave with the mothers, which might influence attitudes towards sexual life after childbirth. Men’s use of parental leave accounts for 18.7% (2004) of the total insurance payment for parental leave, which is an increase of 9% over a 10-year period (9) and has increased to 21.5% in 2008 (The Swedish Social Insurance Agency (Försäkringskassan) 2008, Sten Olsson, Personal communication). Although Sweden is seen as one of the most equal societies in the world, gender segregation in working life is still strong and widespread (10). However, little attention is given to develop knowledge about the transition to fatherhood in caring science taking into account a gender perspective.

Previous research by our group on women’s reflections about sexual life after childbirth and midwives' attitudes to counselling have revealed standards based on gender-biased views that might not be very helpful to men as they struggle to find their new roles as men and fathers (11, 12).

There is a high conformity in our society about what is regarded as typically feminine and masculine characteristics (13). Women and men have adopted the way they think and act from the culture they live in (14). According to Connell (15), gender relations are one of the main structures in society. Masculinity structures the production and distribution of resources and the distribution of power in the form of authority and cathexis. Connell also states that there are multiple masculinities: hegemonic, compliant, marginalised and subordinated. Hegemonic masculinity is the idealised form of masculinity at a given place and time (15) whereas other kinds of masculinities are either marginalised or subordinated. Understanding gender differences contributes to a more complete picture of how sexual relationships and negotiations are performed (16).

The present study is thus part of a larger study, to enhance the understanding of parents’ views on sexual life after childbirth and inform midwives and other health care providers with new knowledge that might help them improve care and counselling on sexual matters after childbirth.

**Aim**

The aim is to describe fathers' experience about sexual life 3–6 months after the birth of their child.

The researchers sought a better understanding of the changes that might occur in fathers’ sexual relationships and the information they would like to receive from midwives. The results from this study could provide midwives and other health care providers with important knowledge about new fathers’ thoughts and needs for information about sexual relationships after childbirth.

**Methods**

A descriptive design based on data from focus group discussions (FGDs) and one-to-one interviews with a qualitative approach was chosen for this study. A FGD can be defined as an in-depth, open-ended group discussion that explores a specific set of issues on a predefined and limited topic (17), and it was thought to be a good way to approach the topic. Most men did not want to participate in a group discussion because they felt embarrassed talking about sexual life in a group, and they were therefore offered one-to-one interviews.

**Setting**

The hospital where this study was conducted is situated in the northern part of Stockholm and has two maternity clinics with a total of 8500 deliveries per year. This hospital serves women/couples from middle- to upper-class backgrounds. Participants were recruited from the postnatal ward of one of the units where 2400 babies were born in 2006. Women giving birth at this ward should have had normal pregnancies and should have given birth between gestational week 37 and 42. The FGDs or interviews took place in a comfortable setting at the clinic.

**Participants**

Eight first-time fathers and two subsequent fathers participated in either an FGD or a semi-structured interview 3–6 months after the births of their babies. The age of the participants ranged from 26 to 51 years, and their infants ages ranged from 3 to 6 months. All were living in couple relationships and had high school education or university education.
Data collection

A total of 65 men were approached at the postnatal ward during 1 week in May, June, July and August, respectively. Both first-time and subsequent fathers were included. The midwife who gave special information before the couple left the ward also informed them about the study and gave them an information sheet. This information sheet included questions on background data, and the men were also invited to participate in an FGD or interview about sexual life after childbirth. Sixty-one fathers returned their questionnaires, and 27 agreed to participate in an FGD or interview. They were contacted by the first author (AO) who verbally gave more details about the study. Of those answering the questionnaire, the majority said that they did not want to attend an FGD. Reasons given were that they would feel uncomfortable to discuss such ‘a delicate topic’ in a group (n = 6). Other reasons were also given: did not want to share intimate feelings with others (n = 6), were not interested (n = 5) and had no time (n = 3). Missing (n = 7). In the end, 10 fathers agreed to participate, and those men who disagreed to participate at that point gave reasons like ‘short of time’ (n = 10), ‘I want to spend as much time as possible with my family’ (n = 3), ‘the child/children got ill’ (n = 2), and ‘I do not give this priority right now’ (n = 2).

Two FGDs were conducted with three men in the first and only two in the second FGD. Groups are typically 6–10 people, but a flexible research process allows results to be based on small groups, sometimes as small as two or three individuals (18, 19). Five one-to-one interviews were held. The FGDs and interviews varied in content and length, from 35 to 60 minutes. The results of each FGD and interview were briefly summarised, and the issues raised were brought up in the subsequent FGD or interviews (17, 20). The FGD and interviews were conducted by a male facilitator in prenatal and postnatal education programs with fathers (MB). The interviewer was chosen because it was perceived that a male interviewer would put the interviewees at ease and make them feel better understood (18). A semi-structured interview guide was used, and the topics addressed were how new fathers looked upon sexual life after childbirth and the importance of the postnatal visit. An observer who was also a man (AB) took notes on two occasions. The FGDs and interviews were audio taped and transcribed verbatim, yielding 77 pages of text material, which was deemed sufficient.

Data analysis

Qualitative content analysis inspired by Graneheim and Lundman was chosen (21). The authors listened to the audiotapes, and the authors read and re-read the transcribed text (AO, EN, AB, ER) to become familiar with all of the texts and to get a sense of the whole. Thereafter, 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 categories based on similarities by the authors. Fifteen codes and eight categories were found. The process of analysis involved back and forth movements between the whole text, the codes and the categories. From the eight categories, three subthemes emerged. One overarching theme emerged from the subthemes (see example Table 1).

Ethics approval

The informants were told about the study both orally and in writing. They were informed about the confidential and voluntary nature of the study, and they gave their written consent to participate. Approval to carry out this study was obtained from the Karolinska Institutet Ethics committee.

Findings

In general, all the fathers thought they would provide good support to their families after the birth and would continue doing household duties to the same extent or more as before childbirth. Demographics of the participants are shown in Table 2.

The results of the interviews and the FGDs will be reported with the overarching theme; the three subthemes that emerged from the categories that were identified in the text (see example Table 1). To illuminate the findings, quotations from the interviews are given for each subtheme. The following subthemes with respective categories were found: (i) Struggling between stereotypes and personal perceptions of male sexuality during the transition to fatherhood, with the categories societal view of sexuality and expectations on sexuality in the relationship after childbirth. (ii) New frames for negotiating sex, with the categories balancing fatherhood, changes in the relation after childbirth, experience of sexual life after childbirth and physical and mental alterations in the partner. (iii) A need to feel safe and at ease with sex in the new family situation with the categories communication and reassurance. The overarching theme ‘Transition to fatherhood brings sexual life to a crossroads,’ emerged from these three subthemes.

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

Societal view of sexuality Men in our study talked about the distinction between sex and no sex. They thought that the media stressed the importance of sex, mostly penetrating sex, too much.

Where is the distinction between sex and no sex? Just being physical, lying together naked and touching each other in a gentle, loving way? But what the fuck
Table 1 Meaning units

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Codes</th>
<th>Categories</th>
<th>Subthemes</th>
<th>Over arching theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>All the prejudices—you are not supposed to be submissive, etc., but you still feel that you want to be at home...</td>
<td>Disagreeing with media message</td>
<td>Societal view of sexuality</td>
<td>Struggling between stereotypes and personal perception of male sexuality during transition to parenthood</td>
<td>Transition to fatherhood brings sexual life to a crossroads</td>
</tr>
<tr>
<td>In all newspapers, like this – how often do you have intercourse? It is ups and downs; it is such a fuss around it</td>
<td>Recognizing the media message</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a myth that men have more sexual desire than women... I don't believe there is any difference between the sexes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think that men have more sexual needs, they are a little bit hornier</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where is the distinction between sex and no sex? Just being physical, lying together naked and touching each other in a gentle, loving way?</td>
<td>What is sex?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before the birth you think, – a few weeks abstinence, but now when the child is born... it can be half a year</td>
<td>Sex life was expected to be postponed</td>
<td>Expectations on sexuality in the relationship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is no one who hangs or shoots himself just because he could not make love for some time</td>
<td>Sex life after birth is not such a big deal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think it is important to be there... if the mother and child becomes one unit, it will be too much ‘they’ and you will be left out a bit. Then it will be tough to get it together</td>
<td>Parenthood’s influences on sexual desire</td>
<td>Balancing fatherhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You can end up turning outwards or trying to compensate somehow... like, ‘if you are completely absorbed with that [child], I’ll be absorbed by something else’ [floor-ball or something like that]</td>
<td>Getting involved in the family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Altogether, sexual life is important in a relationship. To “K” it comes far down on the priority list. To sleep 10 hours during the night, cleaning the house, doing the laundry and... when all this is done she can start thinking about having sex</td>
<td>Being left out</td>
<td>Changes in the relation after childbirth</td>
<td>New frames for negotiating sex</td>
<td></td>
</tr>
<tr>
<td>I never get any sleep. I do not feel peckish for sex. You re-prioritise a little.</td>
<td>Changed roles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Of course sex is important, but closeness and touch is much more important than sex as it usually is. So, therefore it is not the same drive. You have to be aware of this, to keep the conversation about it [sex] going</td>
<td>Sexual desire remains but fewer opportunities for sex occurs</td>
<td>Experience of sexual life after childbirth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>She has got bigger boobs now; they are so full, tender, and awesome</td>
<td>Experiences of sex during transition to fatherhood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>She feels like she has declined. She isn’t very satisfied with her body... She doesn’t feel all that sexy anymore... she’s rather broken up over having torn during the delivery.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>She got depressed, she was crying all the time, sex was not on the map, I focussed on and took care of our son</td>
<td>Physical alterations in relation to sex</td>
<td>Physical and mental alterations in the partner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The idea is to identify some examples of the most common situations couples fall into during the first months after childbirth... so that later on we can look at each other and say, this is exactly what they talked about.</td>
<td>To be informed about connecting to the new family situation</td>
<td>Communication</td>
<td>A need to feel safe and at ease with sex in the new family situation</td>
<td></td>
</tr>
<tr>
<td>I think you should talk about sex and relationships, but in relation to one’s own relationship.</td>
<td>Defuse sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One wants reassurance that the transition to being a family takes some time and give a bit of perspective on that.</td>
<td>To be reassured (by the midwife) that sexual activity can wait</td>
<td>Reassurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A. Olsson et al.

Table 2  Demographics of study sample (n = 61)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Participants in focus group discussion or interview n = 10</th>
<th>Yes to participate but did not n = 17</th>
<th>Did not participate n = 34</th>
</tr>
</thead>
<tbody>
<tr>
<td>26–32</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>33–39</td>
<td>4</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>&gt;40</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Number of children</td>
<td>8</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Level of education</td>
<td>9</td>
<td>17</td>
<td>24</td>
</tr>
<tr>
<td>High school or more</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

(sigh). In all newspapers, like this – how often do you have intercourse? It is up and downs; it is such a fuss around it [sexual life]. (First-time father/FGD)

The participants also questioned the stereotype of men’s sexuality as reflected in the media.

There is a myth that men have more sexual desire than women...I don’t believe there is any difference between the sexes. (Subsequent father/FGD)

These new fathers felt distressed about the gender role ascribed to them about how to manage postpartum sexual life in the media. They believed that there will always be times in life when sex is scarce and asked ‘what’s the problem?’

There is no one who hangs or shoots himself just because he could not make love for some time. (First-time father/FGD)

However, some participants had an opposing view.

I think that men have more sexual needs, they are a little bit hornier. (First-time father/FGD)

Expectations on sexuality in the relationship after childbirth The men in this study reflected upon the importance of sex in the relationship and how it differed between and within couples. They considered sexual desire as an individual matter; and in spite of whatever was shown in the media, their sexual desire was not in focus just after childbirth.

Prepregnancy, men did not expect to engage in sexual life soon after childbirth and thought that it could be postponed. Many of the informants said that they had talked with their partners about sexual life after childbirth. However, it was not really a big issue during pregnancy, because the focus was the preparation for the birth and the baby. The men had heard from friends and read in family magazines that sex would be scarce for the first half year after childbirth and the focus would be elsewhere.

Prior to the birth you think, ‘a few weeks abstinence,’ but now when the child is born…it can be half a year. (First-time father/FGD)

The participants expressed that they had wondered about how sexual relations would be after birth: if there would be physical changes, if sexual desire would be the same, how long sex would be postponed and how the baby would influence opportunities for sex. In spite of all their musings, none of the fathers had sought any special information or tried to talk about this issue with the midwife or any other health care provider. The questions were mainly raised by the first-time fathers. The subsequent fathers reflected on their own previous experiences.

New frames for negotiating sex

Balancing fatherhood During the interviews and discussions that were held 3–6 months after childbirth, the men expressed that there were a lot of things to think about before resuming sex again. The transition to fatherhood brought new meaning and a new focus that fundamentally changed daily life. Even subsequent fathers described changes in daily life because of an additional child in the family.

Now you have a slightly different function in life. It is time to build a nest and all that. Well, sexual life is not that important any more. (Subsequent father/Interview)

I never get any sleep. I do not feel peckish for sex. You reprioritise a little. There is so much closeness anyway. (Subsequent father/Interview)

The new family situation differed from the previous couple relationship, and the informants stressed the importance of focusing on their loving couple relationship.

Of course sex is important, but closeness and touch is much more important than sex as it usually is. So, therefore it is not the same drive. You have to be aware of this, to keep the conversation about it [sex] going. (Subsequent father/Interview)

Changes in the relation after childbirth Some first-time fathers talked about feeling left out in relation to their partner and their child; they felt they were competing with the baby for the attention of the partner. The men in our study expressed different ways of handling the situation, some by escaping the home to work or taking part in sport activities. Others tried to enter the mother-child dyad.

I think it is important to be there … if the mother and child becomes one unit, it will be too much ‘they’ and you will be left out a bit. Then it will be tough to get it together. (to become a triad) (First-time father/Interview)

A subsequent father said that you have to accept the situation as it is, without feeling excluded or left out. He had
experienced that his partner felt overwhelmed with the physical closeness to the baby, and he felt there was no opportunity for closeness.

I [his partner] have this baby latching on all the time – just leave my body alone. (Subsequent father/Interview)

Several men in our study commented that the ways women and men handled everyday life influenced the couple relationship. The men tried to focus on the relationship with the baby and did not care about other practical issues, such as household duties. The women took the full responsibility for the household matters and felt distressed over the time and strength required by the baby’s needs. Some participants expressed that it also seemed to diminish the women’s sexual desire.

Altogether, sexual life is important in a relationship. To ‘K’ it comes far down on the priority list. To sleep 10 hours during the night, cleaning the house, doing the laundry and…when all this is done she can start thinking about having sex. (First-time father/Interview)

Experience of sexual life after childbirth It was important that both parties felt sexual desire, that the perineal tears had healed, and that the woman felt comfortable. Several men said that sleep had first priority. Often both parties wanted to have sex, but they did not always have the strength to do it. The need for sleep outweighed the desire for sex.

The participants expressed differences about when it was time to have intercourse again after birth. It was expressed that it could differ within the couple, that is, sometimes the woman had more desire. Some men stressed a fear of postponing sex too long, because it might be difficult to get started again.

It is good to try to have sex, maybe not a proper intercourse, but still… (First-time father/Interview)

In general, the fathers in this study thought that communication about sex was essential in the relationship, whether their sexual life was active or not. Keeping a sense of humour was a way to handle life in a relaxed way. But even if the men expressed that it was important to get started again, they articulated that it was all right to wait. It was such a short time; they only needed to accept it.

When you start having a functioning sexual life again and it starts being frequent, then I think that the more often you have intercourse …you get used to it. You can’t expect that everything should be just like before. After all, it [childbirth] implies quite a big bodily change. (Subsequent father/FGD)

The informants felt that the woman’s breasts were strictly kept for the baby’s needs, and the men would not be allowed to come close. One father said:

she has got bigger boobs now; they are so full, tender, and awesome. (First-time father/Interview)

Breastfeeding was not problematic, but some of the participants mentioned that they (the couple) were waiting for weaning to start because they had heard that desire would return.

Physical and mental alterations in the partner Some men described that their partners were unhappy with their body images and that they expressed fear of not healing and getting fit again. One man mentioned that his wife was not happy about her body. Some of the men even mentioned that the women thought of having plastic surgery after finishing childbearing.

She does not feel that sexy anymore and is sad about having torn during the birth. (First-time father/FGD)

Despite the women’s worries, the men in this study had a loving eye to the physical alterations their partners underwent during childbirth, such as tears and weight gain. The men considered tears a minor problem in the sexual relationship, but they expressed that the women needed to be reassured that the men did not sense any difference. Some men mentioned that they sensed a small difference but that it did not matter.

It [the laceration] has influenced our sex life and still does. Her skin has lost sensitivity. It causes her some discomfort. But if you compare it with the loss of desire and the constant fatigue, it is a petty hindrance, really. (First-time father/FGD)

One father said that his partner got depressed after childbirth. This turned his thoughts away from sex and directed his effort to their baby.

She got depressed, she was crying all the time, sex was not on the map, I focussed on and took care of our son. (First-time father/FGD)

The participants felt ambivalence between the previous couple relationship and the demands of the new family, and they approached this ambivalence in different ways. On the one hand they adhered to traditional male roles, while on the other, they wanted to turn down the influence of these roles and just stay home and enjoy the baby.

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

Communication Most men in our study mentioned that they had heard about the postpartum checkup (even if they did not recognise the expression) and saw it as an important visit for the woman, especially if there had been any complications. The new fathers had different ideas about what to expect from that visit. The participants said that they thought that it would be important to talk about sex in a relaxed way and not to be stressed about it.

Reassurance However, the men wanted to be reassured by health care providers that transition to fatherhood should be allowed to take time and also that they should be given a perspective on the transition. They experienced the visit to be quite focussed on the baby and less on the relation-
ship and on sexuality. The men perceived that it was difficult to get accurate information about the changes in the sexual relationship after childbirth.

The idea is to identify some examples of the most common situations couples fall into during the first months after childbirth...

...so that later on we can look at each other and say ‘this is exactly what they talked about.’ (Subsequent father/Interview)

**Transition to fatherhood brings sexual life to a crossroads**

The overarching theme guided us to a deeper understanding of the difficulties these men experienced during their transition to fatherhood. The situation brought them to the crossroads between the hegemonic stereotypical picture of male sexuality and their present situation of adapting to their new roles as both fathers and sexual partners. The perception of sexual life extended to all kinds of closeness and touching and deviated from the stereotypical picture of male sexuality. This was also reflected in how the men in our study negotiated sex during their transition to parenthood.

**Discussion**

**Limitations**

This study attempts to shed some light on what fathers think about sexual life after childbirth and on what information they need about this issue from their midwives. We acknowledge some methodological limitations of this study. First, the participants in this study were an extremely homogenous and privileged group, all middle-class and well-educated men. They might have been more aware than many other men about how to answer the questions and what society might expect from them as new fathers, regarding the transition to parenthood, sex and communication about sexuality. It is possible that changes in sexual attitudes first occur in well-educated groups of society, as is usually the case for other behavioural changes (22). If so, this group of fathers might represent early signs of changes, indicating more paternal involvement in the new family followed by a gradually changing opinion about the sexual relationship. Second, the number of fathers in this study is small, and the request to participate in this study occurred soon after the birth of their infant. Many of the fathers who had accepted to participate, later on when the FGD was to take place disagreed to participate, which is common in studies about sexuality. In this study, we have specifically asked for men who were willing to share their experience on this topic. This might narrow the group of men still more.

To broaden the perspective of sexual life after childbirth, both first-time fathers and subsequent fathers were invited. Credibility and trustworthiness for this study are supported by the way we have described the participants in the study, the research process, and by the way we have presented the results (18, 19). We chose to use an experienced male facilitator for the interviews because we thought the interviewees would talk about the study topic more freely with a man. However, using a man to interview other men might also imply a mutual preunderstanding, which prevents the interviewer from delving more deeply into the topic compared with an interviewer who is completely naive to the topic under discussion. Although it was not planned to have both FGDs and interviews, we think that it has strengthened the study.

Even with these limitations, we think this study fills a gap in the research on men’s experience of sexuality after childbirth.

**Result discussion**

This study reveals several interesting findings regarding new fathers’ experience about sexual life 3–6 months after the birth of their child, which are important for midwives and other health care providers who interact with the parents. Three subthemes were identified from the content analysis: struggling between stereotypes and personal perceptions of male sexuality during transition to fatherhood; new frames for negotiating sex; a need to feel safe and at ease in the new family situation. The overarching theme emerged as ‘transition to fatherhood brings sexual life to a crossroads.’ The men in our study could not recognise themselves in the media image of male sexuality as strong and unbending even during transition phases in life. To get their sexual life working, a number of issues had to be solved. These included getting involved in the daily loving care of the baby, household work and getting in tune with their partners in regard to sexual desire and bodily recovery after childbirth. The men needed to be reassured and prepared for this new situation by health professionals.

During transition to fatherhood, the fathers felt ambivalent. They adhered to the male stereotype that fears being subordinated to the wife and family, but they also truly wanted to be an equal member of the new family. In a study by Buist et al. (23), some men expressed insecurity and concerns about their role in childbirth and child care and also expressed distress about control and intimacy in their relationship. It is important for health care professionals to be aware of this ambivalence, because gender relations are one of the main structures for distributing power in society (15). Holland (24) argue that society presents male domination as natural, but at the same time presents men as not powerful.

New fathers in our study expected to postpone sex and felt that sex was not such a big issue in early parenthood. To achieve a balance between fatherhood and all other
activities has previously been shown to be difficult by several authors (25, 26). McVeigh et al. (25) found that it was easier for older men than for younger men to integrate the new role of fatherhood. This might well be owing to a better position in the father’s career that allows him to take time off from work and also spend more time with the baby. The new parental leave insurance in Sweden allows the parents to share parental leave. This might help the new father adapt to the demands of his family, leading to more equality in child-rearing. Even though an equal social insurance system is in the pipeline, it is hard to guard against persistent gender myths that could lead to even stronger role confusion on the outer edge of parenthood (27). However, women still take the major part of all parental leave. Men of working age are expected to devote themselves to their professional lives, and women are expected to devote themselves primarily to unpaid domestic responsibilities and half- or part-time work (28).

All the participants expressed that sexual needs and desires were not in focus during the first months after the birth; closeness, gentle touch and the baby were in focus for the couple. Having a child has been shown to provide men with a sense of completeness and to deepen the couple relationship (26). It is possible that fathers share their partners’ preoccupation with their baby (29). This might contribute to a decreased sexual desire in the first months after childbirth. Premberg et al. (30) have suggested that Swedish men show more presence and are more active in caring for their infants today than only a few decades ago. Getting involved in the new family, sharing the household work and engaging in the care of the baby were also an entrance to approach sex. Several men expressed that unfinished tasks and household duties made their partners less interested in having sex and to negotiate sex in this situation was bound to be unsuccessful. This finding is in line with other researchers (31). If the father was not allowed to get involved or did not want to get involved in the family but wanted to escape the demands of the family, prospects of having sex decreased. What is presented in our society as the male domination of heterosexuality, this construction of ‘reality’ (i.e. what is seen as normal, natural, and right) is regulated and justified by professionals and other experts (24, 32).

The men in our study expressed that a great difference in the new situation was lack of time for the couple and tiredness because of lack of sleep. The strains experienced by fathers might increase irritability in the relationship. To prevent this, men tried to talk to their partners, get together with other families in the same situation and keep a sense of humour to handle life without sex in a more relaxed way. These findings are in line with other authors (33, 34). On the other hand, some studies show that in the heterosexual norm the man is active and the woman is passive, and both his body and her body are for the man’s pleasure (24).

Studies from Australia have shown that nearly half of the men appeared not to have expected changes in frequency of intercourse and sexual satisfaction (1) and that those men urged their partners to resume sexual life (2). The men in our study said that they expected changes in sexual life after childbirth. They stated that the woman’s body image and self-esteem influenced postpartum sexual life, which is also suggested by other researchers (11, 35, 36). The fathers were not concerned about their partners’ body changes. They were concerned about her perception of her body and that she felt less satisfaction with her body image. They stated that the woman’s body image and self-esteem influenced postpartum sexuality, which is also suggested by other researchers (37, 38). Young women put considerable effort into shaping their bodies to meet male desires (24). In a study, men make more explicit reference to their own bodies, and few men express dissatisfaction or concern with their bodies in contrast to women. Social pressures inscribe a different set of requirements on the female body than of the male body (24). The men expressed concerns about the healing of her lacerations and stressed that it was important that the woman felt comfortable again before trying to resume sexual intercourse. They also reported fear of doing physical harm, which has been shown in previous studies (39, 40). These concerns are consistent with views that masculinity is not an unchanging and static phenomenon, which calls into question current gender stereotypes (41). This study contributes to caring science with a gender perspective on adjustment of sexual life after childbirth.

In spite of fatigue, discomfort and lack of sexual desire, it is important to try to have sex, although not necessarily sexual intercourse. It is important for the man not to impose himself on the woman but still to facilitate the re-establishment of their sex life. In this situation, there might be a fine balance between consent and coercion. This highlights the complexity of these issues, and it points out the necessity of being careful in trying to normalise the sexual relationship (11). Hirdman (42) discusses the meaning of sexuality in shaping masculinity and whether power and control are fundamental parts of male sexuality. She also discusses why sexuality is accentuated so strongly in our society today, what part the media play and to what extent women play an active part themselves (42). It is well known that women internalise the male sexual norms in society.

Our study shows that men need reassurance and information that will make them feel connected to the new family situation. Fagerskiold (4) suggested that it would be valuable for new fathers to meet and exchange experiences. Men’s anxieties about childbirth might be missed antenatally because most of the attention is given to the women (23). Our study supports the previous findings by Buist et al. (23), which point out the importance of presenting information in a way that fits men’s past experiences. Femininity is subordinate to masculinity and
thereby has a low status and results in difficulties for men to express female attributes (43, 44).

There is a variance of opinions about when to resume sexual intercourse. It is important for health care professionals, particularly midwives, to recognise this variance and to be aware of the gender-focused and patriarchal construction that has shaped us. These aspects need to be discussed more often by healthcare professionals and be further developed in research within caring science. Fausto-Sterling argues that gender is represented both within social institutions and within individuals, and the subjective sexual self-emerges in this complex system of gender. Gender as a process creates the social differences that define ‘woman’ and ‘man.’ These gendered individuals exist in social institutions strongly marked by a variety of power inequities (45). Health care professionals need to have open discussions about sexual activity and normative gender roles in society with the couple during pregnancy and after the birth (2, 11, 12, 46). The men in our study wished that antenatal classes or postpartum visits included information from the midwives, and they indicated the importance of getting accurate information about the changes in the sexual relationship after childbirth.

Conclusion

New fathers in our study put the baby in focus in early parenthood and were prepared to postpone sex until both parties were ready for sex, although they needed reassurance to feel at ease with the new family situation. This indicates a dawning awareness of how the normality of gender roles directs men and women into certain behaviours. It also points at the importance of presenting information in a way that also fits men and their past experiences, making the transition to fatherhood smoother. The fathers’ perceptions of sexual life extended to include all kinds of closeness and touching, and it deviated from the stereotype of male sexuality. The results of this study help midwives and other health professionals to better understand how new fathers look upon their sexual relationship during transition to parenthood and contribute to caring science with a gender perspective on adjustment of sexual life after childbirth.

Acknowledgement

We would like to thank all the new fathers who have shared their thoughts and experiences with us about sexual life following childbirth. We would also like to thank the male interviewer Mats Berggren, who carried out the interviews.

Author contributions

Ann Olsson, Anders Björklund and Eva Nissen were responsible for the study design and data collection. All authors were involved in data analysis and writing the paper. Ann Olsson, Eva Robertson and Eva Nissen contributed equally to the final revision of the paper.

Funding

This study has been supported by funds from Karolinska Institutet, FoU grants from Pratikertjänt AB and BB Stockholm AB.

References

Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth

Ann Olsson1 RNM, Martina Lundqvist2 RNM, Elisabeth Faxelid3 RNM, PhD
and Eva Nissen4,5 RNMTD, PhD

1Karolinska Institute, Danderyds Hospital, BB Stockholm AB, Stockholm, 2Nycomed AB, Lidingo, 3Division of International Health, Department of Public Health Science, Karolinska Institute, Stockholm, 4School of Life Sciences, University of Skövde, Skövde and 5Division of Reproductive and Perinatal Health Care, Department of Woman and Child Health, Karolinska Institutet, Stockholm, Sweden

Scand J Caring Sci; 2005; 19; 381–387

Women’s thoughts about sexual life after childbirth: focus group discussions with women after childbirth

Background: To give birth and become a parent is a source of many emotions and expectations. Several studies show that women experience different problems after giving birth. It can bring many physical, emotional and social changes that may alter the woman’s sexual needs and impact on her relationship. The aim of this study was to elucidate how some women experienced their sexual life with their partner after giving birth.

Methods: Twenty-seven women participated in six focus group discussions (FGDs). These discussions took place 3–24 months postdelivery. The midwives at their antenatal clinics selected them. A discussion guide with broad questions related to the subject was used and an observer took notes during the FGD.

Results: Four themes were identified: body image after childbirth, how sexual patterns are altered following new stresses of family life, discordance of sexual desire with the partner and the necessity for reassurance. The women did not feel comfortable with the physical changes that had taken place and their body image. Childbirth meant less sleep and less free time; consequently, instead of having sex, women wanted to sleep or have time for themselves and that led to a changed sex pattern. Discordance of sexual desire with the partner was a problem but most of the women expressed confidence that their sexual desire would return shortly. Reassurance and confirmation that they were physically alright and back to normal was essential.

Conclusion: New mothers are concerned with their body image and the ability to adapt to parenting. They need sensitive, professional counselling and reassurance about their body, as well as about sexual life after childbirth. This level of professional counselling is presently not widely available to new mothers, while midwives and gynaecologists should be the key persons to provide this service.

Keywords: childbirth, libido, postpartum care, sexuality.

Submitted 25 October 2004, Accepted 27 June 2005

Introduction

In Sweden, women make frequent visits to the antenatal clinic during pregnancy. These visits mainly concern the health of the woman, control of her pregnancy and preparation for childbirth and breast-feeding. After birth, the mother, possibly together with her partner, returns to the antenatal clinic for a postpartum checkup. This is done either by the midwife or the gynaecologist, 6–12 weeks postchildbirth. The midwife counsels the woman on her experience of childbirth; she makes a physical examination of the uterus, vaginal and perineal lacerations and suggests suitable contraceptives, possibly assuming that the woman and her partner have resumed sexual intercourse. Little attention, if any, is given to postpartum sexual and family life in the new family (1–4).

Sexuality has normal fluctuations during different phases of life, in which childbirth is one phase. Ahlborg (5, 6) has suggested that psychosexual and marital problems can occur at any time but are more prevalent following childbirth. However, it is possible that when parents are able to communicate well about their needs, both as parents and as sexual partners, intimacy and well-being may be enhanced. Difficulty in the marital relationship is an established risk factor for postnatal depression (7) and is also associated with a loss of sexual desire in women after childbirth (8, 9). Sexual interest and activity tend to be reduced for several months following childbirth, compared
with prepregnancy and pregnancy levels (10, 11). Up to 1 year after delivery, 50–87% of women report tiredness, pain due to lacerations, incontinence, depression and problems with the sexual life (8, 12–14). After delivery, many women experience reduced sexual desire and reduced vaginal lubrication, as well as weaker and shorter orgasms (15). Barrett et al. have shown that approximately 90% of the women had resumed their sexual life 6 months after the delivery, but 64% often experienced problems (11, 13). New parents do not reach the same frequency of sexual intercourse as before the birth of the first child until 1 year has passed (16, 17).

Another issue, not often discussed in relation to sexuality, is the phenomenon of healed or healing vaginal and perineal lacerations following vaginal and assisted vaginal birth. Approximately 75% of all primiparas have vaginal lacerations during delivery. Some of them need to be sutured, while other lacerations are left to heal without sutures. A study among women with different types of lacerations after vaginal deliveries showed that women with an intact perineum or a first-degree laceration experienced considerably less painful sexual intercourse, more sexual satisfaction and better orgasms than those with major lacerations and episiotomies (18, 19). To have an assisted vaginal delivery has also been connected with dyspareunia (20). This shows that resuming a satisfactory sexual life after childbirth is not uncomplicated and should not be taken for granted by counselling midwives. It has been established that women consider the information about sex in relation to childbirth insufficient and given too soon after childbirth (2, 3, 13). The Swedish Board of Health and Welfare has not issued any guidelines as to where, when, how and whether or not the antenatal midwife should discuss sexuality issues with new parents (21). The purpose of the present study was to elucidate women’s experience of their sexual life after childbirth in order to get a better understanding of women’s thoughts about this issue and their need for counselling.

Materials and methods

In order to collect data on the delicate issue of sex after childbirth, focus group discussions (FGDs) were used. A focus group can be defined as an in-depth, open-ended group discussion that explores a specific set of issues on a predefined and limited topic; the group consists of four to 12 participants (22). The idea behind the focus group method is that group processes can help people to explore and clarify their views in a way that would be less easily accessible in a one-to-one interview. The method is useful for exploring people’s knowledge and experiences and can be used to examine not only what people think, but also how they think and why they think the way they do. The FGD elucidates the intimate parts that other methods cannot reach revealing dimensions of understanding that often remain untapped by more conventional collection techniques (23).

In the present study, six FGDs were held with four to seven participants in each group, a number that was considered to be sufficient to achieve saturation of the topic (24).

Women were identified by the midwives who had cared for them during the pregnancy. The midwives approached women who would likely agree to discuss this topic in a group and, moreover, who would be willing to openly share their own experiences. The FGDs were held in five different antenatal clinics in Stockholm. Most participants were native to Stockholm, with the exception of one group of participants who were second-generation non-native Swedes and who were selected from one antenatal clinic situated in an area densely populated by immigrants. Furthermore, the participants had to be Swedish-speaking and should have given birth at least 3 months before the FGD session. To guarantee the greatest possible anonymity between the participants, the women were recruited from different sociodemographic areas within the catchment area of each antenatal clinic. Following consent, the authors gave a more detailed presentation of the study over the phone. Written information, including an invitation, was sent to the women 1–2 weeks before the FGD was to take place. The women were given a guarantee that the research group would treat the information given by them confidentially.

Four women changed their minds about participation in the study. Three of them became occupied the same day as the FGD and were not able to participate and the fourth changed her mind and did not want to participate in a group discussion.

Data collection

Data was collected during 2001–2003. Before the FGDs started all the participants filled in their background data (such as age, education, marital status, pregnancies, deliveries, the birth outcome and breast-feeding data) (Table 1).

A moderator (the second author) conducted the FGDs and an observer (the first author) took detailed notes. Neither the moderator nor the observer had any relationship with the participants. A discussion guide was used that contained questions about the sexual life after childbirth and asked whether the midwife, friends or partner had earlier brought up the subject. Questions about desire, physical changes of the body and perineal lacerations in relation to the sexual life were also included. Participants were also asked to indicate whether they had received previous counselling with regard to these topics. The discussions proceeded for 1.5–2 hours. The women talked openly and freely. The moderator balanced the discussion so that all topics in the discussion guide were elucidated. The notes were made as detailed as possible. The research leaders made a summary of each FGD directly after the
session, in order to verify with the participants that everything had been correctly understood. A second observer (the last author) was present during one FGD. This was done 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 sufficient. Furthermore, it was noted whether new topics had been brought up in the group, which could lead to more FGDs or whether saturation of the topic had been reached (25).

**Data-processing and analysis**

The analysis of the data is based on the notes from the FGDs. During the first FGD, technical problems with the tape recording occurred. On the second occasion while a tape-recorder was being used, it was evident that the women felt uncomfortable about the discussions being recorded. Therefore, from that point, only hand-written notes were taken during all the other FGDs, as has been suggested as an alternative to tape recording (26). The data processing was initiated by making a clean copy of the notes using complete sentences, phrases and quotations after each FGD (27).

The initial step in the analysis was to read through the transcripts several times, making notes through the reading on general themes in the transcripts. The aim of this procedure was to become immersed in the data. The next step was to sort data into as many codes as necessary. In this step 19 codes were identified. The next step was to reduce the number of codes by collapsing them into broader categories. Tentative categories and new associations of meanings were developed and, finally, four main themes emerged. The material was revised once again by the last author. This served as an external validation of the analysis. For further validation, the result was given to five of the participants from different FGDs, to discern that their experiences had been correctly understood (‘member checks’) (28). No further comments were added.

**Ethical considerations**

The local ethical committee at the Karolinska Institute, Stockholm, Sweden, approved the study. The participants were informed that individual discussions were available, if needed, at any point following the FGDs; no participant expressed this need.

**Results**

The results of the FGDs elucidated several main themes. Women were keen to observe changes to their personal body image following the birth of the child, with some of these women experiencing anxiety about the permanence of these changes. A second theme to emerge was the influence of stress as it related to coping with a new family life and how this stress altered earlier sex patterns between the couple. Compounding this theme was a recognizable discordance of sexual desire between the partners, mostly with the woman expressing little or no sexual desire following the birth of the child. A final theme to emerge was a stated need by the women that they wanted reassurance from their partners as well as from the medical staff that their bodies had or would soon return to normal. These main themes are shown in Fig. 1.

**Body image after childbirth**

The women said they experienced a physical change and some felt less attractive. Some said that they could hardly cope with this change; it seemed to be permanent and out of their control. Physiotherapeutic advice on exercise was not successful.

It was fun to do my Kegels (pelvic floor exercises) the first time but now after the second child it is not getting any better. It’s going to be like this for the rest of my life. Woman nr 2, age 37 FGD 1

Women were anxious about the vagina, which seemed to be big and loose, and they perceived the breasts to be smaller after weaning.

I do not feel happy with my body. Pregnacies and babies deplete it. The breasts get smaller and my vagina is not as tight as before. Woman nr 1, age 33 FGD 4

Some women even mentioned plastic surgery as a way to circumvent unwanted body changes. These negative interpretations were not shared by everyone, however, and in contrast some women felt that they had gleaned a better knowledge of their bodies following the birth. They could, for example, more easily find their muscles and learned how to reach sexual satisfaction. These women accepted the changes and regarded them as being true life conditions.

---

**Table 1** Demographic characteristics of participants (n = 27)

<table>
<thead>
<tr>
<th>Age (y)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>23–29</td>
<td>10</td>
</tr>
<tr>
<td>30–35</td>
<td>12</td>
</tr>
<tr>
<td>36–39</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school</td>
<td>6</td>
</tr>
<tr>
<td>University</td>
<td>20</td>
</tr>
<tr>
<td>Still studying</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>12</td>
</tr>
<tr>
<td>Living together</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parity</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primipara</td>
<td>9</td>
</tr>
<tr>
<td>Multipara</td>
<td>18</td>
</tr>
</tbody>
</table>
Sutured vaginal and perineal lacerations made some women particularly anxious about what would happen to their sexual life. Women experienced their breasts differently while breast-feeding; the breasts were no longer related to sex in the same way as before. Being caressed on the breasts did not excite them, and they thought that it was difficult to combine the two functions of the breasts, sex and breast-feeding. These opposing functions seemed confusing.

What is supposed to turn him on is also food for the baby. Woman nr 5, age 28 FGD 2
The baby owned my breasts and he (the partner) could not have them until I stopped breastfeeding. Woman nr 2, age 23 FGD 4

Stresses of family life alters sex pattern
There are many changes in the family brought about by childbirth. The most common changes are tiredness, lack of time due to the child and altered sexual activity. The women said that they had different priorities after childbirth as compared with the time before the child was born. If there was time to spare, the women preferred to sleep or read rather than to have sex, as the daily physical contact with the child fatigued them and pronounced the need to have some time of their own. Despite these observations, the women emphasized that it was very important to spend time with their partner.

We don’t have sex as often now, the quality is more important: that special feeling, the look in his eyes. It is not so very often, but it is quality not quantity. Woman nr 2, age 33 FGD 5
Many women thought that the physical changes, as well as the transition to parenthood and their new roles, would require more time to find normality again. Some women were anxious that the child would wake up or be disturbed when they were having sex and therefore they had problems in concentrating; they felt distracted and tense.
If the child was sleeping, I would like to have sex, but if he woke up I couldn’t continue. Woman nr 4, age 29 FGD 2

Discordance of sexual desire with the partner
* The couple are not synchronised regarding sexual desire
* Lack of sexual desire
* The baby satisfies the woman’s need for closeness
* A threshold to step over in order to recover one’s sexual life.
* Negotiations, bargaining and compromising are ways of dealing with different needs.

Reassurance
* Very important to have an "approval" from a professional that the body is "normal" or at least working as usual again.
* Great need to discuss sexual life after childbirth at the post partum check-up
* Women thought that lack of confirmation would lead to low self-esteem
* Acceptance requires confirmation from partner but also from midwife.
considered friendly, but not very professional. Some normal. In some cases, the midwife and the doctor were ensured by a professional that their bodies had returned to birth and stated very clearly that they wanted to be reassured, even though they felt no desire. In some of these cases, they also pretended to have felt desire and had an orgasm.

It might hurt the partner if you say no (to have sex). You pretend to feel desire and that you are having an orgasm. My desire has decreased after the second child, maybe due to having less time. I was not prepared for these feelings. Woman nr. 3, age 35 FGD 2 The women said that there was a threshold to overcome in order to recover one's sexual life. A common feeling was that if one waits too long, it would be more difficult. They expressed confidence that their sexual desire would return shortly.

To touch each other creates desire and the more you touch, the more you desire. Woman nr. 2, age 39 FGD 6 The woman’s lack of sexual desire became a problem in some relationships. The possibility of discussing the issue, without being critical or overcome with guilt, seemed to be vital in determining whether or not conflicts and future problems would occur. Occasionally, women revealed that their relationships had a total lack of communication and understanding.

I stay up on purpose until he has fallen asleep, in order not to have to say no to sex. Woman nr. 1, age 33 FGD 3

Reassurance

The women said that their partners did not confirm their own dissatisfaction with their body image. They did not believe that the men told them the truth, but they agreed that they were more anxious about the size of the vagina than were their partners.

I have asked him if my vagina felt outsized and he said no. I don’t believe him, but it is nice of him to say that.

Woman nr. 2, age 31 FGD 1

The postpartum visit to the midwife was very important for the women, but most of them found the visit too short. They wished to discuss the physical changes after childbirth and stated very clearly that they wanted to be reassured by a professional that their bodies had returned to normal. In some cases, the midwife and the doctor were considered friendly, but not very professional. Some comments were regarded as insulting and made the women upset.

‘Nice and tight, almost like a virgin,’ a doctor said while doing a vaginal exam. Woman nr. 3, age 36 FGD 3 Despite that, the encounters with the health professionals were sometimes unpleasant; the postpartum checkup did have an effect that encouraged the women to resume their sexual life. However, in many cases, it was expressed that the women would rather have liked to talk more about how they felt and about their decreased libido, than about contraceptives. They would have appreciated instead another visit after 4–5 months, when they were more in accordance with these issues, to discuss sexuality and contraceptives.

Discussion

A novel finding in this study was that the women tended to segment their bodies, not only physically but also emotionally. The breasts, which had previously been an erotic zone, had turned into being an area restricted to the baby’s needs, not to be associated with sexual activity (only the area surrounding the lower genitalia was considered ‘okay’ with regard to sex). Our study supports the previous finding by Avery et al. (29) that approximately one third of women in their study reported some degree of difficulty with their breasts having a dual purpose. The women also perceived the vagina as big and loose. Even though the partners did not confirm this perception, their perceptions remained unchanged. The same findings have been reported in other studies (8, 10). Von Sydow found in the metacontent analysis of 59 studies that women generally perceived the vaginal tension as unchanged or tighter on resumption of intercourse, but at 3–4 months postpartum, tension remained mostly unchanged and was described as being ‘slacker’ in about 20% of the cases (10).

The expectations about the body image after the delivery varied, but many women found the changes difficult to accept. A common conception held was that childbirth and breast-feeding should not leave visible traces. A thorough recovery could, therefore, include diet and physical exercise, but plastic surgery was also considered as a valid means of returning to the prepregnancy body. This suggests that some women do not accept alterations of the body created by pregnancy and breast-feeding as a form of development, but consider it instead a negative aspect of childbearing. The women did not feel proud of their new, mature body image. In contrast, they maintained preconceived commercial ideals. Given this insight, it might therefore be worthwhile to take up these cues early during pregnancy in order to facilitate an active reflection upon the attitudes of women and men towards pregnancy and natural female body adjustment.

Pressures on family life indicated that the increased stress and tiredness led to adjusted priorities and sexual

restraints. Tiredness and the full-time occupation of understanding the various needs and cues presented by the child made the women set new priorities. Sleep was considered the most important thing, while sex took on a low priority. This picture of maternal focus on the newborn baby is well known from psychology with regard to women’s adaptation to motherhood (30). However, while the closeness between the mother and the baby makes the mother calm (31) and satisfies her (12, 32), this newly developed maternal preoccupation may also contribute to the discordance of sexual desire with the partner, a factor that may be further accentuated if the father of the baby feels that he is being left-out from the intense mother/infant relationship. Our study supports previous studies that indicate fatigue or tiredness as the most common reason for loss of sexual desire in the postpartum period (8, 9, 14). Conflicts with partners over sexual activity (or the lack thereof), as well as the subsequent stress on the relationship, were common concerns. Research supports that female sexual expression is often motivated by concern about the sexual satisfaction of the partner (10). This notion, combined with our findings and those reports proposing increased communication between the couple (6, 10), supports an initiative towards balance with the new life situation.

The women in this study were anxious about their physical changes and were very eager to ‘recover’ so that during the postpartum checkup with the midwife, reassurance was considered very important. The importance of reassurance from the partners and the professionals is also described in several other studies (2, 3, 14, 29). Some women said that they had looked forward to the postpartum checkup, but that they were ultimately disappointed with both the limited time offered for consultation and with the general attitude disposition of the midwife and/or the gynaecologist. They had hoped to be able to discuss, in particular, the physical changes after childbirth along with its consequences. The women wanted to be reassured that their bodies were okay, but they often instead received the casual comment that ‘it will get better later on’. When the midwife or the gynaecologist was doing a vaginal examination, unintentionally insulting comments were perceived as such and ultimately made the women upset and sad. Kline has previously shown that the ‘experts’ often do not have sufficient knowledge about a woman’s need for information and reassurance and that very often insensitive counselling is provided at a point-time when the information is not asked for (3, 11, 14). The midwife or the gynaecologists doing the postpartum checkup often neglects or overlooks this need. Furthermore, Barrett et al. (13) found that only 18% of women coming for a postpartum checkup at 6 weeks after childbirth had received counselling about the physical changes and sexual life after childbirth, while most of them had only been counselled on contraceptive use. Our findings indicate that a second visit to the clinic, after approximately 4–5 months, would be valuable to discuss aspects of sexual life, contraceptives, etc.

A willingness to openly discuss sexual and family life while sharing personal experiences was a main inclusion criterion in our study. The issues raised by these women provided us with a better understanding of the experiences and needs that women may have with regard to childbirth and postpartum checkup. In order to optimize the results and reduce the risk of over-looking salient information, tape recording and transcription verbatim was our preferred method of data collection. We experienced this method as slightly problematic, however, when some participants did not want their remarks to be taped. Taking notes became the most suitable option and in order to validate this method a second observer participated during one of the FGDs. On comparison of the noted information, the two observers’ notes corresponded very well with each other. For further validation, the results were sent to five of the participants (28). They thought that our recorded notes corresponded well with their descriptions of experience and with their memories of discussions that took place within their own group. We found that the FGDs were open and comprehensive, and the method was feasible for this topic. The participants also confirmed this.

From this study, we have learnt what some new mothers think about sexual life after childbirth. Some of the topics in this study regarding the relationship with the partner, especially the ways of reassurance and acceptance of postponing sex, need to be further elucidated by interviews or FGDs with the partners. A future study should be carried out to find out what new fathers think about sexual life the first year after they have had their first child. In this study, there was a large spread in the time interval that had passed after childbirth, 3–24 months. It would be valuable to survey the perception of sexual life in a representative group of women and men at different points of time after childbirth, on the basis of the results of this study.

**Conclusion**

The results of this study have shown that the women’s concern for sexual life had diminished in favour of other basic needs such as sleep and maternal preoccupation with the new baby. These results have also shown that the new mothers want and need sensitive professional counselling and reassurance about their body shape and function, as well as about the fact that sexual and family life may change postpartum.

**Acknowledgements**

We would like to thank all the women who shared their thoughts and experiences about sexual life following...
childbirth with us. We would also like to thank all the midwives who helped us to recruit the participants for the focus group discussions.

**Author contribution**
The authors contributed equally to the manuscript.

**Funding/sponsorship**
This study has been supported by the Swedish Research Council (grant no. 99-27p-13085-01A) and by the funds of Karolinska Institutet and BB Stockholm AB.

**References**
Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood

Hannah Woolhouse, Ellie McDonald & Stephanie Brown

To cite this article: Hannah Woolhouse, Ellie McDonald & Stephanie Brown (2012) Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood, Journal of Psychosomatic Obstetrics & Gynecology, 33:4, 185-190, DOI: 10.3109/0167482X.2012.720314

To link to this article: http://dx.doi.org/10.3109/0167482X.2012.720314

Published online: 13 Sep 2012.

Submit your article to this journal

Article views: 451

View related articles

Citing articles: 1 View citing articles
Women’s experiences of sex and intimacy after childbirth: making the adjustment to motherhood

Hannah Woolhouse, Ellie McDonald & Stephanie Brown

Murdoch Childrens Research Institute, Healthy Mothers, Healthy Families, Level 5, Royal Children’s Hospital, Parkville, 3052 Australia

The aim of this study was to explore women’s experiences of changes to their sexual relationship, sexuality and intimacy, as a result of pregnancy, childbirth and parenting. A sub-sample of women was purposively selected from a larger prospective pregnancy cohort study of nulliparous women in Melbourne, Australia. Eighteen women (including a mixture of parity, birth methods and relationship status) were interviewed 2.5–3.5 years after a first birth. Interviews were transcribed verbatim and analyzed using interpretive phenomenological analysis. Women identified numerous factors affecting sexual and intimate relationships including extreme tiredness, changing lifestyles and body image issues, leading to changes in libido and intimacy in relationships. Of particular note were feelings of guilt and failure women experienced as a result of a lowered libido. Finding ways to stay connected – whether through sex, quality time together or working as a team – helped women and their partners navigate the transition to parenthood. This study demonstrates that pregnancy, childbirth and parenting can bring about significant changes to women's experiences of sex and intimacy. Women who experience significant reductions in their libido may be vulnerable to feelings of guilt and failure, connected with high expectations that they should be able to “do it all”.

Keywords: Sexuality, intimacy, postnatal, qualitative, adjustment to motherhood

Introduction

While there is considerable research into the physical and mental challenges following childbirth, far less attention has been given to the social changes and adjustments women navigate when they become a mother. Managing changes to one’s relationship with an intimate partner, including role changes, sex, and intimacy, is perhaps one of the most significant challenges women experience after childbirth. Sexual problems in the postpartum period are very common, with around 80% of women reporting issues such as pain during intercourse, vaginal dryness and loss of libido in the first 3 months postpartum [1]. Significant psychosocial changes can also have significant impacts on sexual relationships [2]. Studies have identified that there is often a significant decrease in both the “subjective importance of sexuality” and “contentment with present sex life” over the course of the perinatal period [2,3]. Discrepancy in libido between partners has been identified in several studies as a major issue for couples in the postnatal period [4,5]. Compounding the challenge of the adjustments women make after childbirth are the socially constructed images of being a mother who “has it all” – perfect body, passionate relationship with partner, loving relationships with children, an active social life and professional success [6,7].

Given the subjective nature of sexual experience, it is surprising that women’s voices remain relatively absent in the literature around sex and sexuality. A small number of international studies have reported on what women themselves have to say about sex and intimacy after childbirth [3,4,8]. Explorations of the lived experience and the social and cultural context of sexuality and intimacy are rare, despite their importance to women’s well-being.

The current paper is based on in-depth interviews with women taking part in a prospective pregnancy cohort study in Melbourne, Australia. The aim of the study was to bring to life women’s own voices around their experiences of changes to sex, sexuality and intimacy following childbirth. The paper reports on what women had to say about changes to their sexual and intimate relationships after childbirth, and the factors that may have brought about these changes. We conclude with comments from women about what helped them make this transition more smoothly.

Correspondence: Dr Hannah Woolhouse, Murdoch Childrens Research Institute, Healthy Mothers, Healthy Families, Royal Children’s Hospital, Parkville, Australia. E-mail: hannah.woolhouse@mcri.edu.au
Methods

Design and recruitment
The Maternal Health Study is a prospective longitudinal pregnancy cohort study. Women registered to give birth, at six metropolitan public hospitals in Melbourne Australia, were originally recruited to the study between 1 April 1 2003 and 31 December 31 2005. Further details regarding the study methods and procedures of the Maternal Health Study are available in a published study protocol [9].

Between May and October 2009, a sub-sample of women from the Maternal Health Study was invited to take part in an in-depth face-to-face interview regarding their sexual health and intimate relationships after birth. Selective sampling was used to obtain a variety of experiences related to physical and emotional satisfaction with intimate relationship, method of birth and genital tract trauma. For practical reasons, the sample was also limited to women living within 20 km of central Melbourne. In all, 77 women were invited to take part in the face-to-face interviews. Invitation packages were sent to these women and included an invitation letter, study information sheet, consent form and reply paid envelope. Eighteen women agreed to take part in the study. Given the highly personal nature of the interview subject, this response rate was as expected. Separate ethics approval for the in-depth interview study was obtained from the ethics committee of La Trobe University.

Data collection procedure
Interviews of approximately 60 min were conducted for all of the 18 women who returned completed consent forms. The interviews took place when their first child was between 2.5 and 3.5 years old. Seventeen interviews took place in women’s homes, while one interview was conducted at a participant’s workplace. Children were often present during the interviews. All interviews were digitally recorded and transcribed verbatim shortly after the interview took place. Interviews were conducted by two female members of the Maternal Health Study team (author 1 & 2), who had both undergone training in interviewing techniques. The interviews were designed to explore how women experienced and perceived changes to their sex life, sexuality and intimate relationships after birth. While there was a standard set of questions to guide the interview, the interviewer was encouraged to allow the interviewee to guide the direction of the interview, and follow their interests as they arose. Topics listed in the interview schedule included: sex and intimacy prior to pregnancy, changes to sex and intimacy during and following pregnancy and childbirth, management of problems when they arose, seeking help for relationship issues, and changing sexuality.

Data analysis
All interviews were digitally recorded and transcribed verbatim. Interview transcripts were analyzed using Interpretive Phenomenological Analysis (IPA) [10,11]. The aim of IPA is to conduct an in-depth exploration of how individuals make sense of their personal and social world [11]. At the heart of the IPA approach is an emphasis on the “lived experience” of study participants, and an attempt to understand their perception of the world around them. It is therefore a valuable method for bringing women's own voices to light [12]. In fact, “giving voice” to participants has been identified as central to the phenomenological core of IPA [12], and we therefore considered it a valuable analysis method for the current subject.

Data were analyzed following the step-by-step procedures recommended by Smith [11]. The initial stages of data analysis involved looking at each interview transcript individually, making comments in the left hand margin on emerging areas of interest including: connections, preliminary interpretations, the use of language, a sense of the person being interviewed and contradictions. During a second read-through of the transcript, possible emergent themes were noted in the right-hand margin. As additional transcripts were analyzed, emergent themes were noted down, and connections between them were sought. A detailed table of themes was created, and ordered coherently, with related themes linked together and given a suitable title, and sub-ordinate themes listed below. Translation of the themes into a coherent narrative was then completed. Themes and sub-themes were confirmed in discussions between the co-authors.

Results

Characteristics of the sample are presented in Table I. The age range of the sample was 29–47 years (M = 36). At the time of the interviews, 44% of women had one child and 56% of women had given birth to a second baby. 78% of the subsample had a vaginal birth for their index birth. 61% of the women were married, and 28% were in de-facto relationships. One woman was divorced, another separated and one woman was in a same-sex de-facto relationship.

The current paper reports on what women considered the most important changes to their sexual and intimate relationship. The factors identified have been loosely grouped into psychosocial factors, changes and factors that helped. Themes and sub-themes identified in interviews are presented in Table II.

Psychosocial factors affecting sex and intimacy

Tiredness
Extreme tiredness and exhaustion was reported by all women, especially in the early months after the birth. This was the most commonly reported reason for a decreased frequency of sexual activity.

These days I’m just so tired I feel like I could go without sex forever. Nelly

I just go to bed and go “I’ve got five hours up my sleeve… What do I want to do? Spend an hour having sex and then sleep for four? No, I want five hours to sleep.” Nelly

Changing lifestyles and gender roles
The lifestyle changes following childbirth were experienced as dramatic and challenging by most women. Many spoke of the losses following the birth of their first child – the loss of freedom, the loss of spontaneity, the loss of time together as a couple and the loss of time to oneself.
Women's experiences of sex and intimacy after childbirth

1. I feel like there's not so many elements of our relationship that are sexy anymore…. What we don't have at the moment is 'us time', and I don't feel like that time is prioritised.

Greta

2. I feel as though there's not enough of me to go around. Let alone my own sense of giving to myself.

Abigail

3. The way domestic responsibilities were shared between women and their partners changed after childbirth. Even for couples who had previously shared household tasks equitably, the arrival of children often resulted in couples assuming more stereotypical gender roles. Women expressed some resentment over their increased domestic responsibilities.

There becomes these assumed roles, and that pisses me off…… I feel like I carry around this chip on my shoulder…. And then it affects your view of yourself, in terms of thinking “God, is this all I've become?” Greta

Emotional connections with children

The intense emotional connection women felt with their child sometimes resulted in sex and intimacy taking a back seat, with potentially negative implications for adult intimate relationships.

I think another part of it is that, sometimes I feel as though I'm more in love with my children... Isn't that madness? But that kind of love that… being madly in love the way I was with Michael, it's become more of a stable kind of love, and my children have almost replaced that breath-taking, head-over-heels kind of in love. Abigail

Changes to sexual and intimate relationships

Loss of libido

Many women experienced a dramatic drop in their libido, either during pregnancy or after the birth. The reasons women gave for their drop in libido show how they attempted to understand

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age at first birth</th>
<th>Parity</th>
<th>Country of birth</th>
<th>Relationship status</th>
<th>Education level</th>
<th>Method of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abigail</td>
<td>34</td>
<td>2</td>
<td>Australia</td>
<td>Married</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Bree</td>
<td>35</td>
<td>2</td>
<td>Chile</td>
<td>De-facto</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Carrie</td>
<td>29</td>
<td>2</td>
<td>Australia</td>
<td>Married</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Dianne</td>
<td>34</td>
<td>1</td>
<td>Australia</td>
<td>Married</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Nora</td>
<td>31</td>
<td>1</td>
<td>Australia</td>
<td>Separated</td>
<td>&lt; Year 12</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Greta</td>
<td>29</td>
<td>2</td>
<td>Australia</td>
<td>Married</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Hanh</td>
<td>35</td>
<td>2</td>
<td>India</td>
<td>Married</td>
<td>University degree</td>
<td>Caesarean</td>
</tr>
<tr>
<td>Maria</td>
<td>33</td>
<td>1</td>
<td>Australia</td>
<td>De-facto (same sex)</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Nelly</td>
<td>26</td>
<td>2</td>
<td>Australia</td>
<td>Married</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Sarah</td>
<td>31</td>
<td>1</td>
<td>England</td>
<td>Divorced</td>
<td>University degree</td>
<td>Caesarean</td>
</tr>
<tr>
<td>Pembe</td>
<td>33</td>
<td>2</td>
<td>Australia</td>
<td>Married</td>
<td>Certificate/Diploma</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Lucy</td>
<td>43</td>
<td>1</td>
<td>Australia</td>
<td>De-facto</td>
<td>University degree</td>
<td>Caesarean</td>
</tr>
<tr>
<td>Rachel</td>
<td>29</td>
<td>2</td>
<td>Australia</td>
<td>Married</td>
<td>Year 12</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Victoria</td>
<td>29</td>
<td>1</td>
<td>Australia</td>
<td>De-facto</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Yvette</td>
<td>32</td>
<td>2</td>
<td>Australia</td>
<td>Married</td>
<td>Certificate/Diploma</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Erica</td>
<td>29</td>
<td>2</td>
<td>Denmark</td>
<td>Married</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Ida</td>
<td>35</td>
<td>1</td>
<td>Australia</td>
<td>De-facto</td>
<td>University degree</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Jemima</td>
<td>44</td>
<td>1</td>
<td>South Africa</td>
<td>Married</td>
<td>University degree</td>
<td>Caesarean</td>
</tr>
</tbody>
</table>

Table I. Characteristics of the sample.

Table II. Themes and sub-themes identified in interviews.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial factors</td>
<td>Tiredness</td>
</tr>
<tr>
<td></td>
<td>Changing lifestyles and gender roles</td>
</tr>
<tr>
<td></td>
<td>Emotional connections with children</td>
</tr>
<tr>
<td></td>
<td>Body image issues</td>
</tr>
<tr>
<td>Changes</td>
<td>Loss of libido</td>
</tr>
<tr>
<td></td>
<td>Changing intimacy</td>
</tr>
<tr>
<td></td>
<td>Changing view of sexuality</td>
</tr>
<tr>
<td>Factors that helped</td>
<td>Teamwork</td>
</tr>
<tr>
<td></td>
<td>Time together as a couple</td>
</tr>
<tr>
<td></td>
<td>Agreeing on priorities</td>
</tr>
</tbody>
</table>

Body image issues

Physical changes to a woman's body as a result of pregnancy and childbirth left some women feeling unattractive and self-conscious about their bodies.

There's the whole weight loss thing, and you've got a flabby tummy and your boobs are a different shape and you don't see yourself in the mirror the way you did before you had kids and go "Oh, not too bad", now its like "Oh. Can you turn the light out if we're going to have sex?"…. I am actually horrified by the thought of having sex in broad daylight. Carrie

In contrast, several women spoke of an increased sense of empowerment and respect for their bodies following childbirth.

I feel like if anything, I had more respect for myself and for the female form. I mean, it's quite a miraculous thing, and I found that empowering, rather than sort of negative… You know, it can be very pleasurable, but it can also create life. Victoria

© 2012 Informa UK, Ltd.
this and included a mixture of physical explanations (tiredness, breastfeeding, hormonal changes) and psychosocial explanations (adjusting to becoming a parent, resentment over role changes, emotional connection to the baby).

I guess I went from having a very healthy sex-drive and a very healthy libido and interest in sex, to being completely disinterested, completely...And doing it out of obligation, because I felt that Michael really enjoys it - as most men do (chuckles). So I felt as though I was kind of letting him down, so I pressured myself into it. Abigail

The language women used when talking about their loss of libido was striking, with words such as “obligation”, “duty” and “guilt” used frequently.

Once I fell pregnant, I had no interest in sex. None whatsoever…. And it never came back…. It was more the effect on my marriage that I was worried about. And I still feel guilt. HUGE guilt. It's the only thing in my relationship that I’m not perfectly happy with. Carrie

Women appeared to have high expectations of themselves in regards to sexual activity, and experienced a sense of failure when their sexual drive was not at the same level as before pregnancy. Most women saw these expectations as self-imposed, but some also experienced pressure from their partners.

I almost felt like it was - for want of a better word - my duty. That I could live without it, but I felt that, it had been such a big part, a significant part of our relationship, (laughs)... It sort of surprised me, which is why I think I really remember it, because I'm not a subservient kind of woman who thinks “This is my role, and my duty” but I really felt like I had failed. And maybe it was because I put a lot of expectations on myself and I didn't live up to that, so, you know, that was a failure. Greta

Changing intimacy

Women commented on the bi-directional relationship between emotional intimacy and sex. Some women felt that physical intimacy and emotional intimacy were inextricably connected, and that intimacy had decreased in their relationship as a result of sexual problems.

Because we don't have sex very often now at all, a lot of the intimacy has gone as well. And I think that if we had more intimacy, we'd have more sex, and Marcus thinks that if we had more sex we'd have more intimacy. Jemima

Other couples found sex was a way of remaining closely connected with their partner in the midst of significant lifestyle changes, while some couples found new ways to express their intimacy as a couple.

I think we kind of clung to our sex-life, you know? It was like “As long as we can keep having sex, we’ll be OK.” Yvette

I don’t feel that we’ve grown apart because we’re not having sex. We still have a date where we go out, like every two or three weeks, just the two of us. We still kiss and cuddle and sit on the couch together. And as I said, we may not have intercourse, but we do other things. Rachel

Changing view of sexuality

During the interviews, women were asked directly about changes to their sexuality – defined as “The way you think or feel about yourself as a sexual being”. Consistently, women responded that the role of mothering was “not sexy”, and that becoming a mother had negatively affected their sex life.

I suppose I’ve lost confidence just knowing that I’m a mum… I don’t see myself as sexy anymore because I know that I’m a mum….Those things don't go together. Nelly

I think it's because it's harder to see myself as a sexual being, to tell you the truth…. This is me. This is what I do every day, I look after children, I clean up, I just feel really mundane, and like, how could you find this attractive? It doesn’t feel sexy. Greta

Generally, women reported that they did not think their partners saw them any differently, but rather the way they viewed themselves had changed.

It's kind of like a bit of a conflicting role to be a mother and a nurturer on one side, and a whore in the bedroom on the other side [laughs]. And I don't actually think my husband sees me differently... Whereas I'm a completely different person, I no longer have my own financial independence, I don't work and interact with other adults on a daily basis. I'm a completely different person now to what I was. Carrie

Factors that helped

Teamwork

Women identified a range of factors that helped them and their partners in making the transition to parenthood more smoothly. Teamwork between partners helped maintain a satisfying intimate relationship after birth. Taking on challenges together, with shared responsibilities allowed couples to maintain a stronger relationship both physically and emotionally.

The impact on my life has been about the same as the impact on Dean's life... It's been a real joint venture... And I think the fact that it's been halved, has really helped, and the fact that it's been mutual has really helped. Victoria

Time together as a couple

Time together as a couple, away from children, was also reported as helpful. However, practical difficulties with childcare made this challenging for some couples.

We had this really nice romantic dinner for two, just to reconnect as a couple, that was really nice, and we felt that was important....Having Rainer looked after and having some of our time has been really important...Reconnecting as a couple rather than it always being about Rainer. Dianne

Agreeing on priorities

It was helpful when couples agreed on what was currently a priority, whether it be sex, or sleep, or caring for their new child. For some couples, this meant that sex was not currently a priority.

Look, it's not where our sex life was, but, I kind of think that suits us at the moment. We've got a lot of stuff going on... It works for us... It's definitely not a priority at the moment. Rachel

Journal of Psychosomatic Obstetrics & Gynecology
For other women, prioritizing sex was important. Women spoke of sometimes having sex when they were tired and did not necessarily feel like it, either for their own benefit, for their partner's benefit, or for the benefit of the relationship. This was generally reported positively, as something that had ongoing benefits to the relationship, both sexually and emotionally.

I sort of took the view that, once we started having sex, I always enjoy it... You might not necessarily feel like it right that instant, but if you always say no you kind of regret not having a sex life... If I'd honestly been answering the question would I prefer to read a book or .....[laughs], the answer probably would have been reading a book [laughs]. But once I'd start, it was fine.... I think, maybe the thing is to prioritise it more. Erica

Discussion

The many adjustments women face following pregnancy and childbirth can place considerable strain on sexual and intimate relationships. In the current study, women identified a range of issues that impacted on sex and intimacy, including extreme tiredness, dramatic changes to lifestyles and roles, and body image issues. Loss of libido following pregnancy and childbirth was a commonly reported challenge in the current study. An imbalance in sexual desire between men and women has been identified in previous studies as a key cause of relationship dissatisfaction [13]. Contributing factors to a decrease in sexual desire centered around the significant changes to lifestyle experienced after childbirth, such as no longer being in the workforce, decreased economic independence, reduced social contact with adults and an increase in menial responsibilities such as housework. These changes left many women questioning their own identity, with flow-on consequences to their experiences of sexuality and sexual desire.

Notably, it was common for women to experience this drop in libido as a kind of "failure", or something to feel "huge guilt" about. This is despite the fact that it is a common phenomenon, experienced by many women after birth. It would appear that women have internalized the ever-present socially constructed messages that mothers can "have it all" or "be it all" [14]. Contemporary images of motherhood include women who are devoted and loving primary care-givers, successful career women, and attractive and loving sexual partners [15]. It has been argued that these socially constructed images of motherhood are incongruent with the realities of motherhood that most women experience – fatigue, overwork, stress and identity struggles [6]. When faced with these inconsistencies between their expectations, and the realities of their life, feelings of guilt and inadequacy are somewhat inevitable. In addition to the many role changes and practical demands women experience following the birth of a first child, they are navigating tricky and conflicting cultural messages about sexuality and intimacy within the context of motherhood.

Extreme tiredness was a universal experience among the interviewed women, and a strong inhibitor of sexual intimacy, indicating that increased practical support for women would be helpful. Increasing mother's opportunities for quality sleep would also be helpful for women in the early period after birth. Recent interventions aimed at improving infant sleep behaviours have shown positive impacts on maternal mental health at 2 years postpartum follow-up [16]. Such interventions may also show benefits to sexual and intimate relationships.

In the face of challenges faced by women and their partners as they make the adjustment to parenthood, there are strategies that can help couples make this transition more smoothly. Staying connected was a theme that ran through the comments from women with regard to what helped. For some couples, sex remained a way of staying connected, and acted as a means of increasing intimacy. Other couples found new and different ways of remaining connected, such as spending quality time together away from their children, or feeling a sense of teamwork in their approach to parenting responsibilities. Communication was another essential aspect of staying connected and navigating the transition to parenthood successfully. Increasing communication regarding expectations and concerns, before, during and after pregnancy is likely to be of benefit to most couples.

The findings of the current study should be viewed with some caution due to some important limitations of the study. We are mindful that the views expressed are not necessarily generalizable, or representative of the experiences of women from diverse social and cultural backgrounds. The current sample was not representative of the wider population, i.e. almost all women who participated had tertiary level qualifications. As such, the findings are likely to be somewhat biased. Another important limitation of the study is the exclusive focus on the perspective of mothers. The views and experiences of partners are clearly an essential component of sex and intimacy after childbirth. While the follow-up of partners was beyond the scope of the study, we recommend future studies in this area include the perspectives of partners, to create a more comprehensive understanding of sex and intimacy after childbirth.

Strengths of this study include the fact that participants were drawn from a large longitudinal study of first-time mothers, rather than a self-selecting or clinical sample. By using a theoretical approach to inform purposive sampling, we were able to ensure diversity across a range of characteristics, including method of birth and maternal age. The interviews were conducted around 3 years after a first birth, allowing some distance for reflecting on changes to sexuality and intimacy after a first birth, but not so much distance that memory had faded. It is clear from women's reflections on their experiences that the issues discussed in the interviews remained salient for the women who chose to take part. The use of Interpretative Phenomenological Analysis as a data analysis method was an additional strength of the study, as this method is particularly well suited to exploring changes to phenomena.

Conclusions

Pregnancy, childbirth and parenting can bring about significant changes to intimate relationships and women's feelings about sex and sexuality. Women who experience significant
reductions in their libido may be vulnerable to feelings of guilt and failure, connected with high expectations that they should be able to “do it all”. Open dialogues about the physical, emotional and social challenges women face in their adjustment to motherhood are likely to be helpful. Finding ways to stay connected, whether through sex, quality time together as a couple, or working as a team, can help couples navigate the adjustment to parenthood more smoothly.

Acknowledgements

We are extremely grateful to all of the women who generously agreed to take part in the interviews, contributing their time and energy, and to members of the Healthy Mothers Healthy Families research group at Murdoch Childrens Research Institute who assisted with follow-up of the main cohort and with data management.

Contribution to authorship

All authors have significantly contributed to this article and approved the final version of the manuscript. HW was involved in data collection, conducted literature searches, completed data analyses and interpretation, and wrote the paper. EM was responsible for the sub-study concept and design, purposive recruitment strategies, data collection, data analysis and interpretation, and manuscript revision. SB was responsible for the study concept and design, data analysis and interpretation, and co-wrote the paper.

Declaration of Interest: The authors report no declarations of interest. This work was supported by grants from The National Health and Medical Research Council (NHMRC), the William Buckland Foundation, and the Victorian Government’s Operational Infrastructure Support Program. The National Health and Medical Research Council (NHMRC) funded the establishment of the cohort with a 5 year epidemiology grant (2002–2006). SB held an NHMRC Career Development Award (2008–2011) and currently holds an ARC Future Fellowship (2012–2015). The funding organizations had no involvement in the conduct of the study, and the authors are independent of the funding sources. All authors had full access to the study data and were responsible for the decision to submit the paper for publication. The Sexual Health sub-study was approved by the La Trobe University Human Research Ethics Committee. Written informed consent was obtained from all participants.

References

15. Guendouzi J. I feel quite organized this morning”: how mothering is achieved through talk. Sexual Evol Gend 2005;7:17–35.

Current knowledge on the subject

• Limited attention has been given to the social challenges women face following pregnancy and childbirth
• Navigating changes to intimate relationships after pregnancy and childbirth is a significant challenge faced by women
• Women's voices remain relatively absent in the literature around sex and sexuality after childbirth

What this study adds

• Extreme tiredness and dramatic lifestyle changes appear to be the most significant challenges posed to sexual and intimate relationships after birth
• Women who experience a loss of libido after childbirth may be vulnerable to feelings of “guilt” or “failure” linked with high expectations
• Finding ways to stay connected, either through sex, teamwork or quality time together can help couples make the transition to parenthood more smoothly

Journal of Psychosomatic Obstetrics & Gynecology
## Bilag 9: Tematisering af studierne

<table>
<thead>
<tr>
<th>Studie</th>
<th>Tema</th>
<th>Analyseafsnit</th>
<th>Overordnet hovedtema</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Olsson et al., 2005</strong></td>
<td>Nærhed i stedet for sex</td>
<td>Seksualitetens nye udtryk</td>
<td>Hvordan oplever henholdsvis den nybagte mor og far deres parforhold efter fødslen</td>
</tr>
<tr>
<td></td>
<td>Fysiske ændringer</td>
<td>Kropsforandringer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tabu at tale om sex, lyver for partner</td>
<td>Parforholdets roller</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Søvn i stedet for sex</td>
<td>Træthed og prioritering</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tilknytning med barnet står i vejen for intimitet med partner</td>
<td>Bekræftelse fra partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mangler kommunikation</td>
<td>Kommunikation</td>
<td>Hvordan kan jordemoderen vejlede parret?</td>
</tr>
<tr>
<td></td>
<td>Bristninger, tale om følser</td>
<td>Bekræftelse fra sundhedsprofessionelle</td>
<td></td>
</tr>
<tr>
<td><strong>Woolhouse et al., 2012</strong></td>
<td>Samarbejde</td>
<td>Kommunikation</td>
<td>Hvordan kan jordemoderen vejlede parret?</td>
</tr>
<tr>
<td></td>
<td>For træt til sex</td>
<td>Træthed og prioritering</td>
<td>Hvordan oplever henholdsvis den nybagte mor og far deres parforhold efter fødslen</td>
</tr>
<tr>
<td></td>
<td>Stereotype kønsroller</td>
<td>Parforholdets roller</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ændret selvbilledet</td>
<td>Kropsforandringer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Føler sig ikke tiltrækkende</td>
<td>Kropsforandringer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alenetid uden børn</td>
<td>Træthed og prioritering</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Barnet fylde</td>
<td>Bekræftelse fra partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Høje forventninger til sig selv</td>
<td>Parforholdets roller</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ændring i intimitet</td>
<td>Seksualitetens nye udtryk</td>
<td></td>
</tr>
<tr>
<td><strong>MacAdam et al., 2011</strong></td>
<td>En ny form for nærhed</td>
<td>Seksualitetens nye udtryk</td>
<td>Hvordan oplever henholdsvis den nybagte mor og far deres parforhold efter fødslen</td>
</tr>
<tr>
<td></td>
<td>Barnet i vejen</td>
<td>Bekræftelse fra partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oplevelse af seksualitet afhængig af partner</td>
<td>Bekræftelse fra partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manglende privatliv</td>
<td>Træthed og prioritering</td>
<td></td>
</tr>
<tr>
<td></td>
<td>De små ting i hverdagen betyder mere</td>
<td>Seksualitetens nye udtryk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kommunikation vigtig</td>
<td>Kommunikation</td>
<td>Hvordan kan jordemoderen vejlede parret?</td>
</tr>
<tr>
<td><strong>Olsson et al., 2010</strong></td>
<td>Nærhed vigtigere end sex</td>
<td>Seksualitetens nye udtryk</td>
<td>Hvordan oplever henholdsvis den nybagte mor og far deres parforhold efter fødslen</td>
</tr>
<tr>
<td></td>
<td>Overraskede over hvor lang tid det tager at vende tilbage til normalt</td>
<td>Parforholdets roller</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Konkurrence med barnet</td>
<td>Bekræftelse fra partner</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bryster kun til amning</td>
<td>Kropsforandringer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stereotyper &gt;&gt; personlig seksualitet</td>
<td>Parforholdets roller</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Andre behov</td>
<td>Prioritering og træthed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Samarbejde</td>
<td>Kommunikation</td>
<td>Hvordan kan jordemoderen vejlede parret?</td>
</tr>
<tr>
<td></td>
<td>Postpartum besøg</td>
<td>Bekræftelse fra sundhedsprofessionelle</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ikke søgt information hos jordemoderen</td>
<td>Kommunikation</td>
<td></td>
</tr>
</tbody>
</table>
Figure 2. Application of the P-LI-SS-IT model.